

NATIONAL QUALITY FORUM

**Moderator: Andrew Lyzenga
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11:00 am CT**

Operator: Welcome to the conference and please note, today's call is being recorded.

At this time, I would like to turn the conference over to Andrew Lyzenga. Please go ahead.

Andrew Lyzenga: Thanks. Okay, well, welcome everybody to the Workgroup D conference call for the Patient Safety Complications Steering Committee. I would like to thank everyone for taking the time to call in for this. And we know you're all quite busy, and we gave you pretty short notice on this, so we really appreciate that you could make it on.

What we'd like to do for this call, is just to do a bit of preliminary review and evaluation of this group of measures in a smaller group, in advance of the in-person meeting, which will be occurring next week. And we're hoping this will help us think through the measures a little bit, hash out any questions anyone has, and to the extent that we can, create a, sort of, shared understanding of the measures.

And for those who haven't done this before, we're hoping it'll give you a little bit more of a comfort level with both the measures and the evaluation process itself. We have assigned some of the workgroup members as primary reviewers. I know we don't have all the workgroup members on the call today.

For those of you who are on, we may ask you to help us walk through the measure that we had assigned to you. Just, sort of, give it a bit of introduction, and give your thoughts and impressions of it. For the first few we can just get started ourself, so I don't think the workgroup members we had assigned are on the call today.

But we also have some preliminary evaluations that our workgroup members did online, so we can use those as a, kind of, jumping off point here, and we can see where, for each measure, we've got some degree of consensus, or where they may be a bit of difference. We'll probably try to focus our discussion on those areas where there is some difference in the preliminary reviews.

Before we get started, though, maybe we could have each of our workgroup members introduce themselves. We can start with, how about Jim Smith?

Jim Smith: Hello, Jim Smith, I'm a Professor of Physical Therapy, and what else would you like in the introduction, anything else?

Andrew Lyzenga: Oh, no, that's - and just anything you'd like to add, but that's fine.

Jim Smith: Thank you.

Andrew Lyzenga: Louise Probst? Louise, are you still on? And we've lost Louise. Well, Jean Deleon, are you still on?

Jean Deleon: Yes. My background is Wound Care and Physical Medicine and Rehabilitation. I'm a Physician in the Baylor Health Care System in Dallas.

Andrew Lyzenga: Great, thank you. And Lisa McGiffert.

Lisa McGiffert: Hi, this is Lisa McGiffert. I'm with Consumer's Union's Safe Patient Project, consumer advocacy project.

Andrew Lyzenga: Great, thank you so much. Well, and that, so now I guess we can just jump right into the measure evaluations. We'll start with Measure 0263, which is Patient Burns. Again, if you have the Webinar, access to the Webinar, we've got the preliminary evaluations displayed up here, and we can just, kind of, walk quickly through the measure evaluation criteria, one by one, if that works for everyone.

Jean Deleon: And did we need this up, the Webinar?

Andrew Lyzenga: You don't need it, but it would probably be helpful for you, if you can pull it up. I can describe a little bit about what we're seeing if you're not able to access it.

Lisa McGiffert: And was the Webinar in one of the emails? I don't remember seeing the Webinar.

Andrew Lyzenga: It should be on the agenda.

Lisa McGiffert: It's on the agenda.

Jim Smith: The link on the agenda.

Lisa McGiffert: Okay.

Andrew Lyzenga: And so it was for 0263. It looks like there's a fair degree of consensus regarding the evidence. Some rated it moderate and some set it, rated it high. Does anybody have any particular thoughts or with the evidence?

Lisa McGiffert: Well, this is Lisa McGiffert. I, we're talking about the burn measure, right?

Andrew Lyzenga: Yes.

Lisa McGiffert: Yes, I didn't get a chance to do all the ratings, but I, I mean, my sense is that it is a high, I mean, that it's something that's definitely worth including and looking at further. It seems to be, I mean, for me, it has a lot of things, because it has to do with surgical centers, it's a, you know, there's a lot of surgeries being done in these centers, and it's something that looks like it could be preventable if it was paid attention to.

So it seems like a good measure, and it's an outcome measure.

Andrew Lyzenga: Great, thanks. Any other thoughts on the importance of the measure?

Jean Deleon: But I, this is Jean Deleon, sorry. I didn't see enough to tell me that this is a problem of magnitude. Of course, when it happens, it's terrible. But this is not a daily occurrence. And the percentages that I did see were very, very small. I mean, they did mention one maximum of, like, 3.2%, I think. But most were, really, 0.01%.

I mean, that's my only concern. If it, you know, it's something you never want to happen. It certainly should be preventable. But I didn't see a very large percentage, as I did in some of the other topics, like the confirming endotracheal intubation. I mean, there were much higher percentages to work on there.

Lisa McGiffert: It, this is Lisa again, I mean, I know that often these adverse events are small when looked at per facility, but big when looked at, you know, the whole country, or the volume or the, you know, 3% of a really high volume is a lot of people.

So I think it's definitely worth us looking into more about, you know, the issue of whether it happens enough, but it seems like it's something that happens enough that it's on the radar, and it harms, you know, a significant number of people nationally, and there should be systems in place to prevent them.

Louise Probst: This is Louise Probst. I would agree with that. I think I read somewhere, 500 to 600 cases per year of highly preventable occasions. So I assume that was just, you know, that the, there might actually be more than that. But I really felt like the public really didn't have any understanding that, as many as 500 to 600 people had serious burns as a consequence of surgery a year. And that, that really, in itself was quite large.

Jim Smith: This is Jim, and being new to this process, I was looking for guidance, and part of the criteria for this could be large numbers of patients or, and I think it applies here, when it has a substantial impact for a smaller population. And I, this does appear to be a substantial impact.

Jean Deleon: And I agree with that. I agree that it does have a substantial impact when it occurs.

Andrew Lyzenga: Thanks everyone. We can probably move on from importance to evidence, the quantity, the quality and consistency of the evidence provided by the developers. And I should mention, we will have, we have some of the developers on the line here, so we can ask them questions, or ask them to respond to any concerns if needed.

Operator, I believe we have Donna Slosberg and Kim Wood on the line, if we could open up their lines.

Operator: And their lines are now open.

Andrew Lyzenga: Great, thank you. Now, so, Donna or Kim, did you have any particular responses to the comments that were just made?

Kim Wood: We are happy to respond to any questions that the group may wish to pose.

Andrew Lyzenga: Okay. Now, if there are no specific questions, I think we can just move on. So let's take a look at the evidence. Were there any particular comments or thoughts on the evidence provided by the developer for this measure? Fairly, ratings were, at least relatively consistent.

If there are no particular concerns, we can go ahead and move on, on that, as well, and goes for the reliability and validity of the measure in some consistency, and a really high degree of agreement among the workgroup members. There is one concern expressed by a workgroup member that is not on the call today.

She said, "The validity response did not address possible variability in detection of burns, or documentation of variability that may impact capture of information." Comments on that, or any other part of the reliability or validity testing results provided by the developer?

Okay, if not, then we can go ahead and move on. This may move pretty quickly.

Lisa McGiffert: Should we take that bark as the response?

Andrew Lyzenga: Yes, we could.

Lisa McGiffert: That was good timing.

Andrew Lyzenga: Yes. But yes, let's go ahead to usability.

Louise Probst: Sorry, that was my dogs.

