

NATIONAL QUALITY FORUM

**Moderator: Andrew Lyzenga
(Workgroup B)
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3:00 pm CT**

Operator: Ladies and gentlemen, welcome to conference. Please note today's call is being recorded.

At this time, please welcome Andrew Lyzenga.

Andrew Lyzenga: Hi everybody. Welcome to everybody who has called in and thanks for taking the time to join is today. We know you're all very busy and we gave pretty short notice about these calls, so we really appreciate that you could make it on.

This is probably our most ambitious work group call of the floor we're holding. Both in terms of the complexity of the measure and the numbers of reviews were trying to fit into these two hours because of that time crunch we'll have to work fairly quickly. So I apologize in advance if it seems like were rushing you at any point.

Just to give a quick overview of the goals of this call, what we're doing today is just a preliminary review of the measures before us. We won't be doing any voting or official evaluations. But were hoping this will help you think through some of the issues and advance with the in-person meeting next week and maybe to identify any questions or concerns you have that the developers can answer either today or at the in-person meeting.

For those of you who are new to this process, hopefully this will also get a little bit more comfortable with both the measure and the process itself. For each of the measures we're reviewing today we assigned a work group member as a primary reviewer.

And while we don't have everyone on the call today, those of you who are on could maybe help us walk through the measure that was assigned to you as it comes up and just give your overall impressions of the measure, bring up any issues or questioned that occurred to you as you read it, and that sort of thing.

We've also got some preliminary online evaluations that we'll display on the webinar if you're logged on. We also sent those evaluations out to the work group member shortly before this call. And we can use those as a kind of starting point for discussion as well as a source of some input for those - from those who are unable to join us today.

We'll probably try to walk through the evaluation criteria for each of the measures. And we can see from the preliminary evaluation that there are some areas where there was more agreement among the work group members and some area where there was less agreement.

And it might make sense for us to try to focus our discussion on those areas where there was disagreement in the initial meetings. Before we get started, why don't we have each of the work group members introduce yourselves. Janet, we can start with you if you don't mind.

Janet Nagamine: Good afternoon. This is Janet Nagamine. I am a hospitalist at Kaiser Santa Clara, and this is I believe my third NQF group. I'm a former patient safety officer and quality chief. And I'm currently involved in Society of Hospital Medicine as a board member.

Andrew Lyzenga: Thanks Janet. Jason Adelman?

Jason Adelman: This is Jason Adelman. I'm the patient safety officer at Montefiore Medical Center in the Bronx, New York. And this is my first NQF committee meeting.

Andrew Lyzenga: Okay, thanks. And Ed Septimus?

Ed Septimus: Hi, Ed Septimus, my background's infectious diseases. I am a previous medical director of patient safety. I'm currently on the Quality Improvement Task Force for the Infectious Diseases Society of America, and medical director of infection prevention in epidemiology at HCA. And this is my first NQF committee.

Andrew Lyzenga: Great, thanks. Mary Sieggreen?

Mary Sieggreen: This is Mary Sieggreen. I am a nurse practitioner and a clinical nurse specialist in vascular surgery at Harper Hospital and Detroit Medical Center. And I am a board member of the National Pressure Ulcer Advisor Panel. And this is my first meeting for NQF.

Andrew Lyzenga: Thanks Mary. And Richard White?

Richard White: I'm the MD from UC Davis. I'm Chief of the Division General Medicine, and for 20 years I've been the Director of the Anticoagulation Service here. So my spin is that my major of interest is the epidemiology of inner thrombosis and I do a lot of analysis of administrative data. And it includes a lot of ICD9 codes and alike in trying to ((inaudible)).

I was on the steering committee for the original NQF ((inaudible)) for the short conditions CMS performance measures.

Andrew Lyzenga: Okay, great. Thank you, Richard. So I guess we can go ahead and jump in to the measures. All right, we're actually going to apart from the agenda a little bit. I know Janet has to drop off the call a little bit earlier so we were going to start off with the measure we had initially scheduled to go last, number 503 anticoagulation for acute pulmonary embolus patients.

Janet, do you want to just sort of walk through that measure with us? We can again pull the print preliminary evaluations on the screen here. And looks like there a, you know, a good - some variation in the ratings from the - our work group members here and some insufficient ratings form the low, moderate, a couple highs so.

Helen Burstin: And Andrew, I'll just mention before Janet starts, this is Helen Burstin I'm the Senior VP for Performance Measures, I'm just here as back up for you. If you have questions about evaluation criteria or profit.

Janet Nagamine: Thank you great. So Andrew, the format, do just want me to give a quick overview of the measure itself and then jump into how we voted on it? Or how would you like...

Andrew Lyzenga: That would be great, if you want to do that.

Janet Nagamine: Okay. So mine was 503 which looks at anticoag for Acute PE measure submitted by Ascept, and looking at patients who had orders for anticoagulation in the ED. So I'm not going to go through every detail. But some of the staff notes, do you want me to cover those Andrew, or?

Andrew Lyzenga: If you think that they're relevant or if you, you know.

Janet Nagamine: Okay. I do think that they were relevant, and I'll point out why as we walk through. But they pointed out that this measure looks at orders for anticoagulation without reference to administration.

And that there isn't data or evidence that looks at decrease mortality of PE due to delayed anticoagulation. Or there is one study, but it may or may not be strong evidence.

So those are the highlights of the notes going into it. And jumping into number 1, the impact, I voted low on this. But as I'm looking back, Helen, I'm glad you're here because when you look at impact, you know, it certainly is a high volume, high risk topic here.

But the reason that I put low was because I wasn't able to find strong evidence that having orders in the ED for anticoag would result in reduced mortality. So was I looking at that in the right way? Or would you recommend a different approach there on the high volume, high risk?

Helen Burstin: You know, I think that's an excellent point and I think the way we would look at it is really about evidence for the measure focus. So I think, you know, at the outset certainly BTE is important or we wouldn't be doing this.

Prophylaxis makes sense, and I guess that only question is, you know, would you need to consider since particularly in ED is when something ordered it's usually done, should you also really also consider the evidence for administered?

And I also point out that, you know, much of time we've had measures that have been submitted as ordered which actually in fact are often times recommended by committees to be flipped to administered from - for exactly that reason.

Janet Nagamine: Right, and so that was my reasoning for saying low. And that might be why we have a range from insufficient to high. And I just wanted to throw that out there for the group and clarify, you know, the final voting on that. So you're saying it would be both the combination of evidence for the - for doing this?

Helen Burstin: Yes, I mean, essentially I think it all somewhat depends on how the committee reflects on that. And if you think the evidence is strong only for ordered, I mean, only for administered over ordered that's probably something to talk about with the developer. So that's probably explains part of the sway in people's vote ((inaudible)).

Janet Nagamine: Right. And then the same carries over to the next one on the evidence for number 2, the quantity, quality, and consistency of evidence. There were two studies that were referenced.

One was the JACC article that looked at the outcomes of patients diagnosed with PE in the ED. They concluded actually that the mortality rate in this group was low 1.1% which was lower than some of the other studies, the second one, with early anticoagulation in chest looking at specifically patients who received Heparin in the ED and their outcome.

But when you look at these two articles I'm still not convinced that giving Heparin in the ED would affect mortality. And then there's issue down the line when we get to other criteria about the timing in the ED.

So if your standard is, were there orders in the ED? We all know that with throughput issues and challenges you can be in the ED, that's very efficient for 2 to 4 hours or for 12 to 24 hours. So that sort of in the ED piece maybe very difficult to operationalize and make conclusions about in terms of quality.

For reliability and validity, this is another one that maybe interrupted slightly differently. I put insufficient for reliability for the reasons that I just mentioned. If you look for orders of Heparin in the ED, you're not sure if you're looking in 4 hours or 12 hours or how many hours post actual diagnosis.

And so if you have efficient throughput and someone's upstairs, I don't know that they should be dingd for giving Heparin six hours whether they're upstairs or downstairs in the ED. Validity, I put low. And for validity, Helen, could you help me clarify that piece of the criteria?

Helen Burstin: Yes, it's really about the measure actually represented something that was intended to be measured before performance improvement was done, and that is important. So I think in this instance you would need to look towards what they actually put on their form. I mean, it really is driven by what they put down.

The lowest level of validity would be (face) validity which is often times what we do tend to get. And I don't see a whole lot of detail on the submission form at least, unless Andrew knows about more, about specifically how they looked at validity.

Janet Nagamine: All right.

Andrew Lyzenga: ((inaudible)). But I should mention that we do have the developer on the line today I believe, Emily Graham is on. Operator can you open (Emily)'s line?

Operator: Emily Graham your line is open.

Female: Actually if you could open the line for (Jeremiah Shore) and Anthi Venkatesh. They're both clinician with Aspect, they done the quality and performance committee and I think they're on as well. And they can speak to these issues a lot better than I could ((inaudible)) familiar with our process, so excellent.

Operator: Mr. Venkatesh, Mr. (Shore), your lines are open as well.

(Jeremiah Shore): So when we developed the measure was largely based on (face) validity. I think in our reapplication there are several documents that speak to the validity of the measure. And I'm going to - because the call was a little earlier than I thought, I'm going to turn it over to Dr. Venkatesh who can go through the details on those studies.

Anthi Venkatesh: Yes, hi, Anthi Venkatesh here. I think with reference to the studies and I guess the first thing I should point out was that I know it's challenging when what we're trying to measure is the time of the anticoagulation.

But I think that the evidence that actually has been published is probably some of the better evidence that we'll get around this question. And the reason for that is it would be really challenging to ever have a randomized study that would time anticoagulation because we could ethically never delay somebody's treatment just to see if they did worse or that the people who got earlier did better.

So I think that to some end the data that the retrospective study for male that shows a mortality difference between patients who are anticoagulated in the emergency department has having less mortalities than those who are anticoagulated later on or who had a delayed therapeutic level of Heparin, I think does mean speak to the fact that there's a pretty meaningful outcome from the measure.

