National Quality Forum
Patient Safety Measure Evaluation Web Meeting
Spring 2021 Cycle
Friday, June 25, 2021

The Committee met via Videoconference, at 2:00 p.m. EDT, Ed Septimus and Iona Thraen, Co-Chairs, presiding.

Present:

Ed Septimus, MD, Co-Chair
Iona Thraen, PhD, ACSW, 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
Bret Jackson, The Economic Alliance for Michigan
John James, PhD, Patient Safety America
Raquel Mayne, MS, MPH, RN, Hospital for Special Surgery
Anne Myrka, RPh, MAT, Island Peer Review Organization
Edward Pollak, MD, Henry Ford Health System
Jamie Roney, DNP, NPD-BC, CCRN-K, Covenant Health System
David Seidenwurm, MD, FACR, Sutter Health
Geeta Sood, MD, ScM, The Society for Healthcare Epidemiology of America
Donald Yealy, MD, FACEP, University of Pittsburgh Department of Emergency Medicine
Yanling Yu, PhD, Washington Advocate for Patient Safety

NQF Staff:

Tamara Funk, Manager
Michael Haynie, Senior Managing Director
Yemsrach Kidane, Project Manager

Chris Millet
Matthew Pickering, Senior Director
Isaac Sakyi, Senior Analyst

Also Present:

Ben Shirley, Pharmacy Quality Alliance

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Proceedings

(2:01 p.m.)

Welcome and Review of Meeting Objectives

Mr. Pickering: Let's go ahead and get started and I will say happy Friday to everyone, both developers on the call, our Standing Committee, members on the call as well as others on the public just listening in.

So, happy Friday, we are picking up from Day 1 which was yesterday, an all-day meeting, where we weren't able to finish all of the measures.

We actually weren't able to finish going through one of the measures, 3501e, which we'll pick up today starting with feasibility. But I did want to say thank you again for all of your time yesterday, it was a long day, a lot of information to consider, and also leading up to that meeting for the Standing Committee Members and also the developers.

So, thank you very much.

But today we do have time, three hours, 2:00 p.m. to 5:00 p.m. Eastern, if we are able to finish early we definitely will adjourn early and we'll go through the agenda here a little bit.

But I want to go to the next slide, which is just another welcome slide, and I just want to give an opportunity for both Ed and Iona, our two current Co-Chairs just to provide any welcoming remarks for Day 2.

So, Iona, I'll turn it to you first and then we can go to Ed.

Co-Chair Thraen: I'm just glad to be back in the saddle, I apologize yesterday for having abandoned

everybody but we had a statewide meeting that I needed to participate in.

So, welcome back and thank you for coming back, hopefully we have a quorum today and with that I'll turn it to Ed.

Co-Chair Septimus: Yes, I said my thanks yesterday after our day-long meeting and Ed says if we can get finished within three hours we can quit early.

It's not if, it's a matter of when. It's my hope that we can get out of here well before the three hours.

Mr. Pickering: We'll go to the next slide, and thank you, Ed and Iona. Just some housekeeping items again, I just mentioned briefly that we are using a WebEx platform. You have the raise-hand feature, which all of you were familiar with yesterday, so we will be recognizing you there.

There's also the chat function if you'd like to enter your chats in and be recognized there as well, we can do so. If you are not speaking please keep yourself on mute.

I also encourage or would say that members of the public, if you are chatting through the chat feature please refrain from doing so.

There is an opportunity at the end of the call to raise any points you'd like to make to the Standing Committee during the public comment, so at the end of the meeting or end of the proceedings today.

And also again to the developers, unless there's a clarification question that comes from the Standing Committee as the Co-Chairs will be facilitating this, we would ask for you to refrain from using the chat feature or responding directly without being recognized.

Again, just to make sure that we are using our time effectively today, and if there's any questions that we have for the developer, any clarification items as our Co-Chairs will be facilitating this, we will recognize that and turn to you for any responses.

So, with that, I'll go to the next slide, which I believe is -- no, we're going to do attendance first, excuse me.

Before we go on a recap and do attendance, I'm going to turn it over to Tami just to go through the roll call here, just to see who's present so we can see if we have a quorum for today's call.

So, Tami, I'll turn it over to you.

Ms. Funk: Thanks, Matt. Hello, everyone, I'm going to read through names, please just say present if you are here. Ed Septimus?

Co-Chair Septimus: Present.

Ms. Funk: Iona Thraen?

Co-Chair Thraen: Present.

Ms. Funk: Emily Aaronson, we know is inactive. Joel Bundy? Elissa Charbonneau?

Member Charbonneau: Present.

Ms. Funk: Curtis Collins?

Member Collins: Present, good afternoon.

Ms. Funk: Good afternoon. Theresa Edelstein?

Member Edelstein: Good afternoon, present.

Ms. Funk: Jason Falvey?

Member Falvey: Present.

Ms. Funk: Terry Fairbanks? Robert Green? Sara Hawkins?

Member Hawkins: Present.

Ms. Funk: Brett Jackson?

Member Jackson: Present.

Ms. Funk: John James?

Member James: Present.

Ms. Funk: Laura Kinney? Arpana Mathur? Raquel Mayne? Anne Myrka?

Member Myrka: Present.

Ms. Funk: Edward Pollak?

Member Pollak: Present.

Ms. Funk: Jamie Roney?

Member Roney: Present.

Ms. Funk: Nancy Schoenborn?

Co-Chair Septimus: She's on service, she's not going to be able to make it.

Ms. Funk: David Seidenwurm?

Member Seidenwurm: Present.

Ms. Funk: Geeta Sood?

Member Sood: Present.

Ms. Funk: David Stockwell? Donald Yealy?

Member Yealy: Present.

Ms. Funk: Yanling Yu?

Member Yu: Here.

Ms. Funk: Thanks, you all. Matt?

Co-Chair Septimus: What was the number present, if you could tell us?Mr. Pickering: So, I count 16 and I'm just confirming once more with our quorum number here. So, for 3501e our recusal was David Stockwell, and just to confirm, David Stockwell, are you on the call?

Okay, so even with David Stockwell recused we would need 16, which I counted 16, so we have quorum so we can proceed for voting today with the remaining two measures, which we would need 16.

I do see a couple folks have to jump off at 3:30 p.m. so we will see where we can get to with the quorum that we have here.

So, we will proceed but before I do just one more time, was anyone from the Standing Committee on the call whose name was not recognized or not called? I guess I didn't say that right.

Did anybody join late on the Standing Committee? We'll go to the next slide. Ed, I'll turn it to you for a recap.

Recap of Day 1

Co-Chair Septimus: Thank you very much, we had a really full day yesterday, we started off with this severe sepsis and septic shock management bundle.

We had a robust conversation, I think there's no question in everybody's mind this is an important diagnosis and measure.

The measure was re-endorsed, there were some comments by several societies including the Sepsis Alliance, three societies, IDSA, ACEP, and AMA also

provided comments, concerns about the level of evidence for certain of the bundle elements.

The measure developer did tell us that they're working potentially on some modifications to the measures but we voted on the measures as it was presented to us. And we thank the Committee for their significant contribution.

The next one was a composite weighted average for three CT exams, that was passed. We did have a comment at the end of the day from a radiologist from California who agreed this was an important measure but questioned whether this measure was actually going to get the results they desire.

