

NATIONAL QUALITY FORUM

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PEDIATRICS PERFORMANCE MEASURES COMMITTEE

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THURSDAY

MARCH 2, 2017

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The Pediatrics Performance Measures Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:00 a.m., John Brookey and Jeffrey Susman, Co-Chairs, presiding.

PRESENT:

JOHN BROOKEY, MD, FAAP, Co-Chair

JEFFREY SUSMAN, MD, Co-Chair

LAUREN AGORATUS, MA, Family Voices NJ \*

MARTHA BERGREN, DNS, RN, NCSN, APHN-BC, FNASN,

FASHA, FAAN, University of Illinois Chicago

JAMES BOST, MS, PhD, Children's Healthcare of Atlanta

TARA BRISTOL-ROUSE, MA, Patient and Family Centered Care Partners

KAREN DORSEY, MD, PhD, Yale University School of Medicine

MAUREEN EDIGER, Children's Hospital Colorado

DAVID EINZIG, MD, Children's Hospital and Clinics of Minnesota

DEBORAH FATTORI, MSN, RN, PPCNP-BC, Nemours Alfred I DuPont Hospital for Children

KERRI FEI, MSN, RN, Blue Cross Blue Shield Association

JONATHAN FINKELSTEIN, MD, MPH, Boston Children's Hospital

KAREN HARPSTER, PhD, OTR/L, Cincinnati

Children's Hospital Medical Center

AMY HOUTROW, MD, PhD, MPH, Children's Hospital  
of Pittsburgh  
DAVID KELLER, MD, University of Colorado School  
of Medicine  
KRAIG KNUDSEN, MD, Ohio Department of Mental  
Health and Addiction Services  
SUSAN KONEK, MA, RD, CSP, FAND, Academy of  
Nutrition and Dietetics  
MARLENE MILLER, MD, Msc, John's Hopkins  
Children's Center at JHHS \*  
RAJIV MODAK, MD, El Rio Community Health Center  
JILL MORROW-GORTON, MD, University of  
Massachusetts Medical School  
RICARDO QUINONEZ, MD, FAAP, Baylor College of  
Medicine  
JEFF SCHIFF, MD, MBA, Minnesota Department of  
Human Services  
CAROL STANLEY, MS, CPHQ, Duke University

NQF STAFF:

SHANTANU AGRAWAL, MD, President and CEO  
HELEN BURSTIN, MD, MPH, Chief Scientific Officer  
KAREN JOHNSON, Senior Director  
MADISON JUNG, Project Analyst  
KATE MCQUESTON, Project Manager  
ELISA MUNTHALI, MPH, Vice President, Quality  
Measurement  
ROBYN NISHIMI, PhD, Consultant  
SUZANNE THEBERGE, Senior Project Manager  
MARCIA WILSON, PhD, MBA, Senior Vice President,  
Quality Measurement

ALSO PRESENT:

KIMBERLY ARTHUR, MPH, Seattle Children's  
Research Institute  
RENEE ELLEN FOX, MD, FAAP, Center for Medicare  
and Medicaid Services  
NARAA GOMBOJAV, PhD, The Child and Adolescent  
Health Measurement Initiative \*  
LAWRENCE KLEINMAN, MD, MPH, University Hospitals  
Rainbow Babies and Children's Hospital \*  
CHRISTOPHER LANDRIGAN, MD, MPH, Boston  
Children's Hospital, Harvard Medical School  
SUZANNE LO, MPH, University Hospitals Rainbow  
Babies and Children's Hospital  
RITA MANGIONE-SMITH, MD, MPH, Seattle Children's  
Research Institute  
KAREN MATSUOKA, PhD, Center for Medicare and  
Medicaid Services \*  
SARAH REEVES, PhD, MPH, University of Michigan \*  
MARK SCHUSTER, MD, PhD, Boston Children's  
Hospital, Harvard Medical School  
JEFFREY SILBER, MD, PhD, Children's Hospital of  
Philadelphia  
MICHELLE SOLLOWAY, PhD, The Child and Adolescent  
Health Measurement Initiative \*  
  
DAVID STOCKWELL, MD, MBA, Children's National  
Medical Center  
  
SARA TOOMEY, MD, MPH, MPhil, Msc, Boston  
Children's Hospital, Harvard Medical School

\* present by teleconference

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1 P-R-O-C-E-E-D-I-N-G-S

2 8:02 a.m.

3 MS. MCQUESTON: Welcome to our one-day  
4 meeting for National Consensus Standards for  
5 Pediatric Performance Measures. We are delighted  
6 to have you all here, and thank you so much for  
7 coming with this early start this morning.

8 Just a very few brief announcements  
9 from me before we begin. I am Kate McQueston. I  
10 am the Project Manager supporting this project.  
11 Restrooms, you will go out through the conference  
12 area and turn right. They are down the hallway.  
13 We will have a few breaks today; unfortunately,  
14 not too many. We are keeping you hard at work.  
15 We will have one at 10:45 -- or 10:15. We will  
16 have lunch at noon, and then another break at  
17 3:30.

18 Our wireless information, so that  
19 everyone has it, you will use the NQF wifi  
20 network with the username guest, and the password  
21 is NQFguest, NQFguest, NQF in caps.

22 So we will go ahead and begin the

1 meeting, and we will begin by passing it off to  
2 NQF's new CEO, Dr. Shantanu Agrawal. Thank you.

3 DR. AGRAWAL: Thank you very much. So  
4 this is week five, day four, so I still get to be  
5 called new, I think, for quite some time. We  
6 will have to figure out how long. We will  
7 actually be convening a consensus panel to figure  
8 out how long I can be called new, because that's  
9 how we do it.

10 (Laughter.)

11 DR. AGRAWAL: Thank you very much for  
12 being here today. This is going to be a really  
13 full day, I know, but I just wanted to underscore  
14 the importance of the work. I think you are  
15 reviewing 11 measures today. That is going to  
16 add to a body of about 100 measures that have  
17 already been endorsed in the pediatrics space by  
18 NQF. The second phase of work for this  
19 committee, so again, just really extremely  
20 important.

21 I want to thank John and Jeff for  
22 their leadership of this committee. I also

1 wanted to just reinforce how personally important  
2 this was to me. You know, yes, we are here to  
3 improve the health and healthcare of the  
4 pediatric population, but I should also tell you  
5 that my wife is a pediatric hospitalist. She has  
6 made it very clear we need really good measures  
7 in pediatrics.

8 (Laughter.)

9 DR. AGRAWAL: When -- when I got  
10 offered this job and had accepted it, literally,  
11 she said, you know, let's get to work. We need  
12 pediatric measures. So because I ascribe to the  
13 happy wife, happy life doctrine, please do a good  
14 job today.

15 (Laughter.)

16 DR. AGRAWAL: I need to go home and  
17 report some good news.

18 No, so thank you very much. This is  
19 extremely vital. It has been great in the last  
20 five weeks to sit in on these committees, really  
21 see how they operate. The amount of expertise  
22 that we have here is incredible, and I thank you



1 for donating as much time as you do. Our work  
2 would not be possible without the representation  
3 we have here and your willingness to participate  
4 in this process. Thank you.

5 CO-CHAIR BROOKEY: Good morning,  
6 everybody. I am John Brookey. I recognize most  
7 of you in the room. I feel like I was just here  
8 like -- I walked in the room, and I was like I  
9 have been here yesterday, but I wasn't. It has  
10 been over a year now since we were here.

11 So we are going to go ahead and -- are  
12 we going to do the introductions of the whole  
13 room later, or are we going to do it --

14 MS. MCQUESTON: We will combine that  
15 with our --

16 CO-CHAIR BROOKEY: A little later,  
17 okay.

18 MS. MCQUESTON: -- our disclosure  
19 after we do --

20 CO-CHAIR BROOKEY: So I will let Jeff  
21 say hello. Then we're going to go to our opening  
22 remarks from CMS.

1 CO-CHAIR SUSMAN: So again, welcome to  
2 everybody. It is great to see everybody back,  
3 and a few new faces. This is a really exciting  
4 time I think for measurement and quality, and  
5 particularly in the pediatric space, where we  
6 probably have a dearth of measures available, so  
7 this should be a great meeting.

8 Just a couple of words about process.  
9 We have a hard time seeing people at the ends, so  
10 it will really help us, if you have questions or  
11 things to comment on, to put your cards up like  
12 this so that we know you want to say something.  
13 And I hope this is a really fun meeting. Don't  
14 be worried about disagreeing with each other, but  
15 do it nicely. Thank you.

16 CO-CHAIR BROOKEY: Okay. We are going  
17 to move to -- I believe that Karen and Renee are  
18 on the line, and they are going to -- is that --  
19 oh, Renee is here, okay. Hi Renee.

20 DR. MATSUOKA: Yes, and this is Karen.  
21 Hi, everyone.

22 I wanted to take just a few minutes

1 just to welcome everyone to this meeting and also  
2 just to really thank you for making the time to  
3 be with us. We know how important your time is  
4 and how busy you are, so the fact that you are  
5 willing to lend us some of your time today is  
6 really important, so thank you very much.

7 And apologies for not being able to be  
8 there with you in person. It is by no means any  
9 indicator of how -- how important the work is  
10 because in fact, the reason why CMS decided to  
11 fund a call for measures specifically for  
12 pediatric performance measurement is an  
13 indication of how important we really do think  
14 this work really is.

15 So we funded this measure call because  
16 it really does align and further our mission  
17 under CHIPRA to expand and update the portfolio  
18 of evidence-based pediatric measures available  
19 for public and private use. So the work that you  
20 will be doing today in terms of reviewing and  
21 potentially endorsing new measures that are going  
22 to become available for use not just in Medicaid

1 and CHIP, but to the commercial population as  
2 well, is so important.

3 And just to give you a sense for why  
4 it is so important to Medicaid and CHIP, you  
5 probably all know that Medicaid and CHIP serve  
6 over 70 million beneficiaries in this nation.  
7 That is more than what Medicare and the  
8 marketplace combined cover. And of that total  
9 enrollment, over 51 percent of our enrollees are  
10 children. That is -- almost 40 million  
11 beneficiaries are children, and over 40 percent  
12 of births in this country are also covered by  
13 Medicaid.

14 And of course, on the CHIP side, where  
15 almost all of our beneficiaries are children, we  
16 serve a further 8.4 million kids. So having a  
17 robust slate of measures that we can use to  
18 really assess the extent to which we are  
19 providing evidence-based care to our kids is so  
20 vitally important.

21 And so we thank you for being here  
22 today because NQF endorsement, as you know, helps

1 to really increase the visibility and the use of  
2 measures, and no matter how many measures we  
3 have, people don't know that they exist, and  
4 people don't know that they are reliable and  
5 credible, useable and feasible, and  
6 scientifically rigorously tested. No matter how  
7 many measures we might have, that doesn't do us  
8 any good if people don't actually use them.

9 So I want to just -- before turning it  
10 over to my colleague, Renee Fox, I want to again  
11 thank you for all your work, for lending your  
12 expertise to our work, and hopefully together, we  
13 can start to build a robust slate of measures  
14 that we can use to build a brighter and healthier  
15 future for our nation's children. So with that,  
16 I am going to turn it over to Renee.

17 DR. FOX: Thank you, Karen, and good  
18 morning, everyone.

19 As Karen said, this really started  
20 with the CHIPRA reauthorization, 2009, and before  
21 that there really were no standard measures. One  
22 of the reasons that we have these measures was

1       that we were unable to measure Medicaid  
2       performance across states. States maybe had  
3       their own measures, but they were not -- they  
4       were not reporting them.

5               And so now there is voluntary  
6       reporting on the Child Core Set measures  
7       consistent with consistent metrics across five  
8       domains: primary care access and preventative  
9       care; perinatal health, my specialty; care of  
10      acute and chronic conditions; behavioral  
11      healthcare; and dental and oral health services.  
12      And the Child Core Set, as of 2016, had 26  
13      measures on it, and 50 states and the District  
14      reported on at least one measure, and the median  
15      number of measures reported by states was 16 for  
16      federal fiscal year 2015.

17             And so as Karen said, this is really  
18      a foundation. We don't just want to measure; we  
19      want to help improve the care for Medicaid and  
20      CHIP, and through this, we also look at quality  
21      improvement and CMS has roles in -- through  
22      funding and technical assistance to support

1 states in setting performance goals and  
2 implementing improvement projects, either through  
3 groups, affinity groups like the Maternal and  
4 Infant Health Improvement Initiative, some of the  
5 external quality review organizations'  
6 improvements.

