NATIONAL QUALITY FORUM

Moderator: Patient Safety
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Operator: This is Conference #: 3279529.

Welcome everyone, the webcast is about to begin. Please note, today's call is being recorded, please standby.

Andrew Lyzenga: Thanks, (Diane). This is Andrew Lyzenga from NQF. Welcome everybody from the Patient Safety Standing Committee, good to be back on the phone with you again at least.

We appreciate your time and work with us as always. We are going to just quickly I guess we do introductions first or, Ed and Iona, do you have to have – say any opening remarks or should we jump right in?

Iona Thraen: This is Iona. I just want to say welcome and we're back in play, so go ahead guys.

Ed Septimus: This is Ed. I'll second that, wonderful working again with Iona and a great committee.

Andrew Lyzenga: All right. Well as far as NQF goes on our side, we've got some sort of folks who work with you before. And I know I've met most of you and we got a couple new members of the committee which we'll talk about in a little bit.

In any case, I'm Andrew. I work with the Safety Committee for sometime, been an NQF since about 2009. And I'll let our other team members introduced themselves.

Hiral Dudhwala: Sure. I'm Hiral Dudhwala. I'm actually new to the team but I've been with NQF for a year and I'm very much looking for working with this project.

Desmirra Quinnonez: Hi. I'm Desmi, Desmirra Quinnonez, and I actually had the privilege of working with this committee last year, so I'm happy to be with you again this year as your project analyst.

Kathryn Goodwin: Hi. I'm Kathy Goodwin. I'm a Senior Project Manager at NQF. I've been here for about six years and I look forward to working with you.

Jesse Pines: And this is Jesse Pines. I'm a Professor at GW and also been a consultant for NQF for the Patient Safety Committee for the past six years, so good to hear from everyone again.

Andrew Lyzenga: So we're going to – we'll kind of walk through the agenda here quickly. We've got material that will be kind of old news for a lot of you and sort of rehash. So we'll try to walk through that as quickly as possible and maybe kind of scheme over a few of the things that you guys are very well familiar with.

There are some new parts of the process that we'll try to send a little bit more time on. So you can get sort oriented to those aspects. But as always, if at any point, we're moving through things too quickly and you like us to slow down and explain, or ask any questions absolutely feel welcome to just jump in and let us know.

So, we'll first give an overview of the CDP which again most of you know well but there are couples of small or, you know, more significant changes that have been made recently. So we will talk about those, we'll talk about the roll of the standing committee, just a reminder of what your duties are.

And in particular, in light of some of these changes to the CDP, we'll briefly talk about the patient safety portfolio of measures, go over the project activities and timelines, talk again a little about the measure evaluation criteria and some changes to those that you may want to know about. And then, sort

of a few logistic items and then we will be done. We don't expect to take your full 2 hours, I hope so, we'll jump right in now.

Hiral Dudhwala: OK. So as Andrew mentioned, you know, we do have some additions to this committee. You can see on the slide the names with the asterisks, our new committee members to this project. But we would like for – as I'm going through roll call, if everyone can just briefly state a sentence or two about themselves since we do have new members that would be wonderful.

So I'll just go through the names and when I call your name and just give a little intro. So we'll start with our co-chair, Ed Septimus.

Ed Septimus: Good afternoon everybody. I'm Ed, obviously, I am a Vice President of Research and Infectious Disease at Hospital Corporation of America, and Professor of Medicine at Texas A&M College of Medicine here in Houston. I Co-Chaired with Iona for the last several years, the Patient Safety Committee.

I'm also on CSAC now and I've been on other committees of the NQF. And it's just – I must say that one of the highlights of my time with NQF has really been working with all of you on the Patient Safety Committee, just been extremely satisfying. It's hard work but an incredible group of men and women. So thank you for joining.

Hiral Dudhwala: Thank you, Ed. Iona Thraen?

Andrew Lyzenga: Iona, are you unmute?

Hiral Dudhwala: OK. Maybe we will start.

Iona Thraen: I'm sorry. Iona Thraen, Patient Safety Director for the Utah Department of Health and recently been appointed as Adjunct Professor with the College of Medicine, University of Utah, Department of Biomedical Informatics. I will teach my first biomedical informatics course this coming January.

I have a social work background as well as PhD in Medical Informatics, and I also Chair the IRB for the Utah Department of Health. And my role is really

to facilitate and to make sure that we don't get hang up in the forest with the trees, thanks.

Hiral Dudhwala: Thank you, Iona.

Ed Septimus: And this Ed, I just do Iona what tells me to do.

Iona Thraen: If only.

Hiral Dudhwala: OK. Moving on to Jason Adelman? OK, Charlotte Alexander? Kimberly Applegate? Laura Ardizzone?

Laura Ardizzone: Hi. This is Laura Ardizzone. Can you hear me?

Hiral Dudhwala: Yes.

Andrew Lyzenga: Yes.

Laura Ardizzone: OK. Good morning or afternoon, everybody. I'm the Director of Nurse Anesthetist Services at Memorial Sloan Kettering Cancer Center and an Assistant Clinical Professor at Columbia University School of Nursing. This is my second term on Patient Safety Standing Committee.

I'm dismayed that we're not going to be able to meet in person I think this year, because it's always nice to see everybody. But this has been a really great adventure and I'm happy to be on again.

Hiral Dudhwala: Thank you so much. Richard Brilli, OK. And then, these are the new member to our committee Curtis Collins? All right, Christopher Cook? All right, Melissa Danforth?

Melissa Danforth: Hi. This is Missy Danforth. I'm the Vice President for Healthcare Ratings at the Leapfrog Group. We're a national not for profit that administers two National Hospital Programs including the annual Leapfrog Hospital Survey and also the Hospital Safety Grade, excited to be back with everyone today.

In terms of my involvement in NQF, I also participate on the CSAC, was most recently co-chair the Diagnostic Safety and Quality Committee.

Hiral Dudhwala: Thank you, Melissa. Theresa Edelstein?

Theresa Edelstein: Good afternoon, everyone. This is Theresa Edelstein. I'm Vice President of Post-Acute Care Policy at the New Jersey Hospital Association. I'm very happy to be back to lend a post-acute care perspective to our work as a committee and look forward to continuing on with all of you.

Hiral Dudhwala: Thank you. Lillee Gelinas?

Lillee Gelinas: Hi, Lillee Gelinas. It's good to meet everyone. I am currently a Senior Fellow and Nurse Executive at the University of North Texas, Institute for Patient Safety. And I am currently trying desperately to complete my DMP at Duke University, very honored to be one of the inaugural classes there in the executive leadership track.

This is my second term on the NQF Patient Safety Steering Committee. I have served on several other NQF committees including chairing with Dr. (Marinaler) or the NQF Nursing Sensitive Measures Group and just to find these committees to be energizing. Believe me, I walk away. I feel my IQ goes up after being with all of you in the room. So I look forward to getting to know you better as 2018 unfold. Thank you.

Hiral Dudhwala: Thank you. Another new member to our committee, John James? OK, Stephen Lawless? Lisa McGiffert?

Lisa McGiffert: Hi. This is Lisa McGiffert and I'm the Director of Consumers Union Safe Patient Project. We are the policy and advocacy arm of consumer reports. And I have been on this committee, I think it's my second term but I've been on a number of NQF committee starting with one way back on hospital infection reporting when we working on legislation to require such reporting. And I think that was around 2005 or so.

Good to be back with everybody. This is a great group. And I also learn a lot from every meeting.

Hiral Dudhwala: Thank you. Susan Moffatt-Bruce? Patricia Quigley? Victoria Rich?

Victoria Rich: Hi, this is Victoria Rich. I have been in the facet at the University of Pennsylvania where I was a Chief Nurse of the Health System and also on faculty at UPenn. I'm currently now at the days of the College of Nursing at the University of South Florida and actually engage actively in a professional education.

I'm actually leading a course with engineering and physicians, and with public health. And so, I am delighted to be back on my second term. And it's so nice to see a lot of all trends. Thank you.

Hiral Dudhwala: Thank you. Michele Schreiber? Leslie Schultz?

Leslie Schultz: I'm here. This is Leslie. I'm the Director of the Safety Institute for Premier and serve across the enterprises, clinical and patient safety subject matter expert. Along with that, I also have the privilege now of also sitting on the CSAC. I enjoy patient safety work so much and looking forward to the cross fertilization. And, you know, I'll miss seeing everybody in person.

Hiral Dudhwala: Thank you. Lynda Smirz? Tracy Wang?

