National Quality Forum
Patient Safety Committee
Friday, June 4, 2021

The Committee met via Video Teleconference, at 1:00 p.m. EDT, Ed Septimus, Co-Chair, presiding.

Present:

Ed Septimus, MD, Texas A&M Health Science Center and Harvard Medical School (Co-chair)
Joel Bundy, MD, FACP, FASN, CPE, Sentara Healthcare
Elissa Charbonneau, DO, MS, Encompass Health Corporation
Curtis Collins, PharmD, MS, St. Joseph Mercy Health System
Theresa Edelstein, MPH, LNHA, New Jersey Hospital Association
Jason Falvey, PT, DPT, PhD, University of Maryland School of Medicine
Sara Hawkins, PhD, Rn, Cpps, Eastern Idaho Regional Medical Center
John James, PhD, Patient Safety America
Arpana Mathur, MD, MBA, CVS Health
Raquel Mayne, MPH, MS, RN, Hospital for Special Surgery
Edward Pollak, MD, Henry Ford Health System
Nancy Schoenborn, MD, American Geriatrics Society
David Seidenwurm, MD, Facr, Sutter Health
Geeta Sood, MD, ScM, the Society for Healthcare Epidemiology of America
David Stockwell, MD, MBA, Johns Hopkins University and Pascal Metrics
Donald Yealy, MD, Facep, University of Pittsburgh
Yanling Yu, PhD, Washington Advocate for Patient Safety

NQF Staff:

Matthew Pickering, PharmD
Jesse Pines, MD, MS, MBA
Tamara Funk, MPH
Isaac Sakyi, MSGH

Shalema Brooks, MS, MPH
Yemsrach Kidane, PMP

Also Present:

Rachel Harrington, NCQA
Caitlin Li, Massachusetts General Hospital
Pamela Lighter, NCQA
Doris Peter, Yale Core
Bob Rehm, NCQA
Patrick Romano, UC Davis
Stacie Schilling Jones, IMPAQ International

Contents

Proceedings

(1:01 p.m.)

Welcome and Review of Meeting Objectives

Dr. Pickering: Welcome, everyone. Welcome, again. It's great to see some of you, if you're using your video feature, if you're on the WebEx platform. Welcome to the Post-Comment Standing Committee meeting for the Patient Safety Fall 2020 Measure Evaluation Cycle.

Again, my name is Matt Pickering. It's a pleasure, again, to meet with you all again.

The purpose of these post-comment meetings, just to, for those of you that are new to the Standing Committee, but also just a refresher for those that have been serving on the Standing Committee, is to review comments that have been received for measures that have been evaluated by the Standing Committee. Those comments could be of support or non-support, raise some concerns.

And this same committee evaluates those comments, or at least listens to the themes of those comments, and proposed committee responses that the staff have generated for the Standing Committee to agree with or disagree with, and really think about if there's anything new that has been shared through those comments related to the measure evaluations that have taken place.

In addition, these post-comment meetings are also an opportunity to revote on measures that -- in which consensus was not reached during the previous committee meetings.

So, in this case, there is an opportunity for the Standing Committee to revote on two measures, specifically for the evidence criteria. And we also will

consider comments related to those measures to help inform the Standing Committee's decision to come to consensus.

I'll state now but also will iterate again that there is no gray zone for consensus not reached, or revote decisions, I will say, for post-comment meetings. So if you recall measure evaluation meetings, a gray zone would be between the area of 40 to 60 percent of the votes would not be landing, or excuse me, would not be getting more than 60 percent of the votes in either pass or did not pass. So you would land in between those 40 to 60 percent range.

And that's a consensus not reached, a decision. And so those decisions are then moved to post-comment.

We do not have that 40 to 60 percent gray zone. It's an effort to drive to consensus. So, in order for a measure to pass on a criterion that's being revoted on, such as evidence, there needs to be more than 60 percent of the Standing Committee voting today to pass that measure.

So, if it's a high, moderate, or low type of question or responses, more than 60 percent of the responses need to be in the moderate or high range in order for that measure to pass. So there's no gray zone. It's helping to drive to consensus. So we'll state that again as we get more, closer to the voting portion of the meeting today.

But, again, welcome everyone. I'll go to the next slide, Isaac. And then I'll also turn it over to Ed. You can give some welcoming remarks as well.

And I also will say that Iona, who's our other co-chair, unfortunately could not make the meeting today. But she also sends her welcome and her gratitude for all the work that the Standing Committee is doing this cycle and also the proceedings today.

Ed, would you like to give any welcoming remarks?

Chair Septimus: No -- again, I will second Iona's comments. She felt bad that she couldn't make it. But she did have a pressing thing that she needed to attend to during this time.

And, again, I want to send my great thanks to all of you, because we know this, that being on a NQF committee does require, I think, time, and you've all done a superlative job.

And I also want to say thanks that Matt is sticking with us. And it's really great to have his support and all the support from the other NQF staff. We could not do these kinds of evaluations without their support.

So, with that, Matt, I'm going to turn it back to you.

Dr. Pickering: Thanks, Ed. Thank you very much.

I'm just going to touch a few housekeeping items here. So, first of all, we like to change it up on our Standing Committees. We like to just keep up with the technology and make sure that you're doing the same.

For those of you that have been with NQF for a while, you've seen us go through CenturyLink platforms, some RingCentral platforms. We're now on to Webex.

And so we see that the majority of you have logged in just fine. So we do have our staff monitoring the inbox. So, if you are experiencing technical difficulties, please ensure, or you can send a message through the inbox, which is patientsafety@qualityforum.org.

But like all of our other similar platforms, this has a lot of that functionality. So there's a mute feature, right. There's a raised hand feature.

And what I have found is if you go to the participant list and find your name and just hover over it, you'll then see a little hand that comes up. So you can click on that, and that will indicate that you have your hand raised. So we'll monitor that as well.

And then there's the chat feature. And just like other platforms, you can send comments through chat to everyone or privately if you wish. We also have our team monitoring the chat feature.

We welcome you to just chime in verbally. But if you are just wanting to share some thoughts through the chat or want to be recognized, we will make sure to monitor that and call attention to what you have shared.

If you're not speaking, we do ask that you put yourself on mute just again to prevent any background noise.

And if you'd like to present or talk, provide, add to the discussion, please use the video feature. I mean, this allows us to keep our committees or these meetings more engaging to use the video feature.

So just a few housekeeping items there. Next slide, please, Isaac.

And here's the team. You can see there's quite a few folks here, new faces as well. We've gone through some transitions. So we've got some new faces on the team. I'll just give a brief moment for those on this slide to just say a quick note of hello and introduce themselves.

Again, my name is Matt Pickering, a senior director here at NQF. Been on the Standing Committee now since I've joined NQF, about a year and a half.

I'll turn it to Jesse. And then we can go down the list here. Jesse, are you on the line to say hello to the

group? And Jesse might be running a little behind so far.

So we'll go to Tammy. Tammy, would you like to say hello?

Ms. Funk: Yes, hello. Good afternoon. This is my first meeting with the Patient Safety team. So I'm excited to join you and excited to hear how the discussion goes for this and upcoming meetings.

Dr. Pickering: Thanks, Tammy. And, Isaac?

Mr. Sakyi: Good afternoon, everyone. This is Isaac. I'm the senior analyst on this project. And it's lovely to see some faces again.

Dr. Pickering: Thanks, Isaac. And, Shalema Brooks? So Shalema may not have been able to attend the call today. But Shalema is a new director at NQF. She's helping to support this project as well. So she had a conflict during this time. So, but she definitely wanted to share her thanks for being on this committee and looking forward to learning and working with you all as well.

And Yemi? Yemi also may be tied up as well. It's a Friday. It's a Friday, and everyone is sort of tied up with other meetings. But we appreciate everyone else being on the call today. And the other team members may be joining in a little bit later.

So, for the agenda today, as you can see now we're on slide 5. We'll just do a quick attendance. Again, since we are voting today, we need to establish a quorum. So we want to make sure we recognize who's on the call as well.

And then we'll go straight into the consideration of the consensus not reached measures, so those measures we also will be revoting on, which is two measures.

And then we also will then continue with the review and discussion of public comments. So, after we revote on these measures, we'll then go through the other measures, specifically the comments that were received.

Those measures did pass during the measure evaluation meeting. So this is just an opportunity to review those comments and, like I said, the proposed committee responses related to those comments.

After which, we will do a related and competing measure discussion. We did have this previously during the measure evaluation meeting that happened earlier this year. But it was only for measures that actually passed the, with an overall recommendation for endorsement.

Since we are revoting on two measures, those technically didn't get an overall recommendation for endorsement vote since evidence is a must pass criterion. And so all must pass criteria need to pass in order for an overall recommendation vote to occur.

And then if that passes, we do related and competing measure discussions. So it's only for those measures that have passed with an overall recommendation for endorsement.

So, if those two measures do pass today, we will then go to the related and competing measure discussion for those two measures and see if you have any questions or recommendations to the developer for harmonization purposes for the measures that are listed as related for those two measures.

After that, we will then have, open up for NQF member and public comment, in which we will then adjourn after talking about next steps.

I will go to the next slide. And we can just do some attendance.

And before that, I just want to, I'll take a quick pause to see if there's any questions related to what we'll be doing today or if anybody has any questions related to technical issues.

Chair Septimus: Yeah, Don had had a technical issue. Don, can you hear me? I wonder -- he sent out a message that he could get on, but he couldn't see or hear anyone.

Dr. Pickering: Oh, I'm --

Chair Septimus: So --

Dr. Pickering: -- trying to scroll through. I don't see his name on here.

Chair Septimus: Yeah, so, I don't know if someone could reach out to Don while we're doing attendance --

Dr. Pickering: Yep.

Chair Septimus: -- but he sent that note out.

Dr. Pickering: Yeah, so the team is responding to him through email. So we'll see if we can get him set up. We may have to circle back and see if he's on.

Attendance

Dr. Pickering: So we'll just go through the roll call here. So this is not any sort of disclosure of interests, as we've done previously. This is just to see who's on the call. So you can just say present if you're on the call as I'll go through just for the record. Ed Septimus?

Chair Septimus: Present.

Dr. Pickering: Thank you, sir. All right. And Iona Thraen? Okay. Emily Aaronson? Emily Aaronson?

Participant: She's on maternity leave.