With regards to validity specifically, I think that, you know, this largely is something that is probably more based on (face) validity in the sense there's - what we're trying to measure is just the process measure of whether or not anticoagulation was completed.

And I think what we really don't have right completed is the in - I guess we have, you know, testing that's done that show that obviously that there's a relationship between the orders for anticoagulation, anticoagulation being ((inaudible)).

But I think it'd be a little more challenging to show, like from what I said before that, you know, there's an outcome difference from the time you've anticoagulation because of comparison group. It's very challenging unless you looked at it retrospectively.

Female: Right. That's helpful.

Janet Nagamine: This is Janet. I had a question, though, about this study and the conclusion in the chest article about early anticoagulation. When you look at the population of patients who received Heparin in the ED. they were younger they had a higher wealth score, they were more - less likely to have malignance and CAD and all the other sort of diagnoses.

So could imagine myself easily looking at the populations that didn't - and didn't receive Heparin in the ED at somewhat different. So the patients in the ED were younger and it was more straightforward that you were dealing with the diagnosis of PE as oppose to the other patients who did not receive it.

Where you're saying well wait there, you know, there's a downside here. Well maybe, you know, maybe they have something else going on causing shortness of breath like CHF D-Dimer. And so you're holding off on rushing to give Heparin in this population because of the risk of bleeding.

So that was one question I had though, about this study. Are we looking at two different populations here and concluding that patients have a better outcome without separating sort of the differences in these two populations.

Anthi Venkatesh: Agreed, I think the distinction is that - and I want to be - I think it is valuable to just take a second and step back be clear about this distinction early in the review of the measure. Is that, we're really talking about people who have a confirmed diagnosis of pulmonary embolism.

And so this is - I agree that there is some difference between the populations of people that had earlier and later anticoagulation in that study. But this isn't really - the measure is not designed to measure whether or not people were given anticoagulation empirically with suspected pulmonary embolism.

Rather these were people that had the diagnosis made in the emergency department. And I think that kind of then raises the - that it's a very different decision which is if you know the patient has a PE then really the standard care is anticoagulation for those patients. Unless for some reason it may be unsafe or that patient might not be ideal.

And I think that, that's where a lot of the denominator exclusions for the measure are meant to address those subgroups of patients. The patients that don't really fall in within those groups I think it very reasonable to say at that when the diagnosis of PE is made in the emergency department...

Janet Nagamine: Right.

Anthi Venkatesh: ...anticoagulation should be initiative then.

Janet Nagamine: Right, and thank you for clarifying. I guess I was just wondering if the outcome is related to early Heparin versus their co-morbidities.

Anthi Venkatesh: Okay, sure. A second comment is that ((inaudible)) did, you know, attempt to do a risk adjustment for that. Obviously you're point is correct, there are differences in the populations, but this is not saying you can randomize. And so that's the knowledge we have at this point.

Janet Nagamine: Right, thank you. Thank you. Okay. So thank you for that clarification. So those were really - the usability and seizeability were the next areas. And because of the challenges with knowing sort of around the timing of Heparin being given I think I rated it low.

Because at the end of the day, sure, we want to make sure that we anticoagulant patients as soon as we know they have a PE. And I completely agree with the value of doing that. And I'm just not sure though that this is how we achieve that outcome.

And I also want to say that there are more guidelines coming out that look at the risk benefit ratio of giving Heparin sooner rather than later and prophylaxing.

So I'm just tempering some of the enthusiasm for giving Heparin and doing the right thing and making sure patients are treated with sort of the question of how do we best achieve that and will this measure achieve it? So those are kind of my summery thoughts.

Andrew Lyzenga: Thanks Janet. Do any of the other workgroup members have any thoughts or comments on any of things that we just talked about?

Richard White: Yes, this is Richard White. Can you hear me?

Andrew Lyzenga: Yes.

Richard White: My concern really is that if you're going to provide quality care, you're going to want to give Heparin as soon as there's moderate or high probability of PE. I mean, if you really think the person has a pulmonary embolism and you send them for CT scan they can get lost for hours.

And, you know, the measure of getting it in ED doesn't really tell me that they're really on top of things. And didn't balance the risk versus the benefits and administered it as soon as they reached the threshold of moderate probability. I mean, most people (will be fine) for days, right.

But there are a few where it's really life-threatening and you have to move as fast as you can. And just to kind of pick up that they gave it six hours later in the ED still ((inaudible)) in fact you've lost the ones who died, you know, on the table.

So, you know, I know that my Canadian colleagues and all, at moderate probability they give them more and more (liquid) Heparin and then they send them for the CT scan, or they even wait until morning to get the CT scan.

But I mean, it just seems to me just a little bit short sighted to just, you know, it's kind of an easy quality measure to get it into the ED. It doesn't get you into the drama of what these patients really look like and the need, I think for high quality - to the minute you think about it you ought to treat them.

Now you have to do the risk/benefit but that was my problem. I just - I don't know if it's going to push the quality envelope very far.

Janet Nagamine: And I would add to that, Richard,...

Male: Hello?

Female: Hello?

Male: I think we lost her.

(Michelle Wonder): This is (Michelle Wonder). I agree with all the comments that have been said so far, and particularly about the fact that the timing is the most critical thing rather than the venue.

Male: Yes.

(Michelle Wonder): And, I mean, I don't care who's still in the waiting room it's more, you know, it's more that you get in. And I don't think there's anything wrong with giving it in the ED, but I think it's a little bit - it's not as critical to quality.

Ed Septimus: This is, Ed Septimus. I interpreted the diagnosis was made and that may have been a mistake on my part. I also realize I made a mistake on the scoring card. I'd like to correct the quantity evidence and quality evidence. I really meant to say, well I just noticed that and I apologize.

Andrew Lyzenga: No problem, thanks Ed.

Richard White: The irony is you might lose a few of your patients where they're not even in the measure because they died in the ED, right. I mean, they died there so you never had them admitted. So I don't know where they go.

But I know it can be, in many hospitals, a fair number of hours between ordering the task and getting it. So anyway - that changes the measure. So I'm not sure we're here to do that. Those are my chief concerns.

Male: Can the measure developer make a comment?

Andrew Lyzenga: Sure.

Male: So two comments, one is when the measure was originally developed it was developed in the scope of a measure set and around emergency care. And that's why the measure had to do with patients in the emergency department ((inaudible)).

And it was thought that the appropriate scope of time was within the emergency department. And so the - I think there was (an important) discussion about the whole issue about time, and it does make sense that want it within a certain period of time after the diagnosis but that's why the measure was developed the way it was.

And the second comment I would have that is that I do not think that in the average hospital in the United States there is a long delay between - in emergency medicine between the consideration of PE and getting a CT.

There's a lot of other work showing that the use of CT in the emergency department is easy and probably overused. And so while that's maybe true in Canada and it's clearly true in inpatient medicine, there's not a long delay in the average ED for getting CT scans. They're quite abundant nowadays.

And so the thought about the measure - the reason that we did not make the measure be administration of anticoagulation for patients with a consideration of PE is because it would change the unintended consequences.

If you implement a measure like that it would clearly push the risk benefit calculation for clinicians to aggressively do early anticoagulation because they would be afraid of the measure and there would be a concern about causing more harm than benefit.

But as we do think there is a, you know, a documented gap in the number of patients who are given anticoagulation after being diagnosed with PE in the emergency department, we thought this measure was the way to address it.

Richard White: Thanks.

Male: Any other comments or questions from the work group members?

Male: No I agree that that unintended consequences probably ((inaudible)) probably one of the reasons we have so many CTs now, you know, we're wanting to not miss anything. But in the era of use of various probability tools et cetera, it's possible that could be built in to monitor high probability. But I understand the difficulties.

Male: Any other thoughts, or comments, or questions for the developer?

Andrew Lyzenga: This is, Andrew, again, and I'd just ask for the work group members to keep in mind the discussion we're having today and sort of note the issues and concerns that are coming up.

And we'll ask you to probably to help lead the discussion along at the in-person meeting to raise these concerns and issues that came up so we can get a little bit broader discussion with the full steering committee at that time.

And if there are no other comments, or questions, or thoughts from the work group members, I think we can move on to the next measure. Did anyone have anything else to add on this one? All right, hearing none...

Janet Nagamine: Hello, this is Janet Nagamine. I got bumped out of the call and couldn't get back in. I apologize.

Andrew Lyzenga: Oh, no problem. Did you have any wrap up thoughts on that measure? We were just about to move to the next but we'd love to hear anything you have.

Janet Nagamine: No I didn't hear what was said. I think I pretty much presented my thoughts on that.

Andrew Lyzenga: Okay, great. Okay, so we'll go ahead to number 371 then. We had Mark Luce assigned to this measure but he wasn't able to make the call. He did add a number of comments into the preliminary evaluations spreadsheet though and I can maybe try to summarize those a bit.

This measure is venous thromboembolism prophylaxis. It assesses the number of patients who received VTE prophylaxis or have documentation. Why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.

It looks like we had pretty high consensus on the high impact and performance gap. Everybody gave it a high rating. Did anybody have any thoughts about that in particular the importance criteria?

Sounds like none, and given that we have a pretty high degree of consensus there we can probably move on to the evidence section, the quality, and quantity, and consistency of evidence. Again, and we got pretty high ratings consistently here. Any thoughts or comments about the evidence?

Richard White: For studies that look at medical patients and tie in the level of risk with outcomes, there's a big paper that was just published in Annals of Internal Medicine by the American College of Physicians and their meta analysis suggested that there's a large number of patients who really are quite low risk.

And they provided from the meta analysis evidence that prophylaxis really doesn't reduce the risk of deep vein thrombosis. It only reduces the risk of pulmonary embolism by 30%. And their final recommendation is each doctor must assess the risks versus the benefits in their medical patients.

So really the bottom line is we're going to have to all work really hard, do a lot of research to get a good risk tool to know who is at a low risk, moderate, and high risk.