7 And so to have effective system  
8 reform, we need to have data and performance  
9 metrics that include -- that enable health  
10 service delivery transformation, data and IT,  
11 payment reform, and so we are here in the --  
12 Karen and I sit in the Division of Quality and  
13 Health Outcomes, and we have been referring to  
14 this as DQ 2.0. And so we have multi-level  
15 management measurement.

16 You are aware of the Medicaid CHIP  
17 Child and Adult Core Sets, but we will soon have  
18 forthcoming some first-ever nationwide Medicaid  
19 consumer assessment of child healthcare -- of  
20 healthcare providers and systems, the CAHPS. We  
21 are going to have a quality rating system in  
22 managed care, and we have provider-level

1 measures, including the Health Home Core  
2 Measures, Behavioral Health Clinics Core  
3 Measures, and as many of you know and probably  
4 have worked on, the Center for Clinical Standards  
5 and Quality AHIP Core Measures, which have  
6 released seven adult core sets, and the pediatric  
7 set should be forthcoming.

8           And there are many levels of  
9 performance measures that roll up from provider  
10 to plan to state to Medicaid. I also want to  
11 share my appreciation for the work this committee  
12 and the staff at NQF are doing, and really  
13 understand -- want to highlight that measures are  
14 appropriately designed for different levels of  
15 measurement, from practice to payer to plan and  
16 state levels, say that not all measures are  
17 appropriate for use at each level, but should be  
18 reviewed here in the committee for use at the  
19 level for which they were tested.

20           Your expertise will help ensure that  
21 these measures are important, scientifically  
22 rigorous, useable, feasible at the level they



1       were tested, and we are very mindful at HHS of  
2       the provider burden that results from the  
3       proliferation of measures in general. And the  
4       decision, just as Karen said, made by you at the  
5       committee level will help inform our MAP Medicaid  
6       Task Force, which will meet in May 2017 to  
7       provide input on how to strengthen the core set  
8       for children, and we will look at these measures  
9       in the MAP Task Force as discussed as part of  
10      this call when developing their recommendations  
11      for us, so your work is highly vital to what we  
12      do. It is vital to the care of children and  
13      measuring quality, and I want to appreciate --  
14      thank you, everybody, for your hard work and  
15      volunteering.

16                   CO-CHAIR BROOKEY: Thank you, Karen  
17      and Renee. I think we're turning it over to Ann  
18      for our disclosure of interest.

19                   MS. HAMMERSMITH: Thank you. Hi,  
20      everyone. I am Ann Hammersmith. I am NQF's  
21      General Counsel. I will lead you through the  
22      oral disclosures of interest.

1                   If you recall, when you were nominated  
2                   for the committee, you nominated yourself for the  
3                   committee, you received a conflict of interest  
4                   form that was a few pages longer than we would  
5                   like, but it is necessary, and we asked you a lot  
6                   of information about your professional  
7                   activities. So what we do at the -- at the first  
8                   meeting of a committee is we go around the table  
9                   and you share anything you would like to  
10                  disclose, but only if it is relevant to the work  
11                  that you're going to be doing.

12                  One thing that I want -- want to try  
13                  and reassure you about is, if you disclose  
14                  something, it does not mean it's a conflict.  
15                  Part of the reason to do this is for transparency  
16                  so that everyone understands where you may be  
17                  coming from. An example of that is if you sat on  
18                  a committee for a professional society as a  
19                  volunteer, and it is relevant to the work today,  
20                  we would look for you to disclose that. It is  
21                  not necessarily a conflict of interest.

22                  So before we start, I just want to

1 remind you of a few things. You sit as  
2 individuals. You do not represent your employer.  
3 You do not represent anyone who may have  
4 nominated you for service on the committee.

5 One thing that is different about our  
6 conflict of interest and disclosure process is  
7 that we look at things other than financial  
8 interests. Many disclosure of interest processes  
9 only look at the financial angle. Because of the  
10 unique nature of the work that we do, we are  
11 looking for financial disclosures, but we're also  
12 looking for things that you may have done where  
13 no money was involved, but it is relevant to the  
14 subject matter today, and I will use the example  
15 I just used. If you served on a committee for a  
16 professional society as a volunteer and it is  
17 relevant to the work today, we would like you to  
18 disclose that.

19 The other things we are particularly  
20 interested in are speaking engagements, grants,  
21 research support. If you are on the phone, I  
22 will call on you at the end of the in-person

1 disclosures. Right now, we will start with the  
2 Co-Chairs -- I always start with the Co-Chairs --  
3 and we will go around the room. Tell us who you  
4 are, who you are with and if you have anything to  
5 disclose.

6 Federal government representatives, we  
7 do not ask you for disclosures of interest, so  
8 you don't need to participate in this portion of  
9 the disclosures, so.

10 CO-CHAIR SUSMAN: How could I forget?  
11 I am Jeff Susman. I am the Dean Emeritus at  
12 NEOMED, Northeast Ohio Medical University, and I  
13 am fortunate to have the best job in the world,  
14 which is being on sabbatical now.

15 (Laughter.)

16 CO-CHAIR SUSMAN: And I have nothing  
17 to disclose in this sphere.

18 CO-CHAIR BROOKEY: Good morning. I am  
19 John Brookey. I am a pediatrician and a Quality  
20 Medical Director and a Medical Director for  
21 Medicaid in Kaiser Permanente in Southern  
22 California, and other than being a user of

1 measures, I have nothing to disclose.

2 MEMBER HARPSTER: I am Karen Harpster  
3 from Cincinnati Children's, and I have nothing to  
4 disclose.

5 MEMBER FATTORI: Good morning. I am  
6 Debbie Fattori. I am a pediatric nurse  
7 practitioner, and I serve at the DuPont Hospital  
8 for Children as the Senior Director of Ambulatory  
9 Nursing. I have no disclosures.

10 MEMBER FEI: Hi. I am Kerri Fei. I  
11 work for Blue Cross Blue Shield Association in  
12 Chicago, so we are the trade association for all  
13 36 Blue Plans across the United States. I am an  
14 ER nurse by background, and prior to this, I did  
15 work at the American Medical Association doing  
16 physician-level performance measure development  
17 for -- with the Physician Consortium for  
18 Performance Improvement, and I have been gone  
19 from there for seven years. So I used to sit in  
20 that measure developer chair over there, and I am  
21 happy to be on this side now.

22 (Laughter.)

1                   MEMBER FEI: But I have been gone from  
2 there for seven years, and I have nothing to  
3 disclose.

4                   MEMBER BERGREN: I am Martha Bergren.  
5 I am a Director of Advanced Population Health and  
6 Health Systems Leadership and Informatics at the  
7 University of Illinois Chicago, College of  
8 Nursing. I have been a pediatric nurse, both in  
9 the acute care setting and in the community  
10 setting, for longer than I would like to admit,  
11 and I have no disclosures.

12                  MEMBER MORROW-GORTON: Jill Morrow, I  
13 am a Developmental Behavioral Pediatrician  
14 Associate Professor, Pediatrics and Community  
15 Medicine and Family -- whatever they call it, at  
16 the University of Massachusetts. It has this  
17 really long name. I am also a Senior Medical  
18 Director at MassHealth, which is the  
19 Massachusetts Medicaid program, and the clinical  
20 lead for the Long-Term Services and Supports  
21 Office, where we choose measures and use  
22 measures, but don't develop measures.

1                   MEMBER DORSEY: I am Karen Dorsey. I  
2 am a pediatrician, and I am Associate Director of  
3 Quality Measurement at the Center for Outcomes  
4 Research and Evaluation at Yale, and we develop  
5 measures in the Medicare fee-for-service elderly  
6 population. And I actually do the measure  
7 evaluation work for our measures that are in  
8 public reporting, so I am also usually in that  
9 hot seat over there. Glad to be on this side of  
10 the microphone, and no disclosures.

11                   MEMBER QUINONEZ: I am Ricardo  
12 Quinonez, pediatric hospitalist from Texas  
13 Children's Hospital, Baylor College of Medicine,  
14 and I have nothing to disclose.

15                   MEMBER KELLER: David Keller, the --  
16 I am a Professor of Pediatrics and Vice Chair of  
17 Clinical Affairs and Clinical Transformation at  
18 the University of Colorado School of Medicine and  
19 Children's Hospital Colorado, and if anyone has  
20 any ideas how I can get something to disclose,  
21 please tell me.

22                   (Laughter.)

1                   MEMBER SCHIFF: I am Jeff Schiff. I  
2 am the Chief Medical Officer at the Minnesota  
3 Medicaid Program, and I have something to do with  
4 selection of measures for our -- for quality for  
5 both our managed care organizations and our ACOs.  
6 I do -- I have been a co-investigator with Dr.  
7 Mangione-Smith on her Center of Excellence for  
8 the -- and have not been directly involved in the  
9 continuity of primary care for children with  
10 medical complexity, but some of my researchers  
11 have pulled data and been involved in that.

12                   MEMBER EDIGER: Hi. My name is  
13 Maureen Johnson Ediger. I am a parent committee  
14 of the Quality and Safety Committee of the Board  
15 for Children's Hospital Colorado, and it is  
16 relevant that I have four children, and that is  
17 really why I am here, is because two of them live  
18 with special needs, one physical and one mental  
19 health special needs, so -- and I have nothing to  
20 disclose other than I have four children.

21                   (Laughter.)

22                   MEMBER BRISTOL-ROUSE: I am Tara



1 Bristol-Rouse. I am also here as a parent  
2 partner. I am with Patient and Family Centered  
3 Care Partners, and also I am Director of Patient  
4 and Family Partnership for the State Perinatal  
5 Collaborative in North Carolina, and I have  
6 nothing to disclose.

7 MEMBER EINZIG: I am David Einzig. I  
8 am a child psychiatrist, and I'm also boarded in  
9 pediatrics, so I did come from a triple board  
10 program. Work at a large children's hospital in  
11 Minnesota, Children's Minnesota. Primarily a  
12 clinician and see lots of patients. My primary  
13 interests include collaborative care and co-  
14 located care models. I am also on the Behavioral  
15 Health Steering Committee.

16 MEMBER MODAK: My name is Rajiv Modak.  
17 I have spent the last 15 years working on the  
18 front lines at El Rio Community Health Center in  
19 Tucson, Arizona, and I have nothing to disclose.

20 MEMBER FINKELSTEIN: Hi everybody. I  
21 am Jon Finkelstein. I am at Boston Children's  
22 Hospital, and I'm Professor of Pediatrics at

1 Harvard Medical School. My -- my day job is as  
2 Interim Quality -- Chief Quality and Safety  
3 Officer at Boston Children's. I -- I disclose  
4 two things. One is that I serve on the Board of  
5 the Academic Pediatric Association as the Chair  
6 of the Healthcare Delivery Committee, and the APA  
7 is a voting member of NQF, though I am not here  
8 representing them.

9 The second is that I am a co-  
10 investigator for the Center of Excellence in  
11 Pediatric Quality Measurement at Boston  
12 Children's Hospital, which has developed one of  
13 the measures we are talking about today, 3136,  
14 the GAPPS measure. I was not directly involved  
15 in that development, but I am part of that  
16 Center, so I will recuse myself. Happy to leave  
17 the room or focus on my incredibly compelling  
18 email when you discuss that.

19 (Laughter.)

20 MEMBER STANLEY: Good morning. I am  
21 Carol Stanley. I am currently with Duke  
22 University Department of Pediatrics, have been

1       there roughly nine months now, and last year,  
2       when I was here, I was with Virginia Medicaid and  
3       had been there for about eight years. Also, I  
4       have worked with Medicare with one of the QIOs  
5       previously, and Anthem Blue Cross Blue Shield. I  
6       have no disclosures.

7               MEMBER KONEK: Good morning, I am Sue  
8       Konek, recently now into my second year of  
9       retirement from the Children's Hospital of  
10      Philadelphia as the Director of Clinical  
11      Nutrition. I am the dietician on the group, and  
12      within the last month, I have started working at  
13      Dayton Children's two days a week in my -- my  
14      goal to balance fun and meaningful work. I  
15      really have nothing to disclose.

16             MEMBER BOST: Morning. I am Jim Bost.  
17      Last year when I was here, I was Director of the  
18      Outcome Center at Children's Healthcare of  
19      Atlanta, but as of Monday, I am a Research  
20      Division Chief here at Children's National  
21      Medical Center in D.C. of the Biostats and Study  
22      Methodology Group, and I have nothing to

1 disclose.