Dr. Pickering: Oh, okay. Thank you. That's correct. Joel Bundy?

Member Bundy: Present.

Dr. Pickering: Thank you, Joel. Elissa Charbonneau?

Member Charbonneau: Present.

Dr. Pickering: Thank you. Curtis Collins?

Member Collins: Here.

Dr. Pickering: Thank you. Theresa Edelstein?

Member Edelstein: I'm here.

Dr. Pickering: Thank you. Jason Falvey?

Member Falvey: Present.

Dr. Pickering: Thank you. Terry Fairbanks? Terry Fairbanks? Okay. Robert Green? Is Robert Green on the call? Sara Hawkins? Bret Jackson? John James?

Member James: Present.

Dr. Pickering: Thanks, John. Laura Kinney? Laura Kinney? Okay. Arpana Mathur?

Member Mathur: Good afternoon. Present.

Dr. Pickering: Thank you. Raquel Mayne? Raquel Mayne?

Chair Septimus: I'm sorry. Did you, Raquel, did you say something?

Member Mayne: I did. Can you hear me?

Chair Septimus: Yeah, barely.

(Simultaneous speaking.)

Chair Septimus: Okay. But you're here. Okay. Great. Count her present.

Dr. Pickering: Thank you, Raquel. Okay. Anne Myrka? Anne Myrka? Okay. Edward Pollak?

Member Pollak: Hi. Good afternoon. Present.

Dr. Pickering: Thank you. Jamie Roney? Jamie Roney? Nancy Schoenborn?

Member Schoenborn: Present.

Dr. Pickering: Thank you. David Seidenwurm?

Member Seidenwurm: Here.

Dr. Pickering: Thank you. Geeta Sood?

Chair Septimus: I know she's here.

Dr. Pickering: Geeta, are you there?

Chair Septimus: Geeta --

Member Sood: Yes. Hi. I had trouble unmuting. I'm here.

Chair Septimus: Okay.

Member Sood: I'm looking forward to the discussion.

Dr. Pickering: Thank you, Geeta.

Member Sood: Thank you.

Dr. Pickering: David Stockwell?

Member Stockwell: Hello. David Stockwell is here.

Dr. Pickering: Thank you. Don, I see you're, you've message through the chat. Are you, Don Yealy, are

you able to get on the call? Are you there?

Member Yealy: I am. I'm here.

Chair Septimus: Yeah, he's here. I can see. He signed on. Good, Don. I'm glad you got on.

Dr. Pickering: Okay. And, Yanling Yu?

Member Yu: I'm here.

Dr. Pickering: Okay. Is there anyone else on the call that is not, that we did not call their name?

Chair Septimus: So how many do we have then? Who has a total of the number?

Dr. Pickering: So we have 16. But Emily Aaronson is on maternity leave. So she's actually been moved to sort of -- she's inactive.

Chair Septimus: Okay.

Dr. Pickering: So I'm just confirming with the team here.

Mr. Sakyi: So, with Emily being inactive, that gives us (audio interference) Standing Committee members --

Chair Septimus: I'm sorry. How --

Mr. Sakyi: -- quorum of 15.

Chair Septimus: How many -- so the quorum is 15?

Mr. Sakyi: Yes, with 24 Standing Committee members.

Chair Septimus: All right, 15. So how many do we have? What's the total --

Dr. Pickering: Sixteen. We have 16 on the --

Mr. Sakyi: Sixteen.

Chair Septimus: Sixteen. Okay. Great. I was getting --

Mr. Sakyi: So, with 24, quorum is 16. I apologize. We have 24. A quorum is 16. And we have exactly 16.

Dr. Pickering: Sixteen.

Chair Septimus: Okay. I was getting nervous. We're right at the edge there.

Dr. Pickering: Right at the edge. Is anyone else on the call, just joined that we did not call?

Dr. Li: Hi. I'm on the call. My name is Caitlin Li. I'm one of the CRICO fellows at Mass General Hospital. So I actually work under Emily Aaronson. And I was joining to learn more about the NQF activities.

Dr. Pickering: Oh, thank you. Thank you. Yeah, so we were, so you would be -- thank you for joining in and attending. So, with Emily not being here, you wouldn't have the voting capabilities that she would. But thank you for joining. I appreciate that.

Dr. Li: Oh, yes. I apologize. I understood that. I just wasn't sure whether you wanted to know about any strangers who had joined.

Chair Septimus: Just one quick thing, Matt, just as a follow up, I'm going to try to monitor when you raise your hand so I can make sure that we try to do it in the order and don't miss anybody. So I think, Matt, you're going to monitor this also?

Dr. Pickering: That's correct.

Chair Septimus: Yeah, we'll try making it as orderly as possible. But if you'll, if use the raise your hand function, we'll make sure that everybody gets a

chance to speak, if you want to speak, if you want to speak.

Dr. Pickering: Okay. All right. So we will proceed. So now we're going to go to a voting test. So, again, this is now where you have this Poll Everywhere link, so if you wanted to open up that Poll Everywhere link.

Chair Septimus: Who thought of this question?

Mr. Sakyi: This is for you, Ed.

Chair Septimus: This is for me?

Mr. Sakyi: Yes.

Chair Septimus: I guess my chairmanship or chairpersonship is on the line here.

Mr. Sakyi: So the link to the Poll Everywhere platform was sent out prior to this meeting. Please refrain from posting it in the chat as it is only for Standing Committee members. So, if you don't have access to it, let us know and we'll send it to you directly.

So the question you see on your screen is do pineapples belong on pizza. And the options are A for yes and B for no. And we are expecting 16 votes. And we have 14 so far. Yes, we will see the results. I believe one person is having difficulties with the link.

Dr. Pickering: So, David, was it you?

(Simultaneous speaking.)

Dr. Pickering: David, are you having difficulty with the link? David Seidenwurm, can you hear us?

Mr. Sakyi: Yes, it is David Seidenwurm.

Dr. Pickering: Okay. So we are going to be --

(Simultaneous speaking.)

Member Seidenwurm: -- regarding the link not the pineapples, if you can send me the link again, that would be great.

Dr. Pickering: Sure. Okay. So we'll resend you the link, David. What we can do is we'll follow up with you when we get to the voting portion of the meeting as well.

So we will move forward just to make sure that -- oh, okay. So nine people say yes and six say no. Yeah, so it's a pretty decent distribution there. Okay. Some of you don't --

Chair Septimus: Is that --

Dr. Pickering: -- like pineapple on pizza.

Chair Septimus: Is that consensus reached now, Matt? I mean, we have to --

Dr. Pickering: Yeah.

Chair Septimus: We have to have another question if consensus is not reached.

Dr. Pickering: That's right. That's right. Well, let's see. That's nine in favor. So, no, it's not actually.

Chair Septimus: No, I think we're short.

Dr. Pickering: No, we're a little short.

Participant: Short one vote.

Dr. Pickering: One vote. Okay.

Chair Septimus: So let the minutes reflect that we did not reach consensus on --

Dr. Pickering: Did not reach consensus on --

Chair Septimus: -- whether pineapples should be on

pizza.

Dr. Pickering: -- on pineapple.

Member Yealy: And, Ed, I'm happy that my negative vote made sure we didn't get consensus on that.

(Laughter.)

Dr. Pickering: Okay.

Chair Septimus: Okay. Matt, let's get into the business.

Discussion and Revote on Consensus Not Reached Matters

Dr. Pickering: Yeah, so thank you all very much. And I appreciate, again, going through the voting test.

So, as a reminder, we have two measures that we'll be revoting on today, both on the evidence criterion. And again, there's no gray zone here. So we have to have more than 60 percent of the Standing Committee members vote to pass, in passing to pass on the evidence criterion.

And then if they do pass on the evidence criterion, we then will move to an overall suitability for endorsement vote.

And so, again, that's more than 60 percent of those on the call voting would be in favor of recommending for overall suitability for endorsement.

So the first measure that we have up, and how this will proceed, is that I will remind the group of what happened previously related to the discussions that this committee had related to the specific criterion that we'll be revoting on, as well as do a summary of the comments that were received related to this measure.

I will then turn this over to Ed to also provide the opportunity to, for the Standing Committee to discuss any questions, concerns that still, that you still may have related to the evidence criterion.

Again, these are measures that, we're only focusing on evidence. So we're not revoting on any of the other criterion. So the discussion should be focused on the evidence. Is there evidence to support the measure, right?

And these are process measures. So we're looking to see if there's evidence here that shows that there is some sort of a process that can improve that outcome, so that can improve some sort of outcome in quality of care.

0022: Use of High-Risk Medications in Older Adults (DAE)

Dr. Pickering: For 0022, it's the use of high-risk medications in older adults. And before I get started, I also want to check in with the measure steward, NCQA, the National Committee for Quality Assurance. Is NCQA, is someone from NCQA on the call today?

Ms. Lighter: Hi, this is Pam Lighter. I'm here from NCQA.

Dr. Pickering: Great. Thank you. And so, as you could see, the developer is on the call in case the Standing Committee has any specific questions that maybe the developer can answer.

But for the most part, we do want to ensure that the committee just get some discussion amongst themselves. But if there is a specific question the developer could answer, they are on the call. So thank you, NCQA, for being on the call.

So, a reminder, this measure is the percentage of patients 65 years of age and older who received at

least two dispensing events from the same high-risk medication. A lower rate represents better performance.

Again, we're revoting on evidence. So there was consensus not reached on evidence, because the Standing Committee had several concerns about the list of medications being a list of best practice recommendations rather than sufficient evidence to link their use directly to clinical outcomes.

So, more specifically, the measure is based on the American Geriatric Society, or AGS, Beers criteria, which includes drugs recommended to be avoided for older adults.

So, during the consideration of evidence for this measure, the Standing Committee questioned whether the medications for use within measures included those listed in the Beers criteria, namely Table 2 within the Beers criteria, that had low-grade evidence.

The developer did clarify during the meeting that some medications included in the measure possesses low-grade evidence.

There was also concern raised that the Beers criteria do not consider the dose of the medication either.

Some Standing Committee members agreed that the Beers criteria are endorsed by the AGS. And although there is evidence that some of these drugs are harmful, they are not widely used anymore.

And then some Standing Committee members commented that there are exceptions to the use of some of these medications in practice because there is truly no alternative choice for that patient. This measure should be encouraging providers to avoid these high-risk medications when there are options available.

