NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
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2:00 am ET

Woman: Hello?

Mark Huang: Hi. Mark Huang.

Woman: Oh.

Woman: Hello?

Constance Anderson: Connie Anderson.

Elizabeth Rubinstein: Beth Rubinstein.

Sue Sheridan: Sue Sheridan.

Man: Hello? Shoot.

Woman: Hello?

Woman: You know, I think…

Operator: Self-conferencing is no longer active.

Woman: What does that mean?

Eddie Machado: Hi. This is Eddie Machado.

Heather Smith: Hi. This is Heather Smith.

Man: Hello?

Woman: Hello.

Allen Frommelt: Hi. This is Allen Frommelt.

Madison Jung: Hi, everybody. This is Madison Jung, Project Manager with NQF. We're going to go ahead and get started in just a few minutes but please sit tight for now.

Hi, everybody. My name is Madison Jung, Project Manager with National Quality Forum. I think we're ready to go ahead and started.

Thank you, everybody, for joining us today for the first meeting for the Measure Feedback Loop Committee. During today's call, we'll be viewing introductions, reviewing - giving a project overview, giving a background on NQF and then dive in directly into our first deliverable and discussing our first deliverable, the environmental scan.

So just to start introductions, introducing ourselves, as I said, my name is Madison Jung. I'll be the project manager. I've been at NQF for just over

two years now and have had experience with our consensus development process, our measure applications partner work and along with several other framework projects which we'll discuss the differences today.

I'll turn it over to my colleague, Elisa Munthali, for a quick intro.

Elisa Munthali: Hello, everyone. My name is Elisa Munthali. I want to thank you for being on this committee and welcome you to this Webinar. I've been at NQF for about nine years and I oversee our measure endorsement process, our MEP process, and virtual meeting today and frameworks. And so thanks again and I hope we have a good meeting.

Madison Jung: The next person listed on the slide is not here. She'll be returning at the beginning of the month but her name is Kate McQueston and she'll be the senior project manager on this work.

Jean-Luc Tilly: And, hi, my name is Jean-Luc Tilly. I'm another senior project manager on this work. I've been at NQF for about 3-1/2 years and I've worked on a few different projects that are like these strategic group projects, you know, most recently a couple around emergency medicine, trauma outcomes and chief complaints. So I'm excited to work on this.

Navya Kumar: Hello. My name is Navya Kumar. I'm the project analyst on this project. I'm much newer to this company. I'm five months in now. I'm also working on the healthcare system readiness framework, as well as the CDP perinatal and women's health.

Madison Jung: And then also on the line we have a new team member so new that we didn't have time to add him to the slide. He'll be your senior director on this work, Allen Frommelt.

Allen, are you available to give a quick intro?

Okay. Looks like not but you will certainly be hearing from him on the future Web meetings.

So that was the intro of project staff. The next individuals - group of individuals we want to introduce are federal liaisons. This work for this committee is funded through NQF contract with CMS and HHS. In our federal liaisons, we have (Maria Dura), Sophia Chan, (Patrick Wynn) and (Melissa Evans). Is there anyone from CMS on the line available to introduce themselves?

Sophia Chan: Hi. This is Sophia Chan. I am the CMS official who oversees the IDIQ with NQF. Thank you so much for supporting this task and I look forward to hearing the discussion.

Madison Jung: Great. Thank you, Sophia. Any other colleagues from CMS available? Okay.

Allen Frommelt: This is Allen. I'm sorry. I think I got disconnected.

Madison Jung: That's all right. Hi, Allen. Did you just want to introduce yourself quickly to the committee?

Allen Frommelt: Sure. I'm probably the newest person to the team. My name is Allen Frommelt and I just started about two weeks ago.

Madison Jung: Great. Thank you so much.

So the next group of individuals we'll be introducing is the committee. We have Rose Baez and Eddie Machado as - serving as our co-chairs, as well as 19 other committee members. And we thank you again for your commitment to this work and your willingness to participate.

For introductions, since it's our first Web meeting, if you could all just give a brief intro, maybe two or three sentences about yourself, that would be great when we call upon you.

So we'll start off with Rose.

Rose Baez: Hi. Thank you. Hi. I'm Rose Baez. I'm happy to be co-chairing the Measure Feedback Loop Committee. I've served in leadership executive roles at both large academic and safety net health systems. Currently, I am the director of Provider Measurement Program at Blue Cross Blue Shield Association. I think this project is invaluable to the - to health gains further understanding of how the use of measures affects patient care organizations and providers that implement them.

Also recognizing that measures are used in pay-for-performance, public reporting and other accountability programs. I'm looking forward to this project impacting more timely and comprehensive feedback about measures from the field. So thank you.

Navya Kumar: Eddie Machado?

Eddie Machado: Sure. Hi. Good afternoon, everyone. My name is Eddie Machado. I'm a Chief Strategy Officer at IPRO. And likewise, as was mentioned, I'm very happy to be co-chairing this committee and very interested in hearing the discussion. I think this topic is one of critical importance of moving forward

in trying to identify measure - meaningful measures because I think a lot of meaningfulness really is derived by the end-users which I think this project really will help elevate their voice as part of the process. And so I'm an internal medicine physician by training and just look forward to the discussion today.

Navya Kumar: Thank you. Constance Anderson?

Constance Anderson: Yes, hi. This is Connie Anderson. And I am the Americas Vice President of Clinical Operations from the Northwest Kidney Centers here in Seattle. I serve on the NQF in various capacities for many years but I - starting with the CAT panels and now currently I co-chair the End-stage Renal Disease Standing Committee that reviews renal measures for quality. Part of my job is the vice president of Clinical Operations at the Kidney Center which I oversee quality outcomes.

And so very interested in the discussions in terms of the measure feedback and where we're going with this because the Renal Standing Committee, I think, will - this will be very helpful as we provide feedback to the developers.

Navya Kumar: Thank you. Robert Centor? Elvia Chavarria?

Elvia Chavarria: Hi. This is Elvia Chavarria. I'm with the PCPI, the Measure Development Organization. Originally, we were part of the American Medical Association but as we grew, we spun off on our own. And, as I mentioned, we're still here in Chicago.

We've been developing measures for good 19 years and while we have within our process ways to receive feedback in the measure development of the process, I should say, I think our interest is also to - and very much included

within the scope of this project to get that feedback from those who implement the measure so that in the circular process, we actually receive that feedback and improve our measures, whether it's the evidence that goes behind in supporting the measures or to implement the measures in a more practical way so that it's easier to implement and they represent minimized burden to those physicians and to those other providers who report on our measures.

Navya Kumar: Thank you. (Dan Colica)?

(Dan Colica): Good morning, everyone. Can you hear me?

Navya Kumar: Yes, we can hear you.

(Dan Colica): Excellent. Where should I start? Currently, I'm with the Medicaid Program within the Health and Human Services Commission, working for the state of Texas. And I have been involved in quality measurement for the last eight years as the state has developed 1115 waiver. And now in the quality oversight unit, I'm mostly working on the development of alternative payment models within the value-based payment reform that is also focusing on a series of quality measures.

As previous experience, I have been part of another committee at the NQF for, you know, (unintelligible) the program specifically for developing the quality measures for the beneficiaries with high needs and high cost. And as a background, I am health services researcher, focusing on outcomes research and also a clinician, (cardiovascular) surgeon.

Navya Kumar: Thank you. Robert Centor, are you able to speak now? Okay, we'll try again at the end of the call.

Melody Danko-Holsomback?

Melody Danko-Holsomback: Hi, yes, Melody Danko-Holsomback. I am representing NAACOS, National Association of ACOs. I am currently the director of operations for Keystone Accountable Care Organization out of Danville, Pennsylvania, representing an organization that has eight major organizations, including three systems that include hospitals.