I think they'll make that available to us in the post-comment period. We then had two considerations that residents experiencing one or more falls and decubitus ulcers, both of which were passed and re-endorsed.

And then the measure that we got halfway through with was 3501e, an electronic measure opioid-related adverse events on that. We did not reach consensus on evidence, we passed the gap and the reliability and the validity and we will take up discussion on feasibility when we're ready.

So, that brings us up to date on what we had yesterday. Does anybody on the Committee have any other comments on things I may have missed?

Mr. Pickering: Just a point of clarification, it was performance gap for 3501e that had consensus not reached?

Co-Chair Septimus: Is that what I said? Did I get it wrong?

Mr. Pickering: You said it was evidence, evidence did pass but it was performance gap with the --

Co-Chair Septimus: I got it, thank you very much. In fact my note says it was performance, thank you very much. I wrote it in the wrong spot. That is why Matt is here.

Mr. Pickering: And my team is saying that we have two other Committee Members that have just joined, Raquel Mayne and Joel Bundy. Are you both on? Could you just recognize you both are on?

Member Bundy: Hi, this is Joel, I am here.

Mr. Pickering: Thank you. Raquel, are you there?

Member Mayne: Yes, I'm here.

Co-Chair Septimus: 18.

Mr. Pickering: 18, yes.

Co-Chair Septimus: What we plan to do is finish this measure and then Iona will take us through the last measure.

Voting Test

Mr. Pickering: So, we'll do a quick voting test just to make sure everybody is up and running. We should be expecting 18 votes until about 3:30 p.m. when a couple of folks have to drop.

So, you should receive that Poll Everywhere link, which was sent out a couple times I think today so please just go ahead and log in and we'll open up that voting test.

Co-Chair Septimus: I don't see a test one though.

Mr. Pickering: You can sort of shuffle through that.

Member Seidenwurm: Can you email out the link?

Mr. Pickering: Who was that, sorry?

Member Seidenwurm: I'm David Seidenwurm, can you email the link, a fresh link, I can't find mine.

Mr. Pickering: We sent an email out recently, right after 2:00 p.m.

Member Seidenwurm: Mine goes right to the --

(Simultaneous speaking.)

Mr. Pickering: You got it, David?

Member Mayne: I got it.

Mr. Sakyi: It's Question 7.

Co-Chair Septimus: It's Question 7?

Mr. Sakyi: Yes.

Co-Chair Septimus: Now you're really tricking me here. Got it, thank you.

Mr. Pickering: Vanilla versus chocolate, all right.

Co-Chair Septimus: What's the level of evidence for this, is there a performance gap?

Mr. Pickering: We should be expecting 18 so we've got 16 votes in so far, 17. Anyone have any issues with this question?

It's which flavor of ice cream do you prefer? So, that should be the question you should be answering. Anyone have any issues?

Co-Chair Septimus: Only if it's neither.

Mr. Pickering: And still only 17 votes, is someone not able to vote?

Member Yu: Now you make us want ice cream.

Mr. Pickering: Okay, so let's close it, we'll revisit

this 18th vote so not hold up the time here.

Member James: Sean, I saw some measure come up.

Co-Chair Septimus: You have to skip to Number 7, I had the same problem too, John.

Member James: We skip to 7?

Co-Chair Septimus: It's embedded in the measures we did last week.

Co-Chair Thraen: Is there a performance gap right there?

Consideration of Candidate Measures

3501e: Hospital Harm - Opioid-Related Adverse Events

Mr. Pickering: It's pretty close, consensus not reached. Okay, thanks, John, that was the 18th vote so we can go back to the slides and then we'll start where we left off.

Again, how this we'll proceed, we're going to be starting with 3501e, we'll be starting with feasibility since we were able to get through the scientific acceptability yesterday.

So, starting with feasibility, again, the lead discussants will start. In this case, since we don't need the developer to provide another overview, the lead discussants will start and the discussants will add anything else they'd like to add to the measure.

We'll open it up to the Committee for discussion and then we'll go into vote for feasibility.

Member Yu: This is Yanling, and just to remind everyone, it's a new measure, it's an eMeasure, and it's an outcome measure. Go for it, we'll go to

feasibility.

Thank you, Ed, and the other Ed and Sara, just jump in if you have any comments. And so here we go with feasibility. The preliminary reading is moderate, the developer recorded a few feasibility issues and I don't think they are significant.

But for instance, all size assess for feasibility suddenly report that the anesthesiologist document their use of naloxone on paper records inside OR, and some of the data elements demonstrate the feasibility issues in this format.

And the Committee comments pretty much the same about whether there's a difficulty updating data, 20 percent of facilities indicate they have a difficulty obtaining data required by this measure and issues about use in paper charts like in the OR.

The developer had responded to this question, these issues, and I believe this could be overcome by technical and workflow modifications towards EHR within OR.

So, that's what we had right now for feasibility.

Co-Chair Septimus: If I remember from yesterday, isn't the operating room excluded from this measure also? Am I remembering this correctly?

Member Yu: Yes, you're right.

Co-Chair Septimus: I'm just filling that out.

Member Yu: Thanks for reminding us.

Member Hawkins: Yes, so given that, I think the feasibility is not a concern. Again, any pharmacy or pharmacist could pull records of cases using naloxone and I don't think it would be a challenge to get the data.

Co-Chair Septimus: Anybody else on the Committee want to comment on feasibility?

Member Pollak: I agree with my colleagues.

Co-Chair Septimus: Matt, can you see anyone's hand?

Mr. Pickering: No hands, I don't see any questions in the chat box.

Co-Chair Septimus: Okay, let's go ahead, is Isaac running the show today again?

Mr. Pickering: Isaac always runs the show.

Co-Chair Septimus: Isaac, give us a vote?

Mr. Sakyi: Voting is now open for Measure 3501e for feasibility.

Co-Chair Septimus: What number is this? This other one's on the same page?

Member Hawkins: 8.

Co-Chair Septimus: Just want to make sure.

Mr. Sakyi: Yes, Number 8. The options for the question, A for high, B for moderate, C for low, and D, insufficient. We have 18 votes in already. Voting is now closed for Measure 3501e on feasibility.

We have 7 votes for high, 11 votes for moderate, 0 for low and 0 for insufficient. The measure passes on feasibility.

Co-Chair Septimus: Thank you. Yanling, the next one is use, of course this is currently not in use, it's a new measure I'll remind the Committee.

Member Yu: And like you said, it's a new measure for use, any accountability and public reporting

programs, but following MAP 2021, 2020, 2022 review, the developer envisioned that this measure would be considered for accountability program.

We have a future rulemaking once NQF endorses this measure, and CMS goes through the rulemaking process, the panel measure specifications or implementation will be made publicly available on CMS on appropriate quality recording website.

So, that's the plan.

Co-Chair Septimus: Okay, Ed or Sara?

Member Pollak: I'll cede my time to Sara, any thoughts?

Co-Chair Septimus: Smart man. Sara, any additional comments?

Member Pollak: So, just one point of clarification.

What we're voting on with accountability is if this is an adopted measure, could it be used to drive accountability, right? We're not conflating it with the other questions, right?

Member Sood: That was going to be my question too, for measures that aren't being used what exactly are we answering? Is it that the developer is planning on using it for accountability and planning on having a feedback mechanism?