Andrew Lyzenga: Again, a fairly, fairly high degree of consensus here, a couple of moderates, but mostly highly rated on usability and feasibility. Any comments, questions, or thoughts on the usability or feasibility of the measure? And does everybody understand what we're trying to get at there, for those who haven't been through this process before?

Lisa McGiffert: Could you review it?

Tim Smith: Yes.

Andrew Lyzenga: I believe usability is really referring to the usability for end users. So that would be consumers and to some extent, you know, providers and purchasers as well, whether the results of the measure are understandable, usable. And feasibility really refers to whether the measure is feasible to implement, for those who are going to be implementing it.

Lisa McGiffert: Yes, I mean, I think, and I think the only issue, this is Lisa, is the issue that Jean brought up, is that, we're talking small numbers, when you're looking at a facility, so I think that's always kind of a challenge as to how you present it and, you know, you have to look at the time frames that you're looking at and, you know, what your denominator is and make sure that it's something that makes sense for people.

And I, I mean, I think it's possible, it's just something that needs to be attended to in the development of a measure.

Jean Deleon: And the measure itself is, it does not delineate the degree of the burns. It's all burns. I, of course, the catastrophic burns, but just electrocautery burn, just a small electrocautery burn, each one of those is counted? Is that how the measure is written for the numerator?

Andrew Lyzenga: Could we have the developer respond to that, if you're...

Kim Wood: Correct, that the measure does not delineate the burns by severity.

Jean Deleon: Okay, so if...

Kim Wood: It would consider all burns.

Jean Deleon: ...all burns, and if you had two electrocautery burns in one patient, it's still per admission, so it's per patient, just...

Kim Wood: Right.

Jean Deleon: It counts as one.

Kim Wood: Right,

Lisa McGiffert: And this is Lisa. I was just going to, I meant to mention that I think that is, I think that's good to include all burns and, you know, there may be, when the measurements are out there, there may be different reasons that you might want to carve out the serious ones from the mild ones.

So I think that, if there was any way to include that in the measurement, you know, those kinds of, that kind of information in the measurement, it's helpful. But that we, it is important to look at all of them, and not just the serious ones. Because the ones that aren't so serious may some day become serious if they don't learn how to prevent those.

Donna Slosberg: And this is Donna. If I could, for just a minute, interject, the measure developer. A couple of things, one is that, at this time, surgery centers are not required to report on quality, and so the numbers that you see, this is a voluntary group of ASCs that have been reporting . However, CMS just released the final rule, and ASCs will be reporting.

They have put together a quality program for ASCs to begin October 1 of 2012. And so some of the detail that you're asking for, because of, currently it's a voluntary reporting, we can't get to the detail of the burns. But down the road, that would be a possibility, since this is going to be a requirement for all ASCs in the future.

Lisa McGiffert: That makes perfect sense. And I would think, in the future it would be a value to the consumer to the patients to know, if it's just one number, I mean, they could be burns that you wouldn't even consider treating, you'd just acknowledge that they occur, but they were so minor, they required no other treatment, versus those that required extensive wound care because they were that serious. And you would want to know serious burns versus superficial burns.

Bobbette Bond: Hi, I'm sorry to be late. This is Bobbette Bond; I just got on the call a few minutes ago. And I see my name on the agenda, so I'm just trying to catch up, and just let you know I was here, and I missed a lot of the conversation about burns.

Andrew Lyzenga: Okay, well, if you have, just, if you have any particular thoughts about the measure, we sort of ran through, a bit through the importance...

Bobbette Bond: Okay.

Andrew Lyzenga: We have the evidence, the reliability and validity. Everybody seems to be fairly comfortable with each of those categories. But if you have any particular thoughts that you'd like to share, we'd welcome them.

Bobbette Bond: Okay, no I don't. I think the discussion's been good. I don't have access to the screen, you know, the NQF presentation, it's not installed on my computer. Is anyone else having trouble with it?

Andrew Lyzenga: We'll see if we can figure that out. I'm seeing it on my screen...

Bobbette Bond: Okay.

Andrew Lyzenga: ...and I know the others, that in, some others on, at NQF are...

Bobbette Bond: Are fine, okay.

Andrew Lyzenga: ...if you can, you know, trouble shoot it a little bit...

Bobbette Bond: I'll just follow along, then.

Jean Deleon: I'm seeing it, it's just very small.

Andrew Lyzenga: Yes, okay.

Female: Yes.

Jessica Weber: Sorry, this is Jessica. If you maximize the screen in the top right hand corner, that might help viewing the Webinar.

Jean Deleon: Yes.

Jessica: ...and if not, then we sent...

Jean Deleon: That and my glasses.

Jessica: ...the spreadsheet this morning, so that should help us all, is looking at the spreadsheet.

Andrew Lyzenga: You know, if you didn't hear Jessica there, she sent the workgroup members the updated spreadsheet, so you should be, have it on your email, and...

Bobbette Bond: Okay, I'll look at that, thank you.

Female: Thank you.

Andrew Lyzenga: So with no other comments, it looks like in their preliminary evaluations, each of the workgroup members who rated this gave it a yes for suitability for endorsement. So it looks like we got a high degree of consensus there. Any final thoughts on this measure, or are there any questions that you'd like the developer to respond to? All right, hearing none, we can go ahead and move on to the next measure.

Measure 0346, (Iaxic), sorry, Iatrogenic Pneomothorax Rate, that's a Patient Safety Indicator from AHRQ. I don't know that we have anybody from AHRQ on the call today. I believe they had said they weren't going to be able to make it today. But if you do have any questions, we can compile and collate those, and we can send them to the developer for them to respond at the in-person meeting.

So just make sure to note any questions that you have, and bring them up, and we can take them down and provide them to the developer. Lisa McGiffert, we did have you assigned as the primary...

Lisa McGiffert: Yes, unfortunately...

Andrew Lyzenga: ...and we don't need you to walk through...

Lisa McGiffert: Oh good, but I do have a question.

Andrew Lyzenga: Sure.

Lisa McGiffert: I do have a question. I noticed that, you know, some of these are maintenance measures.

Andrew Lyzenga: Yes.

Lisa McGiffert: And the maintenance measure is what?

Andrew Lyzenga: That means that it was previously endorsed by NQF.

Lisa McGiffert: That's what I thought.

Andrew Lyzenga: Yes, we'll endorse measures, and there's a three-year cycle, after which the measures come up for maintenance, or endorsement maintenance and...

Lisa McGiffert: Okay.

Andrew Lyzenga: ...we'll review them again under all the endorsement criteria. And simply...

Lisa McGiffert: Okay.

Andrew Lyzenga: ...we will ask for them to bring back a, some additional testing results, or that they should have been conducting as they implemented the measure during those past three years.

Lisa McGiffert: Okay, okay thanks.

Andrew Lyzenga: Welcome.

Lisa McGiffert: So do you, are you going to walk through this, or...

Andrew Lyzenga: Yes, I can walk...

Lisa McGiffert: ...you want me to, that'd be helpful. I have to tell you, that I know some about this, but some of the information was a little over my head.

Andrew Lyzenga: Yes...

Lisa McGiffert: And maybe it's just that I didn't know quite how to digest it, so.

Andrew Lyzenga: Well let's see if maybe some of our other workgroup members have some input. On importance, we had some difference, some voting, or rating it moderate, some high. Any particular thoughts, anybody want to give any comments on the importance of the measure?

Jean Deleon: I think, like the first measure, it's one of those things you never want to occur. Not that it occurs with such tremendous frequency but, you know, you never want to drop a lung. I don't think anyone would argue with that.