Tracy Wang: Hi, good morning, it's Tracy Wang. I'm the Program Director for Clinical Strategies and Program at Anthem. I'm very – glad to be back serving on the committee and learning from everyone.

Hiral Dudhwala: Thank you, Tracy. Kendall Webb? Albert Wu? OK. And another new member to our committee, Donald Yealy? OK, and finally Yanling Yu?

Yanling Yu: Yes. Hi everyone. I'm president of Washington Advocates for Patient Safety. My first program is in physical oceanography and the climate change at the University of Washington. Now, I am basically full time patient advocate working on house care, safety, transparency and accountability issues.

And I'm so glad to be able to continue to serve on this committee. And I look forward to work with you all on the matters that came through patient safety.

And by the way my name is misspelled, there's no G in there. So, it's no big deal which is later. Just correct it anytime.

Andrew Lyzenga: Yes, we'll get that corrected. I should note just for the group, several of the new members, I guess, pseudo new members are moving over from other standing committee. So, they have been – they have experience with the CDP. So, hopefully that will, you know, they won't miss too much on this orientation call. We'll reach out to those folks and make sure they're up to speed.

And for – when new – truly new member, John James, will do a briefing for him separately as well. But, in any case, we'll put this orientation call up for the recording and slides up on the website and you can refer back to it at anytime.

Jason Adelman: Andrew, this is Jason Adelman. I'm sorry I missed the roll call but I'm here. And I'm the Chief Patient Safety Officer, Associate Chief Quality Officer at Columbia University Medical Center and New York-Presbyterian Hospital in New York. Sorry I was late.

Andrew Lyzenga: No problem. Thanks, Jason.

Hiral Dudhwala: Is there anyone else who joined late who would like to give their introduction?

John James: Yes, this is John James.

Andrew Lyzenga: Oh, hi. Do you want to quick introduce yourself?

John James: Yes, I'm the new guy. I'm retired from NASA where I was Chief Toxicologist for a long time, became a patient safety activist as result of loss of my son. My goal is to change some of the fundamental interactions between providers and patients, particularly patient rights and informed consent.

Andrew Lyzenga: Thanks, Dr. James. Just another quick note in – you all may remember a former committee member (Martha Deed) stepped off the committee as she is retiring and sort of scaling back her duties of this type. So, we'll miss (Martha), but we pulled John James onto the committee as another patient consumer representative, and are exited to get started with working with him.

Ed Septimus: And another (direction). Another (direction). Hey John, it's Ed. How are you?

Hiral Dudhwala: OK. Is there anyone else who wanted to give an intro before we move on, that missed the introduction?

Male: None.

Hiral Dudhwala: OK, wonderful. Then, I'm going to pass is to our Senior Project Manager, Kathy Goodwin, who's going to give you the overview of NQF, the CDP, and then we'll move onto the roles.

Kathryn Goodwill: OK, thank you. So, as you know we have a unique role here at NQF as a membership-based organization of over 400 members and 800 expert volunteers to help us do our work.

Our mission is to lead national collaboration to improve health and healthcare quality through measurement. And we do this by bringing together public and private sector stakeholders to reach consensus on healthcare performance measurement.

And I will say for transparency, we are a forum. So, everything we do is open to public and member participation, and all materials are accessible on our website.

Just really brief, in addition to performance measure endorsement, we also convene the MAP, the Measure Applications Partnership, as well as National Quality Partner. We are also very active in the area of Measurement Science as well as we help to facilitate efficient measure development and testing through our Measure Incubator. OK.

So, the focus on what we are really working on here as a committee, the Consensus Development Process or CDP which most of you are very familiar with. We do have some changes and that's what we'll be focusing on here today. And as – Andrew mentioned earlier, please feel free to stop and ask us if you have any questions.

So, there are six steps for measure endorsement, intent to submit, call for nominations, measure evaluation, public commenting period with member support, measure endorsement and measure appeals. And this slide does represent some of the revisions to the CDP that we initiated in the summer of 2017. And I'll go into more details about those changes in just a moment.

Also, quickly, if you're not speaking we do ask that you please mute your lines. We're hearing just a little bit of feedback. OK.

So, in May 2017, NQF held a two-day process improvement event that focused on the CDP. The purpose of the event was to examine the timeliness, efficiency and effectiveness of the CDP with the view toward identifying it strengths and weaknesses, and where it might be improve using a more agile process.

More than 40 private and public sector stakeholder including experts from the Centers for Medicare and Medicaid Services and other federal agency, NQF standing committees and organizations that develop measures as well as NQF members and the public attended this event. The goals were to facilitate more timely evaluation of measures. Increase opportunities for submission and review of measures. Reduce cycle time of the CDP, and improve flow of information between CDP and MAP processes.

Here we highlight some of the changes as a result of the event. The significant changes and improvements included more regular predictable cycles and measure evaluation. We have – we now offer increased opportunities to submit measures for review. We have a newly convene scientific methods panel. We have revised process for continuous public comments and member input. And we've made revisions to the content structure of our technical report.

So, to start up, to give you a little bit more information about the increased opportunities for measures submission, we now offer two measures submission cycle for every topic area each year. However, NQF will be limiting the number of measures evaluated by the standing committees and each cycle to a maximum of 12 measures.

Previously, standing committees reviewed new and current measures for a select few topic areas each year. But changing through a twice a year review will reduce committee down time and allow for more frequent opportunities for measures to be submitted and considered for endorsement. Each committee will review measures twice per year.

You'll notice then this slide how the newly condensed CDP cycles begin at the measures submission deadline and end with the Consensus Standard Approval Committee or CSAC final endorsement decisions. And the way it is structured now is that, the measure submission deadlines will occur in October and April of each year. And so now, we are in cycle one for this project.

Due to increase opportunities for measures submission, NQF has consolidated the measure review, topical areas from 22 to 15 topical areas. With the aim of balancing the size of the various NQF portfolio grouping cross cutting clinical areas and distributing measures to committees with the needed expertise to conduct an evaluation.

As you can see several committees were merged into primary and chronic illness, and two were merged into patient experience and function. NQF with the help of qualified clinicians and content experts created these topic areas after a thorough review and evaluation of NQF full portfolio. And that is also the reason why we had the two new committee members from other committees that are joining this committee.

Andrew Lyzenga: Yes, couple of the, I believe, are pulmonary and Critical Care Standing Committee and our Infectious Disease Committee. The portfolios of those groups were wrapped into the Patient Safety Group. So, that's where our – a couple of our new members came from, Curtis Collins, I believe from the Infectious Disease Committee and Don Yealy from Pulmonary and Critical Care.

So, we'll have a little more broader of a portfolio but pretty consistent with the measures we've already seen and reviewed previously. And I don't think should be too much of a change for us. (Kathy), I think we'll also talk a little bit about our expert reviewers who will bring as needed.

Kathryn Goodwill: OK. So, to reduce sort of few burden on committee members, NQF has developed an external scientific method panel to complete a massive review of complex measures.

NQF staff will assess whether a measure is sufficiently complex to require a methodological review by the panel based on the set of criteria. This method review will apply the scientific acceptability criterion, reliability and validity. Both of which are must pass criteria.

The scientific methods panel will support all 15 standing committees. The panel has two specific charges. One to conduct evaluation of complex measure for this criterion of scientific acceptability with the focus on reliability and validity analysis and results; and two, to serve in advisory capacity to NQF on methodologic issue including those related to measure testing, risk adjustment and measurement approaches.

NQF will continue to provide a preliminary analysis including the methods review for non-complex measures. The opportunity for a method review by the scientific method panel is being as a value add for the standing committee and developer because it will reduce committee burden particularly on committee where specific expertise is needed to adequately review and rate the scientific merits of a measure.

By removing this more technical review responsibility from the committee, NQF also helps to encourage greater participation of consumer patient and purchasers within the committee. I would like to note that the scientific method panel will not render endorsement recommendations. However, they will review – the panel review will help to inform the standing committee's endorsement recommendation.

I think I'll pause there, actually, to see if there are any questions about that process. It's kind of a big change that we have here. Any questions about the scientific method panel or the scientific acceptability review process?

Melissa Danforth: Hi, this is Missy Danforth from Leapfrog. I just have a quick question.

So, in terms of the order, the steps that colorize in the said measures would come in at the beginning of the cycle, and you have staff to decide which go to the scientific method panel. They do their work. So, all of these is done prior to the measures being reviewed by this committee.