I have been responsible for reporting quality metrics for our ACO for the past six years and have had positions as an LTN and an RN in the IT department as well, developing IT templates for our providers and also have worked on our quality committee and integrating multiple systems within the ACO into one platform.

So a little bit of IT nursing and I just graduated with my master's in nursing for nurse practitioner. So I have a little bit of background for providers as well.

Navya Kumar: Thank you. Anne Deutsch?

Anne Deutsch: Yes, hi. Anne here and I'm registered nurse by training, have a PhD in epidemiology. I'm a measure developer with RTI International and also have a faculty appointment at Northwestern University as the research associate professor in the Department of Physical Medicine Rehabilitation and I work as a researcher at Shirley Ryan AbilityLab. Really appreciate the opportunity to be on this project as I think this measure feedback loop is critically important. So thank you.

Navya Kumar: Thank you. Tricia Elliott?

Tricia Elliott: Good afternoon. This is Tricia Elliott. And I have the honor of sitting in the room with the NQF folks today. I happen to be here for another meeting. I work at the Joint Commission and oversee the measure development process. And I've been in that role for a little over three years now and we're really excited for this aspect of measurement and getting involved in evaluating the feedback process. So thank you.

Navya Kumar: Thank you. (Lee Fizer) wasn't able to attend today's meeting. So Mark Huang?

Mark Huang: Yes, hi, Mark Huang. I'm the Chief Medical Information Officer at the Shirley Ryan AbilityLab. My specialty is physical medicine and rehab. So, obviously, we have a great interest in sort of specialty specific or measures that are more relevant to what specialists need to do on a day-to-day basis and reflect what they do in their care.

I was also involved with the CMS macro measure development plan for 2018 and we're still meeting for that. I was very excited by being on that type of expert panel and grateful to be part of this processes more to back-end in terms of, like, looking at existing measures and making sure that they're appropriate and meaningful and, like it said in the introduction, it's making sure there's no unanticipated consequences or potentially extra burden in reporting when performing these measures. And then more importantly, really having the measures measure what people are really doing in day-to-day care.

Navya Kumar: Thank you. Joseph Kunisch?

Joseph Kunisch: Hi. My name is Joe Kunisch. I'm a system director for clinical quality informatics at Memorial Hermann Health where I have large healthcare system in the southeast part of Texas. And by background, I've been a critical care nurse and then went into clinical informatics and gravitated over into the quality domain.

My relevant experience I've been involved with multiple quality measure testing activities with CMS Joint Commission, worked with some of the people actually on this committee on those activities and also involved sitting on multiple committees in giving quality measure developers feedback and also EHR vendors and the regulatory agency. Thank you.

Navya Kumar: Thank you. Claire Noel Miller?

Claire Noel Miller: Yes. Hi, everybody. This is Claire Noel Miller. I am a senior strategic policy advisor at AARP's Public Policy Institute and we're located in Washington, DC.

My work focuses primarily on Medicare and Medicare Advantage enrollees. I do a lot of quantitative work sort of trying to put some numbers on the implications of some of the policies that are being proposed for older adults in particular. And I'm really excited to be on this committee.

I think, you know, this is an opportunity to make sure that we develop measures that are not only appropriate but also meaningful for consumers. So very much looking forward to this work.

Navya Kumar: Thank you. Ekta Punwani?

Ekta Punwani: Thank you. This is Ekta. I'm really happy to be part of this team. My - I have actually, in the last year, joined IBM Watson Health. I am leading the 100 Top program which is really a benchmarking leadership tool program that takes Medicare data and allows organizations to better understand where they fit in the spectrum in the nation and where there are opportunities to improve.

For the last 20 years before that, though, I worked really within hospitals and health systems, leading quality performance improvement and analytics. So really driving the change with an organization using a lot of the measures that are developed both within organizations and publicly. So very excited to be part of the team that can really, again, deliver relevant information back to both organizations so that they can help improve the industry but also to consumers.

Navya Kumar: Thank you. (Karin Ruben) wasn't able to make it to today's meeting. Elizabeth Rubinstein?

Elizabeth Rubinstein: Hello, Beth Rubinstein. Thank you. I'm very honored to be a participant in this esteemed group. Humbled, actually.

I am a patient advisor. I have served as a patient advisor for Henry Ford Health System. I am starting in the patient advisor work ten years ago, growing personal experience in the transmit recipient of 11 years. And to my experience, we developed a patient engaged lifestyle education program within the ambulatory and IPD clinic.

I just retired from that position as administrator after having (unintelligible) for 11 years now. I serve as a patient advisor on a national basis with the UNOS Patient Affairs Committee and the Ad Hoc Systems Committee.

I serve also as a participant advisor on governance and participant relations with the tech consortium with the All of Us NIH program. And on a state level, I serve as the co-chair with the Michigan Hospital Association Patient Affairs Council. I'm looking forward to working with this group. I'm new to National Quality Forum and look for a learning opportunity as well. My goal is to help facilitate the patient engaged voice into our healthcare system throughout and make sure that we have that voice.

Our group has been a recipient of the PCORI Grant Tier 1 and Tier 2. And we have served as a presenter at their conferences. Again, thank you for the privilege of participating in this committee.

Navya Kumar: Thank you.

Woman: It looks like the price has also caught a really tough…

Madison Jung: So to give - let's pause here perhaps first and best housekeeping - or housekeeping practices. If everybody who's not speaking could mute their line either via their handset or by pressing star 6, that would be great. Thank you.

Navya Kumar: Okay. Sue Sheridan?

Sue Sheridan: Hi. I'm Sue Sheridan. I currently am the director of patient engagement at the Society to Improve Diagnosis in Medicine. So it's a nonprofit, dedicated solely to improving the accuracy and timing of diagnosis.

Prior to that, I was at CMS as their advisor to patient family engagement. And this is when meaningful measures, the concept of meaningful measures was born by the administrator.

Prior to that, I was the director of patient engagement at PCORI. So I'm delighted to hear that we have some pipeline recipients, the Tier 1 and Tier 2, on the phone. And I was with PCORI for five years. And what, you know, to tie to that, it was fascinating watching our research partnered with patients who are helping determine and how to measure outcomes that mattered most to them. And so that flows very nicely into outcomes at NQF and what we're going to be talking about.

I agree that in the conversation about outcomes and, you know, ensuring the closing of that loop, making sure those outcomes indeed are meaningful, especially to the end-user, and I participated on the NQF Incubator when we brought some patients into that domain.

My succession, I'm an international trade finance banker but my life changed 23 years ago when my son, (Cal), suffered brain damage from his newborn jaundice. So I witnessed the significant medical error. And four years later, my husband had died when his malignant pathology got lost in the system and the healthcare system couldn't save his life six months later after he recognized the error. So I bring the patient voice to this regarding meaningful measures, regarding keeping people safe and getting quality care.

Navya Kumar: Thank you. Jill Shoemaker?

Jill Shoemaker: Hi. I'm Jill Shoemaker and I am the clinician measure director at the American Board of Family Medicine. I work at the Center for Professionalism and Value in Healthcare here in Washington DC. And my role at ABFM is to ensure that the needs of the primary care providers and other stakeholders within our prime registry, which are clinicians, our clinical researchers, the population health assessment folks and then clinical quality

performance improvement colleagues that their clinical quality measure needs are satisfied in their strategic plans and their usage for the measures are indeed cared for through the prime registry.

And I'm just thrilled to be here. I recognize several that are on this committee and listening to everyone's background, it's such a great group and diverse and I really look forward to serving with you guys.

Navya Kumar: Thank you. Heather Smith?

Heather Smith: Hi. This is Heather. I currently serve as the director of quality for the American Physical Therapy Association. Before switching over to my role in quality, I practiced for many years as a physical therapist and then a little over ten years ago moved into the quality world, first in healthcare systems, working on quality improvement and reporting efforts and then later into my role here at the association and have worked on a number of measure development efforts.

