NATIONAL QUALITY FORUM
Moderator: Karen Johnson
September 14, 2012
4:00 p.m. ET

Karen Johnson: Hello and welcome to (inaudible) Forum (ongoing) Assessment for Neurology Phase 2. Thanks everyone for meeting with us this afternoon – on Friday afternoon. So, (inaudible) of (inaudible) and so that's great.

Now, I think I need to turn it over to Suzanne who's going to do our roll call for us.

(Suzanne Theberge): Hi, everybody. Thanks for joining us today. I just want to run down the list of committee members and then developers, so we know who's on the line.

(Daniel Labovitz)? Are you here? I think you may be on mute because I know we spoke with you a minute ago.

(Daniel Labovitz): Yes. I'm here.

(Suzanne Theberge): OK, great! (A.M. Barrett)?

(A.M. Barrett): I'm here.

(Suzanne Theberge): Great! (David Tirschwell)?

(David Tirschwell): Here.

(Suzanne Theberge): (Terri) Richmond?

(Therese Richmond): Here.

(Suzanne Theberge): Dave Knowlton? Gail Cooney? All right. Well, hopefully the last two would join us shortly and the folks from AMA can you introduce yourself?

(Diedra Joseph): Hi, this is (Diedra Joseph) at AMA-PCPI. I also have Mark Antman here, Kendra Hanley, Anu Gupta, and Dr. (Jerry Johnson) should be calling in as well.

(Jerry Johnson): (Jerry Johnson), I'm…

(Suzanne Theberge): OK.

(Jerry Johnson): … on the phone.

(Suzanne Theberge): Great! And is there anyone else on the line who didn't introduce themselves?

(Helen Johnson): This is Dr. (Helen Johnson) from the APA.

(Suzanne Theberge): OK, great! With that I just wanna remind everybody to please mute when you're not speaking. We are getting some feedback on the line then mute and unmute commands are both star six. So, with that I'll turn it over to Karen to begin our measure discussion.

Karen Johnson: Thanks very much and this afternoon we are going to be looking at some dementia measures. So, we have six that we're going to go through and they are all submitted by AMA-PCPI and one thing that I'm sure you will have noticed by now is that these measures have not yet been tested for reliability and validity and I know that the explanation of why we are going to go ahead and look at those kinds of measures basically they may be eligible for time-limited endorsement if that's what the steering committee decides.

So, the – in the in-person meeting, the voting on the validity and reliability questions will be a little bit different than what you're used to but not a lot. Basically, you will be concentrating for the most part on the specifications since that we'll not be testing information for you to consider.

In terms of these reminders from phase 1, I know it's been a while possibly since you thought about our criteria. I think the measures that we're looking at to – in phase 2 are a little bit different than the ones in the phase 1 not only because of the testing that pretty much has not been done for most of the measures but also because of the evidence that underlies the measures. To some extent, I think the evidence where the measures in phase 2 is more limited than what you saw in phase 1, and in terms of that, I think I just want to remind you that what we're trying to get to our measures that our – that more likely to drive improvement in health care quality.

So, again, there are many, many important things that folks should be doing and practices but those kinds of things do not necessarily rise to the level of a national consistent standard for quality improvement. One reason is it – a lot of resource to collect data and to postings in terms of public performance that sort of thing. So, we want to make sure that NQF-endorsed measures are – do have a solid evidence base (inaudible) behind them.

I also just want to remind you that we do have a hierarchy of preference in terms of measures that we would like to see obviously outcome measure would be the preferred types of measures that those are not always easy to get. So, we do have a lot of process measures, and I will just remind you that if process measures that are most closely linked to desired outcomes via evidence are the ones that we would prefer. So, we would like to see measures – process measures that proximal to desired outcomes.

I think the other thing that I want to remind you of is when you're thinking about the evidence, some of guidance we ask you to consider quality, quantity and consistency of the body of evidence and sometimes that is difficult to do because often new developers rely on clinical practice guideline and guidelines are not all created equally, some of them are evidence based some are not. Some of them are mixture of evidence based and

consensus or opinion. Some of them are graded and some are not. So, just that – I think the main question to keep in mind is when you're considering evidences just the evidence meet NQF's criteria for quantity, quality and consistency.

And I think pretty much with that, I will stop and as we go through the measures today, we have roughly 15 minutes per measure. If we can, we're going to try to speak to that. these measures are different in several ways, and I think each one will have its own things that need to be discussed even though other things were similar, but I'd like to do is we've asked many of you to be a lead discussant. So, what I'd like you to do is take, you know, of really brief time and introduce the measure as you did before in the steering committee person and at in-person meeting in phase 1 and then just briefly talk about the results for impact then we'll stop there and open discussion about impact and then go on through the rest of the criteria.

So, and I guess why don't we go ahead now and start and (inaudible).

(David Tirschwell): Before we start – this is (David Tirschwell)…

Karen Johnson: Uh-huh.

(David Tirschwell): … I just have a couple of questions and I actually think it will impact all of these measures which I think are in many ways extremely similar in the issues as they come up. I have to say from my review of them that all of them are probably either going to be time-limited endorsement or not endorsed at all, and I just wanted to clarify for the time-limited endorsement, you referred us back to three criteria that measure has to fulfill for time-limited endorsement, and I'm just reading from page five of the S.C. preliminary evaluation memo which describes these three criteria that they are not complex i.e. no outcome or risk adjusted measures; number two that they fill a gapped area.

There are no measures endorsed on this topic area and three that there is a legislative mandate for their use and they say that the untested measures in this project are all in the 2012 PQRS that meet the other criteria. So, you will review them for time-limited endorsement. Can you – and I guess my question is if they meet those criteria, does any of the other stuff matter or does those three criteria only substitute or the reliability and validity part?

Karen Johnson: Yes, generally, if a measure came in without testing information for reliability and validity, we would automatically just say no we will not even consider that measure, but since they have met all three of them, we are considering the measures and – but the evidence criteria important – impact all of these other things will matter and you will be evaluating on those things. So, really what get to (pass) if you will is the testing information, but even that said, with reliability and validity, there are also questions about specifications and precise specifications would fall under reliability and then basically the link between the evidence and the specifications comes under the validity question.

So, we will ask you t be thinking for reliability and validity rather than the testing to be thinking about the specifications.

(David Tirschwell): OK.

Karen Johnson: Does that make sense Dave?

(David Tirschwell): That is – that is also to some degree but then with each of these measures, the developers also say that the measure is already in use and so one of the things I had trouble for if (you noticed) if the measures are already in use, how could there be and they actually say at some point that it's reliable and valid, how are we not getting reliability and validity data?

Karen Johnson: My understanding is that right now, they have not begun the testing of reliability and validity. That may not be the case. They might be partially through that. I – maybe Diedra, would you like to comment on that?

(Diedra Joseph): Hi. So, this is (Diedra). The testing part because it's not started, it's scheduled to start in October. I'm not sure where in the submission form states that the measures are reliable and valid. If you could point me to that section?

(David Tirschwell): Yes, 3a.1. In list, that's for measure 2004 which was the one that I was the (primer on).

Karen Johnson: We're all (flipping) to it David. (Inaudible).

Diedra Joseph: OK, so…

(David Tirschwell): 3a.1.

Diedra Johnson: I'm looking at that section. I think it was added to the measures in error because the measures haven't been tested at all. So…

(David Tirschwell): I think it says this exact same thing…

(Diedra Joseph): Yes.

(David Tirschwell): … in all of them.