Lisa McGiffert: Yes, and I couldn't quite tell how frequently it did occur. It looked to me like, and I even went online and looked at some things, and it just, it seemed like it was something that occurred

way too often. But there seemed to be, you know, always some caveats about situations where it was hard to prevent it from occurring, that kind of thing, so...

Jean Deleon: I think you're exactly right. That's why it's very difficult to give an absolute number as to, well these are all the ones that were preventable, and it was simply caused by error, versus, part of the condition and the nature of the surgery that had to occur.

Lisa McGiffert: And the other thing is that it seemed like there was a really long line of, there was a lot of exclusions, which to me, is always a flag. If you're excluding, I mean, there's like five or six pages of exclusions, and to me, if you're excluding that much, maybe you're really not getting at the problem.

And I mean, it just seemed odd to me that there were, maybe there's ten pages of exclusions. I'm still going through them. There's a lot of them. Did anyone know, have any insight on all those exclusions?

Louise Probst: Well it seemed to me that, anytime the chest cavity's opened, you're going to have a pneumothorax, or likely to have a pneumothorax, so there are some interventions in which the chest cavity needs to be opened, and so it would be an expected complication of the procedure.

But then, there are other times when you don't want it to happen, but for whatever reason, some patients, because of past trauma or other sorts of things, might be more at risk than others. And I don't know if there's, I'd like to ask the measure developer if the exclusions are able to, sort of, sort through those. I mean, a lot of them are open procedures, so I'm thinking that those were expected.

Andrew Lyzenga: We could use a, just, like a little bit more explanation of why they included the exclusions that they did, is that what you're saying?

Lisa McGiffert: Yes, so, let me ask, I don't know who that was that was just talking...

Andrew Lyzenga: That was Andrew, oh sorry, that was...

Lisa McGiffert: No, the woman that was...

Louise Probst: Louise.

Lisa McGiffert: Louise, that was Louise.

Louise Probst: Yes.

Lisa McGiffert: Hi Louise.

Louise Probst: Hi.

Lisa McGiffert: So if you expect pneumothorax in an open chest cavity, then you're saying that these exclusions look like they're all, you know, that that always happens when you open the chest, is that what you're saying, or you expect it to happen, and you need to be prepared for it?

Louise Probst: Well, they usually put in chest tubes or something to accommodate that.

Lisa McGiffert: Right, and so these, this measure wouldn't capture those who opened the chest and didn't put the chest tubes in, or didn't do the precautions needed, with the expectation that this is likely to occur.

Louise Probst: Yes, and I...

Lisa McGiffert: This would not capture that.

Louise Probst: Yes, I think that they're trying to exclude those...

Lisa McGiffert: Right.

Louise Probst: ...what I didn't know whether...

Lisa McGiffert: Right.

Louise Probst: ...it was a long list, and then there were some that I'm thinking, okay, I wonder why that one's excluded. So there would certainly be times when someone might be at higher risk, maybe because of their anatomy, or something else that's gone on.

But I didn't know what the measure developer felt like they were able to differentiate between excluding cases when it would be an expected, you know, complication or expected occurrence, versus those when it might just be higher risk.

Lisa McGiffert: Yes, I mean, it definitely seems like a good measure would be some kind of outcome measure when there is an open chest cavity. Because it seems like that is a very, I mean, I think, in addition to this one, that would be an important measure to get at, well when the chest cavity is opened, and it's at high risk, and they're not prepared, and they don't, aren't ready for it, then what happens?

You know, what are the outcomes with that? But this wouldn't get at that, because they're all excluded.

Louise Probst: Does the measure developer have some insight on that?

Andrew Lyzenga: I believe...

Lisa McGiffert: I don't think they're here.

Louise Probst: Oh they're not here? Okay.

Andrew Lyzenga: ...that we don't actually have the developer for the....

Lisa McGiffert: I mean, this is an old measure that, you know, was developed, like, ten years ago or so, right? And I remember, by AHRQ?

Andrew Lyzenga: Yes, part of the Patient Safety Indicators that...

Louise Probst: I would assume that it does differentiate for that, I mean it is iatrogenic pneumothorax, so by definition of, it should be pneumothoraces that you didn't expect to happen, that occurred as a complication of a procedure. But I just couldn't answer your earlier question, Lisa, about all those different - because some of them, when I read through them, I was curious about.

Jean Deleon: They're not all open procedures. Some are going to be laparoscopic, some are going to be primary lung infection, things that a pneumothorax can be a very common occurrence as part of the disease process.

Louise Probst: Okay.

Jean Deleon: But...

Lisa McGiffert: But we're looking at the exclusions, or are there some, any exclusions, did you see laparoscopic surgery in the exclusions?

Jean Deleon: Yes, there's some that are going to be...

Lisa McGiffert: Okay.

Jean Deleon: Yes, like the percutaneous needle biopsy of the lung, or a laparoscopic repair of the diaphragm. Those are all in the exclusion criteria.

Lisa McGiffert: Yes, why would you exclude that?

Jean Deleon: Well, because as you are trying to repair the diaphragm, it's absolutely, you know, possible that you can hit the lung. I mean, you try not to, but it can be adhered, and very close, due to infection, or due to trauma there, and it's certainly a possibility.

And when I look at the exclusion criteria, I know, because it was a lot of pages, they put pneumothorax on the consent for all of those procedures as a possible foreseen complication. So the measure covers procedures, and I can't necessarily give you one offhand, but a procedure in which they wouldn't even think to put pneumothorax as a possible complication, when you're trying to consent the patient.

Well, these, you know, you can get infection, you can bleeding, you know, it's possible that, that lung will get hit. They do go over that, and there's some procedures, I'm sure that they do where, you know, there's, I have a simple abdominal hernia repair from having a hernia repair, there's, you shouldn't be near my lungs.

Lisa McGiffert: Right. So I guess that brings, I mean, I, maybe I'm speaking outside of the scope of this measure, but it does seem like, yes, the examples that you're giving, you know, people say there's always a risk for this or that. But we still, you know, ask for measurements of infections, even though, you know, before surgery you're always told there's a risk of infection. That doesn't mean that we shouldn't measure it.

Jean Deleon: True.

Lisa McGiffert: Yes, but it seems to me like, I would just like to talk to the, you know, whoever developed this, of why, what the reasoning is, with all these exclusions. I think we've established that. We all kind of want to know about that. And what kind of effect does that have on the measure? I mean, that's what I'm thinking is, does that sort of make the measure moot?

If, you know, you're only getting at a small segment of the iatrogenic pneumothorax, then is it really going to tell us the whole picture of what's happening?

Andrew Lyzenga: All right, could somebody just sort of give me a brief restatement of the, you know, what I could bring back to the developer, to ask them to prepare for the in-person meeting to give a little bit more explanation or, you know, sort of some of your questions?

Louise Probst: Maybe they could give us, sort of, an understanding of the types of situations for which there are exclusions, and then whether all the exclusions fall within those, or if there are exceptions, in relation to their level of expectation that they would occur. Does that make sense?

Andrew Lyzenga: Yes, that makes ((inaudible))...

Lisa McGiffert: Yes, and why, yes, I mean, is there, and how much iatrogenic pneumothorax are we missing when we have all these exclusions? I mean, I bet they've looked at that. I'm sure they

have. In the development, I'm sure they looked at it, and if, you know, 80% of them are in these situations, then we got a problem if we're only capturing a small portion of it, even if it is, and I quote, "expected or anticipated" issue, the goal is to have it not happen, so that's kind of where I'm at.