So, what would happen to those measures that don't have either reliability or validity or both at that scientific method panel level? Would that come to this committee and like a summary? Would that information as to why they didn't pass or would we just not do those measures at all. Could you speak a little bit to that?

Andrew Lyzenga: I think we're – we've talked about this. And now I'm kind of – I'm not remembering exactly what the decision is. I know that we will let you know if there were measures that were sort of bumped out. I'm not sure if we'll give what sort of the extent of the summary we'll give you.

But other than – so, if they – if there are very minor changes that need to be made, we may still see those measures, developers may make, you know, tweaks and bring them back. But if the method panel and NQF staff decide that they are just not quite ready for a review or, you know, have not met the bar for reliability or validity or, you know, scientific acceptability.

The standard process will be to bump into the next cycle which is sort of, again, another benefit of having this more regular review cycles that developer won't have to wait for, you know, three years or whatever. They'll have roughly six months to make changes as necessary and then bring the measure back to us.

So, we will see those measures again or at least we anticipate it. And we'll let you know that whether there are measures that were initially submitted and that you're not seeing for that particular cycle and let you know that we – whether we expect them to come around for the next cycle. Would that help?

Melissa Danforth: I think this – Sorry, go ahead.

Kathryn Goodwin: No, go ahead.

Yanling Yu: I have a question just piggybacking on the last question. On the – this is Yanling Yu, for the methods panel, if they decide that the – a measure, particular measure meet their criteria after they're reviewed and write a report, (were) they forward just a summary. I guess that you mean summary to the committee that were forward to the past measure. Or they provided, they full evaluation so we can see how they did it in their evaluation in a scientific measure in a content.

Andrew Lyzenga: Yes, yes. And we've create – it will be sort of incorporated into our preliminary analysis that the staff has done in the last couple of rounds of work that we've done. We created a form that the scientific methods panel members will fill out in sort of walk through scientific acceptability criteria.

There will be spaces for them to provide sort of comments, sort of justification for their decisions or rationale. But that will all be laid out in sort of a separate form that will accompany the measure. And you will, as always, have to be – all the full specifications to review yourselves in addition to that.

So, and we'll try to, you know, if we – if there's anything unclear in the material that we get back from our – the methods panel we'll try to do it, asking questions that we have. So, you know, that we can make things clear to you when we do review the measures with you as well.

This is – and again, a new process. We just sort of created our, you know, develop the processes for this very recently. We're kind of in some ways building this plane as we're flying it. So, I suspect the first cycle, maybe the second cycle we'll have, you know, some bumps in the road. We anticipate that in plan to kind of fix and make revisions rapidly as that happens and implement them for the next cycle.

So, we'll certainly appreciate your feedback on that as we go through it. Although I should note, we don't have any measures that are going to the methods panel for this particular cycle.

Kathryn Goodwin: OK. Thanks. Lastly, I want to highlight another change that we've made through our process in the public and member commenting period with member choice.

We previously had two separate commencing periods, 14-day pre-meeting commenting period and a 30-day post-meeting period. In addition to these periods, we also offered a 15-day voting period explicitly for NQF members to express their level of support of the committee's recommendation.

The new public commencing period with member support allows more time for the public and members to comment and express support for at least 16 weeks. The commencing period will open about three weeks prior to any committee's measure evaluation meeting and it will close 30 days after NQF post-address technical report on the NQF website.

That will include all comments received before the meeting at least one week prior to the committee evaluation into your materials for discussion during the meeting. And comments received after that will be discussed on the post-comment call.

As an added member benefit, NQF members have the opportunity to express their support for each measure to inform the committee's recommendations during the same period. OK.

And now we'll turn it over to Hiral to talk about roles of the standing committee and like we mentioned earlier, this will – much of this will be a refresher but we do want to go over again with you.

Hiral Dudhwala: Sure. Thank you, Kathy. So this slide here, I don't think it is pretty new to most of you as you've all been standing committee members, most of you at least. So this is pretty much the same as in previous years, you know, we worked to bring together this group of experts to evaluate the measures and gap, and to make recommendations for endorsement and there's the voting process that goes on, on these measures.

As you know, you know, each member typically have a two- to three-year term. You worked very closely with our staff here at NQF to achieve the goals of the project. Some of the major focus is evaluating the candidate measures using the measure evaluation criteria, looking at comments that are submitted during the commenting period in regards to the measures.

And then, again, you know, respond to any directions we get from the CSAC Committee. So again, this is all pretty much the same as previous years.

Some measure evaluation duties that the standing committee has, again, very similar, you know, all members will evaluate all measures that are submitted. We will measure it against the criteria. You know, looking at if the criteria is met and the rationale for the rating and then, you know, making a recommendation ultimately for endorsement.

Another duty, goal of the committee is also to look at the portfolio of measures for the projects and, you know, focusing in on, you know, are there any gaps, you know, is there any way we can promote alignment and harmonization. I know later on we will be talking a little bit more about the portfolio. But this is just something standard that we have been doing and we'll continue to do as far as the standing committee. OK.

And then, as you know, we have our wonderful co-chairs. And I think you're pretty familiar with their roles as well and this is consistent at it has been in the previous years. But, you know, they will co-facilitate the standing committee meeting. They will work with our staff here at NQF to achieve the goals of the project. They are available to NQF, you know, with any additional questions or information that we would need or that would be helpful for the standing committee. And they also, you know, have been present to share the standing committee view points at CSAC meetings and they themselves participate as a member of the committee. OK.

And then, we have our staff here at NQF. You know, our goal is really to help out the committee and to ensure that everything is being adhered to the current consensus development process. You know, we will help to assist and organize the standing committee meetings and conference calls and in person. We'll work to guide the standing committee through the steps of the CDP process, ensure that, you know, you are familiar with the policies and procedure.

We also review the measure submissions and prepare materials for the committee review. We assist in drafting and editing the reports that will be

for the committee's review. And we just make sure that there's appropriate communication going on among all the project participants, you know, including the committee members, the measure developers. Obviously now, there's also the method panel and, you know, other collaboration going on.

So that is our goal to work as well as we can to help the committee and the developer, then to achieve the goal. OK.

And this is kind of just reiterating some of our goals. But again, just making sure that it's a very transparent process, you know, making sure that we are sharing everything on our NQF website, working with the developer, you know, publishing final reports. So again, these are just the duties that we've always held in the past, so. OK.

And then, again now, as Kathy had already mentioned, we do have the method panel. She really did highlight what their role is. Again, you know, just reiterating that, you know, this is something new and, you know, they really are in charge to be available to evaluate complex measures. So they are just an additional resource and, you know, it's to help and help us decide our endorsement decisions.

And this slide just kind of highlight which ones are complex measures, which ones are non-complex measures. Again, Kathy, had highlighted these but you can kind of see a breakdown of where we would think the methods panel would come into play, so OK.

And then another thing which we really haven't touched on too much but there is a new role of the expert reviewer. So this past year, you know, there have been some changes. There was a new CDP redesign that resulted in the restructuring and reducing the number of topical areas as we had mentioned before. With that change, you know, there was a need for a little bit of a more broad and diverse expertise to projects to supports some of the committees that are no longer existing. So, that is where we have a pool of expert reviewers that we have assigned to each project.

And really, their role is to provide that representation, you know, that may not be available on the standing committee dependent on the measures that are

submitted. So they really will be available to our project on as needed basis. They will provide expertise as needed to review measures submitted for endorsement consideration by, you know, potentially replacing an enactive committee member, replacing a committee member whose term has ended or providing expertise that is not currently represented on the committee.

Expert reviewers may also provide comments and feedback on measures throughout the measure review process, participation in strategic discussions in the event that no measures are submitted for endorsement consideration.

And so, to share with you in regards to this project for the Patient Safety Project, we do have six expert reviewers available and assigned to this project and all of them were previously on other NQF standing committees. And again, just reiterating that they will be pulled in on as ad hoc basis to provide expertise on measure submitted during each project cycle.

And you'll see here listed the names of our six expert reviewers and I believe some of them were able to join in on this call as well. So, you know, we are so happy to have them participating on this project as well, so OK.

So, you know, we talked about a bunch of stuff and some changes …

Lisa McGiffert: Can I ask you a question about the expert reviewers?

Hiral Dudhwala: Yes, please.

Lisa McGiffert: This is Lisa McGiffert. Is there an expert reviewer that would represent the consumer or patient perspective if there were – if that was the person that wasn't present?