They're - they really abdicate against exactly what we do here at UC Davis which we have an opt out the minute they come into the hospital, everybody gets put on prophylaxis unless they have a contra indication to the prophylaxis or have bleeding risks.

And that was specifically - one of the conclusions is that it not be done. So now it's going to make us have to go back and develop a risk tool and then we have to get really good data on what the benefits are again in lower risk patients, so.

Janet Nagamine: Would you give us that reference again?

Richard White: Yes this was - lead author was Lederle, L-E-D-E-R-L-E, Annals of Internal Medicine, November 2011, Volume 155, page 602. And it also included a statement on their new guidelines.

Janet Nagamine: Okay, thanks.

Richard White: So this has kind of thrown some rocks in the road here that I virtually - that meta analysis has all kinds of problems with them. But I think everyone was gliding along thinking that all the other patients should be prophylaxis.

Now we're facing just one group that suggests that we need to develop better risk stratification tools and not give prophylaxis to a fairly large number of medical patients because they perceive the risks outweigh the benefits.

Janet Nagamine: And are all those patient populations included in the measure you're talking about? I'm trying to figure out what population...

Richard White: Well, let's see. We're - in this measure it's - let's take a look at the exact wording. I think it states all patients coming in the hospital, correct? It's not just medical patients?

Janet Nagamine: Yes.

Andrew Lyzenga: Actually at this point maybe we can bring the developer in to the line again. I think we have, Ann Watt. Operator, if you could open her line and any - and, Ann, if there's anyone else who's joining you on the call, we could open their line as well.

Operator: And Ann, your line is open. And, John Bott, your line is open.

Ann Watt: Thank you. This is, Ann Watt, from the Joint Commission and I have with me (Denise Krusenoski), also from the Joint Commission.

We are the developers for this measure and with all due respect to the Lederle article on the Annals, I would also - as you are reviewing it I would refer you to the Joint Commission's Web site where we actually have discussion of the conclusions of that article.

And basically, to make a long story short, the authors of that article did not have a complete understanding of this measure. This measure is not saying that every patient who comes into the

hospital, although it does include all patients who come into the hospital, that they should be (prophylaxed) regardless of anything else.

It says that they should be (prophylaxed) in the absence of a reason to not perform prophylaxis, basically. That is a key data element that we look for in this measure and that seemed to have been overlooked in this discussion - in this article.

Richard White: I don't think they emphasize that you must risk assess. And a lot of us have been avoiding that because of the complexity in the existing risk assessment tools and the lack of any validation that these tools are exactly what you need

And the difficulty of getting all the doctors to then fill out a risk assessment tool, you know, it's (onerous). So at least in our hospital we took the opt-out plan. We've taken the work out of it - put everyone on it which is exactly what they say we shouldn't do. So I was speaking more for ourselves at UC Davis. We can't take that the opt-out approach, at least according to these guidelines.

Ann Watt: So, Dr. White, this is, Ann, again from the Joint Commission.

Richard White: Yes.

Ann Watt: I think that one of the things also that this article doesn't, you know, it assumes that we're talking about pharmaceutical prophylaxis and this measure also allows for mechanical prophylaxis. And I think that the fact that we look for a reason for not doing it implies a risk assessment.

Richard White: Oh it does. No, I agree with you. I would only say, just to show you the bumps in the road, the American College Physicians group couldn't find any articles that looked at the efficacy of mechanic prophylaxis.

The only one they had was compression stockings in patients with stroke and they say there's really no evidence out there. Again, if you really look, there is no evidence for, like, Nevada compression versus nothing.

So yes, we can give them credit for it but there is no evidence that it does any good. In the stroke patients it actually did harm and the problem there is that they use T.E.D.s that are not well fitted and they might be on too tight. And there's a lot of problems with that study that looked at that.

I guess in summary I'm just saying that these are all great ideas and we all think it's going to be beneficial. There are some groups that think that the evidence is weak and we need better evidence.

Ann Watt: This is Ann, again from the Joint Commission. My comment on that is to note that stroke patients are excluded specifically from this measure, just as an educational item.

Richard White: Yes, okay. Good point.

Andrew Lyzenga: Any other thoughts on evidence, or rather the reliability and validity of this measure from the work group?

Richard White: Do we - this measure is only the placing the patient on prophylaxis, correct?

Ann Watt: This is, Ann, and yes that's correct.

Richard White: So again, in a lot of the studies that have been done for root cause analysis et cetera, the dose could be incorrect, the timing could be incorrect, the doses could be missed. So we're really keyed up on those elements. We're just getting square one down of did they actually start the prophylaxis ((inaudible)).

Ann Watt: Yes, basically on the ((inaudible)) you have to walk before you can run.

Richard White: Yes right. But in the papers I've seen that have gone back and looked at the patients who got thromboembolic problems, the major problems were, A, they didn't get put on anything, B, they were put on prophylaxis, and given it absolutely perfectly and it didn't work, 3, they missed doses, 4, they used the wrong medicine or the like.

So when you go to the group that gets the clots and look backwards there are all sorts of different subgroups. And, you know, one measure - one reason that hospitals are going to be kind of upset with this is that in a fair number of cases you're going to do everything right and they're still going to get thrombosis.

Female: And it looks like the Joint Commission is ((inaudible)) data that their aggregate performance in the last five quarters was 83%. So there's still a 17% performance gap.

Richard White: That's quite good. With that I mean 83% seems to be...

Female: Yes.

Richard White: Now how many hospitals are doing that performance measure, like 70?

Female: Ann? I'm asking, Ann Watt to respond, sir, I don't know.

Ann Watt: I'm sorry, I was just double checking and I'm sorry I don't have that number right now. I will certainly have it next week though.

Female: Great.

Andrew Lyzenga: Any other thoughts or comments on this? Did we - so we just covered I believe the liability and validity is that correct, that we were just discussing?

Richard White: Well it's valid to the sense that they did give the first dose. If the implication is they got adequate prophylaxis during their hospitalization course, it's incorrect. But as the measure's written it seems to be that the data you pull is valid.

Andrew Lyzenga: I have a note from, (Mark Moot), who was not able to make the call. He had sort of made a point of stressing this point. I'll just read his comment here from the sheet. Reliability and validity is in question as related to administration of mechanical methods. A presumption in this measure is that mechanical methods of prophylaxis are adequate.

Yet administration of prophylaxis is the criterion. Administration of chemo prophylaxis would be based upon documentation. Typically within the medication administration record of drug delivery not simply orders.

It's unclear to me where this administration data would come from for mechanical methods. My assumption is that it would only come from documented orders which would inherently mean a lower standard that pharmacologic methods would be held to. And in my experience STDs are poorly adhered to. I put that out for the work group's consideration.

Richard White: Well, that's a variant of what I said about not getting ongoing prophylaxis. I mean he's right, you can order them but whether they get put on is another question, whether or not they stay on is another question.

But we're trying to just see if they take that first step and if that's what our measure is then I'm assuming you're looking at the orders. Sometimes they're hard to find, the nursing orders for mechanical maybe not written by physicians and just automatically put on the nurses.

Ann Watt: This is, Ann. Excuse me, just to clarify. This measure does call for medical record review, and part of the review that's required is that the mechanical prophylaxis is in place. We would expect the abstractors to look for more than just orders.

Ed Septimus: Yes, this is Ed Septimus. That's exactly how I interpret it which as you can tell may be problematic.

Richard White: I think, (Mark)'s worry is, is that it stay on them over time, you know. So a cross-section over one point in time doesn't really - he has some questions it.

Saul Weingart: This is, Saul Weingart. I hear the concerns about the different between ordering and consistent application, you know, but I think that's similar - as similar for mechanical prophylaxis as it is for the use of medications.

Since the timing is often messed up, you can never make sure somebody gave it in the right place, the right time, I mean, you know, from my perspective ordering mechanical prophylaxis, some documentation that the order was received and acknowledged is a reasonable bar for this kind of a measure.

Andrew Lyzenga: Thanks. Anymore comments on the reliability or validity?

Helen Burstin: I'm just glad - this is, Helen. It might be helpful, Ann, if you have any other additional information to share with the full committee next week on that issue.

Jason Adelman: This is Jason Adelman. I'm just following up on what, Saul, just said. The way he presented it would almost - please correct me if I'm wrong.

But change the measure just slightly to say that if prophylaxis are ordered or documented, like, there are lots of cases where in my institution where mechanical prophylaxis are ordered and maybe even been placed but not necessarily documented.

So it might be hard to know that it was actually in place, to see the physician attempted at it. And I'm not sure what's all said or the committee members of the Joint Commission would consider that to be good enough. If the doctor ordered it and we just don't know. There is no documentation one way or the other if it's actually in place.

Ann Watt: This is Ann. And I would say that if there is an order and no documentation that it's in place, that case would not pass this measure.

Richard White: This is Rick White again. I have one other comment and that is, at least for my colleagues who really follow the ECCP guidelines carefully their word is, at least in the 2008 guidelines, a little bit murky.

But the notion would be really you ought to take anyone who's deemed at moderate or high risk and put them on chemo prophylaxis. And that mechanical should be reserved either as a superfluous second type of prophylaxis or placed in the patients who are at higher risk of bleeding so that there would be a hierarchy.

And maybe, Ann, you can come on in. I don't think there's a hierarchy here. I think that you could take a very high risk patient and just put him on mechanical prophylaxis and you'd be deemed to be in compliance with this measure. Is that correct?

Ann Watt: That's correct. There is no hierarchy. The only thing that this measure says is if there is a reason for not giving prophylaxis it's okay not to give it.

Richard White: Right. I think that that would be the major point of discussion next week, whether or not it ought to be evolved into a hierarchy because of the really almost absence of evidence that mechanical prophylaxis by itself is equivalent to chemo or that it's even better than placebo.

It's - there's just so little evidence out there that most people would want to push the chemo prophylaxis to a higher level of - that would provide a higher evidence of quality. What's everyone else think?