Louise Probst: I've sort of thought of the measure as being trying to capture lungs that are dropped when someone's trying to put in a central line or, you know, which would be still covered or, you know, some thing's nicked in a procedure when, you know, it's really not expected.

Lisa McGiffert: Okay, well that would be a good question to ask, is that what they're after here?

Louise Probst: Yes, all right.

Lisa McGiffert: But I sure would like to see a measure of when, of these others too, some day.

Andrew Lyzenga: And maybe we could move on to other reliability and validity. We sort of talked about the specifications about it being precisely specified. That covers the exclusions to some degree. Were there any thoughts on the reliability or validity testing for the measure, or whether those were sufficient, if you have any questions about it, or concerns?

Lisa McGiffert: Can you tell us what page that's on?

Andrew Lyzenga: In the...

Lisa McGiffert: Reliability is...

Jim Smith: Reliability starts on 24.

Lisa McGiffert: Thank you.

Jim Smith: No, I may be...

Andrew Lyzenga: I think that's right, 24 yes.

Lisa McGiffert: ((inaudible)).

Andrew Lyzenga: And again, one of the workgroup members who is not on the call gave a comment here, as "Validity response did not address possible variability in detection and burns, or documentation of variability that may impact capture of information," were the comment she had before.

Louise, it looks like you had a comment here as well, saying that the metric and inclusions were well defined, generally easily observed and tracked...

Jim Smith: No, you're on 0263, and now we're on 0346.

Andrew Lyzenga: I'm sorry, you're absolutely right. I was looking at the wrong thing. That's my mistake. Yes, no comments on this one, but...

Lisa McGiffert: And this is extracting from the administrative data, right?

Andrew Lyzenga: I believe so, look at the measure itself.

Heidi Bossley: Yes it is, Andrew, this is Heidi.

Andrew Lyzenga: Heidi, okay, thank you Heidi.

Heidi Bossley: I just joined.

Andrew Lyzenga: Great. Any additional comments, reliability and validity? If not, we can go on to usability and feasibility. Any thoughts on ((inaudible)) issues?

Lisa McGiffert: I notice, I'm sorry, I'm not sure which section I'm in. It's in the validity section, I notice that there was, on Page 25, there was a, there was some, I guess this is the reviewer at NQF's notes, based on the analysis, we've made the following recommendations for future revisions.

So there were some recommendations to drop some of the exclusions. Oh, I guess, just drop one, I guess. So we probably should talk about that more, later.

Andrew Lyzenga: Which page was that?

Lisa McGiffert: Twenty-five, towards the bottom of the page, the 2B, 3.3 results.

Heidi Bossley: Right, this is Heidi. That's actually from the developer, AHRQ.

Lisa McGiffert: Oh, okay, it is the developer. Okay, sorry.

Heidi Bossley: Right. So what, I think what's not clear, and I think this has come up in a couple of workgroups is, have they made these changes now, or is that in the next iteration and it...

Lisa McGiffert: Looks like future revisions, yes.

Heidi Bossley: I think so, yes.

Lisa McGiffert: Okay, I'm sorry; you were on to another section.

Andrew Lyzenga: No, no problem, no problem. Sounds like no - or were there any comments on the usability or feasibility of the measure?

Lisa McGiffert: Well, I think, you know, from the public's perspective, you would, I think it'd be usable if you're really clear about what it is, and what it isn't.

Andrew Lyzenga: Right. And that goes back to the exclusions...

Lisa McGiffert: Right, right.

Jim Smith: Jim here. I just want to clarify that, if we're look at iatrogenic as an inadvertent adverse effect, I think it's clear what is expected here, even if we look back at the exclusions. With the exclusions it, wouldn't any of these, my interpretation was that any of these would not be an inadvertent effect, rather it would be a deliberate or intentional or expected response based on either the pathology or the surgical intervention.

But if there's confusion, we should get clarification from the developers.

Lisa McGiffert: So what's an inadvertent versus a, what would, how would you describe inadvertent?

Jim Smith: Well, the example was given earlier about putting in a central line. Then if I induce a pneumothorax, that was not a reasonable expectation with that procedure. To me, that's clearly iatrogenic.

Lisa McGiffert: Got it, okay, thanks.

Andrew Lyzenga: Thanks Jim. Okay, so we'll make a note of that again. And it appears that everybody gave this a yes on the overall suitability for endorsement. We have consensus there. Any overall comments, thoughts or impressions about the measure overall? Hearing none, we can move on to the next, which is actually just the pediatric version of this same measure, Iatrogenic Pneumothorax.

Does anybody have any ((inaudible)) thoughts on the importance of the measure in the report?

Lisa McGiffert: So they also have a lot of exclusions in this, or some exclusions in the denominator. So...

Andrew Lyzenga: Yes, go ahead.

Lisa McGiffert: No, that's okay. Well, it says it affects large numbers of patients, so that's important. Well, it's 0.15% mortality rate. Or no, that's general.

Louise Probst: And this is Louise. I realize my spot's blank there. I'm not sure why, that was probably just a problem when I was filling it out. But I think I would have given it the same score I gave above, which would be high and high, for some of the same reasons.

Andrew Lyzenga: Great, thanks.

Lisa McGiffert: Yes, I think it would be an important one.

Andrew Lyzenga: On a common understanding of the measure there.

Lisa McGiffert: And this is a current measure, so this is another maintenance, right?

Andrew Lyzenga: It is another maintenance measure, yes. Did, for health outcome, Jean, I noticed that you had said, no. Was there a reason that you had, I don't think this is not...

Jean Deleon: If I said no, then it was probably because I hit the wrong button, sorry.

Andrew Lyzenga: All right, got you, got you, no problem. I just wanted to clarify. All right. So we can move on to evidence. Any thoughts about the quantity, the quality or the consistency of the evidence provided by the developer, or the rationale for this measure?

Lisa McGiffert: This is another AHRQ measure?

Andrew Lyzenga: It is.

Lisa McGiffert: Is it? Yes.

Andrew Lyzenga: Sort of a companion to the previous one, a pediatric version. I know we can make a note of the same concerns you had on the last measure, that we'd like some clarification about the exclusions and the types of occurrences where there are, these exclusions would be expected, and whether they ((inaudible)) that they had given fall within those categories, and so on.

Lisa McGiffert: You know, what's interesting is that some of these, well, I don't know, it, there just doesn't seem to be a lot of information about these measures that have been on the table for a long time, have been used pretty widely with the, you know, how they've been used, and what their impact has been and that kind of thing.

Jim Smith: We have the descriptive statistics. There is not research literature reporting, but we have a robust, descriptive stats.

Bobbette Bond: Bobbette Bond, this is really off point, but in all these measures, and I didn't do my evaluations, I'm sorry, I'll get those done, but it's hard to anticipate what the providers are using, or having these reports be done on them, how they feel about some of this, and I didn't, I don't know if there's NQF work that talks about physician or hospital, are they distinct from this stuff? Or critical ((inaudible)) they have of it?

The only thing that we deal with a lot on these is, the small volume of them makes the hospitals just say that, you know, they're not reliable. And I don't know if you have, like, a general response to that, or if there's, if that's worth discussing on every measure, but that's what we get on a lot of these things. And I don't see it in the review, you know.