2 MEMBER HOUTROW: Hello. My name is  
3 Amy Houtrow. I am a pediatric rehabilitation  
4 medicine physician in Pittsburgh. I have federal  
5 funding from multiple granting agencies unrelated  
6 to measurement development or assessment. I am  
7 the Chair though of the American Academy of  
8 Physical Medicine and Rehabilitation Performance  
9 and Quality Metrics Committee, and we will  
10 eventually be doing measure development and have  
11 not started that.

12 I am also the Chair of an IOM study  
13 committee on improving health outcomes, for which  
14 obviously quality has a role, but we will not be  
15 actively looking at anything in particular  
16 related to measure development. And otherwise, I  
17 have nothing else to disclose.

18 MS. HAMMERSMITH: Okay. Thank you.  
19 I am going to call on some people who are on the  
20 phone. Lauren Agoratus?

21 MEMBER AGORATUS: Yes, hi. You get  
22 two points for saying my name correctly.

1 MS. HAMMERSMITH: That never happens.

2 MEMBER AGORATUS: I am the Coordinator  
3 for Family Voices, and I am the parent of a  
4 medically complex child, and I also most recently  
5 have been participating on a UCLA project on  
6 medical complexity, and I checked with Suzanne,  
7 it is not a conflict, but I am also on the CAMHI  
8 well-planner for children with special healthcare  
9 needs. We are not developing measures. We are  
10 developing a parent guide. Thank you.

11 MS. HAMMERSMITH: Okay. Thank you.  
12 Marlene Miller?

13 (No response.)

14 MS. HAMMERSMITH: Is Marlene Miller on  
15 the line?

16 (No response.)

17 MS. HAMMERSMITH: Are there any other  
18 committee members on the line?

19 (No response.)

20 MS. HAMMERSMITH: Okay. Thank you for  
21 the disclosures.

22 Before I leave you, I just want to

1 remind you of a few things. If you are in the  
2 meeting and you think you may have a conflict,  
3 you think somebody else on the committee may have  
4 a conflict, we ask that you speak up in real  
5 time. We don't want to get several months down  
6 the road and have someone pop up and say, you  
7 know, I think I may have had a conflict on that  
8 measure. We would like to know now.

9 You are always welcome to speak up  
10 during the meeting. If you don't want to do  
11 that, you can go to your Co-Chairs. You can go  
12 directly to NQF staff, and we will figure out how  
13 to resolve it. Any questions before I leave?

14 MEMBER FINKELSTEIN: Just to be clear,  
15 if we recuse ourselves, would you like us to  
16 leave the room, or is it okay to --

17 MS. HAMMERSMITH: I don't think it is  
18 necessary --

19 MEMBER FINKELSTEIN: Okay --

20 MS. HAMMERSMITH: -- for you to --

21 MEMBER FINKELSTEIN: -- fine.

22 MS. HAMMERSMITH: -- leave the room.

1       You can look at your compelling email.

2                       (Laughter.)

3               MS. HAMMERSMITH:   Anybody else?

4                       (No response.)

5               MS. HAMMERSMITH:   Okay.   Thank you.

6       Have a good meeting.

7                       CO-CHAIR BROOKEY:   Thank you, Ann.

8       Before I turn it over to Suzanne, I just want to  
9       say how much I appreciate the work of the staff.  
10       I mean, it is a monumental amount of work to put  
11       this meeting together and all these documents for  
12       us to review, so I really do appreciate it.  You  
13       guys did a great job, and it's just an honor and  
14       privilege to be a part of this process.  So I  
15       will turn it over to Suzanne now.

16                      MS. THEBERGE:   Thank you.  I am  
17       Suzanne Theberge.  I am the Senior Project  
18       Manager on the team, and do quick team  
19       introductions.

20                      MS. MCQUESTON:   I am Kate McQueston,  
21       Project Manager.

22                      MS. JUNG:   I am Madison Jung, Project

1 Analyst.

2 DR. NISHIMI: Robyn Nishimi, I am a  
3 consultant to the project serving in sort of the  
4 Senior Director role, and as well I was the first  
5 Chief Operating Officer for NQF.

6 MS. MUNTHALI: Elisa Munthali, Vice  
7 President from Quality Measurement. Welcome.

8 MS. THEBERGE: And over here, we have  
9 Marcia, who is our Senior Vice President.

10 Now I am going to turn it over to Kate  
11 for some slides.

12 MS. MCQUESTON: Great. Thank you,  
13 Suzanne.

14 So we will begin today with just a  
15 brief project overview. So as you know, this  
16 project will be evaluating measures related to  
17 pediatric populations that can be used for  
18 accountability and public reporting for all  
19 populations and in all settings of care. This is  
20 the second phase of this project.

21 And specifically, the project will be  
22 addressing topic areas including child- and



1 adolescent-focused clinical preventative services  
2 and follow-up to preventative services; child-  
3 and adolescent-focused services for management of  
4 acute conditions; and child- and adolescent-  
5 focused services for management of chronic  
6 conditions.

7           So as all of you know, the project  
8 builds on our previous work last year, where NQF  
9 evaluated 23 newly submitted measures and one  
10 previously reviewed measure against NQF's  
11 standard evaluation criteria. NQF has a large  
12 portfolio of measures that include the pediatric  
13 population. Currently, there are more than 100  
14 NQF-endorsed measures that include the pediatric  
15 population. Some of the measures are specific to  
16 the pediatric population and only include that  
17 group, and other measures are all-patient.

18           Measures fall into areas that pertain  
19 to clinical and cross-cutting areas, including  
20 cardiovascular surgery, pulmonary care, cancer,  
21 perinatal care, health and well-being, and  
22 safety. Many of these measures in the NQF

1 portfolio are used in public or private  
2 accountability and quality improvement programs,  
3 but the work group have identified gaps that  
4 remain in areas of care coordination, screening  
5 and abuse and neglect, and injuries, trauma and  
6 mental health.

7 Next, this is a brief overview of the  
8 measures that were endorsed in last year's cycle  
9 that many of you will be very familiar with.  
10 This is -- we won't go through these measure by  
11 measure, but just want to have them here as a  
12 reference. Here they are, continued.

13 And then these are the measures that  
14 we will be considering for this cycle, the 2016  
15 to 2017 measures under review. We have 11  
16 measures that we will be discussing today.

17 And with that, I will pass it over to  
18 Suzanne for an overview of the evaluation  
19 process.

20 MS. THEBERGE: Okay. So I know most  
21 of you have been through this before, and so this  
22 will be familiar. Let's see if I can get the

1 slide clicker to work. Next slide. Thanks.

2 So I just wanted to speak briefly  
3 about the role of the standing committee and the  
4 process that we will be going through this  
5 morning. As has been mentioned, the committee  
6 members act as a proxy for NQF's membership, and  
7 so we expect varied perspectives and values and  
8 priorities from you all during this discussion,  
9 and so of course we ask you to respect each  
10 other's differences of opinion, and -- and keep  
11 the conversation collegial, as they -- they  
12 always are.

13 And we -- I also wanted to note, we do  
14 have a very full agenda in order to fit  
15 everything into a one-day meeting. We packed it  
16 quite tightly, so we appreciate your early  
17 arrival, and we do really appreciate your helping  
18 us keep on track and -- and staying within --  
19 within our time for the agenda.

20 As you also may remember, once we get  
21 into the measure discussion, we will have our  
22 measure developer colleagues joining us at the

1 table. We have a couple of chairs for them, and  
2 we really appreciate their presence. We do have  
3 several that will be on the phone as well, and we  
4 -- we really appreciate their joining us here, as  
5 that -- that presence is invaluable.

6 They will be providing a very brief  
7 introduction to their measure or measure set, and  
8 then if you have questions, you can ask them to  
9 respond to any questions that you might have  
10 about anything pertaining to the measure.

11 We do ask that you -- we know that our  
12 committee members often like to offer some  
13 suggestions on how a measure could be improved,  
14 or ways it could be refined, but we do ask that  
15 you consider and vote on the measure that has  
16 been submitted to us. That is what we will be  
17 evaluating today.

18 So the -- these are our ground rules.  
19 I don't -- see if anybody has any questions.  
20 They are fairly straightforward.

21 (No response.)

22 MS. THEBERGE: And hearing none, I

1 will go over the major criteria and the process.

2 CO-CHAIR BROOKEY: Can you just back  
3 up one slide?

4 MS. THEBERGE: Sure.

5 CO-CHAIR BROOKEY: Could you talk  
6 about being in the room or out of the room during  
7 voting? Or are you going to get to that?

8 MS. THEBERGE: I could talk about that  
9 right now.

10 CO-CHAIR BROOKEY: Okay.

11 MS. THEBERGE: So we do ask that folks  
12 remain in the room, especially when we are  
13 getting to a vote. I mean, we understand that  
14 you may need to step out for a moment, but if you  
15 could try to be at the table and voting while we  
16 are voting, we would appreciate it, to ensure  
17 that we maintain quorum and that we also maintain  
18 a consistent number of committee members voting  
19 throughout a measure. If you do need to step  
20 away for longer than a couple minutes, please  
21 just let a staff member know.

22 And so now, wanted to speak quickly

1 about our process and the criteria. So the first  
2 criteria is importance to measure and report, and  
3 the -- as you know, we first will be discussing  
4 evidence, so we will look at the evidence base  
5 for the measure, and then we will ask you to vote  
6 on evidence. You should all have a clicker, and  
7 we will be testing those after I get through this  
8 slide.

9 So we ask you to vote. If the measure  
10 passes evidence, then we go on and discuss and  
11 vote on gap, and then if that -- if the measure  
12 passes gap, we go on and discuss the scientific  
13 acceptability, so first reliability, again  
14 discussion and vote, and then validity,  
15 discussion and vote, and both of those as well  
16 are must-pass. The committee must -- must  
17 recommend a measure before we move forward.

18 And then we -- we go to feasibility,  
19 discuss and vote, usability, discuss and vote,  
20 and those two are not must-pass criteria, so we  
21 do continue on after we discuss those, and then  
22 we have a final vote on overall recommendation

1 for endorsement. At that point, if a measure has  
2 been recommended and there is a competing or  
3 related measure, we would have that discussion  
4 and -- and go from there.

5 So I think we will pull up our  
6 practice vote and have you all just do a quick  
7 practice vote and see -- make sure everybody's  
8 clicker is working so if it is not we have a  
9 little bit of time to replace it before we get  
10 into the actual voting.

11 Okay. So the practice question is  
12 which of the following philosophical schools was  
13 most identified with the Greek philosopher  
14 Aristotle? Option one, stoicism; option two,  
15 agnosticism; option three, platonism; and option  
16 four, empiricism. Voting is now open. You can  
17 attribute that to our Project Manager, Kate  
18 McQueston.

19 (Laughter.)

20 MS. MCQUESTON: It's okay to guess.

21 (Laughter.)

22 MS. THEBERGE: So yes, so we -- point

1 at Madison. She has got the voting slides. And  
2 just so folks know, project team will be voting  
3 for the people on the phone. They will be  
4 sending us their votes via chat, and we will be  
5 entering those. So I think we are still waiting  
6 for a few more votes.

7 (Pause.)

8 MS. THEBERGE: All right. Voting is  
9 now closed. Okay. The votes are in. We have 17  
10 percent for stoicism, with four votes; 4 percent  
11 for agnosticism, with one vote; 43 percent for  
12 platonism, with ten votes; and 35 percent for  
13 empiricism, with eight votes. And Kate, what is  
14 the answer?

15 MS. MCQUESTON: The correct answer is  
16 4, empiricism.

17 (Laughter.)

18 MS. THEBERGE: But yes, the bottom  
19 line is all the votes got in. Thank you.

20 (Laughter.)

21 MS. THEBERGE: All right. Thank you,  
22 everyone.



1                   So I wanted to just take a moment and  
2                   look at our algorithms. You do -- next slide.

3                   You do have these printed at your  
4                   seat, and I realize this is unreadable for those  
5                   of you sitting at the table, but you do have a  
6                   printed copy. And as you know, we just -- NQF  
7                   has created these algorithms to help you rate the  
8                   measures according to our criteria, so we ask you  
9                   to look and walk through each of these.

10                  We have one -- one for evidence, and  
11                  I want to just talk for a moment about exceptions  
12                  to the evidence. We have outcome measures, which  
13                  we are not necessarily looking for the quality,  
14                  consistency, and -- and -- the QQC, quality,  
15                  consistency, and I am forgetting the other one.  
16                  What we're looking for is that there is a  
17                  rationale to support the relationship of the  
18                  outcome to processes of care or the importance of  
19                  measuring the outcome.