Ed Septimus: This is Ed Septimus. I agree with that also.

Male: I agree as well.

Janet Nagamine: I agree. This is Janet.

Andrew Lyzenga: Thanks everyone.

Mary Sieggreen: I have one question. This is, Mary. I have one question about this. This measure is looking at just a single day, right?

Ann Watt: It's looking at the day of or the day after admission, or the day of or day after surgery.

Mary Sieggreen: So if either mechanical or pharmacologic prophylaxis was done on that day but no other day, the other days wouldn't count into the measure at all?

Ann Watt: You know, I - this is Ann. And no, that's not the way that this measure is written. But I guess one thing that I would like for you to know is that this measure is part of a measure set. And it's a Joint Commission requirement that anybody who chooses to collect data on the set needs to collect data on all measures.

And one of the measures you'll be talking about here in a little bit is - I'm not sure what the NQF number is - 0376. That is patients who developed a VTE and then to look and see if they had appropriate prophylaxis. So these - we developed measures so that if you look at them as a whole it gives you a pretty clear picture.

Mary Sieggreen: Okay.

Andrew Lyzenga: On that note, we do again, have a pretty good number of measures to go through on this call. So maybe we should move on unless anybody has anymore comments on this issue.

Right, so let's quickly talk about usability and feasibility on this measure. A bit of variability in the ratings here, were there any particular comments about the usability or feasibility of this measure? Does everybody understand what we're asking for in that?

Male: Not really. Can you tell me about usability?

Female: I know this comment's a little far out there, but I was just looking at the intent of prophylaxis and what we want to do surely is to prevent the preventable. Now that said, how do we accomplish that?

In a dream world we would do real-time chart reviews rather than retrospective chart reviews to say, six months ago this guy didn't get it and he died and your performance is not very good. So I'm just throwing this out there.

As we look at the burden of audits retrospectively and the mission of quality and safety, is there a way where we can get to a place where if we're going to audit anyway and extract anyway, can we do it in real-time and still see how we're doing and improve outcomes and performance at the same time. So that was my thought about usability on this.

Ann Watt: This is Ann from the Joint Commission. And just wanting to point out that there is nothing that says that this measure needs to be - the data needs to be collected retrospectively. This one actually lends itself pretty well to prospective or concurrent data collection because it's based on all admissions.

Female: Does anybody do that, Ann?

Ann Watt: Sure, yes. People in real - well what is real-time, but while the patient's still in the hospital, yes a lot of hospitals have developed data collection processes that go on - (ongoingly). That's probably not a word, but.

Female: Yes, but I mean that would I think help a lot really more firmly support these measures despite some of the flaws. That was just my only thought. As we look at all this, the parts, and the criteria and the objectives. So if there's a way that we can promote that more I think that would be...

Richard White: Dr. Greg Maynard at UC San Diego is really pushing this with the Society of Hospital Medicine. And they have EPIC at UC San Diego and they're pulling out all of the data in real-time.

So as they come into the hospital you can see if they have an order for VTE prophylaxis including mechanical, they pull out contraindications like high INRs, platelet counts, et cetera.

And they set up a grid and put everyone in a color, red, yellow, or green. The red ones, they're not on prophylaxis and we need to go in and check those out. And so they have an ongoing way of using the electronic medical record to look at all their patients in real-time. And that's where we're going to be in 10 years so all these - all part of the electronic medical record.

And the nurses, by the way, are having three times a day to say whether or not the pneumatic compression is on the patient. So you can see it in real-time.

Andrew Lyzenga: This is Andrew again. It sounded like there was a little bit of uncertainty about what we're asking for when we're talking about usability and feasibility. So I just thought I'd provide an explanation of that.

With usability, we're looking for the extent to which the intended audiences, for example, consumers, purchasers, providers or policy makers can understand the results of the measure and find them useful for decision making.

With feasibility, we're looking for the extent to which the required data are readily available or could be captured without undue burden, and can be implemented for performance measurement. I don't know if you had any additional thoughts on it.

Female: No, that pretty much sums it up. We are working on usability right now because we realize that's a little bit theoretical and it'll probably move to sort of use and usefulness over time. But for now that's still current. So basically, is the information usable for both quality improvement, is it useable for accountability, you know, and how easy is it to collect?

Andrew Lyzenga: Were there any additional thoughts on those issues, questions for the developer?

Hearing none, I think we can probably move on to the next measure. We had a pretty high level of consensus on the suitability for endorsement.

And again, we have to move through a good number of measures here so let's go ahead and move to measure number 372, which is ICU VTE prophylaxis. Richard, I think.

Richard White: Yes, I think we can go through this very quickly because it really pretty much covers the same material for - as 371 except you're in the intensive care unit. They're a very high risk group of patients. They clearly deserve to be risk assessed and placed on prophylaxis.

I think that the only issues that in ICU patients is that they may have a higher percentage judged to be at risk for bleeding. But they're also higher risk for thrombosis. So it's a very high risk group.

I don't think it's - the only comment I have on what I was given on this material is that it kind of reminds me of electronic medical record. Almost everything was cut and pasted from 371 to put into 372 and they didn't have any data on ICUs even though there's a lot of good ICU data out there.

You know, there's a big review by Cook and Crowther on thromboprophylaxis in the ICU that I'm looking at that, will reference to that, so I was kind of saddened to see that there wasn't a lot of specific stuff for the ICU.

The one big issue that's really not in 371 and not in 372, I think I'll at least bring up and maybe people can bring some ideas on - at the meeting next week.

We picked up a huge gap here at UC Davis of a large percentage of patients coming out of the ICU onto the wards not getting prophylaxis because the house staff don't - aren't allowed to transfer the orders and that's missing in these two measures.

They're not being admitted, you know, not being transferred to the ICU. They're being transferred to the ward after the ICU and that time I don't get prophylaxis. Just to point out the gap.

So I don't understand why 371 couldn't be rephrased like 372 and on transfer from ICU to the ward or on admission. That goes back to 371 but I remembered that point looking at 372. That would be something to consider. I don't think there's a whole lot more to run through.

Female: There's a comment from Lisa Morris specifically, and I don't think is on the call, about her concerns about some of the numerator and denominator definitions of some of these. And also feeling like the VTE prophylaxis in the ICU should be harmonize with CTE 1.

So I guess the question is does it need to be a separate measure or is really a subset of the first measure, I think what she's asking.

Richard White: That's a good point. I agree...

Female: Go ahead.

Richard White: I was just going to say, we brought up the mechanical, there's very little evidence that mechanical works. You know, I think in - I would like to bring up the hierarchical issue of creating this hierarchy particularly in the ICU patients. Many of them are at high risk for bleeding and will only be put on mechanical.

But if you're really going to prevent it, you better put them on mechanical - on pharmacologic prophylaxis. And then we need to harmonize with getting them back to the ward.

Female: Well, it was probably for the same reason that you said, a lot of the citations are similar in both documents that she thought that they could be combined.

Richard White: I see.

Ann Watt: This is Ann from the Joint Commission. This is essentially the same measure. It is harmonized except for it's looking a different patient populations.

Female: I can't speak for Lisa because she's not on the call, but I suspect she is wondering why it's just the same measure. But we can hear from her at the meeting.

Richard White: That's a good point. I even said at the beginning, there's not a whole lot to discuss. It's pretty much the same measure.

Andrew Lyzenga: Any other comments or thoughts from the work group members on this measure?

Saul Weingart: This is, Saul. I mean, I guess the question to put to the developers is the, you know, added value, the incremental value of supporting similar measures for the, you know, ICU compared to the whole hospital.

I think if they have a rationale for that it would be useful for us to know. I don't think it's, you know, per se unreasonable, but it would just be good to have the - that made explicit.

Ann Watt: This is Ann. And I would say basically it's because, as was previously noted, it's known that ICU patients risk for the development of VTE. And therefore our expert panel wanted to look at

them separately because of the relative degree of risk for the general admission population versus the ICU population.

I believe we talk about it more at the meeting when our physician expert is going to be present.

Saul Weingart: (I'd) just imagine there'd be different results. A hospital might be strong in one area and not on the other.

Ann Watt: Okay. And I think that's why we separated it out so we could - so that could be determined.

Andrew Lyzenga: Any additional thoughts or comments, questions for the developer? If not then we can go ahead to 373. This is venous thromboembolism, patients with anticoagulant overlap therapy. And Ann, I might actually just ask you to give a quick introduction of this measure if you don't mind.

Ann Watt: I'll defer to (Denise), my colleague.

Andrew Lyzenga: Okay.

(Denise Krusenoski): This measure is defined - the first date that parenteral or IV or subcutaneous anticoagulation therapy and Warfarin are administered together on the confirmed VTE patient population.

Andrew Lyzenga: All right, thanks. And we have, again, a relatively high degree of consensus on the importance of this measure. Any particular comments on that subject?

Richard White: I think there's some confusion or there's some lack of consensus on the exact nature of that measure, right, between American Heart and I believe one of the other. One says you have to be in the therapeutic range for 24 hours before you stop the heparin.

And one says you have to have an INR of over 2 which means you could be there for a couple hours. And that's created a lot of concern out in the real world. People are unclear whether or not you're supposed to get two INRs in the therapeutic range over 24 hours or a single one.

The way I read it you just have to get into that therapeutic range before you stop your heparin. It's what I know that confusion is out there.

Ann Watt: Were you asking what this measure asks for Doctor?

Richard White: Yes, I believe the measure when I read it said you just have to achieve an INR of 2.0.

(Denise Krusenoski): No you need to have overlap therapy for five days.

Richard White: Right.

(Denise Krusenoski): Or discharged with overlap therapy, or an INR of 2.0 for greater than 24 hours.

Richard White: Great. So you require 2 INR measurements 24 hours apart before you can discontinue the heparin?

(Denise Krusenoski): Yes.