Andrew Lyzenga: All right, can you, quick, just repeat that quickly?

Bobbette Bond: Just that the volume for this, and I don't, 0346 and 0348, I don't know that much about those measures. But on Patient Burns, and on the, specifically on 0501, the ((inaudible)), we hear a lot, not so much with burns, but on 0501 for sure, we hear a lot that it happens so, that this problem so rarely, that either the procedure happens rarely, or there's problems so rarely, that any focus or attention or time spent on these measures is a poor use of limited resources for the hospitals.

And I know they can say that a lot, about a lot, you know. We don't hear it from the doctors, we hear it from the hospitals. So I just, I don't want to delay the progress on this, but in general, I'm wondering if that's a theme that comes up in these NQF things, and if there's a general response to that. You know, how valuable is it if there's so little use of the measure, so little data?

Andrew Lyzenga: Heidi, do you know of any particular responses, or if this is a common occurrence, concerning...

Heidi Bossley: Yes, it's a common occurrence. Thank you, that was a...

Lisa McGiffert: This is Lisa. It definitely is a common occurrence. But this measure is extracted, so they don't really have to report anything. I mean, there may be some benefit to them to report more codes and more information, so that it can be risk adjusted but, you know, my, I mean, I may be wrong, but my sense is, you know, these AHRQ Patient Safety Indicators are, sort of, the least burdensome on...

Heidi Bossley: Least invasive for them, yes.

Lisa McGiffert: ...for them. And you know, I've developed my own, kind of, theory is that, I think, the more burdensome it is for them to report, the more likely it is for them to do something about it. But I may be wrong. I've got this, I'm kind of watching this theory.

But, you know, we certainly have seen, for example, in the past more activity generated from reporting hospital infections than reporting iatrogenic pneumothorax, because, you know, it's done after the fact on the, on these AHRQ measures and, you know, somebody doesn't have to proactively say, okay, we just infected this person, we got to document it, you know.

So there's like an active brain thing, I think, that goes on when people have to say that, you know, at the time that it occurs.

Heidi Bossley: Well, that's a, I think, interesting point.

Lisa McGiffert: But that's just my personal theory, not proven. Be great for somebody to study that.

Bobbette Bond: Thank you.

Andrew Lyzenga: Thanks.

Bobbette Bond: I'll try to think about that in my responses to the rest of these. I just didn't, I'm sorry I didn't get them done, and I'm finding this really helpful, actually. I'm new to this, so I appreciate this process.

Andrew Lyzenga: No problem. Yes, that's what we were hoping to accomplish here. And just to remind you, these are not official evaluations. These are just preliminary evaluations, again, just to help us, kind of, think through and give us some initial direction.

Bobbette Bond: For those that are new, can you remind us again what the process will be, going forward, between now and the meeting next week and...

Andrew Lyzenga: Sure, sure. And I can go over that a bit at the end as well. But we'll ask you to do something similar to this, just in advance of the steering committee meeting. And in fact, we'd like you to go through and evaluate each one of the measures, if possible, so that we'll have something like this to bring to the in-person meeting, as well as some preliminary evaluations of all the measures.

And we'll use those to work through at that meeting, again. And then we will do an official vote on each of the criteria, and on the overall measure, either at that meeting, if we have time to do it, or potentially, just after the meeting, again, in an online survey.

Bobbette Bond: This is Bobbette again. I thought you guys said on the first orientation call, I thought NQF said that this work is all maintenance measures. Is that correct?

Andrew Lyzenga: It's not all maintenance measures.

Bobbette Bond: Okay.

Andrew Lyzenga: It's largely maintenance measures, but there are some newly submitted measures.

Bobbette Bond: Okay.

Andrew Lyzenga: I believe these, the measures that we're looking at right now are all maintenance.

There's maybe three or four that are new.

Bobbette Bond: New, okay.

Andrew Lyzenga: Yes.

Bobbette Bond: That'll be interesting.

Andrew Lyzenga: Yes. So yes, I'm sorry, was somebody going to say something? If not, we can take a look at reliability and validity of this measure, usability, feasibility, if anybody has comments on any of those items. You can take a minute to look over it if you need to.

Hearing no comments for the moment, now, again, it looks like everybody gave this a yes on the overall suitability for endorsement, so I don't think we had any particular problems among those who reviewed it.

Lisa McGiffert: Yes, and we, I think you already said we would just ask the same questions about all these exclusions and everything...

Andrew Lyzenga: Exactly, yes...

Lisa McGiffert: ...yes, that's good.

Andrew Lyzenga: ...we'll ask the same questions...

Lisa McGiffert: Yes.

Andrew Lyzenga: All right then, we can move on to the next measure. And for these, I believe we may have the developer on the line, if we want to ask her some questions. I'll take a look to see who's on the call. Operator, is Keziah Cook still on the line? I believe she may be the, with the developers for this measure.

Operator: Yes, her line is now open. Or their line is now open.

Keziah Cook: Hi, I'm here.

Andrew Lyzenga: Hi. Am I correct; are these your measures, the next few, 0523 and 0524?

Keziah Cook: Yes, that's right.

Andrew Lyzenga: Great, great. All right, so we can walk through these again, and if you have any questions or concerns, we can, we've got the developer on the line for this one for you to ask questions. So we can just start out, again, with importance, whether this is important to measure and report. And sort of, to set back originally...

Female: Excuse me; was this the one that came in late?

Andrew Lyzenga: No, I'm sorry, this is...

Tim Smith: (Dana Sessman) conducted.

Female: This is 0501, right?

Andrew Lyzenga: ...(Dana Sessman) conducted, yes. So actually, we were...

Female: Oh, which one...

Andrew Lyzenga: ...we were thinking...

Female: We're on 0523?

Andrew Lyzenga: Oh five, two, three, that's correct. Sorry, we had 0501 on the agenda, but we didn't manage to get it out to the full workgroup, I believe, and...

Female: Okay, thanks.

Andrew Lyzenga: ...so we're just going to, sort of, skip over that one for now, and we'll probably just review it at the full committee. So again, back to 0523, Pain Assessment. Payment, Pain Assessment Conducted, and if anybody has any comments about the importance to measure or report, the subcriteria, whether it has a high impact or if that's a performance cap, and their rationale for those things.

Lisa McGiffert: Well, this is Lisa. I would just put out there, as an overarching theme for me, this is a process measure. And I think, you know, we should try to move away from process measures for public reporting. I think, you know, process measures are useful for the providers to improve their

care, so I don't, I'm not saying they should be totally discounted but, you know, this, we're looking at this measure for its value for public reporting.

And I just think that outcome measures are more effective.

Jean Deleon: Agreed, agreed. And those are my comments, actually, for both this measure and the next.

This is Jean Deleon. I, you know, asking if, somebody about pain in no way implies an outcome. And all the process measures are like that, they're important to do. I'm not saying that they're endorsed or, it's not saying that they're not important. They're absolutely important to do, and everyone should do them.

But to measure it and report on it, I'm not sure that that's driving quality, unless we were in the very, very beginning stages. When we start implementing quality programs in health care systems, a lot of times we'll start off with these process measures just to get people going. But then we start just measuring outcomes, rather than the process. How long has this measure been in effect? I didn't see.

Heidi Bossley: It's been publicly reported for just about a year.

Jean Deleon: A year.

Heidi Bossley: It received time-limited endorsement in early 2010, and this review would be granting it full endorsement.