Andrew Lyzenga: That's a good question, Lisa. I'm not sure about that. So we will check and I would think that we should have somebody available to …

Lisa McGiffert: Thanks. I think it would be good. It looks like all of these are doctors and one nurse. So it might be good to have somebody around who could fill in if that's needed. Thanks.

Andrew Lyzenga: Yes. We are – we do have higher representation in some other standing committees of patients on this particular committee but I think your point is very well taken. Still be good to have a patient (represent) available should that be needed.

John James: This is John James, can you hear me?

Andrew Lyzenga: Yes.

John James: Quick question, I may have missed it but can the Standing Committee originate measures? Or are we more in let's say policing function. You know, I noticed that we can identify gaps, maybe that's the way we go about making new things.

Andrew Lyzenga: Yes, that's probably the closest thing. We really don't – NQF doesn't develop measures nor do our, you know, the committees that we work with. We really do play the role of reviewing and evaluating existing measures. But we do try to do some work to identify gaps where we're missing measures and may have a need for measure development. I think we're going to try to do some of that in this cycle because we have a pretty low lift in terms of actual measures to review.

So that – I think you're right that that's probably the closest thing that we would get to measure and develop, and is making some recommendations to the field on where there is – where there are gaps and where there is development needed.

John James: Thank you.

Hiral Dudhwala: OK. Any other questions on what we've gone over so far? OK. I'm going to pass it over to Andrew, our senior director to go over the Overview of NQF Patient Safety Portfolio.

Andrew Lyzenga: So, let's see, nothing too new here. As you know, we oversee a portfolio of measures we have a little more than 70 measures at the moment. We've gained some and lost some over the last few years. We have, as we mentioned a little bit earlier, added a few measures related to critical care and

infectious disease which we are – think are fairly consistent with the, you know, safety topic area and with the work you guys have done in the past. So I think we go on to the next slide.

Just a quick breakdown here, 73 endorsed measures in our portfolio that the safety committee is overseeing. There are 23 measures stewards that have developed those measures. Pretty heavy on outcome measures in this particular committee. That's a little unusual I think among our standing committees. Many are a little bit more heavy on the process side. So we are – have more outcome measures and we do process, a couple intermediate outcome and some composite measures that you guys have seen before.

In terms of topic area, the biggest group is medication safety. Again, you guys are pretty well familiar with this I think HAI Measure, Perioperative Safety, Falls, Pressure Ulcers, VTE, and then sort of a smattering of other measures including a few again that have come in under the critical care, HEDIS and some other sort of measures related to general adverse events and complications and the like.

I should note that, again, we are only going to be reviewing one measure for this particular cycle. We had a number of other measures that were slated to come in for maintenance but we did allow the developer to differ the review of those for sort of, you know, special circumstances I think. The majority of those measures were stewarded by AHRQ, the Agency for Health Care Research and Quality and they're facing some fairly significant budget constraints at the moment. They're not able to do their usual contracting to get the analytic work that they usually do.

I know some of you have been at experience with that with Patrick Romano coming in and giving you really great detail on some of AHRQ's patient safety indicators and other measures. They've not been able to sort of have the capacity to do that kind of work at this time. So we're giving them a little bit of time to sort of gather themselves and see if they can find the resources to maintain them. Those measures or potentially to hand them off to other agencies within HHS to do the maintenance and submission to NQF in the future, so more to come on that but only one measure that we'll be reviewing

in this particular cycle that actually has to do with opioid use which is similar to a few measures that we've reviewed in the last go around.

Because we only have that one measure, it's a process measure, fairly simple, non-complex measure. We're going to try to do some other activities with our time. That's also the reason we did not have in-person meeting for this cycle. We had originally been planned to do so but we pushed that to the second cycle because we think it will be better to have this all in-person when we have a larger number of measures to review.

But we will be trying to do as part of the calls in this cycle along with that reviewing that particular measure. We'll try to a little bit of this gap identification as we've kind of done in the past. And also some prioritization of the measures that are in our portfolio.

And we've working on NQF. We have a team that's been working to develop a little bit more of a formal structure for that so that we can go about prioritizing and identifying gaps in the portfolio and a little bit more of a systematic way. So we'll have more on that for you as we move along and get closer to our calls and we'll also give you a little bit more, you know, specifics on what the measures in the portfolio – current measures in the portfolio are and their characteristics and so on to make sure you're prepared for that prioritization discussion.

Here's the timeline, if you want to take a look at that on the webinar. We're having our orientation meeting now. Well, the next web meeting we have scheduled will be January 23rd. We'll have a post-meeting call to kind of – sort of wrap up anything that we didn't cover in the – in that meeting scheduled for February 13th. If we don't need that call, we can cancel it.

And then, we'll have another meeting in April after we've released the draft report and gotten our find around of public comments so that we can review those comments, adjudicate them and respond as needed.

And then, we will jump right back into the next cycle. Start over again and hopefully with some more measures. So that's kind of we'll be working on a

little bit more of a continuous basis from this point on. And at least, that's the plan. Any questions at this point?

John James: This is John James. You know, this is still pretty foggy to me as a new person.

Andrew Lyzenga: Yes.

John James: It seems like one thing we really need to do more than anything else is identify the gaps. Because without gaps identified, there's not a lot of new things that are going to come in. Am I missing something or is that a reason …

Andrew Lyzenga: No, no, I think that's an absolutely a reasonable point and perspective. I think your sentiment is shared by many on the committee. We'd certainly recognized lots of gaps in the past. And I think that's why this will actually be kind of a good opportunity for us to have, you know, some deeper discussions about that given the lack of measures that we actually need to evaluate.

We'll have the opportunity to do – have some more discussion about that. It is very important – a very important part of this committee's work doing that sort of prioritization and gap identification.

So, we look forward to that. But you're certainly right that that's important work and we look forward to getting into it more with you.

Ed Septimus: Andrew, do you want – this is Ed. Do you want to say something about the Measure Incubator?

Andrew Lyzenga: Yes. That's a good point too. That's something sort of NQF had gotten into a little bit more recently that is, yes, you're right, Ed. A little bit kind of closer down the line to the measure development side. And we still don't – aren't, you know, directly involve in measure development but something we've been trying to do recently is standup this, what we're calling a Measure Incubator wherein we serve in kind of a matchmaker role.

We try to identify, again, where there are gaps in measurement, high priority gaps and identify people or, you know, groups or organizations that have maybe a measure concept that could be taken forward further developed into a fully specified measure that's ready to implement.

We take those, you know, groups or people and put them together maybe with another group that has expertise in measure specification and testing, you know, maybe bring in another groups that has access to data or can make out of data available for testing, maybe group that has some funding that can support all of these work.

So, again, sort of trying to coordinate in the areas where there are high priority gaps to bring, you know, relevant groups and groups with the right expertise and resources so that we can sort of accelerate measure development in this key gap areas.

That's, you know, still it's been sort of – we've been building that effort up and it's still in fairly early stages but we do have a couple of project going at this point. And I think largely focused on things like patient reported outcomes, which I think this committee and others have identified as a very important gap area.

So maybe we can talk a little bit more about that in our subsequent calls as well if the group is interested, and then update on their activities and the like. And make sure that reminder …

Female: I would be interested in a patient reported outcome.

Andrew Lyzenga: OK. We can see – we can talk to the team that works on the Incubator and see where they are and if we might be able to get an update from them on their activities and what's going on with that group.

Female: Great.

Andrew Lyzenga: Any other questions or comments? All right.

So we'll now talk about the measure evaluation criteria. Dr. James, this is – I may go through at least a little bit fast because, again, most of these groups has been over it before but I think we'll probably try to schedule a call with you to go over this in a little bit more depth because this is an important part of what we do here.

So, as you all know, we have a set of standardized measure evaluation criteria, the measures that come in. We review them against these criteria, use them as sort of a framework and structured way of evaluating each measure. These criteria have evolved over time in response to feedback, both from our committees and other stakeholders, developers and others. So we've made a few fairly minor changes, I think, some more – so get others recently. And I will try to focus most of my time on those changes here.

So, the first criterion or go over them very quickly here, the criteria overall are, first, importance to measure and report. We want to measure those things that have the greatest potential of driving improvement. The thing if, you know, an area is not important, the other criteria are less meaningful and we don't want to add to measurement burden, and sort of the proliferation of measures unduly, if it's not a very important thing to measure.

Reliability and validity-scientific acceptability as a whole, we want to make sure the measures are making valid conclusions about quality. Feasibility, we want again to cause as little burden as possible and see if there are alternative approaches to measurement, if there's a high burden.