So those are some of the Standing Committee comments.

The developer further commented that they do not anticipate these rates dropping down to zero completely as there is clinical decision-making and patient level nuances that do occur.

So, when the Standing Committee with that discussion that happened moving to a vote, there was consensus not reached.

So, Isaac, if you could go to the next slide.

So, again, now we're in public comment. We considered the comments related to this measure and also specifically to the evidence criterion.

So there were three comments that were received for this measure during public comment period. The comments were supportive of the measure, citing the measure's potential in the prevention of medication-related harm in elderly patients.

Comments also provided support, supporting evidence for the AGS criteria, the Beers criteria, noting that evidence to update the Beers criteria included new literature since the last update in 2015. And the literature focused on control of clinical trials, observational studies, systematic reviews, meta-analyses with older adult participants for individual drugs or drug classes.

Medications with low utilization were excluded from the search to focus on Beers criteria on more commonly used medications, so sort of speaking to some of the medications that were in Table 2 that were of concern.

Further, a commenter stated that the Beers criteria medication list is regarded as a critically important evidence-based guidance document to guard against

the use of potential inappropriate medications for elderly patients.

So it's just a summary of the comments that were received, were also provided to you in our comment table as well for you to look at verbatim in there.

So, with that, again, we are voting on evidence. And we want to see if there's evidence to support the measure.

So, Ed, I'll turn it over to you to see if the Standing Committee has any questions or discussion.

Chair Septimus: Okay. Do I see anyone who has a question? We had the measure developer on the line as well. I don't see anyone's --

Member James: Ed?

Chair Septimus: Yeah.

Member James: Could I ask a question? John.

Chair Septimus: John, yeah, of course you can. That's why I'm asking for people to ask questions.

Member James: Okay. I'm just --

Chair Septimus: If you don't know how to use the hand thing, just shake your hand, and I'll try to recognize you.

Member James: Excellent --

Chair Septimus: Okay, John.

Member James: So this is to the developer to help me understand some things.

So, if I go through Beers list, there's some qualifiers for a number of those medications. For example, one says, okay, this is to be avoided in people 75 and

older, not 65 and older.

Others have qualifying doses and allow doses up to a certain point. And also there are some that allow doses that are acceptable let's say for eight weeks or something like that.

So now my question is, as this process measure is assessed, does it take into account those factors, or does it simply count, hey, there was one prescription for this in a patient over 75, we don't care what the dose was or any rationale, but it gets a ding? That's my question.

Chair Septimus: Okay, measure developer. Hello? Are you on mute?

Ms. Lighter: I was. I'm sorry. Just thinking about how to respond to that.

First, all the drugs in Table 2 of the Beers criteria are not included in the measure. I'm still thinking on how to respond.

Mr. Rehm: This is Bob at NCQA. Given the nature of the (audio interference) and its complexity, can we give Pam a few minutes, please?

Chair Septimus: Well, I don't have a problem. I think John had raised this issue I think the first time we discussed this.

Mr. Rehm: I know. I'm asking for a chance to create an answer that can be helpful to the panel.

Chair Septimus: Oh, no, no, no --

Mr. Rehm: Yeah, thanks. Appreciate it.

Member James: Yeah, this is John. I'm trying to just look from the patient's point of view. Are there -- I mean, I understand the intent and how the measures

apply I think.

But I just want to understand where there's holes and how often patients might fit through those holes when the clinician is prescribing to them.

Mr. Rehm: Right. And Rachel is going to weigh in here if that's okay.

Chair Septimus: No, please.

Ms. Harrington: Thanks so much for the question. So you can imagine the Beers criteria is fairly dense. And we want to make sure we speak both to the general intent of your question, and thank you for helping position that, as well as to some of the specifics that you raised around different scenarios.

So, as Pam mentioned, not every medication in the Beers criteria is reflected in this particular quality measure. And I should say not every medication in Table 2, because this measure is specifically linked to Table 2 of the Beers criteria.

That could be for a number of reasons. And we use a set of guiding principles to help make that decision a bit more systematic.

It could be because of the sort of level of the evidence, level of recommendation, which I think we discussed in a little bit more detail in the comments we provided back, or it could be related to the ability to accurately adjudicate the information in claims data.

So, for example, some medications that require very complex decision-making processes, maybe tried multiple lines of therapy, then transitioning, you know, testing and on and off, may make it difficult to put into a measure like this, which is a pretty straightforward, appropriate, inappropriate type flag.

So I think our intent here is less to capture the entire diversity of the Beers criteria but more to look at where the strength of the recommendation, as well as the sort of ability to adjudicate in the data source used for the measure, which is administrative data, provides support for a reliable and valid estimate of the metric or of quality.

I know we were looking for a specific example to kind of tease out some of the details you mentioned around dose. The measure itself does have a couple of different rates, some that do have specific dose criteria in them, some that have different duration criteria in them.

So we do try and reflect the nuance of the criteria for those measures that we've selected as best as possible.

Chair Septimus: Does that help, John?

Ms. Harrington: So we did not submit new evidence. I apologize for interrupting. I was just --

Chair Septimus: No, no, I thought you were finished, Rachel. I apologize. Keep going.

Ms. Harrington: The comment in the chat, just I know it's the nature of these virtual, and it's sort of the bounce back and forth.

We didn't submit new evidence per se in terms of new research studies. What we did do is try and decompose the Beers criteria evidence evaluation process and then how their strength of evidence and strength of recommendation columns is reflected in this specific measure and the medications that are used in this measure.

Chair Septimus: Does that help, John?

Member James: Yeah. And so let me ask you one

question, and then I'll -- so, if I look at proton pump inhibitors, the criterion is to avoid for use for greater than eight weeks unless it's for a high risk patient.

Now, how is that reflected in the point of measurement of this measure? The evidence to do it this way is strong.

But, just finding a proton pump inhibitor given to someone over 65, is -- seems to me to be counting things that ought to not be counted in some cases.

That's my concern. Is that while this protects some people perhaps from what we might call reckless prescribing, it also might score for people that got what they really needed.

Ms. Harrington: Yeah. So that's actually a great example. Proton pump inhibitors are not in this measure.

And for many of the, the sort of decision making complexity reasons that you, that you outlined. Because it's not clear cut.

And there are -- we don't, one of the things we don't want this measure to be, is a barrier to patients receiving the appropriate care that is indicated for them.

So, PPIs are not in this measure.

Member James: Aha, so that's interesting. Thank you.

Member Sood: This is Geeta. Thank you for that description. I guess I'm a little bit confused still in terms of how you decided what to include, and what not to include, other than just convenience and some of those other variables.

And whether that then tested that the -- that the

medications that you have opted to use are the ones that -- to measure, are the ones that, that there's some rationale for it.

Does that make sense? Like what -- what -- you need a case definition, and that really understanding how you came up with that.

Ms. Harrington: Yep. So, that makes a lot of sense. So, I alluded to this, but we have developed a set of guiding principles for the decision on whether a medication makes it into the measure or not.

The guiding principles were generated, oh gosh, at least going back to 2015 or 2014. They've been in place for a while.

And were developed with input and reference from a couple of different sources. So, we have our measure advisory panels who help us with all of this work.

In particular for this measure, our Geriatrics Advisory Panel, which includes geriatricians, but also pharmacists, and patient representatives, and others who help us vet these guidelines, and really make sure.

And, I can't speak back all the way, but I know currently two members of the Beers Panel are actually on that advisory panel. So, they help us sort through this.

We also have a number of other expert panels. A Pharmacy Panel we take these to. A Technical Panel who's very familiar with the data sources, who helps us adjudicate things.

And these guiding principles were also used at one point, I believe, to help do alignment with other similar quality measures that were based off of the same Beers criteria.

So, PQA for instance, used to have a measure that worked very similarly to this. And we aligned on those guiding principles.

Just to give an idea of what some of them are, and make this maybe a little bit more concrete, you know, the first one is only in quick medications listed in Table Two, for this measure, for the DAE measure.

Only include prescription medications. So, we're not including over the counter medications, because we know you can't really see and measure over the counter in claims data.

Others, only include medications where the recommendation indicates to avoid. And the rationale doesn't include an avoid-for caveat.

So, I -- I know it's hard to kind of parse this when you don't have the exact details in front of you.

But, I hope that helps clarify that we do, to your point, have sort of a working definition for how we adjudicate which medications make it in or not.

And that we do look to expert advisors and sort of consensus building in how we make those decisions.

Chair Septimus: And Rachel, just so I can clarify. Although there wasn't any, as I remember the details, there was not necessarily any new evidence provided.

But they do have evidence that the group that you're looking at, and the measure has been linked to outcomes. Even though it's a process measure.

I think that's a -- their key element here so we can connect those dots.

Ms. Harrington: Yeah. I might look to some of my other colleagues to help build this out.

But, I think first and foremost, we actually heard, I think, in some of the other public comments in the comments in support, of the experience of how these measures can be linked to improved patient care and process of care.

For the actual sort of clinical research outcomes evidence, I will say I think we're a step removed in that we rely on the evidence review done by AGS, in determining the medications that make it into the Beers criteria, and how the recommendation is formulated to substantiate the decision making on medications in the measure.

So, you know, obviously they're reviewing systematic reviews, clinical trials, observational studies, all of that. Grading the evidence.

And that informs their strength of recommendation, and their actual strength of evidence quality. And then we use that as part of our determination on which measures make it into the -- which medications made it into the measure. Too many M words.

Chair Septimus: But, you have data showing that this measure impacts outcomes?

Ms. Harrington: I think I might be missing a distinction in the question. If you're asking, do we have a trial that sort of tests head to head the implementation of this measure versus not, and a comparator arm, we don't.

We know that organizations have worked on implementing this. And have had value in implementing this for quality improvement.

But no, I can't point to a, sort of like a multi-arm study that compares the measure versus not, in terms of outcomes.

Mr. Rehm: Can I provide a little history, Ed?

Chair Septimus: Oh, no. Please do. I can't see who's speaking though.

Mr. Rehm: Oh, I'm sorry. I will go on video if you don't mind my background in my officer here.

Chair Septimus: No, that's fine, because it would help me because I --

Mr. Rehm: Sure.

Chair Septimus: I'm sorry if I missed you on the --

(Simultaneous speaking)

Mr. Rehm: Can you see me okay? I'm not seeing myself on the screen.