Female: But one of the things that I was thinking of when I was looking at this was, is there a outcome measure for pain? Because I think it is a really important issue.

Heidi Bossley: There is a outcome measure for pain. It's Improvement in Pain Interfering with Activity. I don't recall the NQF number.

Female: Okay, thanks.

Heidi Bossley: You're welcome.

Andrew Lyzenga: Any other comments on importance to measure and report?

Bobbette Bond: I just think the issue, this is Bobbette Bond, I think the issue of pain, I mean, I appreciate that these are process measures, and I appreciate that ((inaudible)) outcomes and, we certainly work on pushing for outcome measures also, but pain is such an important topic, that, and so difficult to control, and so, you know, individual-based, that it's very difficult to give up on that until we have good ones.

And I mean, there aren't a lot of great outcome measures for pain yet. That's my only two cents. I'm not arguing at all with the need for process to, you know, transitioning into outcomes. Definitely, but this is outcomes limited outgo, there, it's not qualitative. This is a difficult area, and I think my only point is it's such an important area that I think the, you know, a lot of focus on ((inaudible)) is worthwhile.

Andrew Lyzenga: Thank you Bobbette. And while there's no other thoughts or comments on that action, we can move on to the evidence, the quantity, the quality and the consistency of the evidence provided by the developer. Was, were people generally satisfied with that? Looks like we had a good number of low and moderate ratings on this category. Does anybody have any explanations for that, or thoughts you'd like to add?

Jim Smith: Well, I rated based on the criteria of five or more on the quantity of evidence. I think what's important to remember, if I'm interpreting this one correctly, it is unique to measurements taken off the Oasis, that it's a home care measurement for those patients receiving services in their own home. And that's why it was a unique body of knowledge.

There's much more complementary knowledge available, or information available about pain, either the measurement of pain or treatment, but this was unique to outpatient, I'm sorry, to home care services.

Andrew Lyzenga: I believe that's correct. Any other comments or questions?

Louise Probst: I think that might have been - I had a note, I don't, it's been a while since I've done this, so I don't completely remember, but I think it was something that it said about having consistency or reliability within an institution or a setting, but not across. And that might be, I wasn't completely certain how to interpret those comments, if anybody else remembers reading that.

Lisa McGiffert: I don't remember reading it. I'm wondering if the measure developer...

Keziah Cook: That doesn't sound familiar to me either. We did have some information about reliability, which was, you know, how well this measure could distinguish between various providers, and it, I think, did reasonably well.

Louise Probst: Okay. Was there any of the research that looked at, I guess that might be hard but, how this would then compare to a patient response on, say, like a CAHPS survey?

Keziah Cook: If you could unmute Liz Madigan's line, she's a colleague of mine, and led the literature review, so she may be able to chime in on that.

Andrew Lyzenga: Operator, if you could...

Operator: Her line is open.

Liz Madigan: Thank you. Hi, this is Liz Madigan.

Andrew Lyzenga: Hello.

Liz Madigan: So part of what, part, I mean, part of our limitation, of course, here, is that there's so little home health care specific research, so that it's really hard to identify how we can do those pieces. And home health care just really started with the CAHPS stuff, so we weren't able to actually make any associations in the environmental scan between this measure and patient satisfaction.

Louise Probst: Okay, thank you.

Andrew Lyzenga: And while we're, sort of, already talking a little bit about reliability and validity, were there any additional thoughts about that? Again, relatively consistent responses from the preliminary evaluations. I think Louise Probst, I see you had added a note, saying that an overview of the reliability testing would be helpful, and the inter-rater issues across the agencies, and the...

Louise Probst: And I think I just got that.

Andrew Lyzenga: Excuse me?

Liz Madigan: I guess I can just point out that the reliability testing we conducted for this maintenance was the reliability of the measure, rather than the reliability of the underlying data item. So there was

some earlier inter-rater reliability, I think, that was included in our initial submission a couple years ago. But this information is just about the measure reliability.

Andrew Lyzenga: Reliability of the measure score.

Liz Madigan: Exactly.

Andrew Lyzenga: Thanks. Any additional comments? Questions for the developer? Validity or reliability of the measure.

Lisa McGiffert: And the measure is, I'm, now I'm going back to the numerator, the number of episodes in which the patient was assessed for pain, using the standardized tool, okay.

Andrew Lyzenga: Yes.

Lisa McGiffert: So it doesn't really have any qualitative elements to it. It's just like, did they do it, well, they, did they do an assessment using the standard methods, I guess.

Liz Madigan: Yes, that's correct.

Lisa McGiffert: I wonder, how do you measure whether they did the, did it standardized. I was looking at something that said the guidelines were too voluminous to...

Liz Madigan: Oh, yes, those are the clinical practice guidelines, so...

Lisa McGiffert: Well, that's what they would have to do, right? Oh no, that's not what they had to do.

Liz Madigan: Right, because they're using, actually, well, what's recommended is that they use a standardized and validated pain measure. So they could use something like a 1 to 10 scale, or a faces scale, depending on the patient population, so.

Lisa McGiffert: Got it. Okay. But you're just getting, really, at whether they asked them about pain?

Liz Madigan: Correct.

Andrew Lyzenga: Any more thoughts on that, or more on the next section...

Female: No.

Andrew Lyzenga: ...which is usability and feasibility? Seem like a meaningful measure for users and feasible for implementers?

Jean Deleon: It's certainly easy to implement. I'm not sure that you can explain well to the patient how that's going to impact them, because it implies that you're treating their pain. You're simply going to ask them about it. I don't know how they would position that in their mind.

Andrew Lyzenga: So as you identify these issues, or questions that you have, you know, even if they're not something that you want to ask of the developer, I would ask that you, sort of, keep them in the back of your head, make a note of them maybe, to raise them during the in-person meeting, so that we can potentially have a broader discussion among that larger group and, you know, get maybe a bit of additional input from those around the table on these things that you're asking about.

So just a request to, sort of, keep those things in mind. If you're having questions, concerns about it, make a note of it and try to raise those things at the in-person meeting.

Lisa McGiffert: Yes, as a consumer, I just think, I'm always puzzled as to why these measures aren't a little bit more complex, like, did you ask them about pain, and did you do something about it? You know, because that's really, I think, what consumers are looking for.

Liz Madigan: That's actually the next measure, which is where the pain has been...

Andrew Lyzenga: Yes.

Lisa McGiffert: Oh, all right.

Bobbette Bond: Well, this is Bobbette Bond. I'm, I looked at the next measure, and I see that the next one's another, whether there was any work done on pain itself. But this measure doesn't seem to be linked with that measure, and so I just need a little clarification, when it's a measure type in its process, but then it says that this measure is paired with another measure and you say no.

To the previous speaker's point, is there work to be done where they are linked, so that it's more value if it's in conjunction with something else? Or do they have to stay unlinked? I just don't really understand exactly...

Keziah Cook: So there are some data collection issues regarding linking those measures. The Pain Assessment Conducted is based only on the preliminary assessment that's done when the patient begins home care. The Pain Interventions Implemented is based on the final assessment that's done when that patient is discharged or transferred from home care. So they're...

Bobbette Bond: ...transferred from home care, okay. So they're not the same location?

Keziah Cook: Well, the Pain Interventions Implemented is sort of looking at the whole period of time. You know, did the patient have the intervention during the time period they were receiving home health care.

Bobbette Bond: Okay.