Usability and use, we want to make sure that measures that are being endorsed are useful for decision-making related to accountability and improvement. And then finally, comparison to related or competing measures. We, again, into our – sort of in pursuit of parsimony in the set of measures endorsed by NQF, we want to make sure we're not duplicating efforts or endorsing competing measures when they are not justified, so that another part of what we looked at when we evaluate these measures.

So importance to measure and report, the two or sort of three depending on or, you know, the two main parts of importance to measure and report are

evidence. We'll make sure the measure focus is evidence-based and then opportunity for improvement, making sure there is an opportunity for meaningful improvement or considerable variation.

We want to make sure that the measures are not, say, topped out and does not really useful, again, for improving care or making decisions about quality. In the case where we have composite measures, we also, as part of this criterion, we want to see that quality construct and rationale underlying that composite measure.

So, to get into some of the changes here, I think we have had some feedback, maybe from this committee specifically among others, in this point previously for outcome measures. We didn't actually require empirical evidence to support the focus of those measures. We just asked developers to provide a rationale that would show that the outcome could be affected by one or more processes or interventions or actions on the part of a healthcare provider.

And again, response to the feedback that we've gotten, we are going to now be asking for some empirical data to demonstrate that relationship between the outcome and, at least, one healthcare structure, process, intervention or service. If there is no empirical data available, we may also accept data showing wide variation performance – in performance, which can be used as evidence of a need to measure the outcome, assuming the data are, again, from a robust number of providers and not subject systematic bias.

For structure, process and intermediate outcomes, as always we asked – we do asked for empirical studies and preferably a systematic review and grading of evidence showing that there is good quantity, quality and consistency in the evidence supporting the particular practice, or process, or structure being measured.

Another new part here for measures that are derived from patient-reporting or reporting from a family, parent or the like. We want to see evidence that demonstrate that the target population values the measured outcome and finds it meaningful. And otherwise, the current requirements for structure process

measures, i.e. the quantity, quality and consistency of evidence, and empirical evidence should also apply to patient-reported structure and process measures.

When you think of patient-reported measures, we typically think of patient-reported outcomes but we have actually seen some measures come in that are really should be thought of as structure or process measures. But essentially use their data source as patient-report, you know, asking patients did you receive this or that service, that kind of thing. So we will be treating those as structure or process measures for the purposes of the evidence review.

Any questions about that? I know that's a little bit different from what we've done before. OK.

And we – as usual, have these hopefully useful algorithms for the walk through when you're doing your evidence review. I won't spend too much time on that. You've already seen them and can take a look at those there in your guidebook and available on the committee SharePoint site.

I just want to emphasize here that for importance to measure and report, we do have a little bit different emphasis for new versus maintenance measures. I think we were starting to implement this with the last round of evaluation. But we are decreasing our emphasis a little bit on emphasis if the developer will attest that the evidence is unchanged and the standing committee affirms that they are not aware of any change in evidence that would impact the measure.

And we're trying to place a little bit more emphasis in turn on the current performance, the gap in care and variation to make sure that there does remain an opportunity for improvement with these maintenance measures that they are not being, you know, tapped out or that they are not sort of addressing an area where there is a need for improvement.

Iona Thraen: This is Iona. Before we move on, about that slide, so I'm just wondering if the definition of gap meets the definition or is inclusive enough for – is it Dr. John that was indicating his interest in gaps?

Andrew Lyzenga: Yes. I think maybe a little different. This is, again, sort of part of the evaluation of an existing submitted measure. The questionnaire is, you know, whether that measure is addressing a gap of sorts, if it's a needed measure really, if it rises to the sort of level of importance that we think it was endorsement as a national measure.

So it's a sort of it is speaking to that question to some extent in the sense that, you know, we're asking, does this measure feel a need? But for areas where we don't currently have measures or at least not measures that we're reviewing as a committee, that would sort of take place in that outside of the actual measure evaluation criteria and be done in that process of identifying gaps and prioritizing those gaps. So we separate from the evaluation process. Does that make sense?

Iona Thraen: And I apologized, that's Dr. James, not Dr. John.

John James: Yes. No apology needed. A lot of people get my name mixed up. So, on gaps, I'm trying to sort out how – and for example this committee decides that the gap is work, put in our hands up about in saying something needs to be done, is it by consensus or is it by majority or how does that work?

Andrew Lyzenga: Yes. And that, previously, if we're talking about, you know, identifying sort of gaps in general, it's been done a little bit informally. Previously, we've sort of just gone around when we have some time at our in-person meetings and ask our committee members, what do think the gaps in measurement are. And, you know, see if there is, you know, general agreement among the committee about that and we try to sort of list those out in our reports and make them available to the community so they can see where the committee has identified gaps in measurement.

As I alluded too, we are going to try to begin doing this in a little bit more systematic way. We've got a team at NQF that's working on a framework for prioritizing measures and measured gaps, so a sort of a structure for doing that in a more systematic way. And we will tell you more about that as we move forward.

But that will be done a little bit more formally than it's been done in the past. And I'm not sure if we'll really be doing voting or if it will be more of a, still somewhat informal consensus process, just based in a little bit more of a structured exercise. So, we'll sort of see how that, that whole initiative is sort of still in development. So we will, in some sense still be kind of piloting it, I think a little bit. But we will have a little bit more, again, structure informality to that discussion moving forward.

John James: OK. Thank you.

Yanling Yu: Could I – this is Yanling Yu, could I ask a related question?

Andrew Lyzenga: Sure.

Yanling Yu: Let's say, if the group comes up a consensus that there's a gap that we need to address, and then we found the developer, I assuming, to address the gap was through some means, will that be any, you know, at each year we filled out a form about conflict of interest that whether we are involved with particular measurement development, would that be any conflict of interest or that is totally irrelevant, I'm just asking some dumb question here.

Andrew Lyzenga: Oh no, it's not a dumb question at all. It's certainly worth thinking about I think. Again, this is a little bit new, we would – certainly if we – if one of you sort of, you know, brings up a gap – measurement gap where you are involved maybe in some effort to develop a measure in that area, we would hope that you would disclose that, you know, be very transparent about it with the committee.

And then, you know, should that measure eventually come back to NQF and in this committee for evaluation, then we would likely ask that committee if they were involved directly in the development process to recuse themselves from discussion of that measure.

But I think maybe that's, you know, it's a good question and maybe we can think a little bit more about that on our end for purposes of, you know, just identifying gaps, how we sort of weave that into our conflict and disclosure process. But again, I think it's certainly worth disclosing whatever efforts

here or activities you are involved in when we start that process, so that it's just, you know, transparent to everybody that's involved.

Yanling Yu: Yes, OK. Thank you.

Andrew Lyzenga: OK, so the second criterion scientific acceptability. These are largely the same here, reliability and validity. So both must-pass criteria, so meaning, if a measure gets to or reliability and/or validity evaluation and doesn't pass, then we stop right there and the measure doesn't pass.

Again, John, we can talk a little bit more about all the details of reliability and validity evaluations that is a little bit more complex and we'll probably want to talk a little bit more depths and then we want to get into with the full committee at this point. But I'll talk just about a couple new emphases again with regard to maintenance and – new versus maintenance measures, we can skip this.

Let's get this too, we can – I think the committee knows most of these at this point. Let's get to the next one.

We've got our algorithms to reliability and validity, again, in your committee guidebook, available on the SharePoint page. So, here is one change, previously we have allowed either empirical testing of validity or face validity. And we still will be accepting face validity in the absence of empirical validity for new measures, if they are not able to conduct empirical validity testing.

But for the measures that are coming back to us for maintenance review, we do expect that that at point, they will have been able to do some empirical analysis and will not be accepting only face validity for those maintenance measure.

Again, algorithm, handy algorithm that is available to you. The threats to validity, I think we've been over these before. So, in terms of emphasis for new versus maintenance measures, no difference in terms of the review of specifications. But with reliability and validity for maintenance measures, if they had come in before with empirical testing of reliability and validity, and

they attest that there is no change and no need for additional testing, then we'll have a decrease emphasis on this criterion and we'll sort of, you know, see if the committee is OK with accepting the previous evaluation – results of the previous evaluation, so we don't have to go through the whole process of voting again on this. But if the committee thinks that there is a reason to discuss it, as always, we can certainly do that or if the developers provide a new information or information of change, then we want to, of course, discuss that information as well.