Mr. Pickering: Ed, would you like me to chime in?

Co-Chair Septimus: Go ahead, Matt.

Mr. Pickering: It's a great question. So, for use, especially for new measures that aren't used in some sort of public reporting or accountability application, that's exactly it. Is there a plan for use

or is there a way that developer anticipates how this could be used, and have they articulated that in any way? In this case there is a potential plan for use, as we've discussed being used in one of the accountability programs within future rulemakings.

So, there could be some plans for use in submission to measures under consideration for consideration with use in one of those programs. So, that is something that is a plan potentially for use within accountability applications.

So, with new measures you see this, sometimes new measures are used already but for the most part, for new measures you'll see somewhat of a plan for use.

But there's also a feedback element as well, feedback is when the measure is used and if there is feedback that is received by the steward or the developer or both, related to the measure and its use.

And that could be questions about how to interpret the results, about the risk adjustment model, how to implement the measure. For new measures, feedback could be about feedback in the development of the measure, in which case developers may provide some information about the feedback they've received by the accountable entities in the development of the measure.

And so that's where you're getting a little bit with how to interpret the use criteria for new measures or measures that aren't currently in use.

So, we expect to see after a new measure is endorsed after three to four years that there is some use happening with the measure, and if not, there needs to be some rationale for the Committee to consider why a measure is not in use.

But for new measures like this one, there could be a plan for use. I hope that answers the question there.

Co-Chair Septimus: Is your hand still up? Okay, you're fine, go ahead, Yanling.

Member Yu: Correct me if I'm wrong, I think, Matt, isn't it true that NQF is promoting or has encouraged developers to make specially the outcome measures towards the direction of public reporting into an accountability program because they have greater impact over these measures.

Is that right?

Mr. Pickering: Yes, it's a great question and it's not just necessarily NQF, it's CMS setting strategic priorities to look at more outcome measures and patient reported outcome measures as a priority for driving change in the healthcare system.

And so NQF, with our criteria, the use element is really trying to ensure that these measures, if they're endorsed, are not just sitting on the shelf like bookmarks, but sitting on the shelf. We want them to be used and for that use actually impact care.

So, that's why there's that use criterion which becomes must-pass for maintenance measures. We want to try to incentivize the use. If they're valid if they're evidence-based, they fill a gap, they should be used to try to improve care.

And that's why use and usability are sort of tied together. But for new measures it's harder to really assess that if they're not being used because they're new. But there is a plan for use, we try to recognize that.

Whether it's an outcome or a process, the use is a

little bit agnostic to that, it just depends on whether there really is a gap in care, whether there's evidence to support that.

But the use piece is really trying to ensure that this measure that's valuable and important and is actually being used.

Member Yu: I think before the public, the accountability and public reporting is extremely important when it comes to this type of measure. So, actually, I'll move on to usability.

Co-Chair Septimus: We've got to vote. Any other comments, Matt, that you see?

Mr. Pickering: No questions, no hands raised.

Co-Chair Septimus: Isaac, do your magic, Question 9.

Mr. Sakyi: Voting is --

(Simultaneous speaking.)

-- 3501e. The options are A for pass and B, no pass. We're waiting for one more vote. Mr. Pickering: Question 9, again as Ed mentioned, it's Question 9.

Mr. Sakyi: Voting is now closed for Measure 3501e, we have 17 votes for pass and 1 vote, no pass. The measure passes on use.

Co-Chair Septimus: Thank you, and then the last one is going to be usability again, same thing. It's currently not in use. Yanling?

Member Yu: There's no usability issues in the development of this measure, so from the submission, and the Committees' Members comment that there were no reports on intended consequences and recognized a greater benefit of

this measure than harm.

But one member was wondering if there would be a tendency to not use naloxone, I think we discussed about it yesterday, when it would benefit the patients slightly overdosed on the opioid.

So, that's what basically the summary of the comments is.

Co-Chair Septimus: Ed and Sara? Did Sara get her video taken care of?

Member Hawkins: I am back on but I don't have anything to add to that.

Mr. Pickering: Ed?

Co-Chair Septimus: No. Any Committee comments? I guess one of the recommendations that I heard from Matt was should the measure developer look at unintended consequence? Did I understand that correctly?

Mr. Pickering: Yes, I think part of these evaluations are definitely to consider the unintended consequence or if there are any that have been discovered in the use of the measure. And that also is with evidence as well that comes out of the literature evaluations. So, I think that is something that we can note from the Committee discussion.

Member Myrka: This is Anne, I do have a quick comment. Most hospitals are looking at trigger tools and trigger tools for adverse events. And something similar would be vitamin K for Warfarin reversal.

And they look at that and it's not reducing the use of vitamin K if there's a Warfarin reversal. I think that's something that's similar that we could use as a parallel analogy to this.

So, I don't really buy too much that it's going to drive reduction in naloxone. I think it will correctly drive improvement in management of opioids.

Co-Chair Septimus: Thank you, Anne, we discussed that a lot yesterday.

Member Yealy: Ed, this is Don, the developer shared information that the deployment in naloxone as they recorded did not seem to be off kilter.

But the question of does it affect overall naloxone deployment typically is less addressed. And I hate to disagree with Anne but I actually don't think vitamin K and naloxone are in the same hemispheres.

It's two dramatically different conditions and interventions, they do not compare, and my only point is I don't know how this might have been, naloxone use in the early phases.

I don't think it will have any effect in apnea or near-apnea. High-quality care would deploy naloxone sooner than that.

Co-Chair Septimus: Thank you, Don. Don is, by the way, one of Pittsburgh's best doctors. I see it behind you.

Member Yu: I was wondering wouldn't the medical records show whether there was an overdose.

So, when you use EHR, you always have another code, actually, to document that so you can be sure it's not other issues would not be unusual for not using naloxone for proper use.

Member Yealy: So, the coding of overdose depends on what you do and if the intervention allows you to code it gets circular. There is another diagnostic test for it.

Co-Chair Septimus: We're straining here, I'm trying to get people out on time. Let's finish up on usability.

(Simultaneous speaking.)

Member Yu: I forgot to mention the preliminary reading is moderate.

Co-Chair Septimus: Thank you.

Mr. Pickering: Ed, I don't see any hands raised or any questions in the chat box.

Co-Chair Septimus: Isaac, do your magic again.

Mr. Sakyi: Voting is now open for Measure 3501e on usability, the options are A for high, B moderate, C, low, and D, insufficient.

Co-Chair Septimus: Question 10.

Mr. Sakyi: We have 18 votes, voting is now closed for Measure 3501e in usability. We have 1 vote for high, 11 votes for moderate, 2 for low, and 4 insufficient.

Co-Chair Septimus: What's that percentage?

Mr. Sakyi: That's is 66.7 for pass, it passes on usability.

Co-Chair Septimus: Okay, then the last question of course is suitability for endorsement so Isaac if you can...

Mr. Pickering: We won't vote on that just because --

Co-Chair Septimus: I'm sorry, you're correct, because we did not get consensus routes. Thank you, Matt, I knew there was a reason we kept you around.

That's correct, we'll circle back on this question at our post-comment period and we'll re-vote on consensus not reached.