(Diedra Joseph): It probably does and it was – it was an error. They haven't been tested yet. So, we can't say that they are reliable and valid until we have some testing results.

Karen Johnson: So that would be one of the things that AMA-PCPI folks will go in and fix on their submission if in addition that any other things that may come up on the call that they may want to tweak. That's a good (call), David.

(David Tirschwell): So that – the statement – the PCPI believes reporting has a beneficial effect on a trajectory that still holds but the part that says what sort of justifies the first part which

says, "Which is appropriate since the measure has been tested and the reliability of the performance data has been validated," that's incorrect.

Karen Johnson: That is incorrect. That's an error.

(David Tirschwell): Well, so, I mean a lot of what we all spend time doing then is we have to reassess I imagine on the (fly) on the call.

Karen Johnson: In a way you won't because there is nothing to assess in terms of reliability and validity. So, they have absolutely no results to even consider.

(David Tirschwell): OK.

Well then…

Karen Johnson: Then I…

(David Tirschwell): … final question to bring up for all of the measures and, again, this gets back to the NQF guidance about to how to fill out these forms suggest – I – my reading of the guidance is that in the parts about the evidence with the quantity, the quality and the consistency that yes the developers can depend on guidelines and position statements, but they actually have to tell you what those position statements say and what the evidence is that the position statements bring forth and I don't – I didn't see that information in any of these measures. Also I…

Female: Yes, (inaudible) that.

(David Tirschwell): Also, I see is that they sort of say there were six studies. They don't tell you what it was, what they said, they don't tell you the quality of the studies, they mention a grading system but then your – I don't know, I just – I feel like the evidence is just referred to as if we were supposed to go out and summarize and read for ourselves guidelines. So, you know, all of my grading was one thing because one thing because of that consistent lack of description of what the evidence was. I don't know if they…

(Therese Richmond): (Inaudible).

(David Tirschwell): … so…

(Therese Richmond): I'll concur with – this is (Terri). I totally concur with what you're saying. It was insufficient because it wasn't provided really.

(David Tirschwell): Yes, exactly. It was sort of – they didn't answer the question.

Karen Johnson: And this is Karen, and I think you're absolutely appropriate in your response that they did not really summarize quality, quantity and consistency sometimes and I'm not sure this would be up to you to decide. Sometimes if the guidelines are graded in terms of the evidence and possibly the recommendation, sometimes that might be enough to make you

at least go on phase. I guess, it would be a way to say it that you would think that the evidence is there. So, I know that they – the APA guidelines have a great assign to them – the recommendations do heavily does not work, but…

(Therese Richmond): Karen and this is (Terri) again.

Karen Johnson: Uh-huh.

(Therese Richmond): I agree with what you said, but when we read the destination of the evidence, they'd actually said one evidence has limited the level of confidence also incorporated – when they go to (inaudible) with incentive with regard to a clinical decision which is…

Karen Johnson: Right.

(Therese Richmond): … which is very proud of then sort of (inaudible) driven evidence. So, there's no way to differentiate – I mean, as of this information.

Karen Johnson: Right. That's not something I can say but that's something you can say…

(Therese Richmond): OK.

Karen Johnson: … of this meeting.

(David Tirschwell): All right. I'll be quiet.

Karen Johnson: No, I think – I think those are good questions and you're absolutely right. It's going to be true of all of these measures today. I will remind you that there is a possibility – we didn't have to invoke it at all in phase 1. We do have something called an evidence exception where if there absolutely no evidence, you as a committee may decide that you would like to invoke the exception and basically say, "I understand there is no evidence, and we think it's still a great measure and should be done and the benefits would outweigh the harm."

So, there is that possibility if you as a committee should decide that you would like to invoke that exception. What we do say is that really should be an exception because, again, we would like to see measures that have a strong evidence base and not just that but actually a transparent evidence base so that everybody understands what evidence underlies measures.

So, with that intro, let's go ahead and delve into the first one, (Daniel Less) Measure 1990 Staging of Dementia.

(Daniel Less): Hi, I guess so – I'm no longer muted and I would like to start by saying (David Tirschwell) stole all my thunder. I completely agree with his comments on the issue of impact given that we have only summary data. I think that applies to all of the measures we're looking at today. The second thing that occurred – that we will be concerned I think broadly across the measures is the issue of overlap. I'm not going to address that

now but as they come up I think that repeatedly if we decide that we want to rate these – want to continue rating this measure at all.

This first measure is a measure of provider's scoring of patient's severity of dementia as mild, moderate or severe. The numerator is any scoring of mild, moderate or severe within a 12-month period. The denominator is all patients with an ICD-9 code for dementia within that same 12-month period. On the evidence point, the group generally found that this was a – no, the impact – for number one impact, the group generally found that that this is a high impact area that is – there is strong data support that dementia is common sever problem, very expensive and the group generally found that the – there is evidence of variability and performance both between centers and as well as between race-ethnic groups and other (vulnerable) populations.

Where the group collectively saw a problem was in – what Dr. Tirschwell already pointed out in 1c that is the quality of the evidence – the group – three of us found this to be data insufficient for quantity, quality and consistency. There were, however, a couple of people who rated it as either higher, medium across the board for quantity, quality and consistency. So, there is some heterogeneity in the group's assessment on that point.

Karen Johnson: And (Daniel), can I stop you there just a second? I think on the first two impacting gap, there was pretty much agreement that impact is there, the gap is there, and as you said, for the most part, three of you thought the evidence was insufficient. Maybe the folks who went ahead and assigned something other than insufficient on the evidence, maybe they could explain, is it something – do they know of other evidence outside what was provide and does that – how come you were able to rate the evidence – I'm not sure who said what on those, but…

(A.M. Barrett): This is A.M., and I was one of the people who rated there as having been sufficient evidence, and I guess I would just state that although I agree that there's not systematic presentation of the quality of evidence here this – given this great consistency in clinical practice standards in those area and given my personal assessment on the low identified potential harm or risk in the demonstrated lack of evidence in that area. I would really support the possibility that this is a very strongly likely – a very strong body of evidence.

Gail Cooney: This is Gail Cooney, and I also rated it as high impact and primarily for the reasons that we'll just mention. I though the guidelines were consistent in identifying, this is an area that is important to measure even though they didn't present the specific data for it.

Karen Johnson: OK. So, let me – let me rephrase a little bit. We don't see from the submission at least the summary of evidence that shows that staging of the dementia actually leads to better outcomes. So, are you Gail and (Ana) saying that, you know, that the evidence is out there, that there is evidence that does staging leads to better outcomes or are you saying (there might) not be evidence that you feel like in this case there might be an exception to the evidence criterion.

(A.M. Barrett): Thank you for the guidance. This is A.M. I think I would say that the existence of three clinical practice guidelines papers make that support this – suggest that large groups of

clinicians and clinician scientist feel strongly that change in this area will improve outcome, and so I think that we would – I personally would look for an exception.

Gail Cooney: This is Gail. I agree. I also think that until people get consistently measuring functional status and staging and cognition, it's going to be very hard to collect – large group data on impact.

(David Tirschwell): It seems to me – this is (David Tirschwell) that the data that they presented with the huge variability represents the natural experiment whereby they should have been able to show that there is differences in outcomes and I didn't any of that – and I guess I would also – for this particular one, they refer that did this recommendation was not even graded and the other ones they actually gave some of the recommendations gradings. These ones was not even graded they said in one of the guidelines of these.