Richard White: Okay, I would take - that's not what the real world does (A) and I don't believe there is any evidence that you need to continue it for 24 hours. And we've done a meta regression of multiple

studies. And you can't find any difference between the outcomes in studies where they stop it after they get to an INR 2 or they go for 24 hours.

I think that really creates an owner situation to keep someone on it for another 24 hours to get a second INR.

(Denise Krusenowski): Well, I think the intent is to capture, number one, patients that are going to be discharged to home that are not therapeutic yet so that they are still discharged on overlap therapy.

Richard White: So if I have a patient and at 8:00 a.m., I get back their INR and it's 2.1, I still have to continue to give them another day's of low (milligrade) heparin and get another INR to show that they've been on therapeutic for 24 hours?

(Denise Krusenowski): No, not if they attempt overlap therapy for five days.

Richard White: But then again, you can overlap for five days and not even be in the therapeutic range.

(Denise Krusenowski): Yes, that is true but you are - but the ACTP guideline and the references feel that you are out of a window of developing a VTE then after your five days. You could - your INR could vary for another two weeks and so you might have to bounce around. If you were to be a high risk developed patient then that's the physician's preference.

Richard White: Well this gets down to the point that I think the measures too complex because you have to satisfy all sorts of things at once. You have to be on both therapies, right, you have to have a minimum of five days. And then you have to have this therapeutic INR for 24 hours before you can stop it so you get them all blended into this.

It makes it quite confusing and pretty (ownerous) when the only evidence is if you don't give heparin at all and you just use Warfarin, you get bad outcomes. That's the only evidence we have. You have to give Heparin, but there's been no study that three versus four versus five versus six days, there's been no study of one INR, of 2, or 2, or anything.

I mean, the evidence out there's minimal for such a kind of a complex measure. At least it's complex to me.

Janet Nagamine: And this is Janet. And I would add that the concern would be the harm of bleeding. Unfortunately, I didn't get around to publishing my study. But I did look at adverse events in bleeding on Warfarin and Heparin.

And for a certain subpopulation it was predictable that on day three of bridge therapy was the day that their bleed occurred, particularly in renal patients and particularly in patients over 75.

So with lack of evidence I do think that this complex measure and requirement needs to be reconsidered.

Jason Adelman: This is Jason. I'm - I - I'm just looking at the numerator statement. And I don't see the mention of two INRs over 2 within 24 hours. I saw it later on in the notes. But I don't actually see it in the numerator statement. Am I missing it?

Ann Watt: Well this is Ann and the numerator statement is patients who received overlap therapy, and it includes those patients who received Warfarin and parenteral anticoagulation for five or more days with an INR operator then are equal to 2 prior to discontinuation of the parenteral, or five or more days with an INR less than 2 and discharged on overlap therapy, or less than five days and discharged on overlap therapy or with documentation of a reason for discontinuation, or documentation of a reason for no overlap therapy.

So all of those - all are things that I was just talking about, they are part of the numerator statement. They're in the included populations section.

Jason Adelman: Right. And you didn't measure - you didn't mention -- sorry -- a, you know, two INRs of greater than 2 within 24 hours, and then discontinuing. Like, there's no...

Ann Watt: That would be included in the data element definition for - I'm sorry. I'm looking here. For overlap therapy and - help me, (Denise), here, I'm not seeing...

(Denise Krusenoski): You know what I think is also in discussion is that there has been a revision of the manual to include INR - another data element was INR values. So for this version of the manual, we're looking at five days INR of greater than 2, or the discharge with overlap therapy.

Male: Five days with at least one INR over two? Or the last INR over 2?

(Denise Krusenoski): INR over two. Yes.

Male: The last one.

Male: Hey, that's how I interpret it.

Male: Yes, no I agree with you. I went back and forth on this. I couldn't - one then - one says for 24 hours. And then another place it says INR greater than 2. And I'm confused.

I think the whole measure is pretty confusing in a way. It may not be worth all the time needed to figure it all out if - what was our outcome? Wasn't it like 98%? (Be what your measure.) Were you in compliance in 90 - what percent are in compliance with this?

(Denise Krusenoski): Seventy- nine point seven percent.

Male: Well only 79%. I see. Do you know which element we're not in compliance with? Was it that they didn't send them home one night or were they - hadn't reached an INR of 2 or that they hadn't gotten five days?

Ann Watt: You know, I don't know that we have performed that analysis, doctor.

Male: Okay.

(Denise Krusenoski): Well any ability to bring any of that to the committee next weekend would be helpful. Because it looks like it's also gone up significantly in the last quarter of 2010 to 90%. Again, anything that you can next week I think would be helpful there.

Janet Nagamine: Sure. Thank you.

Male: Thanks.

Male: Yes, didn't it show on this - yes forth quarter 2010 mean...

Ann Watt: Right, right.

Male: ...40%.

Ann Watt: Right.

Male: And the tenth percentile was at 90%. Interesting. Okay.

Jason Adelman: So we can move on to evidence, then -- the quantity of - or the consistency of the evidence. And we had a little bit of variability in the ratings here. And - although it looks like the comments - there don't seem to be too many concerns.

Did anybody have any particular thoughts about that?

Male: So which are we on? Reliability?

Jason Adelman: Quantity, quality and consistency of the evidence. Move on to reliability and validity if nobody has any comments about that. Sounds like none. Any thoughts about reliability or validity?

Male: I think reliability would be low. I mean, you can't understand the measure. So you wouldn't keep getting the same result.

Jason Adelman: Precise specifications is part of that.

Male: Yes, it says - at least I think it somehow needs to be proved. I know what they're getting at. That the worst case scenario is you just put them on Coumadin and you just send them out the door. And that's wrong. But I was probably nitpicking that that last moment that you have to be on a certain amount of ((inaudible)) may be difficult to document.

Jason Adelman: Any other thoughts from the other work group members?

Ann Watt: No.

Jason Adelman: All right. Well let's talk about usability and feasibility, then.

Male: So usability from the perspective of the consumer?

Ann Watt: Of any end users.

Male: Right.

Ann Watt: So consumer, providers -- whoever the case may be.

Male: Well I just thought it was a - such a confusing measure. I don't know how consumers would interpret all this, let alone doctors. But I think we should have more discussion first.

Jason Adelman: Any more thoughts?

Male: I had one question for the joint commission. How hard is it to gather this data? This - isn't this pretty onerous? Is this one hard or is this one easy to gather?

Ann Watt: This is Ann. And I think that what we have found is that hospitals who are collecting these data get used to collecting the data. There are, you know, they're really not, other than general data elements like admission date, discharge date, you know, ICD codes and those kinds of things, the number of data elements for this measure is one, two, three, four, five, six. So, you know, they...

Male: It's not that hard.

Ann Watt: It explains in the medical record.

Male: Okay.

(Ian): This is (Ian). I thought this would be a little bit more difficult to collect.

Male: I would, certainly.

Ann Watt: We use a question-and-answer feedback. And so there is always support from a clinical lead here at the Drug Commission to help differentiate questions abstractors may have.

Jason Adelman: Other thoughts or comments?

Ed Septimus: Hi this is Ed Septimus. And I'm sorry if I'm new. But it's - one of the considerations that I had on other groups is how easy it is to collect the data. And it - could it be potentially in the future electronically captured so as to reduce the data burden at the local facilities? Is that a consideration?

Ann Watt: Yes. That's - that would fit squarely under feasibility.

Ed Septimus: Yes. And so this is one that it is much more difficult to capture electronically.

Ann Watt: We are here working at the Drug Commission to - this is one of our measures that is going for respecification for electronic collection.

Ed Septimus: Okay but if you send them out on a low (molecular rate) Heparin you're done. You don't collect anything else. You just - I think when oral anticoagulants -- and they are certainly going to play a huge role in venous thrombosis treatment -- when they finally get it FDA approved, I think we're almost done. Maybe they could be put on that in you're home free.

Jason Adelman: Any general thoughts to wrap up this measure? Final impressions or questions for the developer? Okay, hearing none I think we can move on to the next one -- VTE patients receiving unfractionated Heparin with dosages of platelet count monitoring by protocol or nomogram.

Ed Septimus, we had you as the primary reviewer. Would you mind walking us through that?

Ed Septimus: Which one was that again? And which number is that?

Jason Adelman: number 374. Sorry.

Ed Septimus: Oh I just want to make sure.

Jason Adelman: Sure.

Ed Septimus: Yes, I thought this one was straightforward in terms of the data and the literature that these - this is a - I thought it was a very straightforward one.

Jason Adelman: Okay. And a fairly high consensus is for the most part on importance? Anybody have any thoughts on importance?

Male: Well let me ask Ann. So this is looking to determine if, when you dose your Heparin you're using a nomogram. Correct?

Ann Watt: That's correct.

Male: And so it doesn't matter one whit that the nomogram doesn't work?

Ann Watt: This measure does not address the components of a nomogram. It's assumed, I guess, that the nomogram is appropriate and - as established by the hospital.

Male: So it's really a surrogate. And, you know, we've been having problems with our monograms -- whether to use ideal body weight, total body weight, percent adjustment based on weight or not.

And we just did a review by a pharmacy resident who went back and, using the Heparin nomogram that we - a lot of people use around the country, we were only getting 45% of the patients into the therapeutic range in the first 36 hours.

So just to let you know, we do great. We use the nomogram. But our patients didn't get into the therapeutic range. I mean, that's - to me that's the problem with the measure, is it doesn't measure what you want it to measure.

Ed Septimus: Let me ask you this question. What would happen if you didn't use a nomogram and people didn't weight-base it?

Male: Oh, it's probably worse.

Ed Septimus: I mean, that's how I sort of looked at this -- that we've sort of learned how to better dose it. Do we have an ideal nomogram? Maybe not. But to not have a nomogram at all, I think would be below the standard.

Male: No, I hear you. And again, I think with (lomo) liquid Heparin, once you get them on a dose, you don't need a nomogram. And with all the new oral agents, you're just going to put them on a dose, you won't need nomogram. It's only going to be in a small subgroup that get IV Heparin. It's going to be a moderate number.