And Matt, correct me if I'm wrong, if we do reach consensus then we will go to suitability.

Mr. Pickering: If it reaches consensus on passing?

Co-Chair Septimus: Correct, so thank you very much.

Member Yu: So, Ed and Matt, would you elaborate a little bit on the reason we didn't reach the consensus because the performance gap, right? Is that the only one on this measure?

Mr. Pickering: Ed, would you like me to chime in?

Co-Chair Septimus: Go ahead, you can express it a lot better than I can.

Mr. Pickering: So, there are a series of must-pass criteria within our criteria, evidence is one of them, performance gap is another, specific acceptability is another, use for maintenance measures, these are must-pass. If there's consensus not reached on one of those criteria, then we will not vote for the overall recommendation for endorsement because there's no consensus on those must-pass criteria.

So, the Committee has to reach consensus and pass the measure on those must-pass criteria in order for the Committee to recommend overall the suitability for the measure for endorsement.

So, for the post-comment meeting, the Committee will be reconvened and consider any of the comments that have been received during the comment period, and then revote on that performance gap criterion.

And if that passes, the Committee comes to a consensus on the passes, then they'll vote on the overall suitability for endorsement towards the measure.

Member Yu: Got it, thank you.

Co-Chair Septimus: This happened a couple of times in the last a couple of years. We'll do it again in the post-comment. So, with that, I'm sure you're happy to hear this, that I'm going to turn over the next measure to Iona.

Mr. Pickering: Thanks, Ed, and before we get started, I just wanted to check in to see if the developer, PQA, is on the line?

Mr. Shirley: Hey, Matt, this is Ben with PQA, can you hear me all right?

Mr. Pickering: Yes, we can, thanks Ben. Iona, over to you. Iona, are you there?

3389: Concurrent Use of Opioids and Benzodiazepines (COB)

Co-Chair Thraen: Had to figure out how to unmute, you think you know. Thank you, this is Measure 3389, concurrent use of opioids and benzodiazepines. The steward developer is PQA, which I believe stands for Pharmacy Quality Association.

The description is the percentage of individuals greater than 18 years of age with concurrent use of prescription opioids and benzodiazepines during the measurement year. A lower rate indicates better performance.

The lead discussant is Curtis and the secondary discussants are Anne, David Stockwell, and David Seidenwurm. So, I will turn it now over to Curtis.

Mr. Pickering: Actually, I don't know if we could let the developer provide an intro?

Co-Chair Thraen: Sure.

Mr. Shirley: Sure, appreciate that and I appreciate everyone coming together here on Friday afternoon. I know there's been a lot of measures so I appreciate you all sticking with it.

My name is Ben Shirley, Director of Performance Management here at the Pharmacy Quality Alliance.

And on behalf of our team, I'm pleased to present the concurrent use of opioids and benzodiazepines, or COB, measure for maintenance of NQF endorsement.

As we're all aware, opioid-related safety continues to be a major concern in our healthcare system. Recent data are especially troubling, overdoses have spiked over the course of the last year with studies suggesting more than a 25 percent increase in total overdose deaths.

And that's primarily been driven by opioids. Opioid safety is as important and urgent now as it ever has been and it's critical that the U.S. healthcare system has appropriate quality measures that address a high-risk opioid prescribing associated with overdose at the population level.

One well established risk for overdose and other adverse events is concurrent use of opioids and benzodiazepines.

The 2016 Centers for Disease Control and Prevention guidelines issued a Class A recommendation, the concurrent use of these medications should be avoided whenever possible. And the FDA issued a black-box warning highlighting the danger of using these medications

together.

Since then, a broad body of evidence has continued to emerge demonstrating the starkly higher overdose risk for patients receiving these drugs concurrently, while demonstrating that co-prescribing continues to occur at substantial levels.

The COB measure specified at the health plan level captures the percentage of individuals 18 years of age and older with concurrent use of opioids and benzodiazepines, specifically with 30 or more overlapping days' supply for the two or more medications. Individuals in hospice or with cancer or sickle cell diagnoses during the measurement year are excluded.

The measure was developed and has been maintained through PQA's standard consensus-based process and has demonstrated face validity, empirical validity, and reliability both in testing and in real-world use.

The feasibility and usability of the measure is well established and it's specified using administrative claims, and is used in several key programs including the Medicaid adult core set and the Medicare Part D display page.

Tracking performance of the COB measure over time has demonstrated encouraging signs of improvement as health plan performance results are used to identify opportunities to decrease high-risk co-prescribing of opioids and benzodiazepines.

However, with substantial variation in measure rates among entities and average measure rates, near 20 percent there is still significant opportunity for improvement with this measure. Equally important to tracking rates, PQA works with program administrators closely as well as our

diverse membership to gather measure feedback and monitor for any unintended consequence which have not been identified to date.

This is a health plan measure that is not intended to guide individual patient care, but rather is intended to identify opportunities to decrease high-risk co-prescribing at a population level.

The COB measure addresses a high-priority area with identified performance gaps and is based on strong guideline recommendations and a body of clinical evidence.

It is a feasible, actionable, and an evidence-based measure that improves patient safety through its use in several major programs. So, I appreciate the Committee's consideration today and we look forward to the discussion.

Co-Chair Thraen: Thank you for that, that was very succinct and to the point, nice. Now, I think I need to turn it over to Curtis and his team.

Member Collins: Thank you, I agree with that, I think Ben really summed up a lot of what we're going to say here, so great job by the developer on that.

In terms of evidence, we will start there. Ben mentioned the measure is based on the CDC guidelines for prescribing opioids in chronic pain, which came out in 2016, which does give a Category A-level evidence Type 3 recommendation for this recommendation.

Ben also mentioned the FDA black box warning. Since that time, updated evidence submitted includes four additional retrospective cohort studies, one case cohort study and a technical brief from AHRQ.

The studies demonstrate the relationship between current use and increased risk for overdose and other adverse events, including higher risk of emergency department visits or hospital admission for opioid overdose, as well as continued prevalence of concurrent use of opioids and benzos and room for improvement. The preliminary rating was high for level of evidence and our Committee generally agreed with that in terms of the comments. I'll turn it over to the secondary discussants, other discussants for any additional comments on evidence?

Co-Chair Thraen: Anne, David, or David?

Member Myrka: I think this is a very interesting and important measure and we are actually doing a similar measure, creating a similar measure, for our opioid dashboarding for our community coalitions and our quality improvement work, and pulling together resources for de-prescribing for both opioids and benzodiazepines.

So, I think this is a really important measure. And one thing that struck me was how the Medicare population is more adversely affected through concurrent use than the other populations that we've seen, there's more prescribing for the Medicare beneficiaries, concomitant prescribing, then, versus the Medicaid patients.

So, I think it's very important. Also, I'm seeing Geeta has a chat question, the sickle cell patients are not in the exclusion denominator for this measure, correct?

It's just hospice and cancer patients, is that correct?

Member Collins: That is my understanding as well, that potentially sickle cell has been removed still the last endorsement. But it is an exclusion criteria

along with cancer, as well as hospice patients.

Member Sood: Thank you, if I could just ask a clarifying question to my colleagues on the Committee.