Chair Septimus: Yeah. Now I can see you, Bob.

Mr. Rehm: Okay. Unnerving not to see yourself though. I'll tell a little story here.

When I first joined NCQA in 2011, Jeff Kelman at CMS approached us, as did some folks from AGS, and they said, you know, you guys have had this measure, a predecessor measure to this, as well as PQA, Pharmacy Quality Alliance.

And, you know, panels are, different panels are reinterpreting the evidence, and making decisions kind of on their own. And we're getting -- it's getting a little bit -- it's getting crazy, to be quite frank.

Because different panels bring different people to the table. And they're second guessing the ATS, I mean, the criteria that had been published at the time.

And then CMS and NCQA approached AGS and said, listen, we'll be happy to support a year of the kind of work that it would take update the current evidence,

which is, I think, five years old at the time, so we're 2011, the evidence was dated.

And we are going to see if we can bring some order out of the chaos, in terms of what -- what the medications are. What the caveats are that Rachel was alluding to.

At that time, we did that for a year. We got the new evidence summary following the grade principles, following the IOM principles for creating guidelines. Also, including public comment, which is kind of new for the AGS.

Then, at that point, AGS says, you know what? This has been so successful that we're going to take this on our own from here on out.

So, you know, HHS, CMS, NCQA, PQA, you know, we don't need your support. Although we want your participation to help make sure that guidelines can be translated into measurement.

When we first took the new approach to NQF, and this was probably in 2012, 2013, the panel was ecstatic that we had A, brought order out of chaos.

C, had a regular updating of these, of table two and the AGS Beers criteria. It's quite extensive if you've looked at the Beers criteria.

There are many tables that are very helpful to clinicians. But recall, this is a health plan level measure. So, we're looking at populations here.

And NQF endorsed it. I believe it was endorsed unanimously, especially because of this constancy of updates. Which is reflected in the evidence that we submitted.

So, CMS is, feels that this was important, continues to. NCQA and all the health plans that report this, all

the Medicare Advantage plans, nary a negative word about an overuse measure.

And I think we've been very cautious, as Rachel's described, in making sure the kinds of issues you've raised, are not dominant in the measure at all.

But, Rachel also points out, are we a scientific organization that does trials? No, we're not.

We take guidelines from respected guideline developers, and I don't think you can find a better group than the American Geriatrics Society for this topic.

And we translate those into measures, and go through our process. For instance, in our public comment period last -- a couple of months ago, we had 1,100 comments.

So, we think we've got this wired pretty well. And I'm reflecting that the NQF history of this was strong endorsement and respect for the work.

And also the idea that measure developers were really collaborating with guideline developers, because it's very helpful.

That's a little bit of history.

Chair Septimus: Well, that's very helpful. I --

(Simultaneous speaking)

Dr. Pickering: Ed, I'm sorry. I didn't mean to cut you off there. I just wanted to just chime in on just the evidence portion of the criteria per se.

And just to remind folks a little bit about from the preliminary analysis that was a little while ago. So again, you know, this is a process measure.

And I know the discussions here are looking at

evidence. And it's specifically related to what medications have been included in the measure.

In addition, we're trying to think about evidence for a process measure in which the process that's been indicated actually ties to some sort of outcome. Some sort of health outcome that the developer has indicated that this measure can improve, because it is a process measure.

I'll just state from the PA, the preliminary analysis, also the measure submission, that the developer did provide a logic model, linking older adults at risk of adverse drug events to clinicians prescribing potentially harmful medications, selecting alternative pharmacological and non-pharmacological treatment approaches when possible, those avoiding adverse drug events, which leads to reduction in mortality.

For evidence, for the evidence review within measure submissions, as what we recommend PQA, Rachel specifically, you are able to submit guidelines, because those guidelines also do these types of systematic reviews for that, you know, quality/quantity/consistency of evidence.

But again, it needs to support the measure. Right? And the evidence needs to support that, that measure.

So, I just wanted to mention that, because I also saw some comments within the chat box that maybe are taking another, some other comments in here that are supporting the Beers criteria.

And maybe Ed, we can recognize those individuals?

Chair Septimus: Yeah. I think I'd like to try to, unless someone has some burning comments on the evidence, I think we're hopefully approaching a time where we can vote.

But, I think, Nancy, I don't know if you want too just briefly mention. I think everybody can see what you wrote in the chat box.

But, you may want to mention that. And I think Dan, unless there's any other burning questions, I think we probably ought to move to vote.

Nancy, do you want to say anything? Or do you just want to get your --

(Simultaneous speaking)

Member Schoenborn: Sure. I -- just want, I guess just reiterating, I think the Beers criterion is generally pretty well accepted within geriatrics, of the evidence to base to go for potentially in proper medicines.

And I think the measure developer's approach to select those medicines that are easily capturable and measurable within the claims data are reasonable.

Chair Septimus: Okay. Well, if there's no other burning questions, why don't -- Matt, let's go to the vote.

I guess turn it over to Isaac?

Mr. Sakyi: Yeah.

Chair Septimus: Go Isaac.

Dr. Pickering: Ed, just real quick. As Isaac's opening that up. Just were there any other questions? Any new questions?

Chair Septimus: That's what I just asked.

Dr. Pickering: Oh. Sorry, Ed. It kind of broke up on my end. The sound kind of broke up on mine. Sorry.

Chair Septimus: That's all right. It's probably good if my statements get broken up.

(Laughing)

Chair Septimus: Okay Isaac, go for it.

Mr. Sakyi: Voting is now open for measure 0022 on evidence. The options are A for moderate, B for low, and C insufficient.

Chair Septimus: And there's still 16, is that correct?

Mr. Sakyi: Yes. We're at 17. So we're expecting 17.

Chair Septimus: Let's go. We're now at 17, okay.

Dr. Pickering: Yeah. And then as Isaac had mentioned that, I believe our 17th person was Sara Hawkins. Sara, are you on the line? Can you just say that you're present?

Member Hawkins: I am present. And I apologize for being late.

Dr. Pickering: No worries. No worries. Ed can forgive you for that.

Chair Septimus: I was going to say, --

(Laughing)

Member Hawkins: Please.

Chair Septimus: We're delighted to have you.

Mr. Sakyi: We're waiting for two more votes. We're at 17. The voting is now closed for measure 0022 on evidence.

Chair Septimus: Oh, the suspense is killing us. All right. Well, what have you got?

Mr. Sakyi: We have 13 votes for moderate, three votes for low, one insufficient.

Chair Septimus: All right. Well, certainly --

(Simultaneous speaking)

Mr. Sakyi: With 13 votes for moderate, the measure passes on evidence.

Chair Septimus: Okay. So, first of all, before go vote to the measure being suitable, thank -- I want to, before I forget, Rachel and Bob for their comments and putting up with us.

Okay Matt, we go to suitability, right?

Dr. Pickering: That is correct. Overall suitability.

Mr. Sakyi: That's correct.

Chair Septimus: So, just before we go for that, I think we've gotten all of our questions answered. I want to make sure I haven't missed anyone.

If not, let's go rock the vote on suitability.

Mr. Sakyi: The voting is now open for measure 0022 on the overall suitability for endorsement. The options are A for yes, and B for no.

I apologize. I need to deactivate this question for a few seconds.

Chair Septimus: Does that mean we should vote again?

Mr. Sakyi: Yes.

Chair Septimus: Okay. So, --

Mr. Sakyi: Okay. The question is back up. Voting is now open for measure 0022 on the overall suitability for endorsement.

And it looks like we have 12 votes so far. We're waiting for one more.

Dr. Pickering: Is anyone not able to vote? Having some technical challenges?

Chair Septimus: Isaac, what are -- how many we got?

Mr. Sakyi: We're at 16, and that is quorum. So, we can move forward with the announcement.

Chair Septimus: What if someone's abstained? Okay.

Dr. Pickering: Is anyone on the phone still not able to vote?

Chair Septimus: Or maybe abstain?

Dr. Pickering: Yeah. I don't see anybody in the chat box.

Mr. Sakyi: Matt, that is -- 16 is quorum. So, we can move forward.

Dr. Pickering: Yep.

Chair Septimus: Okay. Let's see the result.

Mr. Sakyi: Voting is now closed for measure 0022 on the overall suitability for endorsement.

Dr. Pickering: We got the 17th in there, yeah.

Chair Septimus: Okay. Now we're all good.

Mr. Sakyi: Yes. We do. We have 15 votes for yes. And two for no. The measure therefore is recommended for endorsement.

Chair Septimus: Fantastic. Great discussion. I think we have much better clarity. And so thank you, measure developers. And thank all of our members of the committee who ask great questions.

And so we'll go, Matt, I'll turn it back over to you for

the next one.

Dr. Pickering: Sounds good. All right. So Isaac, thank you.

Mr. Sakyi: Yep.

0097: Medication Reconciliation Post-Discharge

Dr. Pickering: So now we're moving onto the second measure that we'll be voting on today.

So, this is 0097: Medication Reconciliation Post-Discharge. So, the standing committee technically did not pass this measure on evidence.

And we will revote today on the criterion. And if it does pass, we will also revote on the overall suitability for endorsement.

So, if you recall, during the meeting, the measure evaluation meeting, and we made an error, NQF staff made an error in calculating the votes that led to the measure proceeding as consensus not reached decision on the call.

Afterwards, after the call -- and so therefore, we actually continued with the rest of the vote for the cri -- for the NQF criteria.

However, after the meeting, after the call, the correct vote totals were calculated and the measure did not pass on evidence. Which is a must pass criterion.

In discussing with the standing committee co-chairs, we -- it was recommended that the standing committee revote on evidence criteria during the post-comment meeting. We are doing currently.

So, during the call, the standing committee considered the evidence submitted by the developer, noting that the evidence did not, or hasn't been

updated since the measure's most recent endorsement in 2015.

The standing committee also recognized that the quality, quantity and consistency analysis of the evidence submitted was not conducted.

As a result, NQF's preliminary staff rating was insufficient. Some committee members commented that there is evidence that the medication reconciliation can have an impact on outcomes.

The developer commented that there is more recent evidence that shows the medication reconciliation does improve outcomes, but this most recent evidence was not included in the measure submission, the original measure submission.

Additionally, one committee member cited a 2018 Cochrane review, showing that there is no improvement in certain outcomes with medication reconciliation, including medication adverse events.