Jason Adelman: Shall we move on to evidence? Quality, quantity or consistency of the ((inaudible))? Any thoughts on that in particular?

Male: Well I'd reiterate. The evidence - you can use - the nomogram is great. But the evidence is that you've actually anticoagulated the patient is not being measured. So I don't know what you mean by the evidence.

Yes, the evidence is good when you look in and they've got a nomogram and they see they're using it. That's excellent. But it doesn't necessarily mean you have the out come you want.

Ann Watt: So what's the measure measuring?

Male: Use of a nomogram.

Ann Watt: Period?

Male: Period.

Ann Watt: And the platelet counts?

Male: Yes, and you monitor the platelet counts. It doesn't mean that if your platelet count drops that you stop the Heparin because you're worried about Heparin to produce thrombocytopenia. You at least monitor it.

So they're - but they're surrogates that you're actually trying to do the best job you can.

Ed Septimus: Well this is Ed. I mean, is - do you have a - another suggestion?

Male: No. I think if we really were concerned we'd want - I can't imagine the abstractors having a hard time looking to see if the APPT was in the designated therapeutic range by 24 or 36 hours, or 48 - - whatever you want. That wouldn't be too hard to find.

Just finding that they used a nomogram, though, doesn't tell you the patient got to the therapeutic range. Again, a lot of this is moot. Because if you use (lomo) liquid Heparin or the new oral anticoagulants they don't even measure anything. So you're home free.

I don't know if it's worth banging our heads on this that long. The only reason I brought it up is we just got a report last week and much to our amazement, we're using the nomogram and they're still not getting into the therapeutic range.

Ed Septimus: Well what you're saying is, using the nomogram on your very first shot, you're not in the normal range. But, you know, you're trying to getting in the normal range, and the amount of time you spend, like, supertherapeutic, let's say, may be shorter and more reliable.

I mean, like you might get there within 24 hours if you use the nomogram. Maybe not on the first shot, as opposed to giving no guidance at all to interns and physician assistants. Maybe if you give no guidance they'll get there, instead of within 24, within 48 hours and they'll spend a lot more time with a PTT greater than 200.

I don't know that as fact. I'm just sort of asking because this is not my area of expertise. If the nomogram might not get you there right away, but does it get you there faster?

Ann Watt: And is that even being measured on this measure?

Male: Right.

Ed Septimus: No, we're not measuring it. And I think you raised good point in the sense that I think it's a very small percentage of patients this is going to apply to.

Male: Right.

Male: Yes, it's only the ones on IV Heparin. Again, all the ones on (lomo) liquid Heparin you don't even do this. We are just really sad. We just - we thought that nomogram was going to do everything and we'd be 100%. And it's...

Ed Septimus: Does anybody have any statistics about what percentage actually get unfractionated Heparin compared to low molecular?

Male: Oh in the hospital?

Ed Septimus: Yes.

Male: Well in our case, if we think the patient's going to be discharged within three days, they go on a low molecular rate Heparin. If they're really sick and we worry about bleeding, we put them on IV Heparin. I don't know the percentages.

So all the stable patients get a low molecular rate Heparin, and all the ones that might need a procedure, you know, look like they're sick, they would give them the IV Heparin because you can turn it off or reverse it. I...

Ann Watt: Does it make a difference in academic settings versus the community hospital?

Male: I don't know.

Janet Nagamine: This is Janet. I could say that from my practice and my experience in Kaiser I would say probably 90% of our patients would be on low molecular weight. But I can try to pull up some more data just locally to get a better sense of that.

Ed Septimus: And again, in being new, I mean, I don't know if we use the 80/20 rule or something like that in these measures, but if it's a small fraction of people compared to low molecular should we have a measure? I'm asking from all of the information.

Janet Nagamine: Yes. Again this is not - I think that's a very appropriate question to see if, you know, the Drug Commission's been using this for a couple years if they have any information about who's in and who's out. So I think it would be very useful for the committee next week.

I mean, again, I think there's a real concern if an, you know, a good portion of the population is not included. I don't know if we have a sure and fast, you know, 80/20 rule.

Ed Septimus: Again, I apologize if you've already discussed this before. I'm just trying to learn.

Janet Nagamine: No. I don't think so. I think it's a good question.

Ann Watt: It's all about all of them.

Male: Yes.

Jason Adelman: Any more comments on this subject? Address reliability and validity then? Whether the measure's precisely specified or the reliability and validity have been demonstrated? Any comments or thoughts or questions for the developer on those issues? Hearing none, usability and feasibility? Any comments about those?

Janet Nagamine: It would seem that -- this is Janet -- in terms of the feasibility I think we sort of just covered it in terms of what percent of the population are we talking about that use low molecular weight versus unfractionated Heparin ((inaudible)). I just wanted to throw that out there.

Male: Thanks.

Male: Well I rate the usability low because it's not telling us anything except that we're using the nomogram. So it's kind of a interpretation of that. I mean, it's easy to measure. I just don't know if I'll walk away feeling more confident that the patients are being treated right.

Jason Adelman: And Lisa Morris, who's not on the call today, made a note about that in here as well. She said usability and feasibilities - feasibility for these are fine. I'm still not sure they are connected to quality outcomes. ((inaudible)).

Any final thoughts about this measure? Any questions for the developer? Ann and (Denise), do you - have you heard some things that you can look into and come back to the in-person meeting?

Ann Watt: Absolutely.

Jason Adelman: Great.

Ann Watt: And we will.

Jason Adelman: All right. Great.

Saul Weingart: This is (Solly). I mean, I think, one of the things we should all bear in mind is that nobody's holding a gun to most organizations to use these measures. And the criteria might - you

know, I worry about letting the ((inaudible)) enemy the good and wonder about whether we ought to make some assessment about whether, you know, the use of these measures would drive best practices or would - and would drive improvement and better outcomes, at least in some environments.

So I, you know, I agree with all the points that have been said before but, you know, by the same token it wasn't long ago when nobody used nomograms that are, you know, gunning it from the hip. You know 10,000 of Heparin and off away we go.

So, you know, I mean, from my perspective, you know, all of these proposed measures have a lot of value in terms of driving best practice. Whether they're ideal measures, I think, is a whole other question.

Male: I agree with you 100%.

Jason Adelman: All right. Thanks. I think we can move on to the next measure then, 375, BTE Warfarin therapy discharge instructions. Mary and (Chris), you're still on.

Mary Sieggreen: Yes, this is Mary.

Jason Adelman: Yes.

Mary Sieggreen: This measure assesses the number of patients diagnosed with confirmed BTE discharged on Warfarin to home, home with health - home health or home hospice with written discharge instructions that address four criteria -- compliance issues, dietary advice, follow-up monitoring and information about the potential for adverse drug reactions and interactions.

This is a very interesting measure, I think, partially because it - there is some background things that go on that we don't have any control over. And that is understanding of the patient. A lot of patient education issues in here. Just because the patient is given something in writing doesn't mean they understand it. So again, what is the outcome going to be?

And I don't think that, again, because they've given - been given this information that they're necessarily going to prevent the complications, which really is not what this measure is measuring. It's measuring were they just given the information?

Andrew Lyzenga: Yes this is (Andy). This reminds me of smoking cessation.

Mary Sieggreen: Yes, yes. And I think that more needs to be added to it in the background. I don't know that the measure itself is sure it's going - it will measure whether they got information right in written form or not. But what does that mean? Where does it go from there?

So I think there's a lot of literature out there that supports patient education and it supports people understanding how to provide patient education.

Unfortunately I don't think either the physicians or the nurses who talk care of patients and have a clear understanding themselves of what's going on have really good teaching, learning theory and have a good understanding about how to impart this information to the patients so it becomes meaningful and changes behavior.

So I know that that's more than the measure measures, but I think those are critical things. If this eventually is going to have a change in outcome, which I think is well our intent is, more has to be done.

Just as you say, like the smoking cessation -- sure we tell them, but do they - I can teach you, but did you learn type of a thing. Or did it make a difference? You know, they still have the choices, even though they have the information to follow through on it or not.

So I think there is a big gap because of our understanding of how patients learn, and who the patient is and what the value system is of that patient.

Male: I have a question. If I have a handout and I hand it to my mom and patient, do I get credit for educating them by handing them in English a written document that describes these four areas, even though they can't read English?

Mary Sieggreen: Ann?

Male: I'll add to this just - Ann I'll add the issue of medical literacy to this as well. Even if they understand English, they may not understand it.

Mary Sieggreen: Right.

(Denise Krusenoski): We leave the - I said for education. I'm sorry, this is (Denise) at the Drug Commission. We leave the method of education to the organization. The documentation is what the measure is looking at.

Ed Septimus: This is Ed again. I don't want to be a little - kind of contrary to this but my observation of things like smoking cessation and others is that the facilities put together things so they can meet the measure. And they do very little to look at the effectiveness of what they do.

And it seems to me that we - if we could find a measure that not only looks at whether they're educated, but whether or not it's effective, would be what we're trying to get at. We can't get that.

(Denise Krusenoski): I agree.

Male: Yes that would be almost impossible to measure quickly, right? I mean...

Ed Septimus: Well unless we're looking at readmission for bleeding or, you know, but that may be multi-factorial. I mean, I realize it's difficult, but I'm also trying to point out that this has limited meaning in some ways, although it's at least something as opposed to nothing.

(Denise Krusenoski): Well if - like the numerator statement has the four components of the discharge instructions, those can be measured. You know, not just a checkoff list that I told them this, but does the patient have - I don't know. If the patient went to a different ER with bleeding I guess that would be kind of hard to follow but...

Male: Well there I've got two comments. One is that the complexity is going to improve dramatically when the oral anticoagulants are approved. The Dabigatran, Rivaroxaban, et cetera. But they're still going to have to be given discharge instructions.