And then I would just finally end, that just because something is a widely accepted standard of care, which I think everybody would agree this probably is doesn't mean that it necessarily becomes a performance measure, again, based on sort of the lack of connection with improving outcomes.

(Diedra Joseph): This is Diedra. I just wanted to comment on your statement that the recommendation wasn't graded. Actually, the submission form states that the body of evidence is not graded but the recommendation itself was graded. That's in section 1c.22 and 1c.23 on the form I'm looking at? It's a category I recommendation.

Female: Yes, it's also in 1c.16.

(David Tirschwell): Sorry, which document are you looking at?

Female: I'm looking on the original submission form.

(David Tirschwell): 1b what?

Female: 1c.22 and 1c.23?

Male: And 1c.16.

Female: And 1c.16.

(David Tirschwell): 1c.22 just says each recommendation falls into one of these three categories.

Female: 1c.16 David.

(David Tirschwell): 16.

Female: So, at the end of each guidance and (recommendation)…

(David Tirschwell): Yes, so aggressive dementias are generally staged – that's what we were talking about here – staging dementia according to level of cognitive and functional impairment and the same categories may be used to described the severity of dementia, recommendation not rated.

Female: I'm sorry, that's you were referring to all of the recommendation. So, some…

(David Tirschwell): What we were talking about staging dementia here. So, I'm focusing on that.

Female: OK.

(David Tirschwell): I'm not sure why those other statements are there. They're not really directly addressing the staging issue.

Female: (Inaudible) case…

(A.M. Barrett): David – and then of the – of the issue of grading recommendations – this A.M., with regard to the difference between a clinical practice standard and a recommendation of a measure for improvement, I would argue that the existence of the clinical practice guideline publication, are the existence of such guidelines suggest that there needs to be an improvement – systematic improvement in the standard and especially when there's more than one recommendation that appear to focus on specific (themes) so that file (received) an exception.

(Daniel Labovitz): (Daniel Labovitz) here. I think NQF has been very clear about the strong desire for real hard data and not expert opinion. We've – in our last sessions; we rejected a measure on stroke education. That's when we're – on the phase that you looked at, you think, "Yes, that must be good." But there was not data to support it and we rejected it on that basis.

I think this is a similar situation where intuitively thinking, "Yes, how can it possibly be a bad idea to grade the dementia severity is mild, moderate or severe record that in the record and assess whether that's been done." But I think we – what I'm finding (woefully) lacking here is anything beyond a bunch of experts sitting around the table, as we are now, offering their opinions and I would like to steer clear of expert opinion and really focus on data.

(A.M. Barrett): Well, David – this is A.M. again, I think I would strongly disagree with your statement because I had thought about the issue of stroke education as well; however, there are identifiable harms to (incorrectly) offering education. I supposed you can make an argument that incorrectly staging patients is, you know, a problem.

Unfortunately, I don't know if that argument would stick very now because the people who is staging patients are probably offering better standards of car and that's one of the reasons why this natural experiment that David – (he) suggested probably wouldn't work very well because those patients were graded and they actually have better outcomes in those (inaudible).

(David Tirschwell): Well, that just the evidence we're looking for.

David Knowlton: This is David Knowlton. Are we (tied) to what's placed before us? One of the problems of the process is that I thought what kind of (tied) with what's in front of us. That was known external to us in front of us. Do we have that problem here?

Karen Johnson: Ah, what would…

Male: They knew that doing this led to good outcomes and they thought there was evidence that just wasn't presented while here that would – that was great to hear and that influenced my grading of this sort of thing, but I haven't heard that.

(A.M. Barrett): But you know – this A.M. again, what do you mean by know. So, we know I think that practitioners in this area I and the number of other people who work in this area feel convince that it personally – does it mean a standard that NQF would consider for more highly developed areas – no, it does not. I think that's why this is up for time-limited endorsement.

(Suzanne Theberge): No, I (inaudible) make sure you understand the time-limited endorsement and time limited this means that because they met those criteria that we mentioned earlier, we're going to give them extra time to get testing.

(A.M. Barrett): Yes, I'm sorry…

(Suzanne Theberge): (Inaudible).

(A.M. Barrett): … I didn't clarify it, Suzanne. OK, and I'm sorry. This is A.M. The reason it's up for time-limited endorsement, however, would imply correct that it is under at a stage of development that may be earlier than some of the other measures that have developed reliability and validity data. Am I incorrect in that?

Karen Johnson: No, you're correct that they have not done their testing, but time limited doesn't give a pass on the evidence. So, I just want to make sure we're all clear on that.

(A.M. Barrett): Absolutely. So, let me restate, I think that's what – that this measure is in a process – (at an) early stage in the process and as part of our acknowledgment of that earlier stage is up currently for time-limited endorsement since it lacks certain reliability and validity data, as well as some of the hard data that the committee has discussed.

Karen Johnson: The time limited only refers to the reliability and validity testing. It doesn't have anything to do with the evidence criteria.

(A.M. Barrett): OK, I guess I would make that connection for my own personal judgment that I am suggesting that others may want to think about that.

Karen Johnson: Well, and again, what you're – what you're struggling with I think is, you know, the desire – the case you know, that folks aren't necessarily doing this and, you know, that

once they start doing that that would improve quality so it's a good thing to do. They're struggling with that and trying to balance that with the NQF criteria for evidence. So, again, you know, that is something that you'll have to decide for yourself and, again, you will have the option if the committee desires to potentially ask for an exception to the evidence.

So, it's going to be – (let's say), the truth is going to be the case for almost all of the measures and stays with you.

Male: Yes.

Karen Johnson: So, it's a very different phase. It sound – at first (flash) it looks easier than phase 1 because phase 1 had all those (the fiscal) messy problems that you had to delve through. This is a different set of problems.

Let's go on. I think to some extent, as David and Daniel and (Terri) said, this is pretty much going to be the case in terms of the evidence for all six of these measures and that I think all six of them also have a couple of other things in terms of specifications, the question about overlap that sort of thing that I want to make sure that we at least touch on today.

So, maybe, when we go through the other measures, maybe we'll just give the evidence discussion. We'll just over that unless you just want to make known that, you know, again, you don't see evidence that you would consider an exception. That might be something that would be good to get on record.

So, (Daniel), if you go on and let's talk a little bit about scientific acceptability and specifically thinking about the…

(Daniel Less): Sorry, you broke up a little bit there but I think I'm certainly prepared to move on from question one and tackle. I think the next step is reliability and validity. Is that…

Karen Johnson: Yes.

(Daniel Less): And…

Karen Johnson: That's correct.

(Daniel Less): There on this measure, no data was provided on the reliability or validity. In terms of the group ratings – I think we were left without the…

Female: If that's what we – is this where we discussed specifications and the numerator and the denominator?

Karen Johnson: Yes.

Female: OK.

Karen Johnson: So, the specifications are there. So that…

Male: Oh, yes. That's true.

Karen Johnson: … is something – yes.

Gail Cooney: This is Gail then. I have a concern that in the denominator they have excluded hospital patients. That – it – the denominator includes long-term care ALS, inpatient and outpatient (psych) facilities and offices. They doesn't include home or hospitals. Actually, I think there's home (inaudible).

Female: (Inaudible).

Female: Excuse me?

Female: I listened – why do you say that it excludes hospitals unless.

Female: Because I know code. The billing code.

Female: Because the code…

Female: The hospitals are…

Female: … no denominator exclusion.

Female: Excuse me?

Female: Because the document says there's no denominator exclusion.

Female: I'm telling you the hospital physician billing codes are not included in the denominator.