I know several people on the panel. And I'm just really excited and appreciative of being appointed to do this really important work of really trying to look at the loop as we think about measures once they're in the quality environment.

Navya Kumar: Thank you. Deborah Struth?

Deborah Struth: Hi. This is Deb Struth. I'm a research associate with the Oncology Nursing Society. And in my 4-1/2 years with ONS, I have maintained our clinical data registry and our qualified clinical data registry. We have been - had a key CDR since 2014 when we were involved in a PQRS program and we are approved for our third year in the MIPS program.

We have a portfolio of custom measures that are patient-centered and symptom-focused and five of those are proof for 2019. So measure development is - has been a large part of my work. In fact, three of those measures were developed over the past year and a half and then we worked with the PCPI. I have experienced working with them to codify and have the measures that we developed.

In addition, I worked - I had a team that looks at - specifically I'm interested in implementation science or those interventions that help facilitate the uptake as evidence into practice and then on the back-end, can we measure that practice change on the measures that we have out there and we have completed our first pilot study of work with community cancer center and we will be scaling up that work also. But that is where I sit within ONS and ONS's contribution to measurement at this point.

Navya Kumar: Thank you. Sara Toomey?

Sara Toomey: Hi. I'm Sara Toomey. I am a general academic pediatrician here at Boston Children's and I have a couple of different hats. I am the PI in the center of excellence for pediatric quality measurement which is funded through ARC and CMS through the Pediatric Quality Measures Program.

Through that program, we've developed - gone through the NQF measure development process and have had, I'm happy to say, five successful measures. And in addition to that, we are now doing a lot more work not only in measure development but also thinking about how from pediatric measures (unintelligible) states should be thinking about reporting and how we can sort of leverage a different level of measurement to drive change.

In addition to that, I'm also Chief Experience Officer for Boston Children's. In that role, I oversee all the measurements and improvement efforts around patient experience and growing into a modest staff engagement also to which I should also say we also have national collaboratives at times I'm currently the chair of for which we - of 20, 25 hospitals come together once again to try to see if we can do a better job in not only measuring patient experience but also sort of improving and learning from one another.

So I'm really excited to be here. I think it really is important as many people had said around closing the loop and making sure that what we are doing in regards to measurement is meaningful not only for those of us as providers, for those of us as measure developers but also those of us for whom we have the consumers, the patients and family, who use this system.

And I'm happy to be one of the people for whom - focused on kids and it seems like there's only a couple of us on the group. So I'm really looking forward to learning from all of you and I think it'd be a great move. So thank you.

Navya Kumar: Thank you. We just have one more who will hopefully be able to speak. Robert Centor?

Robert Centor: Yes. Can you hear me now?

Navya Kumar: Yes, we can hear you.

Robert Centor: Great. I'm Bob Centor. I'm an academic general internist of the University of Alabama at Birmingham and a member of the Performance Measurement Committee at the American College of Physicians.

I have great interest in performance measures that do harm. I'm very concerned that performance measures get accepted by CMS prior to showing that they do good, whereas we would not do that with medication. I'm really glad that we're looking at measure feedback but I wonder if it's too late. We have too many measures that have done harm to patients and we need to be very careful that a measure doesn't have unintended side effects.

It's very nice that we're looking at them in the feedback loop but I certainly wish we were doing it ahead of time.

Navya Kumar: Okay, thank you. I'll give it back to Madison for the overview of NQF.

Madison Jung: Great. Thank you, everybody, for those opening introductions.

Certainly, feeling very fortunate to have people with such varied experience but, nonetheless, everyone with impressive background. So really looking forward to diving in to those works with you all.

Next, I'll just review our agenda for the rest of the meeting. So we've gone over introduction. I'll be doing a brief introduction of NQF background, giving a project overview, then we will dive in, as I said before, our first deliverable which is introducing our environmental scan, and then we'll open it up for committee discussion about our findings to date, and then we will close out the meeting with a quick overview of SharePoint and its capabilities and then having a opportunity for public comments and then quickly reviewing that. That will be the agenda for our meeting today.

So to give a brief introduction about NQF, NQF was established in 1999 as a nonprofit, nonpartisan, membership-based organization that brings together public and private sector stakeholders to reach consensus on healthcare

performance measurement. Our goal is to make healthcare in the US better, safer and more affordable.

This mission is accomplished through several streams. As you can see on this slide, we have board of directors, standing committee members, but we have our measures application partnership groups, national quality partners, as well as several standing committees on several clinical areas.

To give an example of what some of the work that NQF does, listed on this slide are our activities and our multiple measurement areas. Perhaps the most familiar people are with is our performance measurement work or consensus development work or CDP process. NQF has over 600 endorsed measures across multiple clinical areas and endorsing those measures are 15 committee members - or 15 committee panelists - expert committee panelists formed to weigh in on those and help us get to that place.

The other stream of work we have is our measure applications partnership or MAP work. We advise HHS on selecting measures for over 20 federal programs, Medicaid and health exchanges.

Another stream of work we do is our national quality partners. This work we convene stakeholders around critical health and healthcare topics and form action committees on areas, such as patient safety, early directed deliveries and other issues.

And the final stream of work we have outlined here is our measurement science work which this project would actually fall under. This work we convene private and public sector leaders to reach consensus on complex issues in healthcare performance measurement, such as measure feedback, attribution alignment, sociodemographic status adjustment.

So that gives you an idea of the work that NQF has and conduct.

To get into the roles of - to get into describing the roles of individuals working on this project, we have outlined here the roles and expectations of committee members and co-chairs. We ask that you serve as experts, working with NQF staff to achieve the goals of the project. You engage in us via meeting discussions and help provide feedback on project deliverables.

Of note, the co-chairs do have some additional responsibilities. They are designated as group leaders of this committee to assist us in facilitating these meetings and helping us get to consensus on this decision and recommendation for our project.

We ask that co-chairs also help keep the committee on track to meeting project goals without hindering critical discussion input. We also ask that they assist NQF staff in identifying key issues for committee discussion.

Certainly, we won't - for this meeting, we won't hear much from Eddie and Rose. We do look forward to having them help us weigh in and help facilitate future meetings.

To go over the role of the NQF project staff, so our role is to help the committee achieve the goals of this project. So to do, we help organize meetings, these conference calls. We do the communications among all project participants, committee members, public, federal liaisons and one who would like to engage in our work.

We facilitate the communication, as I said, with external stakeholders and into project members. We respond to comments in those public members. We

maintain the documentation of the project activity. And perhaps the main role is we draft and edit the reports and project materials and publish the final project report that will come out of - as a result of this work together.

And then stakeholder we would like to acknowledge their NQF members in the public at large. NQF membership in the public is welcome to engage in this work by reviewing the draft report and - reports and providing feedback to NQF and the committee through public commenting periods, as well as participating in these Web meetings and making comments during the opportunities for public comments. All these Web meetings are open and available to the public.

So I'll keep on moving and get into our overview of our project. So the objective of this project, there are 12 months remaining in this - or, I'm sorry, 15 months? Fifteen months remaining in this project. Our objective is to understand how measure actually performs when in use and what the possible issues or risks are that may be associated with measure implementation.

These efforts will help address whether the measure is having its intended effects on improving quality of care and health outcomes and what unintended consequences are, if any, for the use of the measure. So we are looking to develop a feedback loop as it relates to these CDP process and CMS measures - performance measures.

A few definitions that we would like to clarify upfront to make sure that we're all in the same page about the scoping of this work is feedback loop. As mentioned, the feedback loop refers to the process by which feedback from the measure is relayed back to the multi-stakeholder standing committee members who recommend the measure to be re-endorsed or endorsed or selected for program use.

In previous CDP work, I'm sure we have several committee members here that are familiar. Often, we hear that there is a need to get additional information on how measures are performing after they're endorsed and when they're coming back for re-endorsement.