There were several concerns from the standing committee that standardization of medication reconciliation is lacking. And that more training and best practices are needed.

One standing committee member commented that if this measure is not endorsed, the consideration of other measures in place to fill a gap comes into question. And this measure -- if this measure is to be voted down.

So, NQF staff mentioned that if the standing committee agreed that this was an important measure but the evidence was insufficient, the measure could be granted an insufficient with exception vote.

So, with that, more than 60 percent of the standing committee must vote insufficient for the evidence.

And then there must be a call to vote on an exception.

And then we vote on the exception. And more than 60 percent need to vote on the exception.

So, that would give an insufficient with exception, which would pass it on evidence. But, noting that it's an important measure. It's just there's insufficient evidence to support it.

So, that is similar to the case now. That if there is an insufficient vote, if the committee is leaning that -- agrees that there is -- that the evidence is insufficient, more than 60 percent need to vote insufficient.

And then a call for an exception. And then we would vote on the exception. And more than 60 percent need to vote on the exception.

But, the committee can vote high, moderate -- or excuse me, can vote moderate or low as well for this, for this measure.

So, for the comments that have been received related to this --

Chair Septimus: Matt, can I just interrupt for one second? There's a number of new people on the committee that may not have heard about voting exception.

Does everybody understand that, before Matt moves on?

Member Sood: I'd actually like a little bit more clarification in terms of why would we vote for the exception?

Chair Septimus: Yeah. And Geeta raised her hand. I saw Geeta. I saw it. Thank you.

Dr. Pickering: Thank you, Geeta. Right. If there is a feeling that this measure is important, that there is some need to have this type of measure, whether it be -- or any measure, but there's really not a lot of evidence to support it, then there are opportunities to vote as, with an exception.

I will say that for NQF this is not a common occurrence. It is something that does have rare occurrences that do happen in which there's not a sufficient amount of evidence to vote low, moderate, or high.

But, there is a feeling from the committee that there is, this is an important measure. And that's where some of the discussions around, you know, what would happen to this area if this measure was voted down?

For example, would there be a gap that needs to be filled? Would there be a lack of improving the standardization? Et cetera type of comments that were shared during the previous evaluation.

And so there were a significant amount of insufficient votes. But, there were also some low votes as well, related to this measure.

Which, in looking back at our tallies, it actually was, the committee did not pass the measure as opposed to getting a consensus not reached.

But, there are those instances where the committee feels that this measure is important. Important to the field. But, they feel the evidence really isn't sufficient to support it, but you can grant them an exception.

Chair Septimus: Then we -- Yanling had a question.

Member Yu: Yes. And thank you. I was just curious to remind -- you know, help my memory.

Does it, NS -- NQF have any other measures that are related to medication reconciliation?

Or is this the only one?

Dr. Pickering: No. There are other measures, there are other medication reconciliation measures. And they're actually in the related and competing portion of this.

There are -- there's measures from -- there's medication reconciliation for patients receiving dialysis.

There's medication reconciliation for patients on admission. There's medication reconciliation for -- for unintentional medication discrepancies for medication for patients.

There are some differences. And the developer has articulated those differences within their measure submission form.

And then there's also some medication review measures. But, there are some other measures related to medication reconciliation.

And the developer mentioned that these -- this measure is different than those, by vulnerable population, but also by certain target populations.

But, there are some measures.

Member Yu: Okay.

Chair Septimus: So, I see Jason and then Bob. So --

(Simultaneous speaking)

Dr. Pickering: So -- sorry. Maybe if we -- maybe before, if this is going to be related to some of those other questions, I was wanting to maybe summarize the comments.

And then we can go to committee discussion. Is that all right?

Chair Septimus: Yeah. Jason and Bobby, is this about the exception? Or is it about the measure in general?

Mr. Rehm: No, I just wanted to clarify a statement that Matt just made.

Chair Septimus: Go ahead, Bob.

Mr. Rehm: This is a health plan level measure. And it's the only one to our knowledge.

Remember, you're endorsing this measure for a certain level of accountability. The level of accountability and the submission form is for a health plan.

Chair Septimus: And it's a post-discharge reconciliation, is the other thing.

Mr. Rehm: Thanks so much.

Chair Septimus: Yeah. Jason, did -- is this a clarification? Or you want to wait until we go and see what the comments are?

Member Falvey: No. I'll wait until we move on that.

Chair Septimus: Okay. Well, all right. Go ahead and go then, Matt.

Dr. Pickering: Thanks. Thanks, Ed. Sorry, Jason. We'll definitely circle back. And thanks Bob for the additional clarification.

If we go to the next slide, we'll just talk about the comments. A summary of those comments. There we go. Thanks Isaac.

So, there were four comments received supporting this measure. So, it's very supportive of the measure

until more focused and robust measure effective medication reconciliation process and related outcome measures can be developed and implemented.

Supportive of the measure because of the success of medication reconciliation and decreasing medication discrepancies at discharge.

So, medication reconciliation post-discharge is recommended by the Joint Commission National Patient Safety Goals, the Agency for Healthcare Research and Quality, World Health Organization, Institute of Healthcare Improvement, and the American Geriatrics Society, or AGS.

So, these are all what the commenters have shared. And there were comments stating that recent studies also suggested that medication reconciliation post-discharge, which this measure is, is particularly important for vulnerable populations like older adults.

There is also supportive of the measure to ensure patient safety. And the continuity of care post-discharge.

And that medication reconciliation is a critical component of several widely disseminated care transition models as well.

So, that's a summary of the evidence. And again, it's revoting on evidence. So, this is a process measure, again, trying to associate that process to some sort of health outcome, and the evidence to support that.

So Ed, I turn it over to you, and open it up for comments.

Chair Septimus: So -- Geeta, do you need to put your hand down before I go on?

(No response)

Chair Septimus: Geeta?

Dr. Pickering: I think she put her hand down.

Chair Septimus: Yeah, okay. All right. So, it looks like in terms of still having your hand up -- everyone's hand is down.

(Laughter)

Chair Septimus: Any other comments then? Jason, did you want to say something? You had your hand up before and you were going to wait.

Member Falvey: Yeah. No, I appreciate that. I just wanted to share that this, you know, a medication reconciliation measure is already in effect for home healthcare settings as well.

So, within 48 hours of admission to home care, there has to be medication reconciliation.

It's also a part of the patient engagement surveys that are, you know, given to home healthcare patients. So, they're asking patients about their experiences with medication reconciliation.

So, there's a lot of face validity to this kind of measure in terms of not just, you know, indirectly related to outcomes.

But also, you know, patient centered things that feel like they have a good handle on their medications. Not just for current problems, but also to, you know, kind of stave off problems down the road.

So, I mean, CMS is already using this across other settings. So, I think there is a definite need for a measure like this, for after hospital discharge.

Chair Septimus: So you think the measure produces

consistent and credible validity in terms of measuring the quality of care as a -- as a process measure?

Member Falvey: Yeah. Absolutely. I mean, CMS thinks that. And they ask patients specifically about it, to see if they were engaged in the process.

Chair Septimus: Okay.

Member Falvey: So, those are clear importance.

Chair Septimus: Yanling?

Member Yu: Yeah. Thank you. I think that recently there is one JAMA article published about what is the most critical, maybe not the most critical, it's very critical too actually, for those elderly patients.

That you know, polypharmacy is to try to find out, to pick out those medications that are not necessary.

And not really just match the medication when you come in or in the hospital and where the match with, you know, when you got out of the hospital, if they are, you know, have any mismatch or were in agreement.

It's what to find out what medication they don't need to take. And that seems to have a bigger impact on the patient safety.

Chair Septimus: Thank you, Yanling. Lisa, you had your hand up. And then Nancy.

Member Charbonneau: Yes, thank you.

I would just want to add that we -- so I, my company has 139 inpatient. We have hospitals. And it's the largest provider of inpatient we have, and the fourth largest home health and hospice. And we have done our own readmission risk algorithm, and have found that this is a significant risk factor for readmission to

the acute hospital after discharge from a rehab facility.

So I, you know, I think what we have found in our experience is that this is extremely important to do a good med rec and at the time of discharge, before the patient gets back to the community, to avoid readmission to the acute care hospital.

Chair Septimus: Thank you.

Nancy then Curtis.

Member Schoenborn: I just have a question to clarify. Is this case discharge to any destination, like home, rehab, everywhere, or is it to a particular?

Ms. Lighter: The measure addresses the home and the community.

Member Schoenborn: Okay. Thank you.

Chair Septimus: Curtis?

Member Collins: Yeah, I'll jump in.

So, I was glad to see the comments came from a number of our pharmacy organizations, including our largest organization with, you know, about 40,000 members or so.

You know, in terms of evidence, med rec is, at discharge med rec is done daily by, you know, hundreds of thousands of pharmacists. And, you know, speaking from personal experience, we catch a lot of medication errors. I think in terms of the evidence, the evidence is incredibly good, very strong in terms of catching med discrepancies of any adverse events from those catches or prevention of errors there.

I think, you know, some of the hospital readmissions

mortality figures, those studies are a little more difficult to do. And I think we had some of those discussions before. But every day, you know, pharmacy colleagues and others across the country because of this measure are catching thousands, likely thousands of potential medication discrepancies every day. And I do think that is a very important metric and outcome that we do need to consider. The evidence is very strong for that.

Chair Septimus: Thank you, Curtis.

I don't see any other hands. So, if not, Isaac, let's go to the vote.

Mr. Sakyi: Voting is now open for Measure 0097 on evidence. The options are A for moderate; B for low; and C, insufficient. We're expecting 17 votes.

Dr. Pickering: And anyone still having issues with the votes, because I know that we had somebody come in toward the end there.

Chair Septimus: Yes. Isaac, how many do we have, 16 again?

Mr. Sakyi: Yes.

Dr. Pickering: And then, Curtis, you still have your hand raised. Is that where you still have a question or?

Member Collins: No. I'll put it down. Sorry about that.

Dr. Pickering: No worries.

Mr. Sakyi: We received one vote via chat for moderate.

Chair Septimus: Okay.

Mr. Sakyi: So that brings us to 17.

Chair Septimus: All right. Let's put it up.

Mr. Sakyi: Voting is now closed for Measure 0097 on the evidence.

We have 11 votes for moderate, 3 votes for low, and 3 insufficient. With 11 votes for moderate, the measure passes on evidence.