Female: Oh, yes good. (Developers) to come in or whether this an inpatient, you know, this can be recorded for inpatient?

Karen Johnson: So, the reviewer is correct. The inpatient codes have not been included in the measure. I think in the context of the discussion. At that time, the measures were being developed. This is for sort of more focused on the ambulatory care and then, you know, patient – physicians treating patients for dementia, you know, as part of their ongoing clinical practice and not necessarily in the acute care setting. I don't know if Dr. Johnson would want to (inaudible) on that.

(Jerry Johnson): Yes, let me comment on that. The reasons why we would not want to stage the (severity) of dementia and patients who are hospitalized at least in those hospitals, patients would dementia don't get admitted just because of their dementia or say are admitted to some acute care reason. They might have variant superimposed on dementia and, of course, that

would distort an assessment of what's the underlying dementia severity, and they might be admitted for heart failure or any other number of reasons.

But the setting does not lend itself to an assessment of severity that would then become the basis for a management plan for the dementia. That's the whole purpose for staging so that a management plan can be – and be developed and without diagnosis and assessment of severity then the management plan is going to be (flawed). The acute care hospital which is not be the appropriate setting to do that.

(Daniel Labovitz): (Daniel Labovitz) here. I agree with those comments – would go on to say that if this code – if there's no, you know, in a hospital setting there are primary and secondary ICD-9 code. You may have 15 diagnoses. Dementia might be one of them, but if you were admitted because you had pneumonia I think holding doctor's (feet) to the fire for grading the stage of dementia and that setting would be really inappropriate. But I'm interested in your comment. It didn't occur to me and I'm wondering what your thoughts were as far as the benefits of adding hospital diagnosis in.

Gail Cooney: Like too often the patients there (inaudible) during the (inaudible) end of care and I think (inaudible).

Karen Johnson: Gail, this is Karen. You're really breaking up.

Male: Yes (inaudible).

Karen Johnson: Are you on a…

Male: I could not understand…

Karen Johnson: Are you…

Male: … what was just said.

Karen Johnson: Yes, are you on the cell phone Gail?

Gail Cooney: OK, how about that? Is that better?

Karen Johnson: Oh, that.

Male: Oh, that's much better. Yes.

Gail Cooney: OK, hi. I – it just seems that the functional status of dementia patients is often not taken into account when their plan of care is developed in inpatient setting an d that bringing that to (before), I mean, we're not really holding physician's (feet) to the fire it, you know, they have a wide range of settings in which this can be met. It only has to happen once in a year, but I think including functional assessment (doesn't) drive the care plan in the inpatient setting and so I would argue that it should be included.

(Daniel Labovitz): (Daniel Labovitz) here again. I think that's a – at that point, very well taken and I agree with you that discharge planning is often woefully inadequate particularly in the setting dementia. However, I would suggest that that might be better as a separate measure – a discharge planning measure which accounts for patients frailty for a variety of points perhaps not just dementia. I think here as the developer pointed out, it introduces a lot of – a lot of noise and I think it can be – there are certainly some patients who have certainly in my neighborhood in the Bronx we have very limited medical contact. Their only contact might be hospital, and it would be a very difficult kind of assessment to make in the hospital. They may have no primary care engagement beyond the emergency department.

Female: All the more reason to measure then the hospital Daniel.

Male: Well, I think that's all the more reason to say that they are getting poor quality of care. They are never seen on the outside of the hospital and that's not going to be resolved just measuring their function in the hospital. It's just like the distorted measure because they are not in the hospital because they have dementia. They're in the hospital because they have heart failure, urinary tract infection or pneumonia, and they also have dementia and then maybe barely able to walk because of their heart failure, their urinary tract infection and their delirium. That functional status is estimated. It's just not going to help us make the kind of management decisions that we would try to address with the measure.

Female: And again, I would argue that (inaudible)…

Male: This also may not (inaudible) ignored. I think that's a transitions of care measure, and I think transition of care measures are critical in this age group, and I just think as a separate measures the transitions of care (issue).

Female: I'm not talking about transitions of care. I'm talking about the acute care plan, and I do not see that patients take the preexisting functional status of dementia patients into account when they are making their inpatient plan of care, and I think that this would help to address that.

Karen Johnson: OK, I think we probably are not going to solve that question today, but we will definitely make sure that that is adequately summarized in our summaries that we're going to send out, so if – are there any other questions about the (specs) besides the exclusion of the hospital setting?

David Knowlton: This is Dave Knowlton. I still have my question on the process. It seems to me that this question of assessment is on the inpatient basis is a reasonable question. But the measure before us excludes it. What is the process of the steering committee in term signs of infection making recommendation that they reconsider because it changes the measure does it not, and that's not what's before us. So, I still have my same question. Do we have – how much latitude do we have here? What's the appropriate measure? I mean, are we suggesting a new measure? If we're going to do an inpatient assessment, and this is just an example of the same question that was asked on the evidence before, are we to take

into account extraneous or external information to the measured set or not? And do we have – is there an answer to that or it's just sort of our (judgment)?

Karen Johnson: In terms of the specifications, you pretty much are looking at what's in front of you, and you would have to decide in terms of the hospitalization. Is that something that would affect the validity of the measured score? And if you think it doesn't affect the validity of the measured score but you'd still like to see hospitals included, that would be a recommendation that you could make and we would make sure that that is included in our report, but it would not be (binding) on the developers unless they chose to take your recommendations.

(David Tirschwell): Yes, I think we need this (inaudible) like that. You know, what are – what are our options? Because I think that while – listen, what I'm hearing is a lot of interesting and what sounds like valid clinical judgment; we can't really change the measure. The source of the measure without having some unanticipated consequences and these incentives NQF is to anticipate those consequences and we post in a very transparent and public way. I may be misunderstanding some of these issues. I'm not an expert in – into a commenting (inaudible) but I do think we need to be careful of (ourselves) what we use it, committee are capable of doing under the process that was adopted.

Karen Johnson: No, I think you're right, Dave.

(David Tirschwell): OK.

Karen Johnson: (Daniel), do you want to go ahead and do usability and feasibility? Were there any major questions on those two items?

Mark Antman: Karen, this is Mark Antman of the PCPI. I apologize for interrupting but before the discussion goes further, may I just interject something about the reliability and validity information?

Karen Johnson: Sure.

Mark Antman: OK. Thanks very much. I just want to clarify for the workgroup the – just a little bit of concepts for the absence of the reliability and validity information. It is absolutely the intent of the PCPI to proceed with testing these measures and Diedra had already stated our time frame for doing so. We would not have submitted these measures were if not for the fact that NQF staff contacted us and mentioned the fact that there is a known gap of measure in this area, and they frankly requested our submission of the measures with the potential of their gaining time-limited endorsement because of that gap and because of the – of the timing of the Neurology Phase 2 Project.

So, absolutely, once and I think you, of course, Karen and the workgroup members know that if time-limited endorsement is awarded there is then a strict time frame in which our testing needs to be conducted, and as noted, we have plans to do so. But I don't want to work with members to proceed that we simply decided to submit the measures without

that information because we have not chosen to do so. We would have not chosen to do so where if not to fact that our submissions were requested.

Karen Johnson: Thank you for that clarification. You're right in that – and I should have made this very clear when we accepted these untested measures. We did contact the developers and asked them to verify for us that they intend to do the testing within 12 months should they get the time-limited endorsement for their measures, and AMA-PCPI did give us that assurance, and I think Mark is also correct that out time on projects don't always align with the timing of the development. So, it just so happened that we had a Neurology project dementia, of course, falls into Neurology and we ask for any measures that might be out there. So, again, that's the – it won't be the last time you'll see projects may be not quite lining up with developer schedule.