The next definition we would like to review is feedback, so how are we defining feedback. And for this project, we're referring to feedback as information about measure performance that could be based on quantitative data or qualitative information. And later in this meeting, we'll go through a few examples of that.

So the deliverables for this project are to convene multi-stakeholder standing committee which we have done by virtue of you all being here today. And then we have been charged to develop four documents or four reports. Those four documents are an environmental scan report, a CDP usability document, developing a paper that outlines several options for piloting this measure feedback loop, and then developing a plan to potentially implement one of the options that we have developed.

This work will be conducted over nine Web meetings. As you can see here, this is just - this is posted on our Web site and should be on your calendars as well a schedule of the meetings and their objectives for the upcoming year.

To go into detail of what these deliverables entail, so as I said, there's the environmental scan report and CDP usability document, options for piloting and the implementation plan. The first two deliverables, environmental scan and CDP usability document, can really be seen as documents to lay the foundation and lay the groundwork on information on what data and what

information is available in the field to influence the committee and NQF staff developing these - the latter two deliverables.

Today, we will be diving in to the environment scan report and the main goal of that is to provide a current and comprehensive view of what data information is currently available and how often updates are made.

So I will pause here for any questions about the project, the overall scope, the deliverables or just the scheduling of how things would happen. Please feel free to either unmute yourselves and speak freely for committee members or to send something in via the chat box function.

Great. Hearing no questions then, we will move right into the introduction to the environment scan report which is our first deliverable. So I'll turn it over to Jean-Luc.

Jean-Luc Tilly: Great. Thanks, Madison.

Yes. So, briefly, the environmental scan is the first deliverable. We're really hoping that - our goal here is to do the background work that we think will inform really the (unintelligible) report. So it's a very foundational work.

We need that background to help give us the information we need to - as we design a new feedback loop process. So that includes, you know, what kind of sources we can draw in terms of measure feedback, you know, be that sources of measure performance, sources of feedback from clinicians and others being measured, examples of other feedback loops that are in progress or some implemented or even parts of different feedback loops and just certainly to try and get a strong assessment of the kind of information that would be helpful to the CDP.

The consensus development process here in NQF as we evaluate measures for endorsement as part of our maintenance process which is to say after - three years after measure has been initially endorsed, when it's resubmitted to NQF for evaluation, there are, you know, some new questions and new requirements around, you know, is the measure in use, what are individuals saying about the measure and we want to be sure that we're asking the right questions to get the information we need to the same committee that they can make a good decision about whether or not to continue endorsement of it.

So the timing of this report we'll just quickly review that before we get into specifics. So the - actually, in just about a month in our second Web meeting, at that point, we'll review our progress to date on sort of the literature pieces of that, as well as some of the key informant interviews we'll start to do.

And during that Web meeting, we'll have an opportunity for kind of a full discussion on our findings to date. You know, hopefully, we'll have relatively huge steps. But we'll use the opportunity after that Web meeting before the report is released for public comment to kind of make any revisions.

We'll then pose a first chapter report for public comment and circulate it to all of you, aggregate all that feedback together at the conclusion of the public comment period on March 25, you know, make any final changes to that, continue to, you know, investigate any sources we may have missed and then finally to submit a final report to CMS on April 12.

But then, you know, as I said, use the findings in that report to inform the subsequent report. So you'll see probably a lot of references and callbacks after this initial environmental scan.

So our research question, I mean, this gets back to our purpose but, basically, we want to get an idea of what existing feedback loops are out there, you know, what data elements are prioritized by those collecting and using measure feedback and even what else under the kind of (unintelligible) go into these feedback loops. So, how is the information being displayed and shared, how it's being collected, you know, is it passive as in there's opportunities for individuals to submit feedback or is it active or are they using survey questions or, you know, process of, like, (unintelligible) process to get an idea of implementation.

You know, what kinds of questions are they using to prompt responses, what kind of elements they're looking for. And we'll use that information, put it together to, you know, to inform eventually the desired feedback loop.

So we'll quickly get into a couple of different kinds of data we're looking for. So certainly, some data what we're thinking as kind of the quantitative sources. So these aren't - and this is necessarily quantitative data work like in ourselves but kind of an itemization or catalog of sources of performance measure data or looking at quantitative-oriented sources of feedback.

You know, we're looking, of course, very diverse set of feedback loops or single feedback mechanisms and there's thing that every organization has a distinct approach to collecting and using feedback. We wanted to make sure we have a lot of different perspectives represented there, so when we arrive at a consensus, we're being as fair as possible.

On the next slide, we've got just some examples of some of the data elements we might be looking for. So what are the sources of this data, you know, and what level of analysis is it, you know, and then some of the, again, mechanical things, you know, what's the cost, what's the schedule for release and so on.

The qualitative sources will probably form maybe the bulk of the environmental scan report. This is what we're looking at journal, clear literature publications and this could be anything from, you know, a detailed published implementation overview where maybe a measure dashboard was created and used in a hospital or other facility and they survey clinicians to get an idea of how the implementation went. You know, it could be just an editorial in health affairs - particular measure we're interested and just kind of all that.

You know, a lot of documentation about NQF processes. So, you know, NQF has a kind of feedback tool already. So I want to review the inputs from those, you know, as well as whenever measures are resubmitted for the maintenance process every three years, they fill up a section called The Use and Usability of the Measure. This has a lot of prompting questions that get a lot of the same feedback contents we're talking about today. So, you know, we want to see what's being submitted there, you know, is that information useful and helpful to assess when measures are meeting the terms of that criteria.

And then finally, just, you know, looking for other sources of feedback that's going to measure developers or find measure developers, so - or just using measures. So, you know, for example, as part of the annual rulemaking process, there are many hundreds of comments that are submitted on the re-measure, comments submitted to the measure applications partnership, sending it to meeting today. You know, there are helpdesks reports as part of the implementation process for these measures. You know, there's a real wealth of information there.

And then really finally, the key informant interviews that we'll be conducting, we'll go into those a little bit later. But, you know, the idea there is it's kind of another qualitative source to get at what, you know, what we expect and what we found so far has been relatively scanned information available in the literature.

So the list of terms, I mean, these are fairly broad terms. You know, obviously, performance measure results in quite a few hits. Our goal is to cast a wide net and to eventually tease out these articles that cover, you know, the formal and informal processes that collect these performance measures. So, you know, there, you have terms oriented towards the clinician experience like, you know, burden, burnout, clinician satisfaction, but also, you know, more general terms like data collection, quality improvement or even dashboard to kind of get an idea of what tools are being used to show performance measure and how those are being used by clinicians.

Of course, this, as we said, a - an initial list of terms. We're definitely looking forward to seeing other suggestions from you either on this call or, of course, by e-mail follow-up.

And then the key informant interview, so, yes, as we progress this project, this is pretty typical, a strategic way from projects in NQF. You know, we don't always find everything we need in the literature. You know, if we would, there probably wouldn't be a project to run. So, you know, our expectation is that we'll have to go and collect a lot of the kinds of very specific information we need for this project and, obviously, to, you know, to supplement the environmental scan.

So, you know, you got some example questions up on the slide there but really we want to capture, you know, the best practices in three kind of key areas.

So, you know, how are they collecting feedback, what kinds of feedback they're collecting and also, you know, what are they doing with it, how are they using it. These key informant interviews generally we'll conduct in early through, so pretty soon. So we'll support any suggestions you have.

In terms of the true key informant interviews are, so, I mean, there, we're looking, you know, against a fairly broad perspective. So, you know, registry leaders, other implementation leaders, you know, clinicians themselves, you know, those being measured, measure developers certainly although we have several ones in our committee.

And also, you know, where we see that in the literature we hope to capture a particular perspective of, you know, rural health example is really important to us and is not necessarily as well represented in the literature. So we'll kind of target some key areas there.