It seemed to me that the evidence, if you have it as a Level A evidence, that seems to be quite high, it seems like you really shouldn't be using the two together but the A&A letter and what I remember from internal medicine quite some time ago, it seemed like we would use both benzodiazepines and opioids together in some in-patients that had significant amounts of pain. I see Don is commenting on the chat, would others mind teaching me a little bit about how you see that in your practice and what you see?

Co-Chair Thraen: I'm not sure, Geeta, that is something that someone can comment on. That might be an offline conversation that you might want to have with Members of the Committee.

Member Sood: I think that's important in terms of evaluating evidence. If all the clinicians are using it in many patients, then the evidence is probably not supportive.

Member Myrka: Geeta, this is Anne. This measure is an outpatient population measure, and we know that especially the elderly patient population are at higher risk for falls and fractures just from benzodiazepine use alone.

So, I think the potential diagnoses where both of them might be utilized together should be rare and unusual and it shouldn't be common.

But, you know, in our data we're seeing up to 30 percent co-administration. And that's, I believe, excessive for any kind of diagnoses, in my opinion. I don't know, anybody else want to pipe in?

Co-Chair Thraen: Ed's made a comment in the chat.

Co-Chair Septimus: Yeah, I think Anne just said what I wrote and what Ed is identifying. It's a non-zero event but it's clearly not the frequency that we see right now.

Member Charbonneau: I think also we should remember that in outpatients they can give prescriptions from multiple different providers. So, I think having this measure, look at it from the health plan perspective kind of addresses that.

Co-Chair Thraen: Also, someone's not on mute so we're getting some background noise, FYI. Thank you. No, still there.

Member Collins: And, you know, I should mention that the AMA didn't provide public comment to this and they did as well have some concerns that the population of this measure could include patients for whom prescribing both goods may be appropriate.

But I think we've done a nice job of discussing some of those scenarios and realizing that it may happen. But that is what their comments were surrounding.

Co-Chair Thraen: Okay, any other comments about the evidence at this point in time?

Member Seidenwurm: I think still this measure is specified at the plan level and the evidence is at the population level, I think the evidence supports the measure.

Co-Chair Thraen: Who just spoke, by the way?

Member Seidenwurm: David Seidenwurm.

Co-Chair Thraen: Thank you, David.

Mr. Pickering: David, you had your hand raised, was

that for that comment?

Member Seidenwurm: Yes, it was, I guess so.

Mr. Pickering: Thanks, David.

Co-Chair Thraen: Any other comments? I don't see the hand raising so you have to check that out, Matt.

Mr. Pickering: I don't either, Iona. If there's no other comments I think we can go to vote.

Co-Chair Thraen: Okay, should we go to vote?

Mr. Sakyi You should be able to see the measure number and measure title on your screen.

Co-Chair Thraen: This is Question 1.

Mr. Sakyi: Voting is now open for Measure 3389 on evidence. The options are A for high, B for moderate, C for low, and D, insufficient.

We have 18 votes, voting is now closed for Measure 3389 on evidence. We have 6 votes for high, 12 votes for moderate, 0 for low, and 0 for insufficient, the measure passes on evidence.

Co-Chair Thraen: Thanks, Isaac. All right, the next section is GAP. Colin?

Member Collins: Sure, so data provided by the developer were stratified by line of business, and so that's Medicare advantage prescription drug plan, and then the standalone prescription drug plans.

The mean in 2019 for the Medicare advantage prescription drug planning was around 17.4, the same thing with the prescription drug plan. The data I believe did show disparities by age, race, and socioeconomic status.

The preliminary rating was high from the Committee, and Committee Members generally agreed with that but noted some limitations in reporting in that the data was from 2018 and 2019.

Co-Chair Thraen: Any comments from the discussants? Any questions from the Committee Members? Any hands raised?

Mr. Pickering: I don't see any.

Co-Chair Septimus: I can raise my hand, Iona, if you'd like.

Co-Chair Thraen: You could, all right, let's take a vote.

Mr. Sakyi: Voting is now open for Measure 3389 on performance gaps. The options are A for high, B for moderate, C for low, and D for insufficient.

Mr. Pickering: So, this should be Slide 3.

Co-Chair Thraen: Question 2.

Mr. Pickering: It's Question 2, but it would be, on the screen, it would be number 3 as far as the slide you're going to, importance of measuring the report to be what you're seeing?

Co-Chair Thraen: Yes, we see that.

Co-Chair Septimus: It's Question 2 of 9?

Co-Chair Thraen: Correct.

Mr. Sakyi: We're waiting for one more vote.

Co-Chair Thraen: He took a coffee break.

Mr. Pickering: Anybody have any issues voting? Again, this is importance to measure report, performance gap 1B, there we go.

Co-Chair Thraen: Thank you.

Mr. Sakyi: Voting is now closed on measure 3389 for performance passes. We have 11 votes for high, 6 votes for moderate, 1 vote for low, and 0 insufficient. The measure passes on performance gaps.

Co-Chair Thraen: All right. The next area is reliability.

Member Collins: Okay. In terms of reliability the developer conducted measure score reliability testing on data from the 2018 Part D patient safety reports.

The mean reliability for the Medicare advantage drug plan was 0.86 with the standard deviation of 0.18 and the reliability for the prescription drug plan was 0.91.

So, the preliminary rating from NQF was rated as moderate, and Committee comments agreed with this assessment for the most part, there are no disagreements.

Co-Chair Thraen: Any other comments from the discussants? Any questions from Committee Members? All right, let's vote.

Mr. Sakyi: Voting is now open for Measure 3389 on reliability. The options are A for high, B for moderate, C for low, and D, insufficient. Mr. Pickering: For Question 3 of 9, scientific acceptability, reliability, 2A.

Mr. Sakyi: Voting is now closed for Measure 3389 on reliability. We have 4 votes for high, 14 votes for moderate, 0 for low, 0 for insufficient. The measure passes on reliability.

Co-Chair Thraen: All right. The next one is validity.

Member Collins: Thanks. The developer conducted measure score validity testing and evaluate the correlation between plan-level performance and plan-level rates of a composite of inpatient stays and ED utilization due to adverse events from opioids and benzodiazepines. The developer reported that within the Medicare sample a Spearman's correlation coefficient of 0.45, which is moderate, with the prescription drug plan and 0.21 for Medicare advantage drug plans, which is a weaker level. The preliminary rating was moderate and the Committee generally agreed with this assessment, and a majority of Respondents did not have concerns.

Co-Chair Thraen: Okay. Discussants, any comments? You guys are making this way too easy for me. Committee Members, any questions?

Mr. Pickering: I don't see any hands raised either, Iona.

Mr. Sakyi: Voting is now open for Measure 3389 on validity, the options are A for high, B, moderate, C, low, and D, insufficient.

Co-Chair Thraen: We're missing two, missing one, there it is.

Mr. Sakyi: Voting is now closed for Measure 3389 on validity. We have 3 votes for high, 14 votes for moderate, 1 vote for low, and 0 insufficient. The measure passes on validity.

Member Collins: Feasibility.

Co-Chair Thraen: Feasibility, thank you.

Member Collins: So, all data elements are define fields in electronic claims.

The developer reported they're not aware of

difficulties in implementing the measure, the preliminary rating was moderate and there were no concerns expressed from the Committee on preliminary comments.

Co-Chair Thraen: Discussants, Committee Members? Anne, were you going to say something?