Keziah Cook: The Was the Assessment Conducted is just based on, you know, at the start of care, was the patient's pain assessed? So certainly the implementation measure builds on the assessment.

Liz Madigan: And implementation also requires that it was in a plan of care, the physician-ordered plan of care, so it's sort of a multi-step process.

Bobbette Bond: And then I'm, so this is Bobbette again. So then I'm wondering, in what scenarios would you not, would you link or not link to? Because it does seem like it's more valuable when it's linked to the rest of the entire care cycle.

Liz Madigan: So for example, if you assessed a patient and they, for pain, and they didn't have any pain at the start of care, and of course, then they're reassessing at periodic points. If the patient didn't have any pain, then it wouldn't necessarily be in the physician's ordered plan of care and implemented. Does that help, or is that...

Bobbette Bond: Yes, yes that helps.

Liz Madigan: Okay, okay.

Heidi Bossley: This is Heidi, if I could just, from the NQF perspective, maybe describe a little bit more what we mean by a paired measure, which may help with this as well.

Bobbette Bond: Yes, I think that's what I need, a better definition of that for myself, thank you.

Heidi Bossley: Yes, yes. And it, you know, it can, a recommendation for a paired measure can be initiated by either a developer or the steering committee, with the developer, of course, agreeing to it. But it's intended to have, truly have two separate measures with two separate reporting rates. But the intention is, they would always be used and reported together.

Bobbette Bond: Okay.

Heidi Bossley: That's what we mean by a paired measure. And I think this is something that the committee will have to discuss, and maybe you all can have a preliminary discussion today. Is there a value in having both of these measures? If so, should we recommend that they be paired? And is that feasible?

The other question, though, is, and I think this is what you're struggling with, is having the assessment conducted, is that close enough to the outcome, or by having measure 0524 plus the other measure that actually looks at improvement in pain, are those two sufficient without the 0523, which is Assessment Conducted.

And I think that's probably where most of the discussion will be at the steering committee level, and it may be useful for the workgroup to have a little discussion about that as well.

Bobbette Bond: Okay, thank you. I appreciate that. That is - this is Bobbette; that is what I'm trying to figure out. So...

Heidi Bossley: That's what I thought.

Bobbette Bond: But being the newbie in this group, I'm not exactly sure how to articulate it, because the linkage is important to me.

Heidi Bossley: Yes, and I think the one thing isn't, and this is where, I think, most of the discussion will be on the importance of this measure, is how proximal is it to the outcome? Do we have measures that are more proximal that achieve the same thing or more? And it's, I think that's what you are all are kind of struggling with now, right at the moment.

Bobbette Bond: So we would need to know what the other proximal outcome measures are for this, right, or if there's other, what else is in this arena that would, what the other NQF measures are that would either be proxies for this, or supplement this, or be more precise than this?

Andrew Lyzenga: Well, maybe we could move on to the next measure and, sort of, have these questions in mind as we take a look at that one...

Heidi Bossley: Yes, right, and we can also pull the other measure as well, and mix it up, provided.

Lisa McGiffert: So that, I think what the last person was asking was, you know, if you have a process measure, it makes more sense to link it to an outcome measure also, is that what you were basically saying?

Bobbette Bond: Yes, when you can...

Lisa McGiffert: Yes, because I think that too.

Bobbette Bond: ...another NQF, yes, and then how does NQF handle that, and, you know, what are the rules around that, really? So...

Lisa McGiffert: Yes and linking two processed measures together, to me, is, you know, not that...

Bobbette Bond: Not helpful.

Lisa McGiffert: ...great of an idea. But linking it with an outcome measure might be worthwhile.

Bobbette Bond.: Right. Might be.

Lisa McGiffert: Yes. This is still a process measure.

Bobbette Bond: Exactly. That's helpful.

Andrew Lyzenga: So would everybody agree with moving on to the next measure at this point? Or would you like to discuss 0523 a little bit further?

Lisa McGiffert: I'm ready to move on.

Andrew Lyzenga: Okay, let's go ahead and do that, move to 0524. And we can, sort of, to begin with, take a look at just the description of the measure, a percentage of short term - sorry, the title is Pain Interventions Implemented During Short Term Episodes of Care. And the description, the brief description is, percentage of short term home health episodes of care during which pain interventions were included in the physician-ordered plan of care, and implemented.

And in some sense that does seem to be, I don't mean to overstep my bounds, here, though it sort of includes the previous measure, in the sense that you've got a pain intervention included in the physician-ordered plan of care, which would, I would assume means there have been a pain assessment done. But we'll open up for discussion at this point.

Jean Deleon: But I think how that's worded, this is Jean Deleon, how this is worded makes it difficult to link this with the first one, because the first one is an assessment at the initiation of home health. If you didn't have pain on the initiation of home health, and then two weeks later you now have pain, whatever reason, that's not going to be in your numbers for 0523, but it will be in your numbers for 0524 if they get a physician order for whatever pain intervention.

So it's going to be inconsistent when you look at it, because of the way 0523 is written. It has nothing to do with assessing for pain on each visit, they only ask that you assess pain on the first visit, or on a readmission, but not during the time course of caring for the patient.

And then 0524 is, at any point during that time period of care, was there an implementation of any kind of pain intervention, whether it's effective or not? It doesn't come out in this at all. But it does sound like it's in another NQF measure. So that might be nice to link this one with, perhaps, the one that actually deals with an outcome.

Female: Right.

Jim Smith: But this is unique to home care services, and the other may not be unique to this population.

Jean Deleon: True, I'd have to see the other one. But that's why I don't know that linking these two would make a lot of sense. My complaint about this one is still the same as it was with the one before, that there's no evidence that asking a question has anything to do with the outcome for the patient.

Having any intervention, whether it's appropriate or not, still doesn't tell me whether it was good for the patient. If you gave them narcotics, and it made them so sleepy they couldn't eat anymore and, you know, they had to be readmitted for malnutrition, I don't think you did them a service.

But if you are sitting longer, walking farther, happier, eating more, sleeping better, you tell them on a pain scale that you're better, that tells me way more about the quality of care. Every time we break one of these processes up, I have the same problem. The process itself mostly doesn't impact quality. It's combining certain processes with an outcome.

Keziah Cook: Just for everyone's information, the Improvement in Pain Interfering With Activity measure is a home health specific measure as well.

Andrew Lyzenga: Yes, I just found that as well.

Heidi Bossley: Yes, this is Heidi, I found it as well. It, we'll make sure that everyone has it at the time of the meeting.

Keziah Cook: Okay, I think that'd be useful.

Heidi Bossley: We can give you details now on the phone if it's helpful, as well.

Jean Deleon: I think we should take a look at it when we're at our in-person meet, this, that sounds like the more meaningful measure. Then, but I don't know how to get the more meaningful measure without taking those steps. Pain is important. You have to ask about it. You have to have intervention. We don't seem to have that perfect. We need all of it to take good care of the patient. You have, we have them split up into different measures.

Bobbette Bond: I'd say that's right. This is Bobbette again. I think that's a little bit of my, I'm not frustrated, but I'm trying to figure out, how does NQF, you know, determine value when I completely understand the speaker's concern about, when you break down each process, then you're left with some tiny measures that may not actually add up to outcomes.

And while I could see in the NQF stuff was its ability to link, and it might not be the, you know, I understand that you can't link things all the time every time, and since NQF, I think you just suggested that what NQF does is, when there's a link there, it's all the time. But it would be good to at least have a conversation about what all the pieces are that have to be together to make an outcome, you know, to get to the outcome.