20                  The other thing that we wanted to just  
21                  flag is that expert opinion is not considered  
22                  empirical evidence, but there are exceptional

1 circumstances in which expert opinion could be  
2 considered. In that case, you would vote for an  
3 exception to the evidence, and -- and that would  
4 be in cases when there is really no evidence  
5 available, and there has been a systematic  
6 assessment of expert opinion, and there is a  
7 really strong rationale for why that specific  
8 structural or process measure needs to have a  
9 measure associated with it.

10 So next slide is our reliability  
11 algorithm, which again, pretty straightforward,  
12 and then we have our validity algorithm, and you  
13 should have those at your seat as well.

14 For those of you in the room, up on  
15 the other screens, we do have a quick overview of  
16 our -- our threshold on voting, and I wanted to  
17 speak briefly about that. Measures must have  
18 greater than 60 percent to be considered  
19 recommended within our consensus guidelines, and  
20 measures that achieve between 40 and 60 percent  
21 are considered consensus not reached. We also  
22 sometimes refer to that as the gray zone, and we

1 do continue to review the measure if a measure is  
2 in that consensus not reached zone of, say,  
3 50/50.

4 We keep moving forward up to the final  
5 vote, and there has been a change since the last  
6 time that you all met. If you don't achieve  
7 consensus on a must-pass criterion, then you  
8 don't make a final vote on overall recommendation  
9 for endorsement. The committee would stop at  
10 usability, and we would ask the developer to  
11 bring back further information to address the  
12 issues you had raised, and then we will ask you  
13 to vote again and make your final recommendation  
14 on the post-comment call in May. So that is a  
15 minor change to our process.

16 And then anything that does not  
17 achieve at least 40 percent is -- is considered  
18 not recommended, or does not pass.

19 And so one last slide from me. Just  
20 want to -- we do have appropriate-use measures,  
21 so I wanted to just speak briefly about that. We  
22 had a request for some more information about

1       that.

2                   So appropriate use is a type of  
3       process measure that is used to evaluate  
4       procedures and medical technologies. They are  
5       not cost and resource use measures. They are not  
6       efficiency measures. And we do have some  
7       specific criteria for them, and the evidence  
8       should include a systematic assessment and  
9       grading of the quality, quantity and consistency  
10      of the body of evidence that the measure process  
11      does not lead to a desired health outcome, and --  
12      and we ask you to just make sure that there is a  
13      -- evidence on the effectiveness or lack of  
14      effectiveness or benefit of the test or procedure  
15      to patients.

16                   So, any questions?

17                   CO-CHAIR BROOKEY: So just one process  
18      question: if we do kind of reach an impasse, are  
19      we going to like say at some point we're going to  
20      bring it back to the follow-up phone call, or  
21      what are we going to do if we get into that  
22      situation? Because we do want to be able to

1 finish the majority of these by the end of the  
2 day.

3 MS. THEBERGE: Sure. So if you are  
4 having trouble achieving consensus, eventually, I  
5 think if you -- when we got to a point where  
6 everything -- you know, people had had a chance  
7 to say their perspectives, then we would ask for  
8 a vote. You would call a vote, and we would  
9 either keep going forward, in the case of  
10 consensus not reached, so one of those 50/50  
11 votes, we would have you just move on to the next  
12 criteria --

13 CO-CHAIR BROOKEY: Yes.

14 MS. THEBERGE: -- or, if the measure  
15 did not pass, then it would stop.

16 CO-CHAIR BROOKEY: Okay.

17 MS. THEBERGE: And I think our -- we  
18 have two committee members who joined us here in  
19 the room. If we could ask you just to introduce  
20 yourselves and if you have anything to disclose?

21 MEMBER MILLER: Are you -- this is  
22 Marlene. Are you talking to people on the phone?

1       You said in the room.

2                   MS. THEBERGE: Oh, great, you're on  
3 the phone. Well, we will have -- why don't you  
4 start, and then we also have some folks who  
5 joined us in the room.

6                   MEMBER MILLER: Oh, great, okay. So  
7 I am Marlene Miller. I am Chief Quality Officer  
8 for Pediatrics for the Johns Hopkins Medicine  
9 Health System, and I am I guess a returning  
10 member for this Pediatrics Performance Measures  
11 Committee meeting.

12                   MS. THEBERGE: Great, thank you. And  
13 I think we have just one new committee member.  
14 Sorry.

15                   MEMBER KNUDSEN: I am Kraig Knudsen.  
16 I am the Chief of the Bureau of Research and  
17 Evaluation at the Ohio Department of Mental  
18 Health and Addiction Services, and I have nothing  
19 to disclose.

20                   MEMBER MILLER: Oh, I am sorry. This  
21 is Marlene. I should say I have nothing to  
22 disclose either.

1 MS. THEBERGE: Thank you, both. Okay.  
2 With that, I think we are ready to begin our  
3 measure discussion, and so we will invite our  
4 developers from University of Michigan who I  
5 believe are dialing in on the phone.

6 DR. REEVES: That is true. We are  
7 here on the phone.

8 MS. THEBERGE: Great. Thank you.

9 CO-CHAIR SUSMAN: So John and I are  
10 going to sort of alternate to spell each other,  
11 and I have the good fortune to tackle the first  
12 one here. We're probably going to take a little  
13 longer since everybody is getting back used to  
14 the format. We will start with the developer  
15 overview, try to keep that relatively brief, but  
16 don't hesitate to ask questions. Then I will ask  
17 the lead discussants to give their feedback. We  
18 will go by each of the criteria, starting at the  
19 top and working our way through, remembering the  
20 must-pass, and then at the end, we will take a  
21 final vote on the measure, assuming it passes the  
22 must-pass criteria.

1                   If you have any questions, again, just  
2 hold up your cards, and we will be able to  
3 proceed efficiently. So without further ado,  
4 please welcome our developers to give us an  
5 overview.

6                   DR. REEVES: Good morning, everyone.  
7 Can everyone hear me okay?

8                   CO-CHAIR SUSMAN: Sounds good.

9                   DR. REEVES: Great. Hi. My name is  
10 Sarah Reeves. I am an epidemiologist with the Q-  
11 METRIC team at the University of Michigan.

12                   Our measure list sets a percentage of  
13 children that are ages three months to five years  
14 old with sickle cell anemia that received  
15 appropriate antibiotic prophylaxis in the year.  
16 Development of this quality measure for sickle  
17 cell disease was determined by CMS through a  
18 public process to be a priority for the nation,  
19 and this measure is supported by strong evidence.  
20 Children with sickle cell anemia are at almost  
21 100 times the risk of an invasive pneumococcal  
22 infection as compared to children with normal



1 hemoglobin.

2 What is even more concerning about  
3 this is that these infections are associated with  
4 high mortality. One report indicates that case  
5 fatality is at least 30 percent. And  
6 importantly, these infections can be largely  
7 prevented.

8 In a randomized control trial,  
9 children were randomized to receive either a  
10 daily placebo or penicillin, and among children  
11 in the penicillin arm, the incidence of infection  
12 was reduced by 84 percent. So given the success  
13 of this antibiotic prophylaxis in reducing  
14 infection, an expert panel at the National Heart,  
15 Lung and Blood Institute, or NHLBI, strongly  
16 recommends that all children with sickle cell  
17 anemia should receive twice-daily penicillin  
18 prophylaxis up until the age of five.

19 So in concordance with these  
20 guidelines from NHLBI, our measure uses  
21 administrative claims, and it assesses the  
22 proportion of children ages three months to five

1 years with sickle cell anemia that receive  
2 appropriate antibiotics within the year. As you  
3 all know, there is a lot of hemoglobin  
4 variations, and our measure focuses on the HbFS  
5 cases, or sickle cell anemia, and this is  
6 consistent with the NHLBI recommendations.

7 For the measure, our denominator is  
8 the number of children with sickle cell anemia,  
9 and we identify these children as children that  
10 have at least three healthcare encounters  
11 associated with sickle cell anemia within a year.  
12 We found that compared to the gold standard of  
13 newborn screening records, this case definition  
14 is valid, and it has high sensitivity and  
15 specificity to identify children that should be  
16 in the denominator.

17 Our numerator is the number of  
18 children with sickle cell anemia that received at  
19 least 300 days of appropriate antibiotic  
20 prophylaxis within the year. Receipt of  
21 antibiotics is identified through the presence of  
22 administrative claims for specific NDC codes that

1 are listed within the specification, and we did  
2 find also that this method for the numerator was  
3 valid, as it was highly correlated with the  
4 written prescriptions in the medical records.

5 So in addition to the evidence that  
6 our definitions for the numerator and the  
7 denominator were valid, we assessed the  
8 reliability of this performance score using a  
9 signal-to-noise analysis with Medicaid data  
10 across six different states. We found that the  
11 reliability of this measure was high. All of the  
12 reliability coefficients were over 0.8, and these  
13 usually -- and these all range from 0 to 1.

14 We used the same Medicaid data from  
15 six different states to assess the rates of  
16 antibiotic prophylaxis, meaning as the measure is  
17 300 days filled within the year, from 2005 to  
18 2010, and across this period, children with  
19 sickle cell anemia contributed over 3000 person-  
20 years to the study population. To our knowledge,  
21 this is the largest study population to ever  
22 assess antibiotic prophylaxis among children with

1 sickle cell anemia.

2           Among the children in the study  
3 population, the proportion that received at least  
4 300 days of antibiotics ranged from 3 percent to  
5 36 percent. This obviously indicates that  
6 substantial opportunities for improvement exist.  
7 In addition, we were able to identify differences  
8 in the performance scores by state.

9           So overall, we feel that this measure  
10 is highly important and has a real potential to  
11 make a substantial positive impact in these  
12 children's lives. Our measure focuses on  
13 appropriate antibiotic prophylaxis. This is an  
14 effective method to reduce the incidence of  
15 infection among children with sickle cell anemia.  
16 We found the measure is highly reliable and  
17 valid, and the data elements are readily  
18 available and administratively straightforward.

19           We also found an important and large  
20 performance gap, and we strongly believe that  
21 endorsement of this measure could have a very  
22 positive impact on the health of these high-risk

1 children. We really look forward to talking to  
2 you guys about this measure and addressing any  
3 questions or concerns that you might have. Thank  
4 you for your time.

5 CO-CHAIR SUSMAN: Thank you for that  
6 very lucid overview. So we will go on and ask  
7 Jeff to provide his overview comments and  
8 discussion around evidence.

9 MEMBER SCHIFF: I want to thank the  
10 folks from Michigan for the succinct and complete  
11 response.

12 I -- I want to go through this. I  
13 think the best thing I can do is maybe talk about  
14 how I went through this and looked at some of the  
15 evidence and then looked at some of the questions  
16 I had without getting -- and then we can get into  
17 some issues specifically around validity,  
18 reliability, and et cetera.

19 I think that the -- I guess the -- the  
20 first thing I will say, and I, in looking at the  
21 literature, I think that the authors  
22 appropriately identified a significant issue for

1 a relatively small population, but one that has,  
2 I agree, has significant mortality. I wanted to  
3 look at a few things that may alter this, and I  
4 think that they addressed these, or the  
5 literature addressed them, but I just want to  
6 bring them up for review.

7 One is some of the studies are a  
8 little bit old, and they were -- they -- the  
9 relationship of the studies to the -- to the  
10 pneumococcal vaccination was an issue that I  
11 looked at, and they actually addressed that. The  
12 polysaccharide vaccines were available, and one  
13 of the -- I am not going to go -- I can go dig it  
14 out of there, but the -- the literature did show  
15 that -- that despite the polysaccharide vaccine,  
16 there was still a risk to these kids, and that is  
17 I think an important thing to note, that we don't  
18 -- we're not out of this problem because of the  
19 pneumococcal vaccine or the expansion of the  
20 pneumococcal vaccine.

21 They also looked at -- they also  
22 addressed, or some of the literature addressed,

1 the resistance issue, and I think that -- you  
2 know, the issue of whether we are going to create  
3 more resistant organisms, and I think they have  
4 addressed that as well, and I will let the  
5 authors discuss that.

6 And so those are just I think two of  
7 the most important things in the literature that  
8 I think were addressed that make this still a  
9 viable and important measure. The other things  
10 then I just wanted to talk about with regard to  
11 the measure itself, the -- a couple things I  
12 thought were interesting that may be worth  
13 discussing, and one is that I thought it was  
14 interesting that it took three visits to the --  
15 to -- to reliably identify someone with sickle  
16 cell, and that was the -- the increase in  
17 reliability as we went through from one visit to  
18 three visits was -- I guess that was concerning  
19 to me, like I just -- seems like that is a  
20 diagnosis that should be fairly straightforward,  
21 but if you look at the numbers, they went up  
22 pretty significantly as you went along, so I

1 thought that was -- I thought that was important.