(Daniel), would like to go ahead and talk about usability and feasibility, and I know we're way behind on our time. Again, I think many of these issues that you're raising now would come up on the later measures that we can just send with it, you know, repeating those things. But let's start for usability and feasibility.

(Daniel Less): Very good. So, on the usability point, in terms of usefulness for public reporting, the developers provided data on use of this measure already by CMS and work going on at the AAN, as well as the American Board of Psychiatry and Neurology to develop – use these measures for maintenance of certification.

The – in terms of usefulness for quality improvement, again, I think that that sort of rolls into the public reporting aspect, the same issue (up line) that is if you have to report this data as part of maintenance of certification, you're going to have to – you're going to want to try to improve your numbers and the concept here I think put forth by the developers is that just a very business of measuring these things is the usual way to see what physicians are doing and then promote improvement. As a group, the usability was rated generally high or medium. There was one reviewer who said it was insufficient.

I think the next – if there is no comment on that, perhaps the person who said they thought the data was insufficient might want to speak up. I'd be happy to move on to feasibility.

(Therese Richmond): Yes, this is (Terri) Richmond. I actually said it was insufficient only because it's hard to say it's highly usable for public reporting if we really don't know the validity and reliability data. So, my feeling was, you know, without that I find that – I think it's insufficient but intuitively and clinically I think it's very usable. I was just sort of following my logic because if you don't know validity and reliability, then how can you really say it's valuable for a public reporting.

(Daniel Labovitz): (Daniel Labovitz) here again. I think that's a very fair comment, and I think one of the elements that came out – one of the comments by one of the reviewers in going over this measure in general is that although there are a variety of tools suggested for use in terms of determining whether a patient is mild, moderate or severe dementia, that's not required. It can be a very subjective assessment. It may be that the subject of assessment is really quite good and better than (any of) the tool would deliver, but we really don't know how

this measure will performed and that I think, so I see your point about – if we don't know how it's going to performed, how do we know how usable is.

Female: (Inaudible). Yes.

(Daniel Less): In terms of feasibility, I think in general the group all agreed that the feasibility was high or medium, there were – nobody thought it was low or insufficient. This is something that can be generated in electronic data and already is being – and that's already being done.

Overall, in terms of preliminary assessment for suitability for endorsement, there were three yeses and three noes. We split right down the middle and my suspicion is based on the conversation we've had and the comments from the reviewers, that one of the – that the primary concern is really 1c. We're not worried about the overall impact, but we are worried about the scientific basis for doing this.

Karen Johnson: OK, great! I think that's a great summary, (Daniel). Thank you.

Let's go on to our next measure and that is Measure 2000, and (Ana) this one is yours and, again, and the (sort of) trying to get through all six measures and starts (inaudible) maybe do a very brief intro of the measure and then maybe just get if you're willing to be evidence question which I believe is the same for all of them and just concentrate on the things that maybe you had disagreements among the evaluator.

(Ana): OK, very good. This is a cognitive assessment new submission. The percentage of patients with the diagnosis of dementia, again, outpatient for whom an assessment of cognition is performed with a systematic process for instrument – identified instruments that presumably has demonstrated reliability and validity and as a cognitive neurologist formerly involved in head and (neck) disorder, (inaudible) and caring for patients with Alzheimer's and (tick) disease.

I can just state that, you know, this hidden disabilities unfortunately most practitioners even distinguish academic neurologist have an elevated view of the value of the history especially if it comes from an informant and then fortunately although positive reports are quite sensitive. There are many false negative, and there's not good in internal or external validity to this reports or history and therefore the value of systematic standardize testing is apparent for severities.

We talked about the four – the other area of value, however, is to identify specific syndromes or areas of dysfunction – patterns of dysfunction which not only have functional implications which are tremendously important for prognosis and specific treatment for areas of qualities not just medication adherence, self-management of diabetes, hypertension, et cetera that are also important for genetics identification for example of different syndromes and potentially even public health in ensuing generations.

With regard to the – again, skipping over the importance to measure and report which – as was stated is similar to previous and the scientific acceptability of measured properties which I would just add one note to what's been said before about the timeliness of this

which David referred to which is that – given that the AAN and other – American Academy of Neurology and other professional groups are determining what should be the maintenance certification, so the standards for quality of delivered professional care. It is kind of an important window now plus to look at these measures in a general group of practitioners to see if it turns out but not just experts but also, you know, the regular person doing such medical care would show benefit of doing these kind of regular cognitive assessments that are believed are suggested by consensus to be useful.

With regard to usability and feasibility then is that where I'm taking up Karen?

Karen Johnson: Was there any questions at all about scientific acceptability. I think one or two comments came up on that.

(Ana): No, I think we are…

Karen Johnson: Yes.

(Ana): … in a similar kind of situation to what we've talked about before where, you know, a number of three people voted that it wasn't – they were not as scientific acceptable to – that there was reliability was mixed, however, with three people finding it insufficient and one medium and I guess other people didn't vote.

Validity similarly people aren't impressed (inaudible) and has to do with the lack of specific as review of the information that was presented from the expert – the clinical standard practice guidelines.

Karen Johnson: OK, great! I think the one thing – and technically this comment probably would come under the one that we just finished the 1990. There was a question if you're doing the cognitive assessment in measure 2000, within the staging come under that and is there a need for two different measures?

(Ana): OK, let me just – what I said previously which was not unfortunately mentioned in the – in the application that – there's definite value in terms of quality of care and in outcomes of patients in identifying specific syndromes. So, for example, the visual variant of Alzheimer disease would presumably cause a very early risk of car crashes as – whereas other variants of Alzheimer disease it's more unusual. So, usual – unfortunately, it's usually formal assessment that identifies such a disorder in early stages.

(Daniel Labovitz): (Daniel Labovitz) here. As a non-cognitive specialist, I have to say that that level of sophistication is admirable, and I think important but rare, and I think we're asking a lot of primary care doctors who in terms of making an assessment gets that sophisticated. We're also asking a lot of them in terms of applying batteries that are really fairly lengthy to (TQs). Perhaps the shortest is the many mental state examination which (displayed) the least valid of all of them. And I just worry that one of the goals here is to (inaudible) roll all patient with dementia into sophisticated research clinics where much more time is spent in a typical outpatient practice.

(Jerry Johnson): May I comment on this. This is (Jerry Johnson). Can you hear me?

(Daniel Labovitz): Yes.

Karen Johnson: Mm-hmm.

(Jerry Johnson): The formal neuropsychological evaluation which would a lengthy evaluation and could be part of a research protocol is certainly not the standard is here. We described the submission, several different examples of screening even something as simple as the many (inaudible) which is not going to (take) long time to perform all the (blessed) memory test. Even the MoCA which takes about 10 minutes.

So, we are not talking about trying to get to the level of sophistication to diagnose a rare visual form of Alzheimer disease. We're simply saying here that a general cognitive screen should be – should be (part) of the assessment approach (inaudible) so that anyone who has enough – who has given a diagnosis of dementia should have cognition assessed on a periodic basis.

(Suzanne Theberge): This is Suzanne Dr. Johnson. I think the argument that's been made though is that otherwise this recommendation maybe iterative to the staging. Can you comment on that specifically?