And I'm just a little frustrated with how that would happen, with the way NQF does this. And I love the NQF process, but you do trade off, these tiny increments for the big picture. I'm trying to rebuild those together in my head, is where I'm trying to see what you would do to make it all go together. That's it.

I guess that would turn, I guess my recommendation from that, what everything, my little diatribe there would be, it would be nice if we could see the other measures that might fit together with this, as I think you suggested already, at the live meeting.

Andrew Lyzenga: Yes, and we'll do a little more thorough search and find measures that are relevant and applicable, and we'll have them there for you to review as well. And we'll...

Bobbette Bond: Have a little ((inaudible)) about the topic, okay. It's a very, it's a really serious topic, so I think you should, so, thank you.

Andrew Lyzenga: Any additional comments or questions for the developer? And if you, was there anything that anyone wanted, on these two measures, the developer to provide a specific response on, that they could come back to the in-person meeting and have some materials for you, or responses on or...

We know we have some work to do on the NQF end to get the measures, the relevant measures gathered for you, but was there anything that the developer can do?

Jim Smith: I don't have anything for the developer, excuse me. It's Jim here, but, it's been very enlightening to be involved in this discussion, in particular to help me better appreciate that this is a process, which was something I, this was the first I reviewed, and I got very hung up on that one with 0523. Five twenty-three is the pain assessment.

The other concern I have, and I want us to think about before we meet is, that pain is not universally assessed in home care, based on the data presented to us, and we need to be considerate about achieving consistent and hopefully universal assessment of pain in home care.

If we can influence that, even though it is only a process, and it does not close the loop, I think we should also be considerate about the responsibility to making this change in practice, so that pain is consistently and universally assessed.

Jean Deleon: Jim, would you also agree that it probably should be assessed on every visit, rather than just on the first one?

Jim Smith: Yes.

Jean Deleon: Is it possible to change these measures, Andrew, to make suggestions for revision? That it, instead of reading, only on admission or readmission, that it be on - because then it could be paired very easily.

Female: Right.

Andrew Lyzenga: Sure, we can ask the developer about that. We know that, that may impact their testing. They would likely not have done testing on the specifications, you know, that any, provide

specifications that they would make to that effect, but we could ask the developer at this point whether that is something that could be feasible. Does the developer have any response to that?

Keziah Cook: Go ahead Liz.

Liz Madigan: No, no, you go ahead.

Keziah Cook: Okay, I was just going to say that I think the restriction about when we can, you know, what time points we can collect this is really based on the Oasis Assessment instrument. So the Oasis instrument asks, you know, the question about, was the pain assessment conducted? Were pain interventions in the plan of care? Were they implemented at various time points that are, you know, that are based on that data collection.

And it's certainly possible to revise the data collection, although that's obviously a much more involved process than just revising the instrument, you know, so the, or just revising the measure. I think the measure is specified, it's sort of specified in a logical way based on the data items.

Liz Madigan: So Oasis data are collected at the initiation of home health care...

Keziah Cook: Yes.

Liz Madigan: ...when a patient returns from the hospital, when a - and there are abbreviated Oasis episodes, if, like if a patient dies, there's not a full Oasis, there's not a full Oasis done at a patient death. So there's various time points, and I don't know if you all have access to the full Oasis, and which items are collected at which time points, but that might be helpful for your discussion.

Lisa McGiffert: And this is Lisa, I was just going to, kind of, reiterate my concern of us spending a whole lot of time on process measures.

Andrew Lyzenga: Okay, well it sounds like...

Bobbette Bonds: This is...

Andrew Lyzenga: Yes, go ahead, go ahead.

Bobbette Bonds: This is Bobbette again. I'm looking at the measure, and I'm looking at the write-up you did, and I'm looking at, I don't, I haven't ever, I'm not familiar with Oasis. So it says here that Oasis supports three process measures. They're all related, and I understand the last speaker's concern that we're spending too much time on process. I actually agreed with that.

But the three measures related to pain assessment and using - oh, I got to get my glasses on, related to pain assessment using standardized and validated tools for documentation of pain intervention in the plan of care, and implementation of the physician-ordered plan intervention.

So I think what we're missing in this conversation is that last one, Implementation of Physician-Ordered Plan Interventions, right?

Keziah Cook: What you're looking at right now, 0524, is the Implementation of Interventions measure.

There's an additional measure that is privately reported to the agencies, that measures whether or not pain interventions were included in the physician-ordered plan of care.

Bobbette Bonds: Okay, so none of this gets to the outcome of whether this, whether the patient felt less pain?

Keziah Cook: So there is a separate measure, the Improvement in Pain Interfering With Activity measure, that gets at whether or not the patient's pain improved.

Bobbette Bonds: Okay.

Keziah Cook: So I guess there are four home health pain measures, three of which have been NQF endorsed.

Bobbette Bonds: Okay, that's helpful. All right.

Andrew Lyzenga: It sounds like we've got some good and sort of general themes for discussion at the steering committee meeting. And again, I would ask that you, kind of, try to keep that in your mind as we move toward the in-person meeting, and bring up these points of discussion that we've been having today, for the full steering committee so we can address some of these concerns up front, probably.

It sounds like many of the issues that we've been discussing here toward the end are really fairly relevant for the importance part of the, our process. And but we can talk about that as we begin talking about these particular measures in the importance discussion. And again, I would encourage you to make a note of some of your concerns and questions, and raise those with the larger group when we get into the discussion of these measures.

Otherwise, does anybody have any final comments, or questions or concerns? Sounds like not, and I, we have some time for public comment at this point. Operator, do we have anybody on the line who would like to provide any public comment?

Operator: If you'd like to ask a question or make a comment, you can press star 1. Again, everyone, that's star 1 on your phone line if you'd like to make a comment. And no one has queued up to make a comment.

Andrew Lyzenga: Okay, no public comments, thank you. So just to talk a little bit about next steps again, and your roles at the steering committee meeting, if those people that we assigned to, those workgroup members who we assigned as a primary reviewer to a particular measure could do it again, take another look back at those, give them a good read through, a good review.

And maybe we could have you do a bit of guidance for the committee, help us along with the discussion at that point. That would be very helpful, and we would encourage all the other workgroup members that we have on the call today as well to chime in and help to move that discussion along.

You know, with the discussion that we've had today in mind, and some of the concerns that you have raised, we can bring those up early in the process, and those seem like some pretty important things to talk about. So please don't be afraid to talk about those at the in-person meeting, and raise your concerns there.

Again, we will be sending out another evaluation, like we sent you before, an online survey, where you can enter your evaluations for all of the measures we'll be discussing at the in-person meeting. That will be coming to you very shortly. And we would certainly encourage you to fill those out and fill in some comments that you have on any of the measures in. And we will again use that as a sort of basis for discussion at the in-person meeting.

Once again, we really do appreciate you taking the time to call in for this today. And we look forward to seeing you next week.

Lisa McGiffert: Okay, thank you. And you want us to fill that form out before we get to the meeting, so you can use it to guide it, yes.

Andrew Lyzenga: ...yes, we'll send you that via email, and you'll have it in your hands at the meeting.

Lisa McGiffert: Right. Thank you.

Andrew Lyzenga: All right. Well, I guess that concludes our call. Thanks everybody again...

Lisa McGiffert: Okay, bye bye.

Andrew Lyzenga: Okay, bye.

Female: Thank you.

END