2 I liked the idea of 10 out of 12  
3 months because I think that if we are looking at  
4 people who are actually using the drug -- you  
5 know, there's a number of steps here. The  
6 prescriber has to prescribe it. That is not what  
7 we are measuring because they could prescribe it,  
8 and it couldn't be filled, but if you look at for  
9 the -- the jump from prescribing to actually  
10 having the medicine filled, which is where the  
11 claim comes in, I think that that is a reasonable  
12 thing, and I think it is -- I don't know if it is  
13 reasonable to assume, and I don't think we really  
14 know from this measure whether or not if someone  
15 prescribed it and they filled it, they are  
16 actually getting the med, but I think that if  
17 they are filling it over -- for 300 out of 360  
18 days, I think that that is a relatively good  
19 thing.

20 Most of these children are in the  
21 Medicaid program, so I think that it is a  
22 reasonable measure for Medicaid as well. And



1       then -- I think I will stop there. I think those  
2       are the key points that I got from reviewing  
3       their -- the measure as it is developed and some  
4       of the -- I guess the questions that were raised  
5       for me as I thought about what they were putting  
6       forward.

7                   CO-CHAIR SUSMAN: Thank you very much.  
8       I am going to go then to each of the other  
9       reviewers, and then open it up for further. So  
10      Rajiv?

11                   MEMBER MODAK: Thank you. So a couple  
12      things. I agree with much of what Jeff said. I  
13      wanted to go to that point again about the three  
14      visits because that stuck out to me as well. So  
15      a couple of things with that: by excluding  
16      patients with less than three visits, what I was  
17      concerned with was the possibility that that  
18      could be a significant group of people that  
19      you're missing.

20                   In my practice, when we do quality  
21      improvement measures, for example something  
22      simple like immunizations, you know, there's two

1 steps. One is to -- to take care of those kids  
2 that you are actually seeing in the office, and  
3 then the next step is also to take -- reach out  
4 to those kids that don't come in, and that is  
5 where I potentially see you are missing the kids  
6 who might be at highest risk for sepsis because  
7 of their lack of compliance with care by not  
8 addressing them with revisits.

9 And then, but the other side of this  
10 is that the fact that we are dealing with kids  
11 who often are -- 80 percent or so I think who had  
12 Medicaid at some point, significant opportunity  
13 to address -- to address a gap in care for -- for  
14 the potentially most underserved population, so I  
15 will put that out there.

16 CO-CHAIR SUSMAN: So maybe it would be  
17 appropriate to ask our developers to very briefly  
18 discuss the rationale for the three-visit  
19 criterion?

20 DR. REEVES: Sure. I would be happy  
21 to.

22 The Table 4 that we have in our

1 testing form lays out the sensitivity and  
2 specificity of three different case definitions  
3 that we looked at to identify children with  
4 sickle cell anemia, and as you can see, the area  
5 under the ROC curve is really best for three --  
6 having at least three claims for sickle cell  
7 anemia within the year.

8 Our concern with loosening that  
9 definition any more was appropriately including  
10 children in the denominator that were not even  
11 eligible to receive antibiotic prophylaxis, and  
12 we felt like that would then dilute the measure  
13 inappropriately, so that is why we decided to go  
14 with the three healthcare visits for sickle cell  
15 anemia within the year.

16 CO-CHAIR SUSMAN: Thank you. I think  
17 hopefully folks can look on the screens in the  
18 center aisle and -- or their own materials, so  
19 the ROC curve analysis that was done, a tradeoff  
20 of sensitivity, specificity.

21 Okay. There was a question or a  
22 comment from Jeff.

1                   MEMBER SCHIFF: Oh, I just wanted to  
2 further what the developer said. They -- from  
3 one visit, they went from true positives of 409,  
4 three visits was 374, so they lost a lot of false  
5 positives, but they didn't lose very many true  
6 positives, so I thought that was an okay  
7 tradeoff.

8                   CO-CHAIR SUSMAN: Okay. Good. So I  
9 haven't heard any qualms about the evidence. We  
10 will go to Lauren and Maureen. What I would ask  
11 you to do is not repeat. If you agree, you can  
12 just indicate. And Lauren?

13                  MEMBER AGORATUS: Yes. I agree with  
14 a lot of what was already said. Under evidence,  
15 I was a little bit concerned that it was not --  
16 there was no way to clarify if additional, for  
17 example, not prophylactic antibiotics were  
18 administered for breakthrough infections. Also,  
19 the sources of evidence were related to  
20 penicillin, and yet there would be other  
21 antibiotics that could be used such as  
22 erythromycin, sulfamethoxazole, and trimethoprim.

1                   And then under the performance gap,  
2                   there was a concern noted about the small sample  
3                   size, and I didn't see anything on racial and  
4                   ethnic disparities. Under the specifications for  
5                   reliability, I was also concerned with the three  
6                   health encounters. Also, perhaps consideration  
7                   of exclusion for children who could have  
8                   suppressed immune systems due to comorbid  
9                   conditions such as organ transplant, cancer or  
10                  other immunosuppressive medications such as  
11                  steroids, Humira, et cetera.

12                  Under reliability testing, again, the  
13                  generalization was questionable due to the small  
14                  sample size of the empirical evidence that was  
15                  presented. Under the validity testing --

16                  CO-CHAIR SUSMAN: We are going to try  
17                  to just stick to evidence right now, and I think  
18                  --

19                  MEMBER AGORATUS: Oh --

20                  CO-CHAIR SUSMAN: -- everything you  
21                  are --

22                  MEMBER AGORATUS: -- okay, okay --

1 CO-CHAIR SUSMAN: -- raising are --  
2 are --

3 MEMBER AGORATUS: Yes.

4 CO-CHAIR SUSMAN: -- great comments,  
5 but we will plow through evidence first, and then  
6 we will make sure we get to the other concerns  
7 you're raising.

8 MEMBER AGORATUS: Okay.

9 CO-CHAIR SUSMAN: Okay.

10 MEMBER AGORATUS: I am done.

11 CO-CHAIR SUSMAN: Okay. Sorry to cut  
12 you off. Maureen?

13 MEMBER EDIGER: I don't have anything  
14 else to add.

15 CO-CHAIR SUSMAN: Okay. So let's open  
16 it up for the panel to ask any questions or  
17 clarifications. When you are through talking, if  
18 you can remember to turn off your speaker. I  
19 think after a while, there's only so many people  
20 that can speak at once.

21 MEMBER MILLER: This is Marlene on the  
22 phone. I don't -- can't raise my little hand, so

1 I will -- put me in the queue, though. When you  
2 have questions to go around, I have some.

3 CO-CHAIR SUSMAN: Why don't you start  
4 off?

5 MEMBER MILLER: Oh, great. My  
6 question had to do with just the reality of who  
7 is providing this care for these children. A  
8 colleague that I know well was doing a lot of  
9 research on this and found there's discrepancies  
10 sometimes between whether it's the primary care  
11 provider that is providing the sickle-cell-  
12 specific care, or at times the hematologist, and  
13 so I have two questions for this.

14 The first is does the algorithm to  
15 identify three visits -- you identify whether  
16 they go to the primary care provider for these  
17 sickle cell visits, or to a pediatric  
18 hematologist? And my second related question has  
19 to do with the realities of care for children,  
20 particularly when the children's hospital, which  
21 is where pediatric hematologists are going to be  
22 congregated -- they are usually not in private

1 practice, per se -- what if that is across a  
2 state line, so it's in a different Medicaid  
3 database?

4 For example, what if the child lives  
5 in Maryland and gets their primary care in  
6 Maryland, but happens to see a pediatric  
7 hematologist at D.C. Children's? Will this  
8 methodology pick up those kids across borders?  
9 Because the reality is there's only about 80ish,  
10 you know, kind of full-service children's  
11 hospitals in this country, and then many are  
12 going to be across state lines for some children.

13 CO-CHAIR SUSMAN: So it sounds like a  
14 great question for a developer to clarify.

15 DR. REEVES: Great. So first I would  
16 like to address your first question about the  
17 algorithm and if it distinguishes between visits  
18 with primary care physicians or hematologists.

19 So the algorithm is actually even  
20 broader than being types of visits. It is any  
21 claim whatsoever that is associated with sickle  
22 cell anemia. This could be even durable medical



1 equipment, or a laboratory claim, or any -- it is  
2 a count, just a count of three claims that deal  
3 with sickle cell anemia, so it is not limited to  
4 those that are seen by a primary care or a  
5 hematologist. Does that make sense for that  
6 question?

7 CO-CHAIR SUSMAN: Sounds --

8 MEMBER MILLER: Yes, that is good.

9 (Simultaneous speaking.)

10 CO-CHAIR SUSMAN: -- yes.

11 DR. REEVES: Okay. Great. And the  
12 second question, if it can pick up kids across  
13 state lines, so that would really depend on what  
14 data set you were actually using. If you were  
15 using the state-specific Medicaid data, it really  
16 wouldn't pick up those kids, but if you had maybe  
17 the MACs data set which we use that goes across  
18 states, you could tie children across states, or  
19 perhaps a private insurance company could track  
20 the children irrespective of the state that they  
21 receive, so I think that that question would  
22 really depend on the data set that you were using

1 to identify the children.

2 MEMBER MILLER: So given that the  
3 majority of these kids are likely in a Medicaid  
4 system, the first one you mentioned that you use  
5 that crosses states, what states are included in  
6 that?

7 DR. REEVES: So for the purposes of  
8 this, we used Illinois, Michigan, South Carolina,  
9 Texas, Florida, and -- what was -- Louisiana.

10 MEMBER MILLER: So you have a tool  
11 that links all those as one seamless large data  
12 set?

13 DR. REEVES: Yes.

14 MEMBER MILLER: But all the other  
15 states, would they be able to be linked? And,  
16 you know, this is the perpetual holy grail of  
17 linking all the Medicaid databases so we could  
18 get a perspective on children's care across the  
19 country.

20 DR. REEVES: It could do that. I  
21 mean, to be totally honest, the MACs data set  
22 that we are talking about is also relatively

1 delayed, so there is a several-year gap before we  
2 can look at that, so really, the state Medicaid  
3 databases are more current and are available more  
4 quickly and would be able to assess improvements  
5 in care on a quicker basis.

6 CO-CHAIR SUSMAN: I am going to go --

7 MEMBER MILLER: But --

8 (Simultaneous speaking.)

9 CO-CHAIR SUSMAN: -- down -- oh, go  
10 ahead.

11 MEMBER MILLER: I was going to say,  
12 but then to use them, you would have to be able  
13 to link visits, so my example, you know, of a  
14 child in Maryland and a -- that goes to D.C. for  
15 their hematology care, or you might miss visits  
16 and ordering of prescriptions and ordering of  
17 durable med equipment.

18 DR. REEVES: That's a possibility.

19 CO-CHAIR SUSMAN: Good.

20 (Simultaneous speaking.)

21 DR. REEVES: Thank you.

22 CO-CHAIR SUSMAN: Thank you. Let's go

1 down the row here and start with Jill.

2 MEMBER MORROW-GORTON: So maybe we are  
3 not supposed to do this, but I am a state  
4 Medicaid Medical Director. All Medicaid programs  
5 pay for over-the-border services. I think the --  
6 it is 50 miles, usually, and -- and many Medicaid  
7 programs will approve visits at specialty places  
8 out of state if that is the only place you can  
9 get it, so that would -- that claim would come  
10 back to the Medicaid program.

11 So -- so if you are from Maryland, and  
12 you get seen at National Children's, the claim  
13 that National Children's submits goes to the  
14 Medicaid program in Maryland, so it would be  
15 reflected in their data.

16 CO-CHAIR SUSMAN: Okay.

17 MEMBER KELLER: Hi, David Keller. So  
18 the -- I may be dating myself, but way back when,  
19 when I was a resident in Baltimore, we brought  
20 these kids in once a month for shots of long-  
21 acting bicillin, and it is still listed in the  
22 NHLBI guidelines as an approved method of

1 prophylaxis. Is that captured? I was hunting  
2 through that really long file of which drug codes  
3 were captured, and I could not find it in there.  
4 Is it in there and I have just missed it?