(Jerry Johnson): Absolutely, I was thinking of that. It's clearly not iterative of staging because staging takes into consideration, physical performance, functional status, cognitive and behavioral. I think you know of submission (to you). We talked about cognitive and functional; I'm looking out over the submissions and preparation with this call. I noted that I would have included behavioral in that, too. That's kind of the way that we think about staging in general.

But they – if each of those need to be – needs to be done, so what we have done with the assessment components of the measures today, I think – I think three of them are about assessment and two of them really speak to interventions related to the caregivers but the ones that speak to assessment instead of making general statements about assessment, we are saying that person should be assessed in specific areas on cognition, function and two days ago, we talked about behavior, but the staging itself is a combination of all of those things not just one and the tools that are used with staging are not simply – they are not one as a combination.

So, there is some overlap. Obviously, a person's cognition has some influence on what the stage would be but a person might have very poor cognition and still be able to function at a moderate level depending upon the type of dementia that they have. So, it's not – they're not – they're not equivalent.

(Therese Richmond): OK. So, this is (Terri) Richmond. I know (inaudible) put that comment in there about why do we need both? You – (inaudible) is (satisfied) with that – that makes tremendous sense. So, thank you, Jerry.

(Jerry Johnson): Sure.

(Daniel Labovitz): That was helpful to me, too, as well – (Daniel Labovitz), speaking here. That was helpful to me, too as well but where I'm just puzzled is, it sounds like this measure which is a focus on cognitive assessment is really primarily about diagnosis, and I'm not sure that – I don't quite understand the value of reapproaching it year after year after year when what I've – what I – what I would imagine the main focus would be is – in ongoing follow-up is a degree of of decline in need for additional services or therapy.

Male: Let me comment on that, because you're exactly right. All of these measures are designed to help make decisions about management therapy. But dementia is sufficiently complex that those decisions are going to be based on all of these variables that really do need to be looked at discretely at practitioners for whatever the reasons have not recognized the importance of dementia and have not analyzed it in a critical way the way some other heart failure, heart disease, myocardial infarction, the way some other things are addressed.

So I mean I agree with there that that is point. So for example, it makes a difference when there is someone has mild cognition or severe cognition as to whether we would give them a cognitive enhancer or not and how long we would continue it and whether we would modify the dose or not better just leaving them on something that's not helpful and might even just have side effects.

Male: These points are very well taken and I'm embarrassed to say that my own practice isn't that good and I'm a neurologist. How do you think the primary care doc out in the field is going to manage with this?

Male: Well, we are able to teach medical students and primary care residents how to assess first the (inaudible) patient with dementia. We're not trying to teach them how to perform a neuropsychological evaluation for that. But we do want them to recognize when a neuropsychological evaluation is needed and then referred to a neuropsychologist. But they can screen for cognition and they can use one of these – one of these tools just like they've learned to use tools to give grades for other kinds of (monoclonal) entities.

Male: I think what I'm getting at here doing (inaudible) this is an inspiring perspective and as I look at it I see that there's a great deal more than I really ought to learn about making the assessment in the setting of dementia. But here I'd really want to see data that showed that doing this makes a difference. I think we're – it gets back to some of our trouble in terms of seeing how when this gets implemented, what happens, how do patients benefit, what is the mechanism there.

And I think although I'm inspired by this and would like to emulate some of these concepts in my own practice that's learning to do, I don't see that we have the basis tool, say, this is a quality measure that's valid and justified by clear demonstration that it produces a benefit.

Male: Yes. Let me comment on that. I was fascinated by the opening discussion about all of these measures. And as I was listening to the discussion, I was – I was (jabbed) by how we could possibly improve treatment and management of persons with dementia and monitor that if we don't – if we don't assess them adequately.

And then I wondered if what kind of evident-based or clinical trial the one possibly established that would show that the assessment itself just making the diagnosis and the severity and recognizes. If we (piece) the part each one of these measures and ask does the measure itself lead to improve outcomes, there's no way that could be true except to the pathway of improved management. So the question is does recognition of severity or dysfunction on assessment or does cognitive assessment influence or is it connected to management. That's kind of a research question not whether the assessment is by itself causes improved outcomes.

And almost the catch 22 years is kind of circle reasoning, but I just don't know how we can manage these persons actively without the assessment.

Karen Johnson: This is Karen from NQF. And I hate to do it but I'm (inaudible) stop that conversation now. (Ana) is there anything on feasibility that you wanted to bring out before we get to the next measure?

(Ana): I think the people were happy with that except that there was a comment that cognitive status was required only to be assessed in a quantitative or qualitative manner. Now, I personally didn't – I personally thought that referred to the type – to a deliberate generality in the measure with respect to the type of assessment that has to be done. And qualitative, you know, for example there are semi-quantitative measures that could be used and they could be accused of being qualitative rather than being quantitative, but there was a constraint about inaccuracy and error.

Gail Austin Cooney: This is Gail. That was my comment. But when I read the numerator statement, it seems to require the use of a validated tool, so I withdraw my comment.

Female: OK. So anything else, Karen? Can we go on just discuss the – we were split with regard to the suitability for endorsement.

Karen Johnson: OK, any other discussion on this measure then?

OK. (Ana), sounds like you've got your measure checked off now. And…

Male: Yes.

Karen Johnson: …let's go on to – just a second – Measure 2004. David, this is yours; functional status assessment.

(David Tirschwell): OK. And of course this is another diagnostic assessment that's similar although not precisely overlapping with the other ones. The brief description is that is the percentage

of patients with dementia when a functional status is performed and reviewed within a 12-month period.

And they say that the functional status can be assessed by direct examination or knowledgeable informant to include at a minimum and evaluation of their ability to form instrumental activities of daily living and basic activities of daily living. Can also be assessed using on of a number of available valid and reliable skill. So just you don't have to use the scale as long as you ask about the IADLs and the ADLs and they list the examples.

You know, there are no – the exclusions I guess are just the medical reason for not assessing functional status if they're sort of beyond, they're so severe, they're beyond that or there are some other medical reasons. There is no analysis at the clinical level.

Going to the importance of the measure, 1-A, everybody thinks and believes that Alzheimer's disease is a huge problem. And as far as the performance gap, everybody also believed that this as far as the reports that were described this wasn't being done instantly. In fact only in the minority of cases and so there is a huge gap in the performance of a documented functional assessment.

The evidence of course is the problem area again. In this case, the bottom line was that two thought there was sufficient, four did not think there was sufficient including three people, myself included who consistently rated insufficiently. And again, it was that they simply refer to the guidelines, don't identify studies versus articles. It didn't give any specifics really of what the evidence that was presented.

Contrary to that, the comments for the two influential practice guidelines summarizing hundreds of articles but did not specifically enumerate articles point functional status except the California group called out 13 articles in the functional status section. Another comment was that the studies do not show how measurement of this will change quality of life or long-term (error) placement, the impact of changes in care that seemed to have impact but you need to measure if you're going to change. If so affect though we should measure I think is how that goes.

Moving on. Anybody have any – want to add any comments before I move on to number two?

(Jerry Johnson): This is Jerry. I just want to refer to the article.

Male: Jerry, I was sympathetic to this measure more than the others. I'd like the process and I'd like the idea that we might look to see that people are checking to see how well their patients are functioning. But I'd still – I was one of the people who rated it insufficient. I just want to see the data.

(David Tirschwell): Or at least hear somebody describe how somebody else summarized it which was also lacking. I think our APA representative want to say something.

No? Are you still on line?