And we – if they, and the developer has not previously done so, we would also want them to address this question of social risk factors and whether those have been at least conceptually addressed or/and assessed empirically with regard to whether they need to be incorporated into their Risk Adjustment Strategy.

Iona Thraen: And this is Iona, before you go on, on that one. So, what's the cycle of review for the maintenance group?

Andrew Lyzenga: Still three every years is sort of the general schedule.

Iona Thraen: I thought in one of the conversations we've had in the past that even though their initial testing approach was proven to be adequate, we felt that in the maintenance review, there not needed to be update on, you know, what's happen in the last three years, how it's been using, what's kind of data they've been showing, and et cetera, et cetera.

So, is – and in that effort to assess what's gone on in the three years, though, we have to also assess the reliability and the validity of that effort, that evaluation?

Andrew Lyzenga: Yes. And so, we sort of have been – we've focused that question on in actually the usability's criterion, which we'll talk about in a moment.

Iona Thraen: OK.

Andrew Lyzenga: I mean, it's a fair point I think, again, if the developer attest and the committee agrees that reliability and validity are not – there's no need for new testing,

then we can sort of skip past that a bit in the evaluation. But as you said, we do want to hear about what's happened in the last three years, whether there has been, you know, improvement in performance, whether there has been pick-up of the measure. And that's where we'll plan to have that conversation in the use and usability section.

But if you do see a measure that comes in and you think that it's worth of having a discussion, you know, a renewed discussion on scientific acceptability, that certainly within our bounds to do so.

Iona Thraen: OK. Thanks.

Lisa McGiffert: Hi, this is Lisa. I have a question on the social risk factors for the maintenance. Remind me, the current requirement is that every measure has to somehow be adjusted or show that it doesn't need to be adjusted. And so, that's why these maintenances of efforts are required.

Andrew Lyzenga: Well, they have to, at least, for outcomes measures. We don't, you know, typically expect that process measure would need to be adjusted for, you know, clinical or social risk factors, unless the developer sees a need to do so.

For outcomes measures, we do expect that they will, at least, give us conceptual assessment to say whether there is, again, a conceptual basis potentially for doing social risk adjustment. And if they do find that there is a conceptual basis, we want them to do an empirical analysis showing, you know, whether social – adjusting for social risk factors would make a difference and whether, you know, that analysis shows that it should or should not be incorporated into the measure.

Lisa McGiffert: Can you talk a little – could you talk a little bit about conceptually addressed? I mean, when we talk about social risk factors in the past there have been many discussions about not applying them to patient safety measures. And I know our measure to this committee is kind of wide range but what would – can you explain a little bit more what you mean by conceptually addressed?

Andrew Lyzenga: So, I think we would sort of we – I think want our developers to, for example, do a review of the literature to see there are any sort of concerns with regard

to, you know, socioeconomic stuff status, demographic factors with regard to the outcome in question.

But we would expect them to sort of doing assessment of whether, you know, based on, you know, looking at the literature and other evidence, and also their own evaluation whether it sort of make sense to do adjustment for a given measure.

I know we, as you said, it's a little bit different in patient safety in that. And for that reason, you know, you wouldn't expect say, hospital-acquired infection measure necessarily to be impacted in terms of those rates for, you know, sociodemographic factors. And, you know, we would expect the developer to, in their analysis, you know, provide a rational or justifications that explains that. And, you know, you would have the opportunity to review that and agree or disagree. Do you have any additional thoughts, Jesse?

Jesse Pines: I don't have. I think that just said is that the – is that I think that now there's a, as you said, discussion on this in – there was a separate committee. They looked at this – the one of the goals is for the committee to explicitly look at this and put each measure to be – to have that explicitly address it.

And it may not applied to all measures but it does explicitly address in the measures submission form, and then that evaluation is reviewed by the committee as to whether it's efficient.

Lisa McGiffert: So, if conceptually someone can show that hospital infection rates are higher in places, in hospital that served lower income, people you would consider adjusting for that?

Andrew Lyzenga: Again, we would expect our developers to sort of do that kind of analysis. If they find that there is some, you know, conceptual basis that suggest there might be some justification for doing sociodemographic adjustment. We would want them then to sort of do some empirical testing and analysis to show whether it does make a difference. Whether the results are different, you know, whether it's having any impact when you do that adjustment.

Jesse Pines: But the – for that particular question, the expectation would not be that for hospital infection measures that would be risk-adjusted. More for factors where there maybe other social determinants at play outside of the hospital that could impact a process or an outcome but – and I guess primarily, outcome measures.

Andrew Lyzenga: So, it's really kind of I have to look at it on a case-by-case basis to some degree. And again, we would hope that the developers would provide us enough information both sort of conceptual and empirical to help us make an informed judgment about whether, in fact, there is a rationale for doing sociodemographic adjustment or not, and we can sort of have that discussion for each measure.

Lisa McGiffert: Well, I just kind of want to go on the record that I'm pretty disturbed that these might be applied for medical errors or infections. And I hope the committee would look at those kind of adjustments very seriously.

Andrew Lyzenga: Yes, yes. And we would expect, you know, you all to look at it carefully and let us know what your concerns are, we have (inaudible) that you will do so. And I think to this point, all the outcome measures we've seen have not found a rationale for doing sociodemographic adjustment in terms of the outcomes we reviewed thus far.

And, you know, I would expect that to continue most likely, again, given the sort of particular nature of patient safety, but we'll have to see how it plays out.

Ed Septimus: This is Ed. I think there is – I maybe wrong but I think there's been a real trend of looking at these disparities in our review process over the last five years. And I really trust that that will continue. So I'm relatively comfortable that we will be taking a good look at that.

Andrew Lyzenga: Thanks, Ed.

Lisa McGiffert: Thank you.

Andrew Lyzenga: All right. Feasibility, no changes here. It's pretty much the same as you've seen before. I want to make sure that the required data are readily available, retrievable without undo burden, and can be implemented for performance measurement. Next slide.

So, usability and use, one change here is that this is now a must-pass criterion for maintenance measures. Again, as when they come back to us after the three-year period, after its initial endorsement, we both want to put more emphasis on the scene what data they have in terms of improvement. I think that maybe on the next slide. But if the measure does not pass, the use, the sub-criterion, then we will stop as we would with some of the scientific acceptability sub-criteria because it is now must-pass.

There's also a new sub-criterion here under use which is that we're asking our measure developers to, again, when they come back from maintenance, have thought some feedback by those who are being measured or those who are using measure results. We expect them to sort of solicit from feedback from those groups, give them an opportunity to provide, you know, thoughts and feedback on the measures and its implementation. And that they consider that feedback and presented their sort of conclusions and summary of that for this committee to review.

So again, just sort of a little bit more emphasis on making sure that once these measures have been endorsed and go out into the field into use, we want to make sure that they are, you know, that they are making the difference, that there is, you know, improvement in performance, and that there are not unintended consequences or other adverse consequences or that we're, you know, we're getting good feedbacks from those who are being measured and those using the measure, to make sure that the measures are useful and usable.

Ed Septimus: This is Ed again.

Lisa McGiffert: Oh. Sorry.

Ed Septimus: Quick question.

Lisa McGiffert: Oh, go ahead, Ed.

Ed Septimus: Go back to that previous slide.

Andrew Lyzenga: OK.

Ed Septimus: So, it says here, if I understand this correctly, that within three years, there has to be some accountability application. And then, within six years, it needs to be publicly reported, is that what I'm reading here?

Andrew Lyzenga: That's correct. I think you're right. I didn't touch that. That's a little bit different as well from previous year as we didn't – we did ask that measures be, you know. I think we tried to stress that measure should, by the time they come back for maintenance, be used in some accountability program. And I think even for new measures we have that there are, at least, be a credible plan for putting the measure into application into some sort of accountability or payment or public reporting program. But I think we're just going to the – trying to apply that a little bit more strictly as we move forward. And really require that the measure be used in, at least, one accountability application after three years, and as you noticed publicly reported within six years.

Ed Septimus: Now, just one other question, in terms of seeing improvement, does that have to be since the last endorsement that the measure has led to improvement?

Andrew Lyzenga: I think that maybe an area where, you know, you can apply from judgment. We'll see what kind of data we get from the developers. We would hope that it would as recent as possible now that we would have some, you know, fairly up-to-date performance data and that we can, you know, make some judgment space on that, to let sort of have to see the – what comes in if they're giving us performance over a longer period of time, you know, that maybe useful as well. And again, may have to sort of look at that a little bit on a case-by-case basis.