5 CO-CHAIR SUSMAN: Sounds like --

6 DR. REEVES: No, we --

7 CO-CHAIR SUSMAN: Go ahead.

8 DR. REEVES: I am sorry. We did not  
9 include that in the measure for the oral  
10 antibiotics.

11 CO-CHAIR SUSMAN: Okay. Any other  
12 questions or comments regarding validity? I mean  
13 evidence. I am sorry. Yes, thank you. Yes?

14 MEMBER BRISTOL-ROUSE: This is Tara  
15 Rouse. So Jeff had brought up the issue of  
16 resistance, and I was wondering if the primary  
17 reviewers could say anything more about the  
18 benefits outweighing the potential risks.

19 DR. REEVES: I am sorry. Was that a  
20 question for the developers?

21 MEMBER BRISTOL-ROUSE: Sure. Whoever.

22 DR. REEVES: Okay. Thanks. When we

1 thought about this measure, we did think about  
2 antibiotic resistance, and felt that it wouldn't  
3 be any more likely in this population to develop  
4 antibiotic resistance than any other population.

5 CO-CHAIR SUSMAN: Were there other  
6 complications or negative consequences  
7 considered?

8 DR. REEVES: We did consider the  
9 possibility that a child could be allergic to  
10 penicillin, and that would not be prescribed, and  
11 therefore actually in our definition of  
12 antibiotics in the NDC codes, and this also is a  
13 question that I believe Maureen asked earlier, we  
14 included penicillin, but we also broadened the  
15 definition just a little bit to include  
16 erythromycin for children that could be allergic  
17 to penicillin.

18 CO-CHAIR SUSMAN: Jeff, you had a  
19 comment?

20 MEMBER SCHIFF: Well I just wanted to  
21 ask the developer, you had a number around  
22 resistance in this population I thought in your

1 literature that sticks in my head. It was  
2 relatively low, but I didn't know if you -- that  
3 was nine percent, but is that correct?

4 DR. REEVES: I am looking at the  
5 literature. I actually can't remember the exact  
6 number. I might get back to you about that in  
7 just a minute. I am sorry.

8 CO-CHAIR SUSMAN: I think the --

9 MEMBER MILLER: This is Marlene --

10 CO-CHAIR SUSMAN: -- the --

11 MEMBER MILLER: -- I have a question  
12 that is related to the unintended consequences.  
13 Was there also consideration of post-secondary  
14 infections such as C. difficile, you know, the  
15 rate of, you know, the complications because of  
16 the constant use of antibiotics?

17 DR. REEVES: No. We did not look into  
18 that.

19 CO-CHAIR SUSMAN: Okay. Any other  
20 questions or comments? And yes, we are on  
21 evidence.

22 Looks like we are probably ready to

1 vote here. So again, we're looking at the  
2 evidence, the outcome, and I think this can be  
3 high, moderate, low or insufficient. And we will  
4 vote.

5 MS. JUNG: Voting is now open for  
6 Measure 3166 for evidence. Option 1 is high,  
7 option 2 moderate, option 3 low, and option 4  
8 insufficient.

9 MEMBER MILLER: How do I vote? This  
10 is Marlene.

11 MS. JUNG: Please submit your vote via  
12 the chat function, and the staff will enter it  
13 for you.

14 MEMBER MILLER: You've got to help me  
15 find it. Oh, I see chat here.

16 MS. JUNG: Voting is open, yes. We  
17 are still waiting on a few votes.

18 MEMBER MILLER: Can you confirm you  
19 have my vote?

20 MS. JUNG: We do now, yes. Waiting on  
21 one more.

22 Voting is now closed. The results are



1       39 percent for high, we have nine votes for that;  
2       57 percent for moderate, 13 votes; 4 percent for  
3       low, one vote; and 0 percent for insufficient,  
4       with zero votes. And the criteria has passed for  
5       evidence.

6                   CO-CHAIR SUSMAN: So that is great.  
7       Just remind you that this is a must-pass  
8       criteria, and it easily passed, obviously. So we  
9       are going to go ahead, and I will ask Jeff to  
10      just comment briefly on gap.

11                   MEMBER SCHIFF: I don't -- the  
12      developers talked about a gap that I -- a gap  
13      that I pulled out of the -- of their stuff was  
14      5.7 to 36 percent state range, so there is a lot  
15      of variability in states. Illinois must --  
16      appears to be doing better than some of the other  
17      states, and I am glad Minnesota, I don't think  
18      was measured. But -- but I think there is a -- a  
19      significant variation and a significant room for  
20      improvement.

21                   CO-CHAIR SUSMAN: Okay. Rajiv,  
22      anything different?

1                   MEMBER MODAK: Just to add that I was  
2 shocked how low that was.

3                   CO-CHAIR SUSMAN: So two votes  
4 sounding like there is a significant gap.  
5 Lauren, on the phone?

6                   MEMBER AGORATUS: Nothing else.

7                   CO-CHAIR SUSMAN: Okay. And Maureen,  
8 anything else to add?

9                   MEMBER EDIGER: No.

10                  CO-CHAIR SUSMAN: Okay. Opening up  
11 for any committee comment, and if not, we can  
12 vote on gap.

13                  (No response.)

14                  CO-CHAIR SUSMAN: Okay.

15                  MS. JUNG: Okay. Voting for Measure  
16 3166 for performance gap is now open. Option 1,  
17 high; option 2, moderate; option 3, low; and  
18 option 4, insufficient.

19                  Lauren, can you submit your vote?  
20 There it is. Thank you.

21                  MEMBER AGORATUS: I did. Okay.

22                  MS. JUNG: Voting is now closed. The

1 results are 78 percent high, 18 votes; 17 percent  
2 for moderate, with four votes; 4 percent for low,  
3 with one vote; and 0 percent for insufficient,  
4 with zero votes. And it has passed for  
5 performance gap.

6 CO-CHAIR SUSMAN: Okay. We are now  
7 going to move on our discussion concerning  
8 reliability and validity, so if we can talk.  
9 This first, maybe I will give -- Rajiv, would you  
10 like to take a first shot about reliability?

11 MEMBER MODAK: So as far as  
12 reliability, it seemed to me that there were -- I  
13 noted that there were hundreds of patients from  
14 each state measured, and the reliability was  
15 consistently greater than 80 percent for all the  
16 states, so to me, that sample size does seem  
17 sufficient to generalize for widespread  
18 reliability.

19 CO-CHAIR SUSMAN: Jeff, further  
20 comments?

21 MEMBER SCHIFF: I don't think anything  
22 besides what we have already talked about.

1 Thanks.

2 CO-CHAIR SUSMAN: Lauren, any --

3 MEMBER AGORATUS: Me neither.

4 CO-CHAIR SUSMAN: -- commentary? No?

5 And Maureen?

6 MEMBER EDIGER: No.

7 CO-CHAIR SUSMAN: So it looks, in  
8 briefly reviewing, that there was -- oh, John? I  
9 am sorry. Go ahead, please.

10 MEMBER FINKELSTEIN: So I have one  
11 question for the developers. In claims data, in  
12 pharmacy claims data, the days supplied field is  
13 -- is, in data sets that -- that I have used, is  
14 notoriously finicky, sometimes not populated.  
15 The agent is always populated well, but the days  
16 supplied sometimes isn't, so I wondered in your  
17 analysis if in this data set it was always  
18 populated, if it had extreme values that didn't  
19 make sense, and what you did when effectively the  
20 prescriber wrote quantity sufficient, which is  
21 not so uncommon. How did you -- how did you  
22 count -- how did you count those? How did you

1       come up with 300 days?

2                   DR. REEVES:  Thanks for the question.  
3       We came up with 300 days because, I mean, as you  
4       guys had said, it was about 10 out of the 12  
5       months, and we felt that that allowed for a  
6       little flexibility.

7                   As far as the specific claims, our  
8       days supplied was populated relatively well.  We  
9       -- we did look at a lot of different methods to  
10      try to make sure we were not having very low-  
11      quality data, so we had very very few kids that  
12      had zero days' supply, or even under 50 days'  
13      supply.  Actually, the average days supplied was  
14      186 I believe, so we felt that even if there was  
15      some incompleteness within those claims, that it  
16      was relatively well reflective of the number of  
17      prescriptions that were filled through that time.

18                  MEMBER FINKELSTEIN:  So I -- I am  
19      surprised at 186 days supplied.  So where I work,  
20      I think there is a three-month limit, so -- so  
21      really people were writing single scripts for --  
22      or was that with refills?  Did you count refills?

1 I am just trying to get at how you did this, if -  
2 -

3 DR. REEVES: Yes, I did count the  
4 refills. That would be 186 days throughout the  
5 entire 12-month study period.

6 MEMBER FINKELSTEIN: I see. So yes,  
7 I understand. Yes, plus -- I mean, yes, but it's  
8 going to average out. But these are dispensings.  
9 These are pharmacy claims, so they are  
10 dispensing, not prescriptions, so these are  
11 dispensing events that totaled 186 days, is that  
12 what you're saying? It is not one dispensing  
13 event of 186 days.

14 DR. REEVES: Exactly, you are correct.  
15 It is all of the dispensing events across the  
16 year summed.

17 MEMBER FINKELSTEIN: Right.

18 CO-CHAIR SUSMAN: Okay. Other  
19 clarifications about reliability?

20 (No response.)

21 CO-CHAIR SUSMAN: If not, I think we  
22 can move on to a vote on reliability.

1 MS. JUNG: Voting is now open for  
2 Measure 3166 for reliability. Option 1, high;  
3 option 2, moderate; option 3, low; and option 4,  
4 insufficient.

5 MS. MCQUESTON: Thanks, Laura and  
6 Marlene. We have your votes.

7 Voting is now closed. The results are  
8 30 percent for high, with seven votes; 70 percent  
9 for moderate, with 16 votes; 0 percent for low,  
10 with zero votes; and 0 percent for insufficient,  
11 with zero votes. The measure has passed  
12 reliability.

13 CO-CHAIR SUSMAN: Okay. Now we move  
14 on to validity, and maybe just to mix things up,  
15 I will ask Maureen to comment first.

16 MEMBER EDIGER: I defer to my other  
17 discussants.

18 CO-CHAIR SUSMAN: Okay. And Lauren?

19 MEMBER AGORATUS: The only thing I had  
20 was that the validity testing of the measure, it  
21 was reassuring to see that in addition to just  
22 face validity.

1                   Again, some concern over the sample  
2 size because those that were used were smaller  
3 than the ones in the evidence, which were  
4 considered small, but I know other folks  
5 considered them sufficient, so we will see.

6                   CO-CHAIR SUSMAN: Okay. Rajiv?

7                   MEMBER MODAK: So I just was reassured  
8 by the high correlation between the antibiotics  
9 that were prescribed and the antibiotics that  
10 were dispensed, based on administrative claims  
11 because I was skeptical of that beforehand.

12                  CO-CHAIR SUSMAN: And finally, we will  
13 move to Jeff.

14                  MEMBER SCHIFF: I -- I don't think I  
15 have anything significant to say. I thought the  
16 changes in -- in odds of dispensing 300 days over  
17 time changed a little bit. It is Table 7. So I  
18 don't know if the authors want to address that.  
19 That bounced around a little bit, and I didn't  
20 know if I could explain why that is -- why that  
21 is the case. That is probably the only concern I  
22 had.



1 CO-CHAIR SUSMAN: So is this a  
2 question maybe briefly for the developer --

3 MEMBER SCHIFF: Right.

4 CO-CHAIR SUSMAN: -- on Table 7?

5 MEMBER SCHIFF: Yes.

6 DR. REEVES: Sure, thanks for that  
7 question. As you all know, we also had submitted  
8 the TCD measure last year, and we did see  
9 increases over time in TCD screening rates, so we  
10 were really hopeful that we would see increases  
11 in antibiotic prophylaxis over time also in this  
12 population, and we really didn't. And so I think  
13 that this is, to be totally honest, just  
14 reflective of a lot of opportunity for  
15 improvement and a lack of improvement efforts  
16 over the last few years in antibiotic  
17 prophylaxis.

18 MEMBER SCHIFF: Thanks.

19 CO-CHAIR SUSMAN: Any other questions?  
20 I don't see any cards up -- or on the phone?

21 (No response.)

22 CO-CHAIR SUSMAN: Then let's go ahead

1 and move to vote on validity.

2 MS. JUNG: Voting on validity for  
3 Measure 3166 is now open. Option 1, high; option  
4 2, moderate; option 3, low; and option 4,  
5 insufficient.