To me, at least, you've got to match what you give them with their language that they can read. Or if they can't read, you got to show them some kind of a video.

So I would advocate something - adding something about matching the language on your instructions and/or providing some kind of video. We have videotapes here in nine languages. So we try to match that up. But I couldn't see anything. And I just want to make sure there isn't anything about matching the language. Is that correct?

Ann Watt: This is Ann, and yes it is correct that there is nothing about matching the language. I guess - well, I'll just stop there.

(Denise Krusenoski): Another issue I think in different patient populations is the health belief model of the patient. Oftentimes -- I'm in the Detroit area -- our patients believe that some - it's someone else's responsibility to take care of them.

So we can give them the information but their perception is we're giving it to them just to give them information, not that they're going to assume responsibility for it.

Male: Right.

Janet Nagamine: This is Janet. Hi. I am so torn on this one. I agree with everything that's been said so far. Education of patients on Warfarin is really challenging. Now that said, I also feel that you got to start somewhere. And so I really don't know how to weigh in on this because while we do want to make sure that the patient speaks English, if you're educating in English, I'm thinking also about the abstraction for and complexity that comes with that.

So I'm really struggling with how to make this measure operational, as well as achieve some sort of standard for what we need to do with Warfarin patients. I have studied, as I said, Warfarin, Heparin and bleeding within our system. And we have a very robust anticoagulation outpatient and inpatient pharmacy program. And that said, I still see a lot of challenges with our education.

So there is a lot to be said about how you educate and making sure that they understand. But I think at minimum we want to make sure that there were attempts to do it. So I'm getting down to scratching my head for another week on this ((inaudible)).

Ann Watt: So this is a start.

Male: Kind of. If you don't speak English, though, it's not a start. If you give them something English, you're giving them nothing. So why can't we at least add a language match? You haven't taught them a thing if they don't understand...

Janet Nagamine: Then we have to audit that. Because then we have to audit that.

Male: Well we've done it - well maybe that's why I feel uncomfortable. We've done it in nine languages on a...

Janet Nagamine: And photographs - and pictures.

Male: Yes. And we have a video that we show them. So we've got to be in compliance. You need to match the language. So we just got our interpreters to come in and dub the video in all the different languages and then we're also...

Ann Watt: I think you're talking about being in compliance with patient education. That's a different measure.

Male: That could be the patient safety...

Ann Watt: Yes.

Male: ...that we had to be in compliance with. This comes out of a patient safety goal. But the measure is the documentation of the education, not the material itself.

Male: Right.

Male: So wouldn't it be easy just to say that you provided whatever education in the patient's language?

I mean, that would be all I would suggest. Maybe that would be too hard to document.

Jason Adelman: Any additional thoughts on how - in the interest of time I'll just say, you know, any other aspect of this measure? Any other evaluation criteria or just general thoughts or comments, concerns?

(Denise Krusenoski): Well I think it'll be easy for the abstractors because it's very clear. They just have to be handed - they just have to document that the patient was given material.

Ed Septimus: It can be verbal education as well, right? It didn't specify that it has to be written.

Ann Watt: They have to have a record of written instructions home.

Ed Septimus: Well I don't think it says that. And I think this is based from a patient safety goal that also doesn't say that. Meaning like to the nurse on discharging a patient go over if they need to go for a lab test, they should avoid vitamin K, broccoli, let's see.

(Denise Krusenoski): It says right on the description measure that written discharge instructions that address all four criteria.

Male: Wait a second.

Ed Septimus: And that includes the number of elements, including dietary advice. Well it says or other education material. I guess material suggests something that's handed to them.

Male: I would push very hard that it has to be in the language that the patient can read. It just doesn't make any sense to hand them something in English. I mean, it's silly.

I mean, why - how can I hand something in English and pass this measure and the person can't read a word of English?

Jason Adelman: Well I think we've got some good stuff to discuss at the in-person meeting...

Male: Yes.

Ed Septimus: ..about this. And I think we can move on to the next measure at this point, which is incidence of potentially preventable VTE -- this one an outcome measure. And number 376, I think we had (Vu) as the primary reviewer, so...

(Vu): So I'm not sure I actually realized that till just a few moments ago. So I will do my best, which is fine. I have to go in a few minutes too so I'm just going to give you a core dump and then...

Jason Adelman: Sure.

(Vu): ...run. So this is a measure that -- and please folks, jump in and correct me if I don't get it quite right -- but this is kind of a lookback measure. You look at patients who've had a VTE that was not present on admission. And then you look back and see if they had prophylaxis of the kinds that have been described previously.

So, you know, on initial blush I thought, well, you know that's a reasonable, you know, that's a reasonable thing. You select this denominator of patients who've had the event and then see whether they got the treatment they needed.

There were a number of comments that I made to myself in that, you know, when I looked at the grid many of you had raised it all, which I think are really quite to the point.

One question is, you know, it's not possible to have zero on this. There are going to be treatment failures. That's just inherent in the nature of anticoagulation. So expecting a zero performance just doesn't make sense.

So the second issue is, you know, should we in some ways think about risk adjusting this? The process - or the measure proposers suggest that it's a, you know, it's a - it's sort of a measure of intent. You can't guarantee the outcome but simply having, you know, having somebody who's had an event who had been appropriately treated versus hadn't, that that is sort of a, you know, face, there is some face validity to that.

I guess my concern is if you're aggregating up to the hospital level and it turns out that your population is enriched in patients who have orthopedic conditions who are oncology patients, the rate of treatment failure is going to vary. So there may be some problems comparing one institution from another.

I think the authors appropriately eliminate present on admission as a criteria. And that's - the problem is that's a little challenging in some cases to ascertain. It makes you wonder if somebody, you know, who presented with it - whose VBT was diagnosed on day two or three if they might have actually had it when they come in but nobody got around to picking it up until that time.

And what else did I write here? Oh, and then there's this other question about denominator -- whether it should be patient, or whether it might be appropriate to think about number of days at risk, since that could potentially correct for the period of vulnerability of patients.

You know, that said, you know, I don't think it's a terrible measure. I think it is kind of a first cut. I think in terms of the various criteria -- let me see. Let me go to the various criteria. Is there a rationale for anticoagulation? Yes there is. There's a good rationale for that.

Is there evidence that anticoagulation prevents thrombotic events? Of course there is.

Is there evidence that this particular measure distinguishes high and low quality institutions? I'm not sure that that is the case. I think the issues around reliability and validity depend on this ascertainment of present on admission and questions about risk adjustment and case mix that are potentially problematic.

Now I have to run. So I don't get to hear why I'm wrong about all those things. But I just do want to say the next one about the PSIs I think are really fraught. There are a bunch of articles that have come out that raise problems with PSIs, particularly at post op. A venous thromboembolism as a quality measure, it's really great at finding cases but not greatest quality measures.

So I'm sure Jason will have a lot of interesting things to say. So I'm sorry I have to run.

Jason Adelman: Take care of yourself.

(Vu): Okay.

Ed Septimus: This is Ed. The issue of present on admission, most of the facilities are getting pretty good about that, especially because of HACs -- healthcare associated conditions -- so I'm not sure that that's going to be a difficult item.

Janet Nagamine: This is Janet. The one thing that I did want to add about present on admission is that you could potentially miss the target population that perhaps could have been discharged one or

two days ago after surgery, and then they return with a DVT or PE. So it's present on admission but they were just discharged a few days ago.

Jason Adelman: Okay. I think present on admission is more an issue for the next indicator because this has a - administrative claims, but it also has paper record review where the PSI is solely using administrative claims data. I'm not sure if the documentation intended this to be also purely on administrative claims or if it required chart review.

Male: I've got a question for Ann or the joint commission. Actually I got a question about where Table 7.03 or 7.04 is? Do I have access to that table to see what codes they used?

Ann Watt: I believe it was an attachment to our submission. This is Ann. I believe it was an attachment to our submission materials. But if not, it is available on the joint commissions Web site...

Male: Is it labeled as Appendix A...

Ann Watt: ...applications manual, sure.

Male: Is it under Table 7.03, Appendix A?

Ann Watt: Yes.

Male: Okay. So Ann, let me ask you this. So if you ended up with a catheter induced thrombosis in your auxiliary vein, does that - do we apply the very same criteria to upper extremity and lower or is there a - in the logic do you only focus on low extremity deep vein thrombosis?

Ann Watt: We're looking at the...

Male: (That was the right) question. That was exactly my question.

Ann Watt: We are looking at phlebitis and thrombophlebitis of deep vessels of lower extremities femoral vein deep and thrombophlebitis of iliac veins and venous embolism and thrombosis of deep vessels of proximal lower extremity.

Male: So not upper?

Ann Watt: Right.

Male: Okay. All right. So you - we're - so this is really just kind of a root cause analysis of all the patients who have a lower extremity VBT -- not pulmonary embolism though, right?

Female: ESP is included.

Ann Watt: Yes.

Male: ESP is included. Okay. so we're just doing a root cause analysis so the people who develop the pulmonary embolism or a deep vein thrombosis in the lower extremity during their hospitalization.

Ann Watt: Yes I -- this is Ann -- and I guess, you know, to speak - I don't know that you want to talk root cause analysis to somebody from the joint commission. But I think what you're trying to say is the point of this measure -- and this is the point of the measure -- is to look at people who actually did develop VTEs during their hospitalization to see if they were appropriately prophylaxed.

And the point there is then that if a hospital determines that they have a large proportion of those patients, then they need to look at their prophylaxis policies.

Male: Yes, yes. Yes, okay. I didn't have access to that table so I wasn't sure -- if it includes ((inaudible)) it would be a big mistake because there's no evidence that prophylaxis helps for catheter-induced upper extremity cause. And it would be inappropriate to look at, you know, patients how have superficial phlebitis, et cetera. So I need to get a hold of that table and look at that.

Ann Watt: Yes, well, you know, we will bring it too, doctor.