So I think with that, we can turn it back over to Rose and Eddie to kick off any discussion of our…

Madison Jung: Great. And then this is Madison. Just before we dive in to any discussion, so really what we presented you here today is our initial task and our initial work on how to answer the question laid out in front of us. Again, the question being we're looking for sources for both quantitative and qualitative feedback.

So what we'd like your feedback today on is just your thoughts on our search strategy, if there are other sources that you think that we should be looking at, if there are things that you think we should be redefining in our search strategy, if you have any thoughts on key informant interviewers, thoughts on additional questions to ask these key informant, we welcome those today.

So sorry to interrupt but I'll turn it back over to Rose and Eddie for any questions.

Eddie Machado: So thanks, Madison, and, Rose, maybe I can just kick things off. And, Madison, I think you went basically through the litany of probably questions that are screening up in the committee members' mind. But, you know, it might help to just sort of take these sequentially.

So maybe if we could go back to Slide 15, I think it is, where the objective and definitions are listed. And maybe just for the group, if we can just get started maybe in getting feedback on folks' comfort level in terms of what's laid out there in terms of definitions and objective, I mean, this really forms the basis for the project moving forward and I know a lot of thoughts got into it.

So I don't know if folks have particular thoughts on the way feedback loop or feedback is defined here that they'd like to share.

Mark Huang: This is Mark Huang. You know, so one thing, you know, when we look at the objective and talking about the intended versus unintended so that when you look at the data collected, obviously, you see the data that's going to be focused on what are the intended consequences and it's much harder than from the actual measure - of the measure itself, like, where the unintended consequences occur and how do you get that information as feedback on that particular measure.

And then the other piece is really a little bit subjective in some respects but it's really the relevancy of the measure, you know, how relevant is that measure to that particular clinician and I think that's also harder to elicit from the data collected because, you know, providers will try and meet the

measure, so they're going to collect that data but that may not necessarily represent what they really, you know, value or do with a patient or with patient care for that particular provider.

((Crosstalk))

Woman: Oh. Sorry.

Sue Sheridan: This is Sue Sheridan. I have a question.

Yes, I have a question about I'm not that familiar with how feedback happens now. I'm more familiar with the beginning of the process and creating the measures. And so I'm curious as you do the literature scan and collect this information, from what avenues do we get feedback from patients or are we getting any feedback from patients regarding the measures?

Tricia Elliott: Hi. This is Trish Elliott, the joint commission. I can speak to our processes…

Sue Sheridan: Yes.

Tricia Elliott: …which are related to some more so organizationally-based measures. So, because we're the measure steward for both our own measures and measures that are embedded in the CMS program, we do have platforms that we call - we have a Wiki platform. We participate in JIRA with CMS.

So a lot of times you'll get question from the field, either organizations or clinicians, related to those measures and we kind of consider that feedback. You know, sometimes it helps us to clarify an exclusion or better defined as denominator. But we use all of that, you know, for our own internal improvement of a measure.

So I think depending on the measure developer, there's probably avenues like that available that, you know, so JIRA with CMS may be a good first place to look because that would be where folks go if they have questions in the measures that are in the CMS program. So - and JIRA is just a name for a platform for people…

Woman: Right.

Tricia Elliott: …questions and answers and everything for those that might not be familiar. So, that's kind of how we get feedback. And then we typically convene technical advisory panels in the specific specialties to give us, you know, real-time feedback there as well.

You know, is this measure still on track? Is there new literature that should influence changes to the measure? So those are the types of processes that we use.

Constance Anderson: This is Connie.

Woman: Yes, yes.

Constance Anderson: And we use very similar. Certainly within the technical expert panel, there is patient representatives that are giving their feedback in terms of the potential measure that's being presented but also…

Woman: Right.

Constance Anderson: …on our community, we also have patients representing representation on the committee. So the patient voice can be heard.

I'd like to go back a little bit to what Mark was saying in terms of the unintended consequences and how we can get feedback back to the measure developers that maybe it should be the measure doesn't really - isn't a usable measure, I guess is the better way to put it, and it's not focused at the right entity. So maybe they're focused at providers and they should be focused at clinicians or vice versa or whatever.

And I don't feel that we have a good mechanism to do that. And so when I was reading and I just sat here and reread the objective again, it's improving the quality of care and health outcomes but it's got - the measure has to be focused at the right audience that can improve the quality and the health outcomes and many times the measures aren't focused in the right direction and that leads to these unintended consequences.

So I'm somewhat echoing what Mark is saying that I think this is really part of a key focus of the measure feedback loop is how do you identify upfront that maybe the measure isn't focused in the right direction and what those unintended consequences are going to be because there have been significant ones in - at least I'll speak to the renal field where - and I can relate it to the access, the ADF, arterial fistulas and catheters never and no one recognized the graph where this is good.

So you have all these people going for vein mapping that are never going to have an AD fistula. This is not going to happen. And that became an unintended consequence of that measure in the way the measure was written.

So I'm really interested in - I think that objective, and how it is stated, is a very, very important language and how we are going to identify whether the measure is correctly focused and what those unintended consequences are.

((Crosstalk))

Jill Shoemaker: This is Jill. I just wanted to make one comment about the feedback. I want to make sure that we're also including feedback on implementing the measure, so especially our ECQM, and that we're receiving feedback from those end-users on is it impacting clinicians' workflows, is it impacting any EHR electronic processes.

I think all of that feedback on the implementation of the measure is really good to understand because there may be times that those unintended consequences where the burden of implementation is really greater than the measure - the output of the measure itself.

Robert Centor: This is Bob Centor. There's a very nuance, complex problem. As some of you know and some of you don't know, the American College of Physicians Performance Measurement Committee gets performance measures that CMS is considering from NQF and other performance measure organizations and we evaluate them.

And we had a paper in the New England Journal of Medicine about how many of these performance measures. Before it was ever implemented, we could predict the unintended consequences. And it was very large number. It did not seem to influence CMS and whether they're going to accept those as performance measures which disappointed us greatly.

There are several different things that we - that I would suggest we do ahead of time. We really ought to look at performance measures that have caused significant unintended consequences -- there are quite a few that are reported in the literature -- and see what's common about those that will help us

understand how to do this prospectively as well as retrospectively. If we don't take advantage of the history of bad measures, they're not really bad measures but measures that do - don't do what they're intended to do.

The other thing we have to worry about is measurement overload and how that affects the doctor-patient relationship from the patient's point of view. So trying to figure out how to do that -- and I was very glad that our patient representative mentioned this -- when I talk to physicians who feel overwhelmed with performance measures and clicking on the computer for those performance measures, it has - it can have a very negative impact on the interaction with the patient because the physician feels that he or she needs to work on the performance measure instead of listening to the patient. If that's happening, that's really a bad thing.

And so that's why this is - the idea here is really important but we really can't wait to try to figure out how to collect data without finding out what data have been shown in the past to be problematic.

Melody Danko-Holsomback: This is Melody Danko-Holsomback. I totally agree with that statement. So a lot of feedback we get from providers are on doing so many clicks and so many quality measures, things to get these measures that I don't have time to really do with what my patient is here for. So that burden is definitely out there. I think there are a lot of things - just working with the ACO and the collection, there are a lot of things that could be collected through claims data that really will need to be, you know, quite as burdensome to others.

And definitely those unintended consequences are there because, you know, the patient maybe is there because they're sick and they're not eligible for something but you have to still go in that computer and give a reason why

you're not giving, you know, the patient their pneumonia shot today or their flu shot. There's a little bit consequences where you're getting, you know, the provider to say, "I'm getting dinged for this and the patient's insurance doesn't cover it."

So all of those types of things, I think, they do become very burdensome for the providers in the office and it takes their purpose away from the patient and the reason that they're basically in the clinic, you know, unless it's for a well visit, you know, obviously, there are things that you can work into your practice as you do them. But if your patient is one of those that comes in once or twice a year and it's one that's really sick, you know, how do you manage those things without it becoming a burden on the patient and the clinician?