Member Myrka: No, I was going to say I don't have anything. Thank you.

Co-Chair Thraen: Any questions? Any hands? All right, let's vote.

Mr. Sakyi: Voting is now open for Measure 3389, feasibility. The options are A for high, B, moderate, C, low, and D, insufficient.

Voting is now closed for Measure 3389 on feasibility. We have 6 votes for high, 12 votes for moderate, 0 for low, and 0 insufficient.

The measure passes on feasibility. Co-Chair Thraen: Thanks, Isaac. Curtis, on use?

Member Collins: So, this measure is publicly reported, Medicare Part B safety reports, and the CMS Medicaid core adult data set, but it's not in an accountability program.

The developer mentioned that it may be in an accountability program in the 2023 star ratings and the preliminary rating from NQF is passed. And I would agree with that.

Co-Chair Thraen: Discussants, any comments? Committee Members? All right, we'll vote.

Mr. Sakyi: Voting is now open for Measure 3389 on use. The options are A for pass and B, no pass. Voting is now closed for Measure 3389 on use. We have 18 votes for pass and 0 no pass. The measure

passes on use.

Co-Chair Thraen: And then the last section is usability, Curtis.

Member Collins: Sure, so the developer has reported improvements between their 2018 and 2019 reports.

For both, going from roughly 19 percent down to 17 percent between 2018 and 2019. The preliminary rating on this is high and there were no substantial comments, I would agree.

Co-Chair Thraen: Thank you. Discussants? Committee Members? All right, shall we vote?

Mr. Sakyi: Voting is now open for Measure 3389 on usability. The options are A for high, B, moderate, C, low, and D, insufficient.

Co-Chair Thraen: We're missing three votes, one more. We're one vote outstanding.

Mr. Pickering: This is usability 4B1, is anybody having issues voting?

Co-Chair Thraen: There it is.

Mr. Sakyi: Voting is now closed for Measure 3389 on usability. We have 11 votes for high, 7 votes for moderate, 0 for low, and 0 insufficient.

The measure passes on usability.

Co-Chair Thraen: So, do we have one last vote for endorsement?

Mr. Sakyi: Yes, voting is now open for Measure 3389 on the overall suitability for endorsement. The options are A for yes, B, no.

Co-Chair Thraen: One more vote.

Mr. Pickering: So you should see overall suitability for endorsement on this question. Anyone having any issues, it's just a yes or no question. Overall suitability for endorsement?

Co-Chair Thraen: Someone's having a cyber trip around the world.

Co-Chair Septimus: There it goes.

Co-Chair Thraen: Got it.

Mr. Sakyi: Voting is now closed for Measure 3389 on the overall suitability for endorsement. We have 17 votes for yes and 1 vote for no. The measure is therefore recommended for endorsement.

Co-Chair Thraen: All right, thank you. I think that finalizes it. I'll turn it back to you, Matt.

Related and Competing Measures

Mr. Pickering: All right, thanks, Isaac, if we could go back to the slides? I'd like to thank the developers for their time today as well. So, again, there's going to be a post-comment meeting for the CNR measure.

We do have to cover just a few more things related and competing with the Standing Committee before we go to the next steps in adjournment. So, there is just a brief moment of your time as we go through related and competing. If you go to the next slide, Isaac, just to remind the Committee, the difference here between related and competing measures.

This is part of our criteria, that portion of the preliminary analysis as well as our criteria that I'll look at with related and competing measures is trying to harmonize measures within the system and also try to mitigate any potential burden of measurement by trying to identify best in class

measures, if there are best in class measures, if their measures are competing. In this case, there hasn't been any competing measures identified, only related. You can see the differences there in this 2 by 2 table in which a related measure has either the same target population or the same concept.

If they have the same concept and the same target population, it's called a competing measure and there's a best in class discussion that the Committee has related to that.

If not the related, if they have the same concept or the same target population, they're related. And then there's some discussion around harmonization.

The developer identifies whether there's measures that currently exist that are related or competing, and if they are related they are asked to describe any harmonization that has been done, or to the extent possible.

All this is within the measure submission information which is provided to the Standing Committee, which I know everyone has been able to look at.

But we offer this opportunity for the Standing Committee to ask questions if needed or make any recommendations to the developer to consider further harmonization beyond what the developer has already mentioned.

So, we'll go to the next slide and probably skip that slide, the further description there, Isaac.

There we go, I'll just start on the first measure and what we'll do is I'll just present the measure here, which is 0500. I'll talk about the other measure that's been related as well as what the developer has mentioned as far as the harmonization.

If the Standing Committee has any comments or recommendations, they can either ask questions of the developer or recommend for the developer, and then we will capture that within the draft technical reports.

And this, again, is one of those items that will be revisited for future evaluation cycles. And so for 0500, the developer identified two measures, one being NQF endorsed, one being NQF non-endorsed, 0500 is related to 3215.

And the developer's mentioned similar target populations but different measure types. So, 0500 assesses the performance of sepsis care processes and NQF 3215 evaluates the impact of sepsis care processes have on outcome and mortality rates. So, 3215 uses NQF 0500 data elements for many of its process adherence variables.

The 3215 collects additional demographic variables such as the source of admission and pregnancy status, the actual lactate value of variables for severity adjustment and morbidity, which are used for risk adjustment.

So, that's 3215. For the New York State Sepsis Improvement Initiative adult composite bundle and 0500, they both include many identical data elements and several similar data elements, which are harmonized with Versions 5.7 of the Step 1 measurement specifications.

So, you think about harmonizing to the extent possible, the developer has mentioned that they are harmonized with that version 5.7 of the Step 1 measure specifications.

So, some key differences with that measure is that the New York State measure requires that hospitals in New York report all cases of severe sepsis and

septic shock. It does not exclude cases transferred to other hospitals, and the New York State measure also requires that hospitals report the actual lactate level numerically rather than categorically as in Step 1.

It has one variation in the types of blood cultures accepted for blood culture acceptable delay data element.

So, those are the two measures that have been identified as related and the developer has identified there are some differences, but there are some areas of harmonization as well. Does the Standing Committee have any questions or recommendations for the developer related to 0500 and 3215 specifically?

We really are looking at the endorsed measures, however, the developer did also mention that there is a non-endorsement measure that is related but, as mentioned, is harmonized through specifications.

Any questions at all, any recommendations?

Member Roney: Matt, this is Jamie, and I would just say the New York State Sepsis improvement initiative adds a whole lot more burden onto the organizations, just based on what you've said the differences are.

And we're seeing that they are aggressively pushing it to be adopted nationwide across all of our sepsis forums, but in having been in the group that looked at 3215 for its first endorsement, they very much compete, but I think one is less burdensome, and I don't know that we need or that sepsis guidance needs to be driven that far down in the weeds at the national level, that we see what the New York State Improvement Initiative is.

I don't know if that's what you're looking for,

though.

Mr. Pickering: That's perfectly fine, that's great commentary as well related to that New York State sepsis measure. And so we can definitely augment that. I'm sorry, was there another comment?

Co-Chair Septimus: I think the direction for future measurement in sepsis is really looking more at an eMeasure and the CDC has adopted some of this but I think that's going to be the future direction of sepsis.

Mr. Pickering: Anyone else?