Andrew Lyzenga: Admit -- this is Andrew -- and I believe it may be in the materials in the folder we sent you on trying to take a look at...

Male: Yes. I didn't see it in that zip file, though. I couldn't see Appendix A labeled as readily.

Andrew Lyzenga: Okay. Hold on.

Male: If you get it, you can even send it to me by email if you want to send it right now.

Janet Nagamine: This is Janet. I had a question again about what about the population that was discharged after a three-day stay, was home for a day, and gets admitted with a VTE condition? Will we capture that population or completely miss some?

Ann Watt: This is Ann from the joint commission. And that population would not be included in this measure. This is only patients who develop it during the present hospitalization.

Janet Nagamine: Yes because I will say I admit a fair amount of patients that were just discharged a day or two ago and then come back with that condition. So I jus think that that's an important population that we want to capture.

Ann Watt: You know, the problem is that's a very difficult group to capture - to define the population via codes in order to be able to identify them, you know, for the initial data poll.

Male: Could there be a modifier for how many days they're out of the hospital?

Male: Well the problem is that when they get readmitted they're not in this pool to begin with. They don't have a hospital-acquired VTE. They're coming in with a principal diagnosis of CVT and it's in the principal position of POA is yes.

So looking for a hospital, you look for the POA as no. So they're saying you'd have to take all the POA yeses and look back and see when they were last hospitalized and where.

Ed Septimus: Yes, let me - I mean I'm not sure this is possible with this, but I can tell you with healthcare associated infections there is time limits put on this. So if you come back after having surgery and you come back within a week and you have the surgical site infection, that's a healthcare-associated infection, even though it was present on the readmission.

I don't know if that can be done and whether it's - the data is solid enough to know how many days you've been out to not be associated with the prior admission.

Ann Watt: Catheter-associated urinary tract infection would be the same way.

Ed Septimus: Yes. All the HAIs are the same way. But I don't - I mean I'm not - this is not to say my (content) in expertise, but I don't know if there's any data to tell us, you know, if you get readmitted within seven days it's associated with something that happened during the prior hospitalization for VBTs. I don't know.

Andrew Lyzenga: Sorry to interrupt everyone. This is Andrew again. Just a warning that we look like - it looks like we're going to run a little bit over and we're going to have a network ((inaudible)) being run here at NQF at 6 o'clock. So it's possible we'll have some disruptions to the webinar portion of this. But I don't think that our phone call will get cut off or anything. So just a kind of warning for those on the phone on the webinar.

By the way, I think the numerator statement is incorrect. I think unintentionally, but it says patients who receive no VT prophylaxis prior to the VT diagnostic test or a (D).

I think what's meant is patients who have confirmed VTE and how receive no VT prophylaxis prior to the VT diagnostic testing.

Ann Watt: The denominator is patients who develop VTE and then the numerator is of those patients...

Jason Adelman: Right. It just...

Ann Watt: ...because it's the measure. How many had no prophylaxis.

Jason Adelman: Right. It just doesn't say that. What you said...

Ann Watt: Oh I'm sorry. I'm sorry.

Male: Again, this measure misses the person who did get it, but only every other day or the wrong dose, you know, so you can drill down to some real exact figures. It's kind of a yes or no which may be confusing.

Jason Adelman: Well in the interest of time maybe we can move on to the next measure here -- to the next measure is 0450, postoperative pulmonary embolism more in deep themed thrombosis rate.

This is an AHRQ measure. And I believe we have John Bott on the line if he's stuck around with us this long. Operator, could we open John Bott's line?

Operator: John, your line is open.

Jason Adelman: Hi John.

John Bott: Yes, hi.

Jason Adelman: So Jason Adelman. I think we had you as the primary reviewer if you wouldn't mind just giving us a quick run through.

John Bott: Sure. So this is the AHRQ PSI 12. That's a postoperative pulmonary embolism or deepening thrombosis rate. So I'm - my read I thought the impact was very high and the performance gap, in my view, was established. And I think that the PSI tool is - has shown to be - it's given out free, it's usable and it's repeatable. If you ran it on the same data set you'd get the same results.

My issue was with the - or one of my issues was with the validity testing. It showed a positive predictive value that was two numbers given. I think 50% and around 90%.

But I wasn't sure why only a positive predictive value was given and not like a negative predictive value or a sensitivity specificity, meaning like without sensitivity - without knowing how many false negatives there are, we don't really know how many VTs are being picked up.

I was wondering if the developers can address that.

Male: Well that's a good point. And I know in the validation studies we did for some measures, there were studies of false positives and in some measures there weren't. And I'm just assuming that if it's not here this was a measure where that was not studied.

I don't have the full context as to why that was. Most of these studies largely occurred before my time at AHRQ. I do know that when Patrick Romano will be there in person next week he wanted to -- and Andrew has been so kind to allow us to do a bit of updating of the literature.

I didn't get that literature from Patrick but I do know not to steal his thunder, so to speak. There is some literature in the pipeline where we did some further validation work and he may be citing that. But he definitely raised a good point.

Ed Septimus: Yes, this is Ed. I had the same concern. If there is additional literature, that would be very helpful.

John Bott: Yes. Well I review it and I know we have a paper in the pipeline right now for a publication. And I'm guessing that's one of the several Patrick's going to cite. I didn't have a lot of time to communicate with Patrick this week. I apologize. I just came back from a vacation.

Jason Adelman: And we'll send out an updated measure once that additional - additions are given to us.

John Bott: Yes. And we expect to make those revisions by the end of Monday. So my apologies we don't have it updated at this time.

Male: I can just say that the codes became dramatically better in October of '09. Because new codes were added for upper superficial chronic. And so now the remaining codes for acute lower extremity MPE are going to be a lot more specific.

So I think the predictive value of the codes is going to be dramatically better. And it just has to do with the fact that they ICD9 codes are now very, very specific, or more specific.

So, yes, when he presents it, I think it'll reflect the new ICD9 codes, which is what they used to find the cases.

John Bott: So the only other thing - so I - that was my main issue. But I thought it affected usability. It's like, clearly understandable and easy to read. It's just in question because the validity of testing has not been thorough enough.

And then to the feasibility, it's just, you know, suspect because it's relate - it relates on proper coding. And again, the validity testing at issue there. But it sounds like it's, you know, they're presenting more data. So we can review the new data, I guess, by next week.

And that was it.

Jason Adelman: Thanks. Any thoughts from the other work group members on any of the evaluation criteria, or just general impressions, concerns or questions for the developer?

Male: We're talking about 450 still?

Jason Adelman: Yes, 450 still.

Janet Nagamine: I think you meant to say that PE is the third leading cause of postoperative death, not hospital-related death. Is that correct?

John Bott: I - it's going to take me a while to readily find that. But what question is it? And I'll make a note of it for that.

Janet Nagamine: But that the incidence of this ((inaudible)).

John Bott: Yes. I'm not in front of the computer. I - the - one of the issues is that I printed it off as we submitted it and it - for whatever reason it's not in the same sequence that you're looking at. So I'm just not able to readily find that. I'm sorry. I'll - if you can say the question number I'll look into it.

Janet Nagamine: Sure. The incidence of PE and the mortality. I think it said that PE was the third leading cause of hospital death. But I believe the data would show that it's the third leading cause of postoperative death. So just...

John Bott: Okay.

Janet Nagamine: ...((inaudible)) kind of clarification.

John Bott: Okay. I'll - we'll look into that before the meeting.

Janet Nagamine: Thanks.

Male: One issue I have is I believe in the software all it does is it looks to see if you have a major operating room procedure. And then it looks to see if you get a (quat), and that's hospital-acquired. And, you know, some patients are really sick in the hospital for a long time. So you could be in the hospital for 35 days. You get a DVT on day 10 and need surgery on day 40. And I just - I don't understand why, to make it a little bit more accurate and valid, why you don't restrict the day of the operating room procedure to day 0, 1, 2 or 3.

In other words, make it the reason they come in the hospital. And then - because some of these DVTs are occurring before the surgery. And it's really not postoperative. And it'd be pretty easy to change the software. I just would ask next week, you know, what's the rationale for taking patients who have operating room procedure at any time and then finding a VTE code.

Because there's no way to use administrative data if you don't know what day the VTE occurred. So you're - the longer you go or the longer hospitalization, the more likely it is the clot came before the surgery.

John Bott: Yes, I...

Male: So I just don't know why they - I would just say you have to have had the operating room procedure early in your hospitalization so you can kind of get rid of that problem.

John Bott: Okay. Well I - this seems like one of those questions we've dialed at numerous times because it does seem very logical. So I'm sure Patrick and Jess'll have a response to that. I doubt it's something we've missed all these years. The (measure's) been out here for about a decade.

So we'll make sure we - thanks for the heads-up and we'll make sure that's answered.

Jason Adelman: I mean, any more questions or comments? All right. Hearing none, I think we should give a bit of time for public comment. Operator, if you could ask for a public comment at this time?

Operator: Ladies and gentlemen at the phone audience, if you do have a question at this time, please signal by pressing star 1 on your phone. We have no registered comments at this time.

Jason Adelman: Okay. Thank you. Well that just about finishes us up. I guess I'll just reiterate quickly that for the steering committee meeting we'd appreciate it if you could try to remember some of

these issues that we've discussed and bring them up with the larger steering committee and try to guide - and we'll probably ask the primary reviewers to again do a quick overview of the measure and guide the discussion along at the in-person meeting.

And we would ask the rest of the work group members to kind of chip in as well and talk about the things that were raised during this discussion so we can sort of move things along quickly and efficiently at the in-person steering committee meeting.

And with that, I think we're all done. Thanks again to everybody for taking the time to call in.

Male: Thank you.

Jason Adelman: And see you next week.

Female: Thanks, bye.

Male: Okay. Have a good weekend.

Jason Adelman: You too.

Female: Thank you.

Operator: And ladies and gentlemen, again we are ((inaudible)) this conference call. Thank you for your participation. Have a nice day.

END