Chair Septimus: Okay. A little closer but it still passes.

And I guess now, Matt, we go to suitability for endorsement; correct?

Dr. Pickering: That is correct.

Chair Septimus: Okay. Let's go to -- Okay. Whoops. So, we don't have to worry about an exception. Okay.

Mr. Sakyi: Voting is now open for Measure 0097 on the overall suitability for endorsement. The options are A for yes and B for no.

Dr. Pickering: And then whoever is having some challenges with the voting platform, if you wouldn't mind chatting that, your vote as well.

Mr. Sakyi: Yes, we got one more vote for yes. So we're at 17.

Voting is now closed for Measure 0097 on the overall suitability for endorsement.

We have 16 votes for yes, one vote for no. The measure is, therefore, recommended for endorsement.

Discussion of Comments Received

Chair Septimus: I want to thank everybody for these last two measure discussions. I am just always amazed at how robust the discussion is and how we

come to greater understanding through these conversations.

So, thank all of you, and thank the measure developers for coming back. And we'll go to the next item, Matt.

Dr. Pickering: Great. Isaac, we can proceed.

And I always want to say thank you again to the committee and to the developers going to those votes.

We'll now consider other comments for the remainder of the measures as well. So, I think if we could go to the next slide.

Just check-in, so the next couple of measures the developer is Yale CORE. So, I just wanted to check in to see do we have a representative from Yale CORE on the call in case there's any questions?

Ms. Peter: Hi. Yes, Doris Peter. Thank you.

Chair Septimus: Matt, you may want to also tell people again, new people, about what we do with this. And we don't necessarily have to reconsider measures, et cetera, based on the comments. But you may want to go through the process with the new members.

Dr. Pickering: Thanks, Ed. Appreciate you always reminding me to remind others. So, thank you.

Chair Septimus: No, it's usually you reminding me.

Dr. Pickering: As Ed did mention, so as we go through the public comments now for the other measures, these other measures did pass so there's no re-voting that we're doing like we just did previously because theirs is, you know, consensus not reached or re-vote decisions related to that.

So, what we are now doing is hearing the public comment that has been received for these measures. I will then summarize those public comments.

If there are comments that were of concern, we will -- the developer was provided an opportunity to respond to those comments. And I'll provide a summary of those responses as well.

And then, similarly, we want to extend to the committee to have an opportunity to provide any questions or discussion related to the comments that have been received. But before I do that, I'll see if the developer has anything to add related to the comments that I have summarized, the responses.

I'll also then state the proposed committee response. So, this is a proposed committee response related to those comments. And you, you are able to disagree with that proposed committee response, make recommendations to change the proposed committee response if you feel, if you feel that is needed.

The point of this is to consider any new information that the Standing Committee did not previously receive. So, some of the proposed committee responses, as you may have looked at within your comment memo, are really thanking the commenters and the committee, as well as the Scientific Methods Panel for certain measures, review some of this information, and still ultimately passed these measures on recommending for endorsement.

So, with the first measure here it's 0468. It's the Hospital 30-day, all-cause, risk-standardized mortality rate measure for following pneumonia hospitalization. The developer is Yale CORE. And the steward for this measure is CMS.

This is a maintenance measure. As a reminder, just a brief description.

The measure estimates a hospital level 30-day off, 30-day risk-standardized mortality rate. And mortality is defined as death for any cause within 30 days after the date of admission for the indexed admission.

Discharge from the hospital with a principal diagnosis of pneumonia, including aspiration pneumonia or principal diagnosis of sepsis, not severe sepsis, with a secondary diagnosis of pneumonia, including aspiration pneumonia coded as present on admission.

And this looked at Medicare beneficiaries, fee-for-service, who are 65 years and older, and hospitalized in non-federal hospital or patients hospitalized in VA facilities.

If you go to the next slide, Isaac. There we go.

So, we received two comments for this measure. There is non-support due to concerns around the reliability thresholds and intraclass correlation coefficients, that's a minimum sample size.

And there was also concern regarding the lack of inclusion of social risk factors in the risk adjustment model.

For the developer's response, they really provided, their responses really referred back to the measure submission form for both of these concerns related to both of these comments. For reliability they mention that they calculated the intraclass correlation coefficient with 25 admissions or more.

And the agreement between the two independent assessments for this measure, for that reliability approach for each hospital was .668.

They also calculated signal-to-noise ratio for this measure for each hospital with at least 25

admissions. The median reliability score was .78 and the range was .31 to .98.

They also referred to their interquartile rate at the 25 and 75 percentiles as .59 and .88 respectively.

For the social risk factor, again referring to what has been previously submitted in the measure submission form, while there is a conceptual pathway which patients with social risk factors could experience for its outcomes == again this is what the developer is responding == the empiric evidence does not support risk adjustment at the hospital level.

The developer states that the main empiric finding is that adjusting for social risk has little impact on the measure's scores.

Mean changes in measure scores are small. And the correlations between measure scores related to -- related with or without that adjustment for social risk is near 1.

The developer states that given these empiric findings, so the approaches that they took to test for social risk factors within their model, and the recent ASPE reports or ASPE recommendations, CMS, who is the steward of this measure, chose not to incorporate social risk factors, social risk variables within the measure.

As far as the proposed committee response -- so you can hear from the developer's responses that they were referring back to what's been previously submitted in the submission, so the Standing Committee did consider this information, and had this information, and discussed some of this information during the measure evaluation meeting.

So, for the proposed committee response, the Standing Committee thanks the commenters for their

comments.

The Standing Committee and the NQF Scientific Methods Panel have previously considered the scientific acceptability of these measures, including the reliability testing and risk adjustment models.

In evaluating these measures against NQF endorsement criteria, the Standing Committee determined to recommend these measures for endorsement.

So, I'll ask the developer if they have anything in addition to add before I turn it over to Ed and the Standing Committee.

Ms. Peter: No, Matt. You did a great job. Thank you. We have nothing to add.

Dr. Pickering: Thanks, Doris.

Ed, I'll turn it over to you.

Chair Septimus: Thanks. That was a great discussion.

Are there any other comments. Geeta had your hand up; right? Did I get that right?

Member Sood: Yes. Thank you very much.

I remember this metric well. And I thought it was very, very well done and well put together.

I guess as far as the NQF comments or response, I think if others agree, especially these are all so actively thinking about equity issues, I would probably add something about the fact that we all -- that we recognize, know, and think that social determinants of health are important for all of these metrics. However, generally we don't have very terrific methods of ascertaining what the different socioeconomic variables are to be able to effectively

and validly incorporate that into the best risk adjustment model.

I don't think I'm expressing that as well as those of you that are more eloquent than me. But do you sort of understand what I'm getting at?

Like, I would emphasize that we, that we agree and we do think it is important to be looking at social risk factors. In addition to the fact that the developer did inherently test for it, there is a limitation in the data that's available and the evidence that's available to be able to effectively risk adjust for social risk factors.

Chair Septimus: I think you said it just fine, Geeta. I think one of the -- and Matt can jump in here -- this has gone on for years. NQF has been trying to really be very proactive in really strongly encouraging measure developers to look at those social risk factors as part of the measure.

So, I think that NQF is certainly onboard with your comments. It sounds like -- and I'll let the measure developer speak -- they did try to include that. But it doesn't sound like it had significant impact on the measure.

I'll let the measure developer speak and see if anybody else has any questions.

Ms. Peter: You're right, we did empiric testing, and it doesn't support the addition of the factors we have available to us to the point that the other commenter that, you know, there aren't necessarily the best fields available.

But another thing I want to point out is that there is, you know, I don't want to get into a big debate, but there are philosophical differences about the perch that with which we should look at disparities. You know, should we report measures, should we stratify measures for example?

CMS has also developed measures that look at within and between hospital disparities with regard to, so patients with disparities within the hospital, how are they treated compared to patients without the disparity, and then between hospitals as well.

So, there are other ways to look at it also. So, we don't want to presume that we would adjust these measures, but we agree with you that, you know, looking at disparities, understanding disparities through the eyes of these measures is important.

I hope that helps.

Chair Septimus: Thank you. So, is there any other comments?

If not, I think, I don't know, we don't want to officially vote on this, Matt.

Dr. Pickering: No.

Chair Septimus: But unless the committee thinks that we need to reopen discussion on this measure, we thank, we thank everybody for their comments. And we stand by our original decision.

Dr. Pickering: Yeah. And I'll just, I'll just -- Geeta, thank you for your comments. But maybe adding that acknowledgment that, you know, furthermore the Standing Committee appreciates the importance of social determinants of health, and considering those within measurements, and recognizes that there are limitations to availability and feasibility to effectively adjust for social risk factors. And we will continue to evaluate measures as more, more approaches, more approaches and data are accessible.

Does that summarize what you mean?

Member Sood: Yeah, that, well, that's more eloquently put than I can ever phrase it. That was so

beautifully expressed.

Chair Septimus: All right, Matt, one for you.

Dr. Pickering: I just want to make sure, are there any disagreements with that from the Standing Committee? So, this is just an added acknowledgement of the importance of social risk factors.

Chair Septimus: Okay. I think, unless people are disagreeable, we'll add that to our discussion of this measure but not choose to reopen this measure. Okay.

Dr. Pickering: Right.

Chair Septimus: So, Matt, why don't you go on to the next one, Matt, and stay on top of it.

Dr. Pickering: Well, go on to the next one, yes.

So, the next one is 1983, this is also Yale CORE. It's a maintenance measure from CMS for hospital 30-day, all-cause, risk-standardized mortality rate following chronic obstructive disease. So, it's a very similar constructive measure, but looking at COPD.

You can see the brief description here, which I won't read aloud. You can read it there.

In itself this, again very similar, looking at 65 years and older, fee-for-service Medicare patients, looking at COPD for that 30-day risk mortality rate.

Isaac, if you'd go to the next slide I'll just summarize the comments.

So, there were two comments received, very similar concerns as we saw with the previous measure relating to (unintelligible), relating to social risk factors.

The responses from the developer, also very similar to what I summarized previously, just some differences in some of the data points. But these information or these data, these data points, and this information that was submitted in the measure submission form, the Standing Committee had already previously received.

So, the developer just pointed to the data points, the reliability testing they did, which is the intraclass correlation coefficient of 25 admissions or more. And they also did a signal-to-noise reliability score for each hospital. And they reported, you know, sufficient measure reliability scores for both of those that the Standing Committee and Scientific Methods Panel could consider and pass.