6 Voting is now closed. The results are  
7 39 percent for high, with nine votes; 61 percent  
8 for moderate, with 14 votes; 0 percent for low,  
9 with zero votes; and 0 percent for insufficient,  
10 with zero votes. The measure has passed for  
11 validity.

12 CO-CHAIR SUSMAN: And now on to  
13 feasibility. So if I can ask Jeff maybe to  
14 briefly comment on feasibility?

15 MEMBER SCHIFF: We in Medicaid like  
16 claims-based measures because we don't have to go  
17 to our providers and ask for them to be  
18 calculated because we get -- we get beaten up at  
19 retirement parties for --

20 (Laughter.)

21 MEMBER SCHIFF: -- and at other times  
22 when people -- when people say why are you making

1       us do chart abstractions for this stuff? So I  
2       think this is a measure that actually gets to a  
3       significant quality issue that is -- that is  
4       feasible to do, and with enough reliability and  
5       validity, so --

6               CO-CHAIR SUSMAN: Okay.

7               MEMBER SCHIFF: -- comment --

8               CO-CHAIR SUSMAN: It's going to be  
9       hard to top that. Rajiv?

10              MEMBER MODAK: I agree. In fact, just  
11       as an anecdote, we in my health center actually  
12       have direct log-ins to Medicaid, so we can  
13       actually receive our own data directly, which is  
14       immensely helpful for outcomes.

15              CO-CHAIR SUSMAN: That's cool.

16              MEMBER MODAK: Yes.

17              CO-CHAIR SUSMAN: Wow. All right.

18       Lauren?

19              MEMBER AGORATUS: No concerns.

20              CO-CHAIR SUSMAN: And Maureen?

21              MEMBER EDIGER: Nothing additional.

22              CO-CHAIR SUSMAN: Okay. Any other

1        comments or questions?

2                    (No response.)

3                    CO-CHAIR SUSMAN:    Seeing none, we will  
4        move on to a vote on feasibility.

5                    MS. JUNG:    Voting for feasibility for  
6        Measure 3166 is now open.    Option 1, high; option  
7        2, moderate; option 3, low; and option 4,  
8        insufficient.

9                    Voting is now closed.    The results of  
10       voting are 74 percent for high, with 17 votes; 26  
11       percent for moderate, with six votes; 0 percent  
12       for low, with zero votes; 0 percent for  
13       insufficient, with zero votes.    And the measure  
14       has passed for feasibility.

15                   CO-CHAIR SUSMAN:    And that leads us to  
16       usability.    How about, Rajiv, you want to talk a  
17       little bit about usability and use?

18                   MEMBER MODAK:    Yes, and I just noted  
19       that the measure is not currently being used as a  
20       quality measure, and -- but it obviously has the  
21       potential to improve high-quality care by  
22       reducing the burden of preventable pneumococcal

1 infections. And I just noted that -- no, I take  
2 that back. I noted that the antibiotic  
3 resistance was not quantified, but that actually  
4 was, so that is it.

5 CO-CHAIR SUSMAN: Jeff?

6 MEMBER SCHIFF: I think at the level  
7 of either health plans or the state, this is a --  
8 a very viable measure because I don't think it is  
9 designed to be a measure for individual  
10 clinicians, but I think it assesses the ability  
11 of -- of organizational structures to get these  
12 kids on these meds.

13 CO-CHAIR SUSMAN: Okay. And then we  
14 will go to Lauren?

15 MEMBER AGORATUS: No additional  
16 concerns.

17 CO-CHAIR SUSMAN: And Maureen?

18 MEMBER EDIGER: Nothing additional.

19 CO-CHAIR SUSMAN: All right. Let's  
20 vote on usability and use, unless there are any  
21 questions?

22 (No response.)

1 CO-CHAIR SUSMAN: And again, seeing,  
2 hearing none, we will go to vote.

3 MS. JUNG: Voting is now open for  
4 Measure 3166 for use and -- usability and use.  
5 Option 1, high; option 2, moderate; option 3,  
6 low; and option 4, insufficient.

7 CO-CHAIR SUSMAN: Are we having voting  
8 issues?

9 MS. JUNG: Yes, we are having some  
10 voting issues. Just a moment and we will try and  
11 reload this slide here.

12 CO-CHAIR SUSMAN: While we are  
13 correcting the technical difficulties, I just  
14 want to thank everybody for really being succinct  
15 and on point with comments. It really helps us  
16 to move along, and you evidently have been  
17 studying how to do this, because everybody has  
18 been quite up to par. Now, if we can get our  
19 computers to work, we will be doing fine.

20 Any questions about process or  
21 comments about process while we are waiting here?

22 (No response.)

1 CO-CHAIR SUSMAN: Okay. Thanks.

2 Just to highlight, we're going to go  
3 on although we were supposed to break after this  
4 first measure. You guys have been so wonderful  
5 we get to do another one. But looking ahead, it  
6 is probably a good idea that we use our time to  
7 get -- plow through this.

8 MS. JUNG: Okay. Let's try that  
9 again.

10 CO-CHAIR SUSMAN: Okay.

11 MS. JUNG: Voting is now open for  
12 Measure 3166 for use and usability. Oh, it is  
13 working, great.

14 CO-CHAIR SUSMAN: Yay.

15 MS. JUNG: Waiting on -- oh, voting is  
16 now closed. The results are 52 percent for high,  
17 with 12 votes; 48 percent for moderate, with 11  
18 votes; 0 percent for low, with zero votes; and 0  
19 percent for insufficient, with zero votes. The  
20 measure has passed for use and usability.

21 CO-CHAIR SUSMAN: Okay. And now, if  
22 I am not mistaken, we get to vote on the overall

1 measure.

2 MS. JUNG: Okay. Voting for Measure  
3 3166 for overall suitability for endorsement is  
4 now open. Option 1, yes; option 2, no.

5 Voting is now closed, and we have  
6 reached consensus with 100 percent, with 23  
7 votes. This measure is now endorsed by NQF.

8 CO-CHAIR SUSMAN: Well done, folks.

9 MS. JUNG: Recommended for --

10 CO-CHAIR SUSMAN: Excellent.

11 MS. JUNG: -- endorsement.

12 CO-CHAIR SUSMAN: Yes. Give a round  
13 of applause for yourselves.

14 (Applause.)

15 CO-CHAIR SUSMAN: So, thank you. We  
16 are going to do a switch, and John is going to  
17 take on the next couple, but I just want to thank  
18 everybody for being really efficient and directed  
19 with their comments.

20 CO-CHAIR BROOKEY: Do we have a  
21 developer here for the -- the GAPPS preventable  
22 adverse event measure?



1                   Great. So we're going to NQF Measure  
2                   3136, and I will ask you to introduce yourself  
3                   and give us a brief overview of the measure, if  
4                   you would.

5                   DR. LANDRIGAN: There it is. Is that  
6                   it? Great, thanks.

7                   So thanks very much. My name is Chris  
8                   Landrigan. I am a pediatric hospitalist and  
9                   health services researcher at Boston Children's  
10                  Hospital, and I am joined today by Mark Schuster  
11                  and Sara Toomey from the Boston Children's  
12                  Center, as well as David Stockwell from  
13                  Children's National here in D.C. We represent  
14                  the core team that developed the GAPPS, or Global  
15                  Assessment of Pediatric Patient Safety Measure.

16                  As many of you know, adverse events,  
17                  events in which medical care causes harm, have  
18                  been recognized as a leading cause of death and  
19                  injury in the U.S. since the 1990s. Although  
20                  there is now excellent awareness of the problem  
21                  of patient safety in U.S. hospitals, systematic  
22                  measurement of AE rates in hospitals is lacking.

1 The large majority of hospitals in the U.S.  
2 currently identify preventable adverse events  
3 through voluntary reports by staff.

4 Unfortunately, a series of studies  
5 have shown that only between 2 and 10 percent of  
6 all adverse events are reported through these  
7 systems. As a result, comparisons across  
8 hospitals are not reliable, as it is unclear if  
9 any differences represent true differences --  
10 excuse me -- or simply differences in reporting  
11 patterns.

12 Over the past decade, work has been  
13 conducted to develop a more systematic approach  
14 to measuring rates of adverse events using so-  
15 called trigger tools. Triggers are not  
16 themselves adverse events, but they help to  
17 identify them because triggers are often  
18 associated with an adverse event. When a trigger  
19 occurs, review of the medical record is required  
20 to confirm whether an adverse event did or did  
21 not in fact occur.

22 An example of a trigger is the

1 administration of Naloxone. If a chart is  
2 identified because Naloxone was given, a review  
3 might find that an adolescent was brought to a  
4 hospital because of a heroin overdose and was  
5 given Naloxone to save her. If that is the case,  
6 the trigger would not have identified an adverse  
7 event. However, if Naloxone were given because  
8 the hospital gave the patient a narcotic overdose  
9 as part of treatment, then there was a  
10 preventable adverse event. A review of the  
11 record is required to sort these things out.

12           Studies of trigger tools have shown  
13 that they are far more sensitive and reliable  
14 than voluntary reporting systems or screening  
15 tools that rely on administrative billing data  
16 alone. Trigger tools identify adverse events at  
17 10 to 100 times the rate of these other methods,  
18 and with better specificity.

19           To develop GAPPS, we began with a  
20 systematic review of the pediatric and adult  
21 literature to identify candidate triggers for  
22 possible inclusion in GAPPS. In addition, we

1 spoke with trigger developers. From our review,  
2 we compiled a list of 78 candidate triggers for  
3 possible inclusion in GAPPS.

4 Using the RAND/UCLA Appropriateness  
5 Method, we convened an expert stakeholder panel  
6 to review candidate triggers and assess their  
7 validity and feasibility. Panelists were chosen  
8 as -- or nominated rather by professional  
9 societies from the U.S., including for example  
10 the Academic Pediatric Association, the American  
11 Nurses Association, Consumers Advancing Patient  
12 Safety, and the National Patient Safety  
13 Foundation.

14 An initial list of 54 triggers were  
15 determined by our panel to be valid and feasible  
16 and were included in our draft tool. To  
17 rigorously evaluate the performance of GAPPS  
18 across a range of pediatric inpatient settings,  
19 we identified 16 hospitals to participate in the  
20 GAPPS national field test through the Pediatric  
21 Research in Inpatient Settings, or PRIS, Network.  
22 In each hospital, we reviewed approximately 240

1 records per hospital from randomly selected  
2 admissions for a total of 3814 records in total.

3 Nurses served as our primary  
4 reviewers. Primary reviewers presented all  
5 suspected adverse events to two secondary  
6 reviewers, who were physicians working in the  
7 study hospitals. These physicians independently  
8 made final determinations about the presence,  
9 severity, and preventability of any suspected  
10 adverse events. Secondary reviewers discussed  
11 and resolved any cases for which they had initial  
12 disagreement.

13 Of note, physician reviewers do not  
14 conduct reviews of the entire medical record.  
15 They only review suspected incidents identified  
16 by the nurse primary reviewers. These secondary  
17 reviews take about five minutes each. Since only  
18 a fraction of charts contain a suspected adverse  
19 event, the time burden for physicians is minimal.

20 GAPPS proved to be a reliable tool for  
21 detecting preventable adverse events. Primary  
22 reviewers agreed 92 percent of the time on the

1 presence or absence of a suspected adverse event,  
2 with a kappa of 0.69. Secondary reviewers  
3 verifying adverse event presence or absence  
4 agreed 92 percent of the time, with a kappa of  
5 0.81.

6 We refined the GAPPS tool at the end  
7 of our study based on an analysis of each  
8 individual trigger's incident and so-called  
9 positivity rate, that is, the frequency with  
10 which a particular trigger indicated the  
11 confirmed adverse event. Following removal of  
12 triggers that did not yield many adverse events,  
13 the tool was streamlined to include 27 triggers  
14 in the Manual GAPPS Trigger List.

15 To further decrease the time burden on  
16 nurse reviewers, we also developed an automated  
17 trigger list that allows hospitals to scan for  
18 triggers through the electronic health record.  
19 Using the automated list, the process of nurses  
20 investigating these triggers and then reviewing  
21 suspected adverse events with physicians is  
22 unchanged. The automated trigger list simply

1 speeds the initial step of looking for triggers.

2 In order to measure rates of  
3 preventable adverse events, we recommend that  
4 hospitals conduct 60 chart reviews per quarter.  
5 This requires a maximum of 30 hours of nurse  
6 reviewer time per quarter and an estimated  
7 maximum of one to two hours of physician time per  
8 quarter to conduct reviews.