Ed Septimus: Yes. Because some of these measures don't get instantly implemented.

Andrew Lyzenga: Right.

Ed Septimus: And some of them, it may take a little bit longer to see improvement. So, what you're saying is we can use our judgment on some of those features?

Andrew Lyzenga: Yes, absolutely.

Ed Septimus: OK. Thanks.

John James: This is John. I'd like to ask a quick question. Is there any function within NQF to sort of advertise new measures and try to make them happen on a broader playing field or we'd just expect hospitals and whatever to sort of pick this up as they hear about it?

Andrew Lyzenga: Yes. We don't really have too much of a process for – yes, I guess, you know, advertising you might call it. We put out our reports. Those are all available to the public, and we hope that they are read and considered by the Measure Development Community and, you know, the community of – that's implementing the measures and that they will pick these measures up.

I think typically, we sort of, you know, that responsibility has been more on the developers who have developed the measure to make sure they're advancing their measures and getting them into use and getting them implemented.

So, it's not something that NQF has really played a role in but as we do, again, move more into this sort of try to stress a little bit more activities around gap identification and prioritization. As when were – if we're sort of identifying particular measures of higher priority that gives us another opportunity to sort of send a signal to the field that we think particular measures are important and ought to be picked up.

But we don't really have any kind of, you know, formal or systematic way of trying to push measures out to the field. It sort of not been our role when we do the evaluation and we do our endorsement, then, the measures will go out and the developers are, you know, able to kind of do what they will or what they can with them, and we don't really have a role in their pick-up or use.

Though, as part of our evaluation, again, we've tried to incentives that to occur, you know, by making it part of our review, we tried to, you know, encourage our developers to make sure that they are putting the measures into use. So, that's kind of the extent of it on our end.

But, you know, it's something we could think about, maybe in the future of trying to play some role into getting the measures into use as appropriate, but that would be sort of discussion that we would have to have more broadly at NQF, I think.

John James: Sure, but that's – I like the end part of your answer. Thank you.

Andrew Lyzenga: OK.

Melissa Danforth: Hi, this is Missy. Can I ask a question going back to the new – the must-pass criteria for 4A?

Andrew Lyzenga: Sure.

Melissa Danforth: So, I had a couple of different meetings, and honestly, I don't remember which. I really stressed the importance of making sure that feedback is being obtained, not just by those being measured but more specifically, and I think this really needs to be explicit by the people that are actually administering the measures in the field, so doing the data collection piece.

So, what we found, as an organization, that's often the only organization putting these measures into the field, and I'll give you a perfect example.

So, in 2015, the National Quality Forum endorsed a measure for medication reconciliation. It's called Unintentional Medication Discrepancies. It was created by developer, Dr. Jeffrey Schnipper of Brigham and Women's Hospital. And it's been through the endorsement process and already through the maintenance process one.

We had spent literally hundreds of hours working with him to make sure that the measure specifications are such that they actually be put in the field. So, that the measure is actually specified in a way that we can collect data from

say 2,000 hospital, because most every instance, the materials that are available in the NQF website actually aren't adequate to do data collection on the measure.

If you expect hospitals or providers or any healthcare setting to be doing it in a uniform way, right? Particularly since, I'm talking about the non-claim space measures.

And so, I'm see here that the emphasis is really on getting feedback from both the measures. And, of course, that's really important. But I don't think saying and others have been given opportunity for feedback is really adequate because it really doesn't put any burden at all on the measure developers to get the feedback from the folks that are using the measure.

And I can tell you from experience that we often have to chase some of these developers down to get answers to just minor basic questions, including things like identifying typos and wanting to make sure that it's really typo and things like ICD-10 codes are included in the NQF documentation.

When we try to use it, the hospital will say this isn't a real ICD-10 code. And there's been time that we've had to drop measures because of just what I would consider like the steward's inability or, you know, unwillingness to communicate with us in a way that we can ensure that we're putting out the right information.

So I really want to stress that again, that it's incredibly important and it's disappointing that it's not on here. Given the amount of resources, the organizations like mine and, you know, even folks that consumer report, put into or trying to take these measures off the shelf at NQF, and actually put them into the field.

We can't see some of the improvement work if no one is using the measures, and the folks that are doing that work, I hope their feedback is really valued, and that the stewards have some obligation to trying to obtain that feedback directly from them.

Andrew Lyzenga: OK. I think that is within the intent I think of this sub-criterion but your point is well taken that it probably ought to be made a little bit more explicit, so we can maybe make that adjustment to the language so that we're stressing that appropriately.

Jesse Pines: And, Missy, I would never ignore your comments.

Melissa Danforth: Oh. I know you wouldn't. And Dr. Schnipper probably has no idea what he was in for when we made that first call and said, "Do you think this is a good idea?" And he said, "Yes". But it's hard work to put these measures in the field, and we want to do it. We did the same thing with Rebecca Smith-Bindman put through a measure for pediatric CT dose.

And again, there's another one we've spend literally hundreds of staff hours working with her to make sure that the measure specified in a way that we can get reliable result from, you know, 2,000 different hospitals across the country. So we want to continue doing it. We just want to make sure we have that feedback look with these measure developers, so we can, you know, again, just advance the work that NQF is doing which we think is extremely important.

Andrew Lyzenga: Thanks, Missy. OK.

So, again, no difference in feasibility in terms of new versus maintenance measures but for usability and use, we do want to place a little bit more emphasis on these particular criteria for maintenance measures. So we'll – again, applicable to this cycle. I think we only got one new measure but we'll stress that a little bit more as we go forward.

So as usual, we'll also take a look at related work and competing measures. And that maybe an issue we'll want to talk about during this cycle because, again, this is a measure related to prescription of opioids I believe. And we just endorsed a set of those measures in the last go-around.

I think this one sort of in my, at least, initial review is a little bit different but in some way is addressing the same general issue, but we'll take a closer look

at that one. We get to our evaluation process and make some judgment about whether the measure is related, competing and what we want to do about that.

So for ICD-10 coding as you are just talking about a little bit, Missy. We're sort of – we've been sort in a continue process of trying to encourage the move to ICD-10 coding and sort of hold our developers to that, to the guidance that we've been put out in recent years.

So if measure is based on ICD claims, we would hope that they would ask that they would submit updated reliability testing if they've re-specified their measure using ICD-10 codes. If they don't have updated testing, then the testing based on ICD-9 coding will suffice. But we want them to, you know, give us sort of some justification for that and we'll, again, kind of look at that on a case-by-case basis to some degree if we've only got ICD-9 coding for testing.

So again, so if they move to ICD-10, we want them to submit updated empirical validity testing is available. If they don't have that data available, we want to give them – them to give us, at least face validity of the ICD coding scheme and sort of the crosswalks to the ICD-9 codes, and face validity of the measure score based on the ICD-10 score, ICD-10 code, excuse me.

Or score level empirical validity based on the ICD-9 coding and face validity or face validity plus data element level validity testing. So, again, we want them to give us some justification and testing to sort of justify that the ICD coding scheme remains valid and that it does have at least face validity. And hopefully, some other empirical validity testing based on that ICD-9 to ICD-10 crosswalk.

For e-Measures, this question of legacy e-Measures, again, I don't think we'll be applicable for us, although we do, the one measure that we do have to review is in e-Measure but it's not a re-specified one. But for all e-Measures, reliance on data from structured data field is expected. If they're using unstructured data, then, we would like them to provide some evidence or analysis to show that data is both reliable and valid.

Just for your information, for those so-called Legacy e-Measures, we had previously – we allowed what's called Bonnie testing which is basically testing based on simulated data, but we're no longer allowing only that option. We're asking – where all the specified measure submissions to do actual empirical testing on real world data as I understand it. Is that right, Kathy? OK.

All right. So in terms of the evaluation process, we're running a little short on time. I'll try to move a little more quickly here.

As we've done the last couple of times, we will provide you with a preliminary analysis of the measure submission, try to sort of summarize a little more briefly what the most key and salient points of the submission are.

And we'll ask you each to do an individual evaluation of the measure as well. We'll collect your evaluation via SurveyMonkey. Again, for this go around, we've only got one measure. So, we won't probably be doing the lead discussions in that sort of thing this time because we'll just ask everybody to do a pretty in-depth review of the measure and have your discussion prepared beforehand.

We will do our evaluation and recommendations at the web meeting. The next time, we'll do it at the in-person meeting. As usual, we'll prepare a draft report summarizing your discussion and recommendation and release that for a public and member comment period. We'll do a call after that to review and adjudicate the comments.