Eddie Machado: So this is Eddie. I think this has been a great discussion and it sounds like from the comments that have been put forth thus far that folks seem to resonate a bit with the objective and in particular the measured consequence aspect of it as it relates to whether it'd be issues around implementation or the measure focus, per se, and I think thinking a little further even trying to see if there's opportunities to gain or identify best practices on what good measures or bad measures looks like.

Given all of that, what do folks think about the search strategy the NQF team has put forth in terms of trying to help meet this objective? Do folks feel what Jean-Luc covered will allow us to get to help us address some of the issues that have been raised?

Melody Danko-Holsomback: This is Melody again. I just - I'm just trying to link it into what I am supposed to be doing. So how is my interaction with people and at what level do you want me to interact with people to get that information on how

they're feeding back now? Do I go to the front levels? Are we only working at big organizations? Are we working at the patient or the provider level?

Eddie Machado: I'll defer to the NQF staff but I would imagine that it's pretty broad at this stage. But I don't know, Madison or Jean-Luc, if you have a comment.

Jean-Luc Tilly: Yes, that's right. I think at all levels you mentioned certainly we would be interested and see that. I mean, interested of you all. So the NQF staff will be doing the bulk of kind of the searching and so on but, you know, certainly, if you have any - either people get in touch with her or people would like to talk with herself as to inform the, you know, your eventual participation in future meetings and so on, that would all be really helpful or if you ended up talking to folks and run across the different articles or other kind of published sources that we can use and incorporate into this effort, that would be, yes, just that all of the above.

Rose Baez: Hi, this is Rose. I think it was actually Bob who talked about whether to review and being able to tease out some of those unintended consequences. So I wonder if we can look at the preliminary list of terms that you have -- I think it was Slide 26 -- to see if there's other terms that would be - that's not captured here that we might want NQF team to include as part of that environmental scan. Will these terms get us to the - to those articles that talk about examples where these measures had these unintended consequences?

Claire Noel Miller: So the only - this is Claire Noel Miller. The only thing that was addressed for this list is to add some key terms that get directly to feedback loops that involve consumers and patients. We have a couple of the terms that focus on the clinician experience and I just want to make sure that, you know, at the outset we are sort of searching in a way that allows us to uncover any

feedback loops that, you know, that try to capture the patient in the consumer voice.

Eddie Machado: Thanks, Claire. That's an excellent suggestion and we'll add those terms.

Woman: And I just want to read a few comments that I have actually that Beth Rubinstein was able to chat in. She noted that patient experience is missing from the list of terms but also had noted a - another potential source of qualitative feedback being the Patient and Family Advisory Council or PFAC that has been a source for qualitative feedback, especially with focus topic areas.

An example she gave was the feedback specific to a transplant unit. She noted that patient advisors are - patient advisors embedded in business units are extremely helpful in the scope of the health system and where for the development of quality measurement.

She also noted a root cause analysis of past cases with Quality Improvement Committee at a patient advisor. They were able to identify overlooked performance actions with many centering around the lack of direct patient family education. So perhaps patient education or family education as well as a search term to add on here.

Tricia Elliott: And this is Tricia Elliott again. I think it was Bob that mentioned the publishing of information, the predicting unintended consequences. So maybe even just adding the terms of unintended consequences there and a review of that research that they had done may help trigger some more contents.

Jean-Luc Tilly: Yes, I think.

Constance Anderson: And this is (Connie) again. The other thing you might want to consider as a term is the usability of the measure.

Jean-Luc Tilly: Yes. I think that's a term we're very familiar here at NQF. So we'll be happy to put that to feasibility or other criterion.

Woman: And I also think classification of the measures is important. So is it, you know, an outcome measure, is it a, you know, kind of a check lost measure, that type of thing. I think each measure needs to be categorized as what the intent of it is and what the consequences of the market.

Those can be great measures but they're aimed at just getting it done and not looking at what they're actually impacting and how those outcomes are - can make this huge difference on whether they really are a burden for providers or not and patients.

Man: Great. Thank you.

Madison Jung: And this is Madison. I see from Anne Deutsch we have a comment, suggesting adding something to the list related to safety. And not to put you on the spot but I was just wondering if you could maybe expand upon that and give us some more context in what you're referring to safety.

Anne Deutsch: Sure. So this is Anne. So I guess I was thinking about Mark's comments about unintended consequences. And so potentially if one of the unintended consequences is an issue related to a safety problem, I guess it would probably be pretty dependent on each measure but I guess I was just referring that out as an idea.

Madison Jung: Great.

Anne Deutsch: Does that help?

Madison Jung: Yes.

Tricia Elliott: This is Tricia again. More questions, sorry. Is the emphasis or focus maybe initially on the chart drafted or chart-based measures versus ECQM because I think it would be very different conversation if you start looking at ECQM as part of - I mean, I think it needs to be looked at as part of the measurement feedback but I think the results of, like, literature scan will be very different between the two because I think one of the influencing factors is the age of the measure.

You know, how long has it been out there? Has it been so vetted that all the unintended consequences have been worked out or, you know, either set back into measure already so it's a pretty solid measure or is it very new and we're still working the kinks out of it kind of thing? So maybe those two factors, the type of measure and the age of the measure and how long has it been around.

Jean-Luc Tilly: Yes, that can be another access of, you know, in the same way that we just talked about outcome and process measures…

Tricia Elliott: Yes.

Jean-Luc Tilly: …being a little bit different.

Tricia Elliott: The attributes.

Jean-Luc Tilly: And even re-specify the ECQM. You know, you don't find the results of this. So there's a lot to think about here.

Tricia Elliott: Yes, because they need an even layer on chart based that has become an ECQM.

Jean-Luc Tilly: Right.

Tricia Elliott: And what do you see there, too, so…

Joseph Kunisch: And this is Joe Kunisch. I might add onto that kind of something around the reliability and validity of the measure, you know, especially once it's been out there and used then when you go back and look at the data, you know, was it - was there any kind of reliability testing done on it and then you need to validate that it's actually measuring what the intended measurement was.

Jean-Luc Tilly: Right. It's certainly not every measure had the good fortune of going to the NQF endorsement process. So, yes, we'll look for testing information that might not have gone through the process but that might have done some kind of an equivalent of the concept testing that we look for here.

Sara Toomey: Hi. This is Sara. (Unintelligible) related questions. So I just was part of that committee arc that went through all of the - kind of similar sort of stance to all of their PSIs and (unintelligible). And I think one of the things that we struggled with that I think we might struggle with here, too, is actually the lack of data, the lack of articles and information we're going to be able to find on the measures, especially specific measures in the line. Have you guys given any thought about that?

Because I worry a little bit that there will be some that will rise the thought that, you know, a lot of work done and there will be a lot that won't have much on it. I mean, have you guys thought about how we might be able to get information on them or how you're thinking about - or (unintelligible) registered nurse to see if we can get any feedback from this that might not publish, you know, about variations on some of those measures?

Jean-Luc Tilly: Yes, I can assure you our expectations are quite low as far as the literature is concerned. So, I mean, that's really the goal of the key informant interviews is to supplement the missing elements of the scan. So that's where we'll look to get kind of specifics for any case studies that we can use to help inform some of this information.

And of course, you know, luckily, NQF has quite a bit of data that we've collected internally that we also hope to leverage this part of this project. So, you know, we have some few hundred submissions of measures that have included some of this new usability in these questions that we've begun to incorporate, I think, about a year and a half ago or two years ago.

So between those two, you know, kind of primary research that we'll be conducting we hope to have something to go on to supplement which - what will be, you know, as you say, not the extensive literature that we might otherwise hope for.