9 We believe that GAPPS fills a critical  
10 need for a public measure of pediatric healthcare  
11 safety. It will serve as a valid and valuable  
12 tool to assess health system quality and motivate  
13 improvements in patient safety. Thanks for the  
14 opportunity to discuss the measure. Look forward  
15 to questions.

16 CO-CHAIR BROOKEY: Thank you very  
17 much. I apologize. I forgot in reading this,  
18 this is done retrospectively and not  
19 concurrently, is that correct?

20 DR. LANDRIGAN: It is done  
21 retrospectively, that is correct.

22 CO-CHAIR BROOKEY: Okay. So it is not

1 -- okay.

2 DR. LANDRIGAN: It is not done in real  
3 time --

4 CO-CHAIR BROOKEY: Ideally --

5 DR. LANDRIGAN: -- in hospitals.

6 CO-CHAIR BROOKEY: -- concurrent would  
7 be great, so very good. So we have -- I want to  
8 remind everyone about the algorithm, as your  
9 cheat sheet for this is an outcome measure, and  
10 so if we go along the top of the sheet here,  
11 which means that the -- the relationship between  
12 the measured health outcome should have -- there  
13 should be one health -- relationship with one  
14 healthcare action.

15 So when we talk about the evidence  
16 review, we need to look at -- from that  
17 perspective. So let's see. I think I am  
18 actually one of the discussants here, but I am  
19 going to defer to my colleagues here, and I  
20 believe Jill is the primary discussant, if Jill  
21 would like to begin.

22 MEMBER MORROW-GORTON: Sorry. I was



1 going to say this is an outcome measure.

2 (Laughter.)

3 MEMBER MORROW-GORTON: And I think  
4 that you did a really nice description and  
5 actually answered a couple of questions that I  
6 had reading the -- the information, that it was  
7 very helpful to hear that the nurses were your  
8 primary reviewers, because there was some  
9 question about that, and that the physicians were  
10 in fact only reviewing the ones where there was a  
11 suspected event and not reviewing the entire  
12 record. That I think answers some questions down  
13 the road in terms of the rest of the discussion.

14 I -- I think that most of this  
15 evidence is in the adult literature in terms of  
16 trigger -- using -- using triggers and that sort  
17 of thing. I think the concept of, you know, do  
18 you do kind of a sentinel reporting versus  
19 looking at every single record or a good number  
20 of records. This seems to be a fairly good  
21 middle ground in terms of being able to use your  
22 resources efficiently and still identify sentinel

1 events that can lead to processes that need to be  
2 improved to try to prevent those from occurring.

3 I had a couple of questions about  
4 community hospitals versus academic hospitals,  
5 and I wondered if -- if you could talk a little  
6 bit more about that, and then -- and then a  
7 couple questions about your -- your automated  
8 list versus your manual list because I noted that  
9 your -- your automated list had some elements in  
10 it that your -- one of them had some elements  
11 that --

12 DR. LANDRIGAN: Sure.

13 MEMBER MORROW-GORTON: -- the other  
14 one didn't because your hospital didn't measure  
15 that, but I just was curious why that was not  
16 there, so -- .

17 DR. LANDRIGAN: Sure. So -- so to  
18 answer the first part of your question about the  
19 community versus academic centers, so the way  
20 that the GAPPS field test was conducted is  
21 through the PRIS Network, we identified eight  
22 community and eight academic centers and rolled

1 the -- rolled the -- the GAPPS measure out in  
2 both, really in order to try to assess how well  
3 this performed at a range of different  
4 institutions that had varying degrees of  
5 electronic health records, for example, and  
6 different patient populations, obviously, and  
7 found that it was really able to be used pretty  
8 reliably in both. You know, the rates of harm,  
9 as we can get into if folks are interested, were  
10 certainly different in those two settings, but --  
11 but it functioned well in both.

12 And then with respect to the automated  
13 versus the manual trigger lists, you know, really  
14 the -- the idea here was that, you know, manual  
15 review, while it is not enormously burdensome if  
16 the sample size is not huge, still certainly  
17 represents some burden for institutions, and  
18 there has been a bit of a movement, to some  
19 degree in the adult side and to some degree in  
20 pediatrics as well, to begin to automate some of  
21 these triggers as the past few years have gone  
22 by, since many of them are based on laboratory

1 values and other things that are pretty easily  
2 scanned for in the electronic medical record.

3 And so we did that in our institution  
4 and were able to automate the large majority of  
5 them. In addition to providing some efficiencies  
6 in terms of even the common measures, the other  
7 advantage of doing this in an automated fashion  
8 is that you can include things that are  
9 relatively rare and probably were not worth the  
10 effort of a manual comb-through, if a nurse is  
11 kind of going through the charts one by one to  
12 look for -- look for triggers, but, you know,  
13 that might add some degree of value: for example,  
14 elevations in relatively rare drugs levels,  
15 things like that that can provide clues about  
16 adverse events that -- that add a little bit of  
17 depth and richness to the measure.

18 CO-CHAIR BROOKEY: Okay. Who else is  
19 -- Karen?

20 MEMBER HARPSTER: So I guess to  
21 comment from that question, how many -- of the 16  
22 institutions that were in the sample, how many

1       were electronic, and how many were paper?  
2       Because that I think would be -- make a huge  
3       difference.

4               DR. LANDRIGAN:   Yes.   So the large  
5       majority of the institutions actually had some  
6       degree of electronic health records there, but,  
7       you know, as -- as I am sure many of you are  
8       aware, that it is sort of this constantly moving  
9       picture at this point where there are  
10      institutions like those that are now on Cerner  
11      and Epic that have relatively robust electronic  
12      health records, and the large majority of their  
13      functions, including note-taking as well as labs  
14      and pharmacy and everything else, is sort of  
15      under one system.

16             Lots of others within this study set,  
17      particularly as we stretched back to 2007, when  
18      we began the review process, many of them were  
19      sort of in a mixed state, where labs for example  
20      or pharmacy might have been electronic, but much  
21      of the rest of it was paper.

22             MEMBER HARPSTER:   Sure.

1 DR. LANDRIGAN: And we found that, you  
2 know, really the measure functioned pretty  
3 equivalently either way.

4 MEMBER HARPSTER: Okay. I would say  
5 the only thing else I would have to add is that I  
6 was astounded by the number of adverse events.  
7 The one that, you know, stuck out, 11.1 adverse  
8 events per drug event per 100 in patient --  
9 pediatric patients, 74 adverse events per 100  
10 NICU patients --

11 DR. LANDRIGAN: Yes.

12 MEMBER HARPSTER: -- and 203 per 100  
13 PICU patients, which that was really astounding.

14 DR. LANDRIGAN: Right, yes. It -- I  
15 think it really is pretty astounding, and  
16 particularly some of our sicker patients who are  
17 in the neonatal ICU, or in the, you know,  
18 pediatric intensive care units, the frequency  
19 with which they suffer relatively minor adverse  
20 events is tremendous, as David knows. David is  
21 an intensivist.

22 And, you know, these things are -- are

1 just daily events, unfortunately, in our ICUs.  
2 Many of them are minor and transient, but  
3 certainly a subset of them are much more serious  
4 than that, and --

5 MEMBER HARPSTER: Yes.

6 DR. LANDRIGAN: -- important to  
7 tackle, I think.

8 MEMBER HARPSTER: Thank you.

9 CO-CHAIR BROOKEY: Okay. Ricardo?

10 MEMBER QUINONEZ: So you have  
11 identified, or you presented evidence both from  
12 adult and pediatric literature that -- that you  
13 can do a better job of identifying these adverse  
14 events, but really, what we are trying to prevent  
15 is the events.

16 DR. LANDRIGAN: Right.

17 MEMBER QUINONEZ: So is there -- is  
18 there evidence from the adult literature or  
19 pediatric literature that the identification  
20 itself improves the ultimate outcome?

21 DR. LANDRIGAN: Well, I mean, I will  
22 -- I suppose I would almost think of it in

1 reverse, in that if we don't identify the events,  
2 it is hard to take actions to improve, I think  
3 for a couple of reasons.

4 First, it is if these things are not  
5 transparent and the data about them is not there  
6 in the public domain there before the leaders of  
7 hospitals, it is difficult for them to commit  
8 resources and prioritize efforts to improve  
9 patient safety, and I think that that is probably  
10 reflected most clearly in the fact that if you  
11 look at adverse event studies in adults,  
12 particularly in -- and to some degree we now have  
13 some data in pediatrics from this GAPPs measure,  
14 over the past 6 to 12 years, the rate of  
15 improvement has been relatively slow.

16 And I -- and I think it is because  
17 there tends to be patchy focusing on discrete  
18 patient safety problems over time, but often,  
19 there is not a very well-coordinated, unified  
20 institution to drive the total rate of these  
21 things down. And so my sense is that, you know,  
22 like many other measures that the NQF endorses,



1 the first step is really to make these things --  
2 make these things apparent to everyone, and then,  
3 you know, the hope is that that stimulates  
4 improvement.

5 I don't think that -- that measuring  
6 all by itself stimulates improvement, but I --  
7 but it is a critical first step, in my mind.

8 DR. STOCKWELL: If I could add, the --  
9 there is -- the adult literature is a little bit  
10 further ahead than the pediatric literature. The  
11 pediatric literature is developing, though, there  
12 is no question.

13 Specifically, to answer your question,  
14 there are -- there is evidence that hospitals  
15 that have used a manual global trigger tool  
16 approach have been able to alter their overall  
17 harm rates. That is certainly the case. I would  
18 echo what Chris says, though: if it is not  
19 measured, it is not managed, and so we think this  
20 is one of the great disparities in our measure  
21 field, that we are not more robustly measuring  
22 safety events in pediatric inpatient setting.

1                   MEMBER MILLER: This is Marlene. I  
2 also have some questions I want to get into.

3                   MEMBER HARPSTER: Thank you. Sorry.  
4 I am wondering if you could speak to the  
5 admission time frame. I -- you did -- you  
6 excluded patients that were in the hospital less  
7 than 24 hours, and though I appreciate that that  
8 does speak to acuity, we are seeing more and more  
9 in my hospital patients being, you know, moved  
10 out of the hospital --

11                  DR. LANDRIGAN: Sure.

12                  MEMBER HARPSTER: -- quickly, and  
13 still having somewhat I would consider high-risk  
14 procedures. For example, an appendectomy  
15 oftentimes without a rupture is discharged in  
16 less than 24 hours, but that patient probably is  
17 at risk for some adverse events, and I am  
18 wondering if you could speak to that a little  
19 bit?

20                  DR. LANDRIGAN: Yes. I mean, I think  
21 that that is absolutely right. This measure is -  
22 - in a sense, it is broad. We are trying to

1 capture adverse events across the entire medical  
2 center, and really a wide range of adverse  
3 events, but it is narrow in the sense that it  
4 really is restricted to patients who would  
5 traditionally have been considered inpatients as  
6 opposed to observation state patients or, you  
7 know, the emergency departments transitioning to  
8 the outpatient and so forth.

9 And I -- I completely agree with you  
10 that adverse events occur at a very high rate in  
11 those settings as well, but just in trying to  
12 define the measure and keep things as consistent  
13 as possible across settings, that is sort of  
14 where we drew our lines.

15 CO-CHAIR BROOKEY: Marlene?

16 MEMBER MILLER: Yes. I have two  
17 questions. I am wondering if the developers can  
18 speak to the feasibility of automating this in  
19 IT. As an institution that recently moved from,  
20 you know, the Sunrise Eclipsis kind of system to  
21 Epic, it astounds me how even though we all --  
22 everyone on Epic, or everyone on Cerna may want

1 to do the same thing, each one of us has to de  
2 novo rebuild it, which is an enormous burden. So  
3 I am wondering if they can speak to the ease of  
4 the IT automation, how easy that is to -- does it  
5 still need specific institutional development  
6 work to make that active and live? Because  
7 obviously I am trying to get at burden here.

8 The other one I am confused a bit on  
9 the last statements on the development, is the  
10 recommendation for this as a sampling strategy  
11 over every quarter? And if that is, because that  
12 is how I sort of heard what you were saying in  
13 the development, how -- what is the recommended  
14 sampling to ensure removal of bias of charts?

15 DR. LANDRIGAN: So I will answer the  
16 second question first, and then David will tackle  
17 the first one.

18 So with respect to sampling, our  
19 recommendation is that there are 60 charts  
20 sampled per quarter across the hospital, or 20  
21 per month, in order to get a sense of -- of what  
22 is happening within the institution as a whole,

1 and we recommend that it essentially be random  
2 sampling across the entire institution, where,  