Co-Chair Thraen: I guess the only comment I have about the 0500 measure, one of the criticisms was about the fact that it was more process in nature than outcome.

And in the harmonization activities between the measure with developers, do you know if there's been any conversation with 0500 developers about including an outcome component, i.e. in this instance mortality, with their process measure.

Mr. Pickering: I don't know, Matt hasn't mentioned in their rationale and I'm not sure if the developer for 0500 is on the call.

Member Roney: I saw Dr. Rivers on here earlier, Matt.

Co-Chair Septimus: But Iona, the same group that's working with the eMeasure does have a risk adjustment component to it as well.

But we talked to the developers about this years ago. Apparently it's a big deal to go from a process measure to an outcome measure because of the risk adjustment.

Co-Chair Thraen: Okay. Thank you.

Mr. Pickering: Thanks, Iona. I will make mention of this as part of the related computing portion within our report.

If there's no other comments? I'm just looking at the hands. No, so we can go to the next measure that we have. Isaac?

So, that's 3621, again, this was the composite measure that we evaluated yesterday, 3621 was related to 2A20, which as you can see right there, there's a different target population where it's looking at pediatric computed tomography radiation dose.

So, the developers mention the 3621 which is that composite of those C2 procedures evaluates the whole population that is not limited to the pediatric population. Additionally, 3621 performance for facilities and groups is calculated comparing dose indices to publish benchmarks, whereas 2820 provides a framework for how facilities can assess their dose, compare their doses to published benchmarks, and identify opportunities to improve their doses are higher than the benchmarks.

3621, as the developers mentioned, uses data published in the ACR 2017 study which we had discussed yesterday, and also, it represents the first time that a national adult DRLs have been developed as a function of patient size, a milestone in optimizing radiation dose to patients.

So, I think the biggest difference here is the population here. They are related in the concept, the population is different but as you can see, there is a reason for the population being different for pediatric versus 3621 being more holistic.

Does the Standing Committee have any question or

recommendations related to this related measure?

Member Yealy: This was my measure, and I think this exactly, perfectly quantifies the related but not necessarily competing, and I think they both stand well on their own.

Mr. Pickering: Thanks, Don. If there's no others, I think we could move to the next measure, which is 0674.

So, there are three measures listed here, 0674 being related to 0202, falls with injury for acute care prevention of falls, 0101 falls screening risk assessment and plan of care to prevent future falls, and 01401 which is patient fall rate.

So, for 0101 the developers mention that this is a clinical process measure that assesses falls see prevention in older adults. And the measure has three rates but this measure is different in that it is a process measure rather than an outcome measure.

For 01401, the patient fall rate, this measure has similar focus of 0674 but it's different because it focuses on the adult acute care inpatient and adult rehabilitation patients and does not discriminated between falls with and without injuries, which is an important distinction for 0674.

Lastly, for 0202, this measure has a similar focus as 0674 but it's different because it focuses on, again, adult acute care inpatient and adult rehabilitation patients as a rate rather than a percentage.

And this measure also includes any injury from minor to major. So, there's those differences with those measures and 0674.

Does anybody have any questions or discussions with those measures?

Member Roney: Matt, again, I don't know if my comments align with what you're looking for, it's Jamie. But it seems like expanding the denominator to include outside of just long-term care facilities makes sense.

0101 looks like it's proactive, whereas the outcome measures are just not even reactive but just reporting, but falls is a huge issue across the spectrum of acute care rehab and long-term care and even within the home.

So, I don't know if the measure owners would want to try to combine those or look at that differently, or even the feasibility of that.

Mr. Pickering: I'll just see if the developer of 0674 is on the call, I don't know if Acumen is on the call today?

So, thank you, Jamie, for your comment, we can definitely put that into the related and competing portion of the technical report for the developer to consider. I appreciate the comment.

Geeta, for 0697 are you meaning 0679, the next measure? You had a comment in the chat.

Member Sood: Yes, sorry.

Mr. Pickering: Anyone else for 0674? Elissa?

Member Charbonneau: I just want to make a comment that what we have found in acute inpatient rehab is that the fall screening tool, which is the Morse assessment, which is used across the board by nurses is really not very helpful because in our population, it equates to about 80 percent of patients being identified as high risk.

So, I'll just throw that out there. We are actually working on a different scale that we are hoping will

be more sensitive in the inpatient rehab population.

Mr. Pickering: Thanks, Elissa. Okay, let's go onto 0679. You can see the measures listed there, 0201, 0337 and 0538.

The developers mentioned 0201, pressure ulcer prevalence. This measure has a similar focus but a different target population in the hospital, and data source in addition to only capturing new and worsened pressure ulcers.

For 0337, pressure ulcer rate, the measure, as the developer has mentioned, has a similar focus but different target population, again, being the hospital. And the measure only captures Stage 3 and 4 ulcers and is claims-based.

For 0538, pressure ulcer prevention and care, the measure has a similar focus but different target populations being home health patients in addition to being a process measure focusing on pressure ulcer risk plan of care development and prevention implementation. So, those different care settings being also an area that are related but have some differences by care settings across these measures.

Does the Standing Committee have any questions or recommendations? And Geeta, this is where you had mentioned your comment, I don't know if you wanted share it from the chat?

Member Sood: No, you summarized it perfectly so thank you.

Mr. Pickering: Okay.

Member Roney: Again, Matt, is there any benefit in combining -- this is Jamie in case you didn't know -- but any benefit in combining it into one group of looking at pressure ulcers no matter where they develop. I don't know that's as usable for quality

improvement but at the national level we shouldn't care as much where the patient is. It's more protecting them from harm, so it seems like there's a lot of competing measures in this category.

Co-Chair Thraen: I agree with you conceptually but I do know from -- this is Iona -- the work that I've done looking at the same issue from different data sources, you get two different buckets that have some then crossover but not a lot of then crossover.

So, the different surveillance systems using different data sources gives you different perspectives on the same kind of issue. Conceptually, it seems like this shouldn't be a big deal, we should be able to define it in such a way that it doesn't matter but it does matter depending on how you look at it.

So I don't know what the answer is. Member Roney: Thanks, Iona.

Co-Chair Thraen: I agree with you conceptually, absolutely, but one's using claims, one's using --- I can't remember the source of the information but the information sources are varying by measure.

Mr. Pickering: Elissa, your hand is raised, I'm not sure if that's from the previous discussion? And then Jason?

Member Charbonneau: No, I was just going to add that I think these are such different patient populations because the measure was looking at long-term care patients who had been there for over, I think it was 100 days.

I think it's worthwhile to have that in a separate bucket, again, I think somebody mentioned for quality improvement purposes in that setting.

Member Falvey: I'll just echo that, I think the other

purpose of doing the numbers is to feedback to the organizations, and I think the mechanisms and interventions for a long-term care population in terms of development of pressure ulcers is probably very different than in terms of acute care and exactly what you target, and the patient populations that you're targeting are going to be very, very different so I agree with what Elissa said.

Mr. Pickering: Thank you for the comments. Any others? Okay, we'll go to the first of the last two measures, 3501e.

So, this measure related to two measures, 3316 and 3389. So as a result of varying measure focuses, the hospital harm measure, which is 3501e, has a broad denominator of all patients greater than or equal to 18 years who has received a hospital-administered opioid, while NQF 3316 has a narrow denominator or patients. So, that being those 18 years of age and older prescribed an opioid or a benzodiazepine and discharged from the hospital-based encounter. So, it's a little bit narrower as the developer as stated.