Elisa Munthali: And I would just - this is Elisa from NQF. In addition to some of the information being in a more structured form to our evaluation process, all of the measures that come to our process for the last ten-plus years go to a public commentary then. It can be very challenging to pull up that information but typically, when folks are having challenges with measure implementation and use, that's where we see some of the feedback.

So, I'm looking at the team with sympathetic eyes because there's a lot of data there to come through. But at least it's here and it's housed at NQF.

Melody Danko-Holsomback: And this is Melody. I think, you know, my understanding of the intent of this committee is to, you know, how do we get the feedback of the everyday provider and how do we develop a process for that and I hope I'm not mistaken the intent of that.

But I think what we will find is we are going to have, like, the comments of overarching, you know, either companies or, you know, the medical associations and so forth and how often - I think we need to figure out how often do we really get the thoughts and the comments of the everyday providers because most of the time they're just busy taking care of patients and that's their focus.

And how do we really develop a tool in my mind that is something that they feel that they can go out and reach out to and make those comments without it being more of a burden on them but it gives the effects to things that they are seeing, you know, maybe repeatedly making the unintended consequences and so forth.

((Crosstalk))

Eddie Machado: Hi, this is Eddie. Melody, I feel like you read my mind because as I've listened to the discussion here, I think there's been quite a bit on type of information or data we'd like to capture, as well as potentially really getting at the uses of it but not so much on the vehicles or the methods of collection. And I agree with you. I think that, you know, a critical aspect of the work

here that we do to see what is currently done and - or identify what could be done along those lines.

Madison Jung: Yes. This is Madison. To echo those thoughts, you guys are hitting the exact nail on the head with this. And in terms of scoping, bringing up the points that we have identified in the project as being necessary such as - I'm just going to show the - an example for quantitative but this is certainly points that we can also capture for qualitative.

For example, where is this data coming from, how often is this getting to - these updates getting released, what are the methods, what are the associated costs. So just wanted to reiterate and very gladly hear that these questions that you guys are raising are very much in line with the questions that we're looking for.

Rose Baez: Hi, this is Rose. I just wanted to sort of on a related note, I know that the American Hospital Association has Measures that Matter collaborative that's currently ongoing where they're looking at exactly that burden versus benefit of these measures. And so I'm wondering how we can leverage that work that's in progress.

I think they're wrapping up in Quarter 1 of this year to help inform us on some of that burden and unintended consequences. I know that there is an NQF representative along with myself that participates in that collaborative but I think that would be a good resource to leverage as we go through this work.

Jean-Luc Tilly: Excellent, thank you. That's very helpful. We'll be sure to reach out to our friends over there.

(Dan Colica): This is (Dan) in Austin. I have a question for the group. Are we going to focus on certain domains of work or this is going to be just a general process? In other words, would be certain areas of clinical areas or governance areas or - you know what I mean? Is this process going to concern all the quality measures or just certain domains of quality measures?

Madison Jung: This is Madison with NQF. I think, ideally, it would involve all the domains of quality of measurement. The way this project we've soaked it out is that it's related to the CDP process or consensus development process and how we can get feedback into that process and the CDP process does cut across many topical and clinical areas of domain.

(Dan Colica): Thank you.

Melody Danko-Holsomback: Yes. I think it's important -- this is Melody again -- because our providers, you know, we have the quality measures set for them. So maybe our specialty providers have a different subset of quality measure compared to the primary care and sometimes patients have unintended consequences. And one group doesn't know that of the other.

You know, you have a cardiologist discontinuing an ACE or an ARB, not thinking about the fact that the patient is a diabetic and they're on it because we're trying to protect the kidneys or, you know, because that's not cardiology and in the front, you know, maybe it is for some, maybe it isn't but I think just looking at making a tool that's accessible that maybe you're looking in the measure that's not in your measure set.

But it's something that you're seeing as consistently interfering or causing a consequence in your area because somebody else is responsible for doing that measure, you know. So it's just another thought to throw out there when

we're thinking about the structure of how we're going to create this method of…

((Crosstalk))

Elvia Chavarria: …all goes in to PCPI. And I - that comment you just made resonates because you're talking about the process to get the data and that's what we have been focusing the discussion - much of the discussion on. But then I also think there's another key to it and that we have to really look at the quality of the data.

And if we are going to - to ensure that the measures are, in fact, implemented consistently and accurately as well, we've heard of instances in which if a measure has exclusions or exceptions, those are not being accounted for. So you're going to get data reported that is very different from the actual intent and from the data that are being reported by other groups or perhaps are implemented in the measures correctly.

And also we, at the PCPI, use CMS data quite a bit, too. But we also indicate that within the CMS data, this remains voluntary. So then what we get in terms of the data and in terms of the responses and the scores maybe a bit inflated if we are taking it within the scope of everyone who would be reporting the measures.

And then also just, again, making sure that the data are similarly - or the measures are similarly captured so that the data that we receive can be either compared or can be looked at accurately.

Jean-Luc Tilly: Yes. Thank you. And so actually one of the first projects I worked on in NQF was a variation and measure specification as - which, you know,

(unintelligible) issue in some detail. But certainly, we're very sensitive to hear in NQF, especially, you know, as we think about, you know, the endorsed set of measure specifications as a part of pretty much a point in time, measures like consistently going through updates and so on and are continually revised even in the annual rulemaking processes, for example. So, yes, we definitely want to be sensitive to be sure that we're making appropriate comparisons and collecting feedback on the same measures.

Madison Jung: And then I have a comment in the chat box from Beth Rubinstein. We should keep in mind the representation of underrepresented population equity and population data reporting so that unintended consequences do not occur.

And then she also supported the comment asking for clarification on the domain of quality of measures since several - or methods of feedback collection and data collection may not always translate from one domain to another.

So hear - so hearing all this rich feedback, I think the NQF staff we have a lot to consider and to do some additional research on. So just to summarize a bit of what I've heard, I've heard several additional search terms for the qualitative section, such as unintended consequences, safety, patient experience, patient education, looking in terms of the reliability, usability and validity of the measures, so seeing if there's any information that exists out there in the field.

I've also seen that we - another point - data point or lack of a data point is just noting that there will be not many articles out there that will fill our need. I think that's something NQF staff has definitely considered and expects rich gaps and challenges section of this report.

And then another section of comments that I've seen or heard and collected is that to look and consider how specialty organizations - how they're reporting measure sets or how their measure sets that they would like to report or just the measures that they endorse and support differ from specialty to specialty and considering the ability to compare those measures.

I've also seen -- I've also heard that we should also consider looking at this -- or the domain of this quality measures needs to be considered when examining that, again, just for the same purposes that these often aren't comparable.

Another perspective that I've noted is that we need to consider how quality measurement and the relationship of the physician and how measure burden is something to look into and measure burden in the context of a physician's relationship with the patient and how that is impacting that patient.

And then the last point I have down here is looking at the expert panels and the technical expert panels that these measure developers are - and maybe even specialty organizations and societies are utilizing to collect feedback on and see - and noting that as a potential source of feedback.

Sue Sheridan: You know, this is Sue Sheridan. In thinking about the patient and consumer, I know you've listed the patient experience. Should we look at patient-reported outcomes?

Woman: Yes.

Madison Jung: We can certainly add that to a list as a search term, yes.

Sue Sheridan: Okay.

Jean-Luc Tilly: Right. And I think even - as we think about how we categorize the information we have through measures, you know, process outcomes you can - I mean, patient-reported outcomes, I think, also fall on that same dimension.

Sue Sheridan: Right. Right.

Madison Jung: Were there any other points? So I'm just looking through some of the questions we had for you. I think we've answered most of them.

I guess my question for you in terms of executing on the search strategy and specifically to the qualitative source section, any tips or tricks we've got a few - quite a few search terms identified. So beyond searching for a specific measure or specific topical area, do you have any recommendations on just how to collect this information?