For social risk, the concern there very similar. They did that empirical testing approach. Determined there wasn't a strong impact for those social risk factors, and that CMS ultimately made those findings. As well as the ASPE reports, they also did not want to incorporate those social risk factors into the measure or the model itself because of the empiric findings and the recommendations from ASPE.

So, a similar response. A proposed committee response as I read off previously:

The Standing Committee thanks the commenters for their comments. The Standing Committee and NQF Scientific Methods Panel have previously considered the scientific acceptability of these measures, including the reliability testing and risk adjustment model.

In evaluating these measures against NQF endorsement criteria, the Standing Committee determined to recommend these measures for endorsement.

And based on what our discussion was previously, adding an acknowledgment that, furthermore, the Standing Committee appreciates the importance of social determinants of health and considering those within measurements, and recognizes that there is a limitation of data that are available to effectively adjust for social risk factors. And we'll continue to evaluate measures and more approaches to social risk factor adjustment as they become accessible.

Chair Septimus: Okay. Oh, I'm sorry, I thought you were finished, Matt. I thought you were finished.

Dr. Pickering: I was just going, I was just going to see if the developer had anything to add and then turn it over to you, Ed.

Ms. Peter: No, thank you. We're good. Thanks, that was great.

Chair Septimus: Okay. Does anybody have any comments beyond what we mentioned on the previous measure, because there's a lot of overlap between the two measures?

If not, I think we will thank the developers and thank the people who commented, and we'll stand by our original decision.

All right, next, next measure.

Dr. Pickering: Okay. And thanks. Yeah, I agree, available rather than accessible. I'll change that to be "available." Thank you.

So, for 0531 -- So thank you, Yale CORE. Appreciate your time and being ready to answer any questions that the committee had.

I now want to check in if anyone from Impaq International is on the line?

Ms. Schilling: Yes.

Mr. Romano: Yes.

Ms. Schilling: This is Stacie Schilling, and we have Patrick Romano from UC Davis on.

Dr. Pickering: Excellent.

Chair Septimus: We are going to call this the Don Yealy measure. Don discussed this just beautifully at our meeting, better than anyone I've ever seen discuss a complex composite measure.

So, I wanted to again single out Don for his excellent discussion.

Member Yealy: You say that to all the boys, Ed.

(Laughter.)

Dr. Pickering: All right. All right.

Okay, so this, this measure is the Patient Safety Indicator (PSI) 90 measure for patient safety and adverse events composite measure.

The developer for this measure is Impaq International. And the steward again is CMS.

It is a maintenance measure. The brief description here is PSI 90 is a composite measure somewhat measuring patient safety across multiple indicators for the CMS Medicare fee-for-service population.

So, Isaac, you can go to the next slide.

As a reminder, the Standing Committee did pass this measure, actually unanimously with a 23 yes, 0 no.

There were three comments that were received: non-support due to concerns related to reliability threshold; intraclass correlation coefficients, with a

minimum sample size concern regarding the lack of inclusion of social risk factors in the risk adjustment model; and concern with the measure of post-surgical risk factor being used as the only representative measure for falls with injured -- injury. Excuse me.

The developer did provide responses. And I'll just summarize those.

For the reliability concern, the developer clarified that 67 percent using split sample methods, and 51 percent using the test/retest methods across non-overlapping periods represent the percentage of hospitals that did meet the ICC reliability threshold of .6 rather than the percentage that did not.

And CMS plans to set a minimum threshold of 25 hospital discharges, aligning with thresholds set for other CMS plain safety measures.

CMS also plans to require at least seven PSI 90 components to be available for PSI 90 score calculation. This will ensure that the hospitals have enough components to contribute to at least 50 percent of the total weight of PSI 90.

These changes will drop roughly 6 percent of the hospitals that have very low reliability values, and will yield reliability distributions that are very similar to those for other claims-based hospital measures.

So, that was the developer's summary response to the reliability concerns.

Regarding social factors, in this measure submission form CMS did reference the 2020 ASPE report, but not solely for the recommendation to not include, they also did some additional empirical analyses. And following the submission, CMS conducted parallel analyses based on dual eligibility.

Some racial, and ethnic, and dual eligibility disparities exist for the PSI 90 component measures. So, there is no consistent pattern across these components.

For the majority of the PSI 90 component measures Black and Hispanic patients had lower or similar adjusted grids compared to White patients.

And, similarly, fully dual-eligible beneficiaries had at least 20 percent higher adjusted PSI rates relative to non-dual-eligible beneficiaries for only 3 of 10 PSI 90 components.

So, with this information CMS agrees with the comments as regarding the value of linked data from the American Community Survey. And will follow ASPE's ongoing work in this domain, and will conduct further testing of additional data when social risk factors become available.

So that's the developer's response to the social risk factor issue.

And then for the falls with injury representation, CMS agrees that falls with injury are an important cause for harm in acute care hospitals. The developer states that the in-hospital fall with hip fracture rate measure has been expanded to include both medical and surgical adults, adult patients 18 years and older.

It also is no longer limited to post-surgical patients. And the denominator was further expanded by (unintelligible) excluding exclusion criteria that were not well justified on clinical and empirical grounds.

So, CMS agrees that further expansion of this component measure to include other significant harms resulting from falls would help to drive further improvements in patient safety, and that these efforts are currently underway and will be reflected in future submissions.

So, for the proposed committee response, since this information has previously also been considered and evaluated by the Standing Committee, but also the Scientific Methods Panel, the proposed committee response is the Standing Committee thanks the commenters for these comments, or for their comments.

The Standing Committee and the Scientific Methods Panel have previously considered and previously considered the specifications and scientific acceptability of this measure, including the reliability testing and the risk assessment model.

In evaluating this measure and endorsement criteria, the Standing Committee determined to recommend this measure for endorsement.

And, similarly, we can add the additional acknowledgment for the importance of social risk factors to this comment as well.

Before I go to Ed and the Standing Committee, I want to see if anyone from the developer has anything additional to add related to the summary of their responses?

Dr. Romano: This is Dr. Romano. Good afternoon.

And I don't think we have anything to add. Thank you for an excellent summary, Dr. Pickering.

Dr. Pickering: Thank you, Patrick.

Chair Septimus: Nice to see you, Patrick.

So, is there any other discussion from the committee. I mean, Matt said it beautifully. But is there any other comment from the committee?

Patrick, remind me. In terms of the post-surgical hip fracture, I remember this. This goes back a long

ways. But one of the reasons that I was concerned, that was a very objective find that could occur that's usually measurable from a fall versus some other ones that may be less nebulous -- or more nebulous.

Dr. Romano: Yeah, that's exactly right.

Chair Septimus: That's what I thought.

Dr. Romano: I mean, there's objective finds that result from in-hospital falls and falls at other health care settings.

And I think that we, and of course CMS, understand that perhaps a broader spectrum of falls, of fall-related injuries could be captured. And so there has been sort of a serial effort to reconsider and expand that measure.

As you mentioned in the written comments, we previously expanded it to include both medical and surgical patients. And we're now in the process of looking at other potential fall-related injuries such as wrist fractures, upper extremity fractures, and serious lacerations and so forth.

But, yes, in the past there's been some concern about whether those would be accurately coded. But I think that, again, we're looking at that more carefully not.

Chair Septimus: Thank you, Patrick.

Any other comments. I think Matt really summarized everything quite well.

If I don't see any hands for the committee, then I think we'll stand by Matt's comments and our response to the comments.

Dr. Pickering: Yeah. And I'm just looking at the chat, too, sir.

Geeta, thank you. It says, Geeta shares nice answers from the developer.

There is a comment from Sara just saying intracranial bleeds. I'm not sure what that's referring to, Sara. I don't know if you wanted to chime in.

Member Hawkins: Just I appreciate that they are expanding that falls with injury. In fact, Joint Commission as an example, expanded their definition of falls with injury and, you know, what are reportable to include things like intracranial bleeds, patients on anticoagulants who require interventions, and things of that nature.

So, I appreciate the reference to other types of injuries that can be quantified after a fall.

Chair Septimus: So, Sara, just to make sure I understand you. So, these are people on anticoagulants who fall, have a head injury, and have an intracranial bleed because of the fall?

Member Hawkins: Yes.

Chair Septimus: Okay.

Dr. Romano: Yes. And we are in fact working on developing a measure that would incorporate that exact scenario.

Chair Septimus: Thank you, Sara.

Anybody else?

Dr. Pickering: So, Geeta also just commented to Dr. Romano, I am sure you will follow through about this, but hopefully we could include higher volume output as well. Almost all of our quality output seem to be low volume events.

I don't know of you have any response to that, Dr.

Romano.

And then Jason also mentioned most TBIs, traumatic brain injuries, are in older adults from falls.

Fall with permanent harm is sentinel, is also from Ed Pollak.

Dr. Romano: Yes. We understand, of course, he's referring to the Joint Commission list of sentinel events, which includes falls with permanent harm. So that is captured under the Joint Commission sentinel events.

Of course part of the reason for a composite like this as a PSI 90 design is to bring together a lot of different low volume events, each of which has separate risk factors. So, each event has to be separately analyzed and risk adjusted, but we bring them together into a composite precisely to address this issue, which many of the relevant outcomes are low volume events, and yet they are informative, especially in aggregate.

Chair Septimus: Okay. I don't see anything, questions or in the chat box.

Okay, Matt, why don't we go down to the next measure.

Dr. Pickering: Okay. Sounds good.

So, the next measure -- and thank you Dr. Romano and Impaq. Appreciate your availability and time to answer any questions. And thank you to the committee for also sharing your thoughts related to this comment.

I just want to check in. I know it's been a little while, but NCQA, do we still have representatives from NCQA on the line?

(No response.)

Dr. Pickering: Well, anyone from NCQA?

Ms. Lighter: Hi. This is Pam Lighter. I'm still here.

Dr. Pickering: Thanks, Pam. Just checking in.

So, 2993, this is the potentially harmful drug-disease interactions in older adults measure. NCQA is the measure steward and developer. It's a maintenance measure.

The brief description here is the potential for patients 65 years and older to have evidence of an underlying disease due to health concern who are dispensed an ambulatory prescription for a potentially harmful medication concurrent with other -- current with or after the diagnosis. And there's three ways to report it per the ICC listed here. And a lower rate is better for performance.