And then, we will have a final endorsement decision by the CSAC. I'm not sure if we mentioned this earlier, but also as part of this sort of CDP revamp. We actually removed the NQF board from the process. The board is no longer ratifying each one of the endorsement decisions.

The CSAC will actually be the final endorsement body. And then if we have any appeals come in, we have a special appeals group that will be reviewing those in I think conjunction with the CSAC or with review by …

Ed Septimus: Yes. And this is Ed. So, those two members who may seem overwhelming at first. But I must tell you and I'm sure Iona will agree with this that the staff does an incredible job at doing most of the heavy lifting to make our work much easier.

Andrew Lyzenga: We'll do our best. All right, any questions? I know we've had a few as we've been talking, but any additional questions or comments?

All right. Hearing none, we'll turn it over to Desmi to give you a SharePoint overview.

Desmirra Quinnonez: Thanks, Andrew. So very briefly, I'm just going to give you a quick overview of SharePoint and what you can find on the committee side of SharePoint. And so, these are the following documents.

Instead of going through all of the screens, I am actually going to screen share with you so that you will be able to see some of the documents, see the actual website firsthand. OK. Can everyone see my screen?

Ed Septimus: Yes, it works.

Female: Yes.

Desmirra Quinnonez: All right, perfect. So here, you'll find the committee side of – the committee homepage for SharePoint for the Patient Safety Project. And so, I just want to go over a few things with these so you know where to find things.

On the left side, you'll see the navigation panel where you'll find committee homepage so that let you know where you are. Underneath that, you'll see the committee calendar where we'll have a list of each of the events that will be happening for this project, committee quick links as well as the committee roster.

So if you click on any of these page, you'll be able to – any of these pages, this links will take you directly to the pages where you can locate how to contact or the contact information for your committee members as well as staff contacts.

In the middle, at the top, under the patient safety sign, you'll see a host of reference materials that we've placed there for you. And these links will take you directly to the updated documents such as your standing committee guidebook, the standing committee policy which has been updated as well as some other samples of what good measure submissions look like.

If you go below that, you'll see the general document section where you'll notice you'll have the 2017 measure evaluation criteria and guidance, the committee guidebook as well, some of those other documents, the PDF versions of those and a measure submission form as well as the final report from last year's work and the standing committee roster and bio.

If you go down a little bit further, you'll notice the measure document section. In this section, you'll notice we only have one, a whopping one measure that we're going to review this cycle of work. So, you'll notice the project, the measure number.

And to the right, you move over, you'll see the measure title, the measure description and whoever this measure steward or developer is. If you click on that measure, it will take you inside the folder which will have a host of documents that would help you throughout your measure evaluation, so the evidence attachment and feasibility. You'll see the testing attachments and this is the e-Measure.

So, you'll see all the different things that you'll need, but you'll also find the measure worksheet which is what is going to be most important for you to walkthrough. So, I'll actually pull up e-Measure worksheet just so that you can get a vision of what the measure worksheet will look like.

So, you'll notice all of the measure information, submission information up top. But I want to draw your attention to these links. So, you notice the – that there are several hyperlinks within the document. And if you hit CRTL and click on that link, it will take you directly to – say this evidence will take you directly to the evidence submission form.

And so to go back, you would just hit ALT and your Left Arrow and it will take you directly back to where you started from. So, that's just a little quick tip as you're going through this document as it will be pretty long.

So you notice that if you go through each of the sections, you'll notice the green boxes will have the guidance and evidence algorithm and the preliminary rating from staff. You'll go through as well. And you'll notice the pink boxes will have an area for committee pre-evaluation comments.

This is where we will be placing all of the committee comments as we receive them. And so, you'll be able to – they'll be in one place where you can review especially when it comes down to those measure review meetings. OK. If you go down a little further, there's one more section, the purple box.

And this purple box is where all of your public and member comments will be. And so, we'll list all of those there so that you can find them. And the last thing that I will show you in the measure worksheet will be there's sort of a new area that we've included in the measure worksheets. This time, it's the new preliminary analysis worksheet and it goes through the evaluation from staff.

And if a measure had to go to the scientific methods panel, then their evaluations would be in here as well. So, it's more of a check box. It goes through each of the categories that it did in the measure worksheet. But these attachments will also be here so that you can see the rationale for why the reading was what it – what the ratings – what rating it was given actually.

So if you follow through – throughout the remainder of the measure worksheet, you'll notice that all of your attachments are here and you'll be able to find just about everything you need within this worksheet.

But we will go back briefly to the committee homepage. So any time that you'll notice that wherever you are on SharePoint, you'll see the left navigational planes. So, you can also just hit committee home and it will take you right back to where you want to be to start.

Moving down a little further on this webpage, you'll notice underneath the measurement document section, you'll notice meeting and call documents. If you click on these, you'll notice there are minus signs and there are plus signs.

Sometimes when you go on, they may be drawn up with a plus sign. If you click on that plus sign, it will take you directly to another one. Click on there again and it just opens up the doors to the information that you need. So under all of our meetings that we have, you can come on the SharePoint page to locate all of your agendas, your meeting materials. As well as after the meetings, we will be able to place the recording there for you as well as the updated meeting slides so that you'll have those there for your convenience.

And you can also access the calendar which I mentioned earlier on the left. And that is pretty much the big synopsis of what you can find on your committee SharePoint pages.

And if you have any problems or if you have any issues with accessing the page or if you've forgotten your log-in information, feel free to give us a call here and we can actually – or e-mail us the project team and we'll be more than happy to help walk you through the process of getting you set up again. OK.

Andrew Lyzenga: Any questions or comments at this point?

Male: I think I'm glad we have only one measure to …

Andrew Lyzenga: It’s kind of nice especially as we're just getting into this sort of newer process …

Ed Septimus: And you can see – for those of you who are new, you’ll notice that on the slide, the hyperlink to – you might want to bookmark as the – for the SharePoint.

Andrew Lyzenga: Yes. That'll be a valuable resource for you. All right. So, next steps.

Desmirra Quinnonez: All right. So moving forward next step, we'll have our – a series of our committee measure evaluation web meetings. Our next one is going to be on Tuesday, January 23rd from 1:00 to 3:00.

Following that, in February, we'll have our committee post-meeting which will be another web meeting and that will be from 1:00 to 3:00 on February 13th. Well, following that in April, we'll be able to wrap up with our committee post-comment web meeting and that will be on Tuesday, April 17th from 1:00 to 3:00.

And we do highly encourage all of your participation. We really like to see – here, everyone have a voice and for everyone to be able to submit their comments and feedback as we go through this process and we look forward to hearing from you all.

If you notice on this page, you'll have all of our contact information, our project safety – our patient safety project team, e-mail as well as our phone number to the organization and our project page on the website as well as your SharePoint hyperlink. All that information is here for you for future reference.

Andrew Lyzenga: Please do reach out and we know, we went through a lot of the information here on this call, although a lot of it is, you know, old news to you, some of it is new. And if you have any questions or clarifications, please don't hesitate to reach out to us. We'll be happy to help out.

Iona Thraen: This is Iona. I just have one comment. There were quite a few of the older members and I think a few of the newer members that were not here on this orientation. And I'm a little bit worried about some of the changes that are relevant for them to understand when we get started.

So, I don't know what the solution is. But I think maybe some outreach to the ones who did not attend to make sure that they understand that there's been some changes.

Ed Septimus: Isn't this recorded? Isn't this recorded?

Andrew Lyzenga: It's also recorded. So, we'll make that available to them. But I agree, we'll do a little bit of specific outreach to those individuals and make sure that at least they are aware of the recording and have a chance to go and look at that and we'll, you know, kind of ask, you know, be there to give them any guidance or ask for any questions if needed as well.

Ed Septimus: Yes, especially the new members. There were a few that I don't think were able to make the call if I remember the callout. Those are the ones I'm most concerned about.

Andrew Lyzenga: OK. Good point.

Iona Thraen: Thanks.

Andrew Lyzenga: All right. If nothing else, then we'll let you guys go, actually went right up to our time. So, thank you for bearing with us and for your patience and we'll talk to you all soon.

Ed Septimus: Thank you, bye-bye.

Andrew Lyzenga: All right.

Male: Bye-bye.

Andrew Lyzenga: Bye.

Female: Yes. Bye.

Operator: Ladies and gentlemen, this does conclude today's webinar. You may now disconnect.

END