Also, for 3316, it excludes patients with an active cancer diagnosis, palliative care order, or length of stay more than 120 days.

For 3389, which is the measure that we also just reviewed, so 3501e had mentioned related to this measure but 3389 addresses outpatient prescription claims and it excludes patients in hospitals who have a cancer or sickle cell disease diagnosis.

So, that being the difference, again, outpatient type of environment with 3389. Does the Standing Committee have any questions or recommendations for 3501e with these two measures? Okay, I'm not seeing any.

Okay, Isaac, I think we can go to the last measure, 3389. There's a series of measures listed here that are related and as the developer has mentioned, at the time of the maintenance endorsement the developer identified a series of these measures.

And specifically 3316, which is where you see down there safe use of opioids of concurred prescribing measure as related. Although the area of focus for this measure overlaps, 3316 is specified at the facility level and also has an eMeasure version, 3316e, as opposed to 3389, which is specified at the health plan level and is claims-based. So there are differences there.

Also, the developer identified 3558, initial opioid prescribing for long duration, 3541, the annual monitoring for persons on long-term opioid therapy. These measures are related to opioid prescribing, although the area of focus for the initial opioid prescribing annual monitoring are different than 3389, which is concurrent use of opioids and benzos.

So, differences by level of accountability, differences in some of the focus there, but does the Standing Committee have any recommendations or questions for the developer or for these measures?

Not seeing any hands or any in the chat box. I appreciate the comments that have been received on some of the other measures. We'll reflect those within today's proceedings as well as the meeting summary and the draft technical report for future considerations.

I will then go to the next slide, Isaac.

Co-Chair Septimus: Matt, before you do that, I want to say this was probably the best organized way to look at competing measures, the way you

organized it.

Generally, it's very nebulous kinds of discussions but you really made it very nice, measure by measure, it's the best one that I've seen yet in all my years at NQF as you've discussed this.

So, I applaud you for that organization, thank you.

Mr. Pickering: You're too kind, Ed, I appreciate the comments and really, it's the developer as well that has also done their diligence.

So, a tip of the hat to the developers as well for identifying this and making your job a little bit easier.

But thank you for the kind comments, Ed, and I appreciate the Committee's time, as well as your recommendations with that process. So, for those related measures that were identified. Ed's been through this before about competing measures and he knows how challenging that can be. So, there may be one of those days where we'll have to bring you back to go through the competing process.

Co-Chair Septimus: As long as it's not on medication reconciliation.

NQF Member and Public Comment

Mr. Pickering: Right, right. So I'm going to open up the floor for public comment and then I'll turn it to Isaac to do some next steps before we adjourn.

So, if there's any members from the public that are on the call that would like to make a comment, please use the raise-hand feature on your platform. We will identify you as it comes through.

If you're unable to find out where that is, you hover over your name and there's a little hand that pops

up in the participant list, or if you'd like to chime in on the phone, we encourage you to use the raised-hand feature.

So, now is the perfect opportunity for the public or any NQF members to make a comment. We'll just give it a little bit of time here.

Co-Chair Septimus: I promised the Commission we'd be finished early.

Mr. Pickering: You're pretty good with that there, Ed.

Co-Chair Septimus: Iona marched us through that last mission so well.

Co-Chair Thraen: I think you beat everybody to death, they're exhausted. That's what helped.

Co-Chair Septimus: Maybe they're just tired of hearing me.

Co-Chair Thraen: Yes.

Member Roney: We're going to miss you all's leadership, both of you so it was nice to spend this time together.

Co-Chair Septimus: I wish we could have done it in person because as I said, last night, I was willing -- you know, Iona and I have been known to buy the wine for the group.

Co-Chair Thraen: I think it was Ed that bought the wine, I don't think I bought any wine along the way. I think that was Ed.

Member Roney: Got to watch that with Texans, Iona.

Co-Chair Thraen: Got to keep them straight. I'm from Utah, you know how that goes.

Mr. Pickering: Hopefully we can all meet again in person and there will be opportunities for those types of engagements. I'll just pause once more just to see if there's anyone from the public or any NQF members that would like to make a comment. I'll give it a few seconds here.

Co-Chair Thraen: You better hurry, because they're going to the scotch now.

Mr. Pickering: All right, Isaac, I'll turn it to you. Let's get some next steps so we can adjourn the call.

Next Steps

Mr. Sakyi: Thanks, Matt. Following the conclusion of this meeting, NQF staff will prepare a draft report detailing the Committee's discussion and recommendations.

The report will be released for a 30-day public and member comment period. All comments received will be compiled into a comment table, which will be shared with developers and Committee Members.

The Standing Committee will then reconvene post comment call to discuss comments submitted. Comments and their responses will be incorporated into the draft report in preparation for the Consensus Standards Approval Committee meeting.

The CSAC will need to endorse measures followed by an opportunity for the public to appeal endorsement decisions. Here are some of the dates for this cycle.

The draft report comment period will be from August 11th to September 9th followed by the Committee's post-comment meeting on October 13th from 2:00 p.m. to 5:00 p.m., and the CSAC review from November 30th to December 1st,

followed by the 30-day appeals period.

As always, if you have any additional feedback, questions, or concerns, please reach out via email at patientsafetyqualityforum.org or by phone at 202-783-1300.

For any information on meeting materials, you can go to the project page or the Committee's SharePoint page if you are on the Committee.

At this point in time I'd like to pause to see if there are any questions.

Co-Chair Thraen: I have one clarification question. So, the one in which we did not have, consensus not reached on performance gap, what do we have to do about that one in follow-up?

Mr. Sakyi: That will be for the post-comment call, where the Standing Committee will discuss and try to reach consensus on that.

Co-Chair Thraen: Okay, thank you.

Mr. Sakyi: And then that meeting is --

Mr. Pickering: October 13th.

Co-Chair Thraen: Okay, October. All right. Thank you.

Mr. Sakyi: If there are no further questions I'll turn it over to Matt and the Co-Chair for closing remarks.

Mr. Pickering: I'll just say thank you again, to the developers are still on the line, thank you, and members of the public as well.

As I said in the chat, this Committee has been fantastic, your patience, your dedication and your time, you make this work possible.

So I very much appreciate all of you, including the lead discussants that we had throughout the proceedings these past two days and our wonderful Co-Chairs for all of your hard work and facilitation.

Thank you all very much. Ed and Iona, I don't know if you have anything else you'd like to add?

Co-Chair Septimus: I think you said it all, Matt. And again, another kudos to the NQF staff that make our work manageable, couldn't do it without you.

Co-Chair Thraen: Absolutely true.

Adjourn

Mr. Pickering: I do thank the team, Tami and Isaac and I'm trying to think of everyone, Michael and Jesse and everyone, they're fantastic.

So, thank you very much, with that, have a great remainder of your Friday, have a great weekend and we'll be in touch as we move forward with everything else we'll be doing this cycle, so thank you all very much.

Co-Chair Thraen: Thank you, guys. Bye, have a good weekend.

Mr. Pickering: Bye.

(Whereupon, the above-entitled matter went off the record at 3:33 p.m.)