As a reminder, the Standing Committee also unanimously voted in favor of this measure. It's recommended for endorsement with a 20 yes, 0 no vote.

As far as the comments that were received for this measure on the next slide, we only received one comment, and it was a supportive comment. So, supportive comments, we don't send those to the developer to necessarily respond to as a comment of concern.

So, we just, we also just made mention of it in the Standing Committee just to say that it is a comment that we received. So, there's no proposed committee response here other than thank you for your comment.

So, this is a supportive comment noting that the drug-disease interactions in the setting of a history

of falls, dementia, and chronic kidney disease, warrant performance measurement and continued prioritization in outpatient settings.

So, we've reported the measure. Again, the Standing Committee passed it. So, really just a response here, thank you for your comment.

And, again, the developer didn't have any responses to this because it was not a comment of concern that the developer needed to respond to.

Ed, I don't know if there's any questions from the committee.

Chair Septimus: No. Yanling has her hand up. I don't know if it's about this. Or maybe it's --

Member Yu: Oh, I'm sorry. Actually it was about the last measure's comments. But you didn't call me, so.

Chair Septimus: I'm sorry, Yanling. I didn't see it. I apologize.

Member Yu: No problem.

Chair Septimus: What was your comment. I'm sorry, I tried to look and I didn't see it. Go ahead.

Member Yu: Oh, it's no big deal.

I would just say I'm really glad the developer is looking at bringing in the bleeding after fall. And I didn't know if they were included those delayed bleeding. You know, for elderly sometimes they can fall, but the bleeding is really slow process and can't be detected after some time, and then some activity or something else.

So, I just start wondering if they thought about that. But it's not really important.

Chair Septimus: I don't know if Patrick's still on.

Dr. Romano: Can you hear me?

Member Yu: Is it included, the delayed bleeding?

Dr. Romano: It's an important observation. The practical problem is that when we design the measures, essentially electronic measures, we're limited, the scope is limited to the episode of care. And so what it means is that for aggregation purposes if there's delay in the diagnosis of intracranial hemorrhage, then it may be hard to know whether it was attributable to a fall in the inpatient setting, or a fall after discharge from the hospital at home.

So, this is the practical problem that we're addressing there.

So I'm not sure that we would be able to capture those kinds of delayed presentations with intracranial hemorrhage because of this attribution problem.

Member Yu: Yes. Yes. Okay, thank you, Patrick.

Chair Septimus: Thank you. Again, I apologize I missed your hand.

Member Yu: Oh, no problem.

Chair Septimus: Any other discussion on 2993? It's pretty straightforward.

So, I think having seen none, we'll just go on to the next one.

Dr. Pickering: Sounds good.

So, that was all of our comments. So that concludes the public comment portion.

Again, want to thank all of our developers. There will -- there is still related review, and it's for the two measures that did pass, so they're both NCQA

measures. So, we still have a conversation to have there.

Related and Competing Measure Discussion

So, just a 2 by 2 table to remind folks of related and competing are what we see in this table. We don't have any competing measures. But a competing measure will be a same concept and same target population.

In instances like this, the Standing Committee would have a best in class conversation. And Ed, I'm sure, can speak to those discussions.

But we do have related measures for this cycle, so, for the two measures 0097 and 0022.

The related measures have a different target population or a different concept. And if they're both different, then neither harmonization or competing measures exist.

So, if there are some similarities for these related measures, the point of this conversation is to see if the Standing Committee has any questions or concerns related to what the developer has listed within the measure submission form of the related measures, and if there's any recommendations they'd like to offer the developer which will get included in the final report and be evaluated again once the measure comes back through for endorsement, to see if there's any effort on that harmonization.

The overall goal of this is to try to mitigate any potential burden to the system in the number of measures and the differences across related measures.

So, we'll go on to the next slide and the next slide after that.

This is just a summary of what I just stated. So, I'll just talk about 0097 since it did pass.

So that you can see the series of measures that are listed here. This is the medication reconciliation measure. And as Bob also clarified, that again this being a health fund level measure, the measures that are listed here at different levels of accountability and different care settings.

So, for measure 0553, and for all of these measures, first of all, the developer said that they are harmonized to the extent possible. And to the extent possible means that there may be some differences in the care settings, maybe some differences in the target populations.

And the developer has mentioned that 0553 is conducted at a special needs plan level.

And then measure 0419E is conducted at the provider level. And this measure only looks at the documentation's current medication, not focusing on reconciliation medications after discharge.

For measure 2456 it's conducted at the hospital facility level, but this measure does not address whether reconciled medication must be documented in the outpatient medical record. Therefore, the measure is different than 0097.

For 3317 it's conducted at the facility level as well. However, this measure looks at whether medications should be continued, or discontinued, or modified. It also targets medications prior to an admission and assesses adult and pediatric medications. So it's somewhat of a different target population.

And, finally, there is the 2988, conducted at the facility level. It's target population is members receiving dialysis there. And the measure aims to assess the use of home medications compared to

medications in the dialysis medication record.

So, does the Standing Committee have any questions related to the harmonization rationale that the developers provided, or any potential recommendations to the developer?

Again, your recommendation is not going to change the endorsement vote in any way, but it's able to be noted within the final report for future evaluation by the Standing Committee.

Chair Septimus: Okay. If you have a comment about this, please raise your hand. And Matt explained it beautifully, the difference between competing and related measures.

I think that one that you will see here are great examples of what we mean by related measures.

I don't see any hands.

Okay, I guess we'll go to the next one.

Dr. Pickering: Okay. I believe this slide and the next slide are certainly clips. Or maybe it's just this one slide.

But it's 0022. So, again, that measure did pass. And the measure that it's been related to is also a measure going through this, going through measure evaluation cycle currently. But the measure is related to potential harmful drug-disease interactions in older adults.

And the developer does state that the measure is harmonized to the extent potential to the potentially harmful drug-disease interactions in older adults measure and NQF 0022. They have a similar focus, so measure of inappropriate medication use in older adults, and reporting level to health, and how are they a different part of the population. So this is what

the developer had stated within the measure submission form.

And that the DDE measure that is listed here targets patients with specific condition or disease that can experience adverse effects when combined with certain medications that are recommended to avoid for that condition.

The NQF 0022 targets a larger population of all older adults, and assesses use of high risk medications that have been recommended to avoid in older adults.

The developer states that together these measures cover a significant portion of the AGS Beers criteria, both recommendations for population or medication safety especially.

NQF 0022 is harmonized with NCQA's use of high risk medications in the elderly. However, this measure is being retired, the high risk medication used in the elderly, from CMS' 5-star rating exploiting hazards for health plan accountability in 2021.

I'll turn it over to you, Ed, to see if the Standing Committee has any questions of comments.

Chair Septimus: Okay. Any questions or recommendations?

So I think, again, you can see how invaluable the staff is to running these meetings.

Any other comments? I don't see any. So, let's go to the next slide.

Dr. Pickering: Okay. And that concludes our relating and competing. So I'll put it over to Isaac who will open it for any member and public comments and go through the next step.

So, Isaac, I'll turn it to you.

Opportunity for NQF Members and Public Comment

Mr. Sakyi: Thanks, Matt.

At this moment we would like to give some time for NQF members and the public to share any comments. And we will be monitoring the chat for any received.

Chair Septimus: I don't see anything, Isaac.

Mr. Sakyi: Okay, hearing none, we will move on to the next steps.

Chair Septimus: Okay. Next steps, Matt.

Go to the next slide.

Dr. Pickering: And I just want to make -- I'm hearing some background noise a little bit. Please address that. Thank you.

Oh, no, still there.

There we go. Thank you.

Isaac, go ahead.

Wrap Up/Next Steps

Mr. Sakyi: Thanks. So, following the conclusion of today's meeting the discussion and voting results will be captured in the meeting summary. That will be made publicly available in the upcoming weeks.

The results of today's votes will also be added to the fall 2020 draft report in preparation for the upcoming CSAC review meeting.

So, just a recap for the 2020 cycle. The Standing Committee reviewed six measures. Four were recommended for endorsement. Consensus was not reached on one. And the other was adjudicated today due to an error in the initial voting process.

During today's meeting the two measures were recommended for endorsement.

Next the measures will proceed to the CSAC review meeting on June 29th and June 30th. Following the CSAC's review and final vote of endorsement status, the measures will then move to the 30-day appeals period from July 7th to August 5th, during which the NQF members and members of the public will have the opportunity to submit an appeal on the final endorsement status.

Once the appeal period closes, NQF will finalize the fall 2020 technical report for public release at the end of the year. Should NQF receive any appeals, they will be reviewed accordingly prior to producing the final fall 2020 technical report.

Just a brief note for spring 2021, we have six measures under review. And the Standing Committee will reconvene on June 24th from 10 a.m. to 5 p.m. Eastern Time, and June 25th, 2 p.m. to 5 p.m. Eastern Time for the spring 2021 patient safety measure violation web meeting.

Chair Septimus: Is that on the next slide, Isaac? Oh, never mind. Okay.

And all of you, all of you should have received a link to those six measures.

Mr. Sakyi: That is correct.

As always, if you have any additional feedback, questions, or concerns, please do not hesitate to reach out via our email at patientsafetyqualityforum.org, or by phone at 202-783-1300.

For any additional information or meeting materials you can find that on the project page or on the committee SharePoint if you are on the Standing

Committee.

And at this point I would like to pause to see if there are any questions.

(No response.)

Adjourn

Chair Septimus: Okay. So, now we can give people back 10 minutes which is -- which is great.

Dr. Pickering: Yes. Yeah, I was just going to say thank you. Thank you, Ed, for running an efficient meeting, as always.

Thank you to the Standing Committee for your engagement as well as getting through all of what we had to do today.

Thank you to the developers for your time as well. Thank you to the Standing Committee members again. And thank you to the NQF staff for all of their work leading up to this meeting.

Ed, I don't know if you have any final remarks.

Chair Septimus: No. Again, also from Iona, she sends her best. Anne, I know, thanks all of you for the hard work that you've done. And we'll look forward to discussing the next six measures at the end of this month.

So, with that, I thank everyone for their time. I hope everybody has a good weekend. And we'll talk to you guys in about two or three weeks. Thanks.

(Whereupon, at 2:51 p.m., the committee was adjourned.)