Female: Yes sure they are, David. And just a reminder it's star-six if you want to unmute. Just to take the APA folks (inaudible).

(David Tirschwell): OK. Well, I'm going to proceed ahead.

As far as scientific acceptability measure properties, reliability and validity, there were a couple of high and moderates two and three insufficient. But they, you know, clearly didn't try to present any reliability and validity data. As far as the specifications go, nobody seemed to bring up any points in argument against those specifications as presented. As far usability goes, three rated high, one medium, two insufficient.

You know, as far as using it for Q.I. and this was comment, he described that the neuro P.I., process improvement, that's when the American Academy of Neurology are going to be used it but don't really have any evidence to suggest that it's meaningful, understandable or changes quality of care.

Another comment that a number of organizations will be using the information, somebody else noted that it was insufficient because of the lack of validity and reliability, but intuitively it made sense. As far as feasibility goes, seems like most people thought it was at least moderately feasible. One person comment there was no requirement that the functional assessment use a validated tool. And so if not, how will changes over time be measured if not objective so it could be a minor issue there as to how things are defined.

So and then, as far as preliminary assessment feasibility for endorsement it was split right down in middle; yes three, no three and it's really just a reiteration of the same arguments that we've already covered.

(Diedra Joseph): Hi. This is Diedra. I just wanted to add a comment if I may about the evidence. We realized that within the submission forms, there's a lot of information with regards to the studies and the review of the body of evidence in order to develop the guideline recommendations. However, we just wanted to clarify that the information that you're looking for is not available in the actual guideline.

And so, we would like to be able to provide this information that's not available to us either and I'm certainly going to try and reach out to APA staff offline and try and locate more information. But all we really have is in the beginning of the guideline it states how the review was conducted and, you know, like a Medline review that yielded, you know, so many articles, so really all we have is what's in the guideline and of citations and so that's what we've provided.

(David Tirschwell): That's the long version of the guideline or is that like the executive summary with just the recommendations? Because…

(Diedra Joseph): No, that's the long version of the guideline as same as true with the other guidelines that we have. And I have reached out to with the California workgroup which is another

guideline developer that we cited in some of the measures and the information is just not available to us as the measure developer. But…

(David Tirschwell): So they present these references but don't describe at all what the study showed?

(Diedra Joseph): Correct. There are some – whatever they described is included in the submission form. And if we have more information and we would love to give it to you, we just don't have it.

(Terri Wilson): This is (Terri Wilson). I find that even more concerning then in terms of how we are supposed to adjust the evidence of this for the first criteria.

(Jerry Johnson): This is Jerry. I wanted to say one thing about some of the evidence, ex this kind of presented in more than one place. For example, under 1C.1, this structure process outcome relationship they are referenced as to specific article, not references to the clinical guidelines. And these are references that speak to the importance of functional status assessment. They don't necessarily – there's not one of them that's a randomized trial of outcomes, but their specific reference is not, they're not just the clinical guidelines.

And the last comment I will make is that in relation to the guidelines that are mentioned across this; the APA, California workgroup, and the Canadian Consensus Conference. The Canadian Consensus Conference won, is kind of the most scientific and the way that it's described its recommendations and the basis for its recommendations.

(David Tirschwell): Sounds like (inaudible) to put in a revised (inaudible).

(Jerry Johnson): But I don't know if those references are under 1C.1 were acknowledged when it was stated that there are no references to specific articles.

(David Tirschwell): So those don't link structures or processes to outcomes. They just emphasize the point that functional status declines. Of course we agree with.

(Jerry Johnson): No. For example, I'm looking at an article the Ability to Perform Activities of Daily Living. It's the main factor affecting quality of life, by (Anderson). So that is the question.

(David Tirschwell): Well, actually I think the question is whether measuring whether providers are documenting with the form of scale functional status affects quality of life.

(Jerry Johnson): Yes. That's the testing issue. So we're proposing a measure based upon evidence that the measure makes sense as an important and is important and it's a performance gap. And now we've got a test to reliability and validity of these measures itself.

Karen Johnson: This is Karen. And I do want to point out that David is correct. The measure is, are you – it is documenting functional status and the articles cited don't actually share the link of the documentation to the outcome.

Because of time, I think we do need to go on to the next measure. So that is Measure 2028, counseling regarding safety concerns. And Terri, that was yours.

(Terri Wilson): OK. So this is another class of measure that (inaudible) submission that's looking at a the denominator I believe of all patients with a diagnosis of dementia and the numerator is the percentage of patients with that diagnosis or their caregiver ordered counsels or referred for counseling for safety concerns in the previous 12-month period.

And then so it's easier to say we're counseled or they are referred from counseling and counseling as defined. They've provided a list of comment basic concerns that would fit with the numerator, but clearly there are safety concerns that extend beyond this list. So that's the measure.

The impact, the group felt was moderate to high. The performance (inaudible) performance improvement was also favorably with (youth). The issues with the evidence were sustained, so I'm not going to reiterate that. Is that OK?

Karen Johnson: That's great, (Terri). Thank you.

(Terri Wilson): OK. The scientific accessibility, there's the same issue. I think that there is a – I've made a comment actually about the numerator. And that what we're comparing is to meet this because it's yes I did it. We just had to be able to (inaudible) either counseled or refer for counseling for any safety concern.

So I can have one provider instead of providers, you know, really counseling for every safety concerns because there's probably a highly interrelated versus (inaudible) you know, assesses for one. So I'm just wondering really to comparing the same thing across the board. And my other question with the specification is, really isn't that we've assessed any safety concerns with this and the counseling is (inaudible) with our safety concern it's just that they're counseled for safety concern.

So nobody else had comments or concerns on that, so that's maybe isolated to me.

Karen Johnson: Does anybody have any – any of the steering committee members have any comments about that that (Terri) brought up?

OK. Sounds like not, (Terri). Go ahead.

(Terri Wilson): All right then. We're going to move on to usability. Usability was either a high or moderate except the one (inaudible) with me again because of the essence of validity and reliability. And feasibility was also possibly (inaudible) as either high or moderate and overall in terms of needing feasibility for endorsement is the same breakdown as there yes and three no.

Karen Johnson: OK, great. Do any of the steering committee members have any concerns or questions about this measure that haven't already been addressed with the other measures?

OK.

Male: Speaking up here.

Karen Johnson: Oh, go ahead. Yes.

Male: Sorry. The American Academy of Neurology just published I think last year a practice parameter on assessment of driving in the setting of dementia. I think there was – that was a report that had a tremendous amount of data cited. It was clearly an evolution in the way the American Academy has been approaching this stuff and it's more and more building into the evidence base.

And I feel like – I know from that that there are good data out there that there are studies that really look at this question, but I feel like I didn't have the time to do the research that would have been necessary to do it. Now I would have hoped to really get more on this from the developers. There's stuff out there and it can be found. This is – that's my only comment, otherwise unless – looking at what I've got in front of me, I can't make an assessment.

Female: This is the – at the AMA, I just wanted to point out that the information is your reference name that was published by the AAN actually support the counseling regarding risks of driving measure which is measure number 2029 and that report is sighted in support of the risk of driving measure specifically.

Male: I do apologize I got 2028 and 2029 reversed. I think that speaks to how difficult it is (inaudible) when she got down this deep so I reserved my comments for the next discussion.

Female: OK. With that why don't we go ahead into the driving measure and Dave, that one's yours.

(Joseph Smith): Hi. It's (Joseph Smith), David Knowlton's assistant. His cell phone unfortunately died in the middle of the call but he and I worked on these issues together and he informed that it would be all right if I would present what he would have presented to the group.