A lot of comments I heard were we know that there are certain measures that are troublesome in the industry. I guess beyond searching on a one-by-one basis, you guys have any thoughts on how to tackle that issue?

Okay. That sounds like a difficult problem we're going to have to tackle. That'll be something that will rise through our challenges. Great.

Any other comments or questions of discussion? Eddie, Rose, anything from you? If not, we can move ahead and maybe wrap up a little early and get into our - or closing out this meeting.

Joseph Kunisch: This is Joe. And it's just one comment around the key informant interviews. I highly recommend that you include EHR vendors in this discussion because, you know, from the implementation end-user standpoint, we rely on them

heavily to actually build out the code to support this in interfaces and we run into - we can run into a lot of challenges you don't - because they're trying to do it across all their clients and all their clients are slightly different. And then it makes some of us have to create custom clinical decision support rules or interfaces to support this stuff.

So then you have a lot of feedback and some of our testing measure development activities have progressed where we started out and not involving the vendor at all. Eventually, we brought them into the discussion. It helped tremendously. They had feedback on the measure why it would be difficult for them to actually capture in their existing interface.

So in the end, you know, again, we're relying on them to provide that ability to actually capture this documentation and data to support the measures.

Mark Huang: Yes. This is Mark Huang. I would absolutely echo that including measures because there are certain measures, especially the ones that were ECQMs that, you know, are specifically vendor reported. So there were some measures that were very, very difficult to meet just because of the complexity of the build or the data they're looking at and there were several measures that, you know, that were really unfeasible to implement because of the nature of the builder how the EHR is built.

One specific one closing the referral loop preceded the specialist's report. I'm going to mention that because we were going to use that. We found that almost technically unfeasible to implement because they would mean that we'd have to loop back and report to a specific encounter associated with that particular patient's visit and that was going to be very difficult from our medical record standpoint to identify the correct encounter. They'd have to

track down the notes, identify which note and which encounter you go into in order to be able to tag the report back to the order for the encounter.

So it's very complicated. So it's like taking something simple as, yes, you ask for referral and get a report that makes sense. You create specifications around it, but in the end, it becomes very difficult from a vendor standpoint to actually implement.

You know, I think there was another one in regard to some of the psychiatric measures of depression and screening which are also very unfeasible to be able to successfully implement to make it a measure that's easy to measure and then easy to report on.

Melody Danko-Holsomback: Yes. This is Melody. I agree. Even something as simple as the diabetic eye exam, the patient - the order is there, the claim is there, but you're asking that the providers get a report back from someone and then get it stand in the chart and it's administratively very burdensome and costly to have - to just make sure that that's consistently happening so that they get credit for the work that they've really already done.

Elvia Chavarria: And this is Elvia from the PCPI. And I absolutely am in favor of that. And in addition to EHR vendors, (unintelligible) vendors as well because sometimes they have a bit of a different approach.

One of the things that we are interested in when we develop the measures is hearing some of them regarding the data elements. So we include all of the different data elements to accurately capture a measure, but at times, for example, a PCI measure that we were working on not too long ago, the - many of the data elements were not included within the EHR Capture, but rather in a

PCI cath lab's report. So how are those data points or those data elements brought into the EHR for accurate reporting and accurate implementation?

So I think absolutely, there are some issues there where we receive feedback on that. I think that would be invaluable as well.

Eddie Machado: This is Eddie. One comment I would make. You know, this project is a little bit different, I think, than the previous NQF projects I've been a part of in terms of having implementation plan and options for a pilot as part of the deliverables. And in most cases, it ends with a report or the environmental scan and so forth.

So, I think along those lines, I'm wondering what the group thinks about maybe potentially querying the key informants to really get a sense of, you know, what type of incentives or what things would drive them to help participate in measure feedback because obviously, a lot of folks have - actively interested and trying to do this. But you obviously bump up against, you know, the burden and, you know, the issues of doing so.

So I was just curious in the group whether or not there's any value in sort of querying the informants group as to what might stimulate their folks to participate in a process like this on a regular basis.

Woman: I think the main thing is ease of use.

(Dan Colica): Again, this is (Dan) in Austin. I just came from a vendor-based quality improvement committee this morning with all the MCOs throughout the state and I think there was unanimity of desire from the both providers and the health plans to have a dialogue on the performance measure that would be implemented or adopted for developing alternative payment models.

So I think that this is quite critical in this process, so just as an example.

Madison Jung: Great. Thank you so much, everyone, for your feedback. Any last comments or questions before we move onto closing out our meeting today?

Okay. Hearing none, I will turn it over to my colleague, Navya, to give us an overview of the SharePoint.

Navya Kumar: Thank you, Madison. And thank you all for such a good discussion today.

So SharePoint is where we share our meeting materials, as well as the committee roster and biographies of the committee members. The slide shows the link where you'll have access to the Measure Feedback Loop SharePoint site. You should have the log-in information I e-mailed to you. If you do not, please e-mail our Project inbox and we can get that sorted out for you.

So this is the viewpoint for our SharePoint. So this is the home page that you will see for committee members. The top is General Document where we will have the roster. The bottom is Meeting Materials. We have divided it by the Web meeting. The first includes the slides and agenda and would later on include summary and recordings of our meetings.

And if you do not see any of the documents, it might just be hiding within the tabs. The plus and minus shows if it's open or not and the parenthesis shows how many documents are within the tabs.

Are there any questions for that?

Okay. So I am trying to think. So maybe just to give you a public comment scheduled for 3:50, why don't we go ahead and review next steps and gain a few minutes and then toggle back to public comments to close it out?

Okay. So for next steps, we'll be having our second Web meeting. That'll be on February the 19th from 2:00 to 4:00 pm. Like Jean-Luc said earlier, we'll be reviewing the environmental scan as well as asking for feedback on the scan report contents and any additional insights on the sources of the measure feedback data that could be helpful to inform the CDP Standing Committees, including which measures are priorities for obtaining feedback.

And then from March 11 to March 25 will be our 14-day public commenting period. That'll be for the environmental draft report. And then on April 12 is when we will deliver the final report to CMS. Following that will be our third Web meeting on April 30 from 2:00 to 5:00 pm. This is when we will review the existing CDP Use and Usability criteria and evaluation process. And we'll also provide a comprehensive view of the current NQF processes and mechanism.

And if you do have any additional questions or comments from this conversation today, please feel free to e-mail us or call us. Please review our Projects page and the SharePoint. The links are provided for you.

Madison Jung: Great. Any questions from the committee members on next steps or where to find the information for this project? If not, we can go ahead and open it up for public comment.

Man: Just quick question. So did - was the SharePoint e-mail sent out already? I don't seem to recall receiving that for the individual committee members.

Madison Jung: It should have been sent out when you - around the time you got your nomination. There is…

Man: Okay.

Madison Jung: …yes.

((Crosstalk))

Madison Jung: Yes. So there is a link included in the calendar appointment. It's about the third line down and it's labeled Committee SharePoint Site. But if you have an issue logging in or can't find the log-in, the log-in should either come from nominations@qualityforum.org or info@qualityforum.org. So take a look…

((Crosstalk))

Madison Jung: …for that and if you can't find it, of course, please feel free to e-mail us and we can get your account and everything reset.

Great. I think we can go to public comment now. So for individual - for members of the public, please either unmute your line and make a statement now or use the call function star 7 to unmute your line as well. Or chat us in the chat function.

Okay. Hearing no public comments, I just want to thank - this is Madison. I just want to thank everybody for joining us today and for your really rich and thoughtful discussion. We appreciate it and we're very excited to continue this work, just the indication from the first Web meeting.

So, thank you so much, everybody. We'll let everybody go early. And we will be in touch soon.

Have a great day, everyone.

Man: Good bye.

Woman: Thank you.

Woman: Bye.

Woman: Thank you.

Woman: Thank you.

Woman: Thank you.

END