Female: I think that's OK. Just if you can do it very quickly and just make sure that we have plenty of discussion from the committee members.

(Joseph Smith): Of course. So this is measure 2029 counseling regarding risks of driving. It's dementia patients were counseled about risk of driving the past 12 months in the numerator dominator it's on all those patients diagnosed with dementia, there were some exemptions including those who weren't currently driving and so would not require this type of counseling.

The group are keen to agree on the performance gap is even moderator high and she would agree on impact but it's split on quality, quantity and consistency of evidence at

previous discussions uploaded. In other categories there was one person, her scientific acceptability split down the middle. So if there's any discussion on that point?

Female: OK, sounds like nobody has any extra comments on importance. You want to move on to scientific acceptability?

(Joseph Smith): Yes. Scientific acceptability is one that we put down – we put down the middle. On usability, there was one person who said there was insufficient, the other – the others – everyone else in the committee said either high or moderate for that – for that person. Want to just speak up?

Male: There's a (inaudible) that I have with the other measures that in the absence of solidity and reliability data. It's hard to say it's adequate yet for public reporting.

Male: OK, anything else as far as usability? Usability was again are moderate for most – for all members of the group. The vote this time was endorsement was two yes and four no. An additional issue noted for this measure that Dave actually noted in his comments was that the driving is listed as one of the things to be considered in the numerator statement in measure 2028.

And so there is a question as to whether communization between measure 2028 and 2029 would be appropriate.

Karen Johnson: And this is Karen and maybe another question might be, is the separate driving measure necessary given the safety measures (inaudible).

Male: Yes. I think Dave would also agree with that question.

(Jerry Johnson): This is Jerry I (inaudible).

Female: Discussion from committee members? What's if committee members discuss a little bit first this if you mind (inaudible).

Female: Committee members have no comments on this?

(Daniel Labovitz): (Daniel Labovitz) here just to make a point, I couldn't – I had a hard time distinguishing between these two measures and got them confused. I think If they really were separate distinct measures to be put out there it would become a logistical nightmare to keep track of for the practitioner.

I think we're now talking about a very large list of things that have to be done once a year on a patient who has dementia. I'm also a little concerned on this one particular in terms of driving. I don't think that's a reasonable discussion to have in many patients who are in the hospital with other diseases.

I also am worried that the exclusions are really uncertain for me here when I didn't quite understand but it seems to me that there are many reasons why you might not discuss

driving with the patients, they may not drive at all. But you have to document that and that becomes I think a real burden to put down the obvious particularly in some who has got advanced dementia or otherwise severely ill or like me just a city dweller. And it just doesn't seem fully cooked

Is there – maybe you can speak to that. Is there a place in most electronic medical record for (inaudible) something like that? You know, to present action systematic that could be evaluated if you want them to collect some more quantitative analysis on the center.

(Daniel Labovitz): (Daniel Labovitz) here. I'm not aware of anything that exist now that would accomplish that. Certainly an EMR could be the one could create a field that might start to capture those data but it would be fairly complicated field.

There are lots of reasons why you might not be a driver but it might be imminently obvious to the practitioner when you roll into the room, you know, you're in a wheelchair and so it's capturing those data and doing it appropriately. It's another click for the provider and an EMR, another field that has to be filled out among hundreds. And I think that it starts to interfere with the process of actually providing care to the patient when you're required to document the obvious.

Male: Thank you for that. Are there any other comments regarding this issue on whether the measure is necessary or communization was measured 2028 or comments in general on this particular measure?

Female: OK, sounds everybody is done with that measure for now at least. Let's go ahead and go to measure 2030 and (Gail) that one's yours, caregiver education and support.

(Gail Cooney): Hi, 2030 is a process measure looking at the percentage of patients who's caregiver is provided with education on dementia disease management and referred to additional resources so this one is a little different than the other that we've – others that we've looked at. The denominator exclusions or medical reasons for not providing the caregiver with education, including the patient doesn't have a caregiver.

The importance to report had the same split and the same issues everything that we've talked about for both impact and evidence. Scientific acceptability again, we don't have any data. I think the one question would be which is a little bit with the counseling on (inaudible) that came up earlier is whether or not what the quality of the recommendations were as opposed to whether or not they just happened.

Usability, there was one insufficient and I respect that the same question we'd been having. Feasibility again they generated CPT-2 codes for measuring these which makes it barely feasible for position billing and we are split two-four – two-four, most of them were three-three, this one ended up two-four in terms of its (suitability) and the rationale was that the connection between education resource (inaudible) and improved care is that clearly made.

I do not think that the comment at the contents of the measure are included in 2028. I don't think they are but if somebody would like to speak to that.

Female: I'm sorry, can you restate the question?

(Gail Cooney): Somebody had made a comment under preliminary assessment that the contents of measure 2030 are explicitly included in measure 2028, that's the same comment that was made on the driving issue but because this is a caregiver education, I think it is clearly a different measure.

(Joseph Smith): Sorry. Just a question, (Joseph) just jumping in here. That comment with Dave, the reason is because the numerator statement or measure 2028 notes patients or caregivers who were counseled. And so that's why you need that comment.

Female: But I think that the subject of the counseling is different in the two, the subject of the counseling and the safety concerns is safety for the patient and the subject of the counseling in 2030 is support for the caregiver.

Male: And also on the case management of the patient, that 2028 and I agree with you. I think they are to stick with that plan.

Female: Any other discussion about this? Again, we're sort of lacking the connection between whether measuring this results in improved care but again I guess I'm on the side of the argument that we have to measure first in order to know what we're doing and so that we can then just know what we're taking care of so that we can offer appropriate care.

If we don't measure, we don't know what we have. OK. So then, everybody's quiet.

Female: OK. Well, again I think the issue is that you guys talk through on this six measures are also going to be very apparent and the other measures and your colleagues on the steering committee in the different work groups looked at the epilepsy measures and the Parkinson's disease measures then the other dementia measures did struggle with that whole idea of it's good to be doing practice should it be a national standard.

So with that, I think if nobody else has any questions or any other comment, I will hand it over to Suzanne.

(Suzanne Theberge): All right. Thanks everybody. So for next step, we'll follow up with the developer regarding any changes that may need to be made to these measures. For the steering committee members, your next steps are to begin reviewing the rest of the measures, everything that was not covered on this group that are all listed on PowerPoint. You've probably seen those already.

And we'll be seeing you in a couple of weeks here in DC for the in-person meeting. You should have received an email from our meetings department last week with information about registration for the meeting, travel arrangements and your hotel reservations. So

please register for the meeting so we can get everything setup for you and make sure you have a hotel room.

If you did not get that email please let me know and we'll resend it. It appears that a couple of people didn't get it so let me know if you didn't get that. And that's about it, I think. Yes, we'll follow up with you next week with the summaries and transcripts for this calls.

And oh, and I've been just reminded that we actually need to do the public and member comment period and so before jump in to that, I just want to see if any committee members have any process questions.

OK. With that we'll open up for public and member comment. (Kathy) can you open the lines for public comment?

Operator: Just a minute. This time if you would like to ask a question please press star then the number one on your telephone keypad. And there are no questions at this time.

Female: All right. Well with that we will sign off and everybody have a good weekend and you'll hear from us next week.

Female: OK, thanks so much.

Male: Thank you.

Female: Thank you everybody.

Male: (Inaudible) bye.

Operator: Thank you. This concludes today's conference call. You may now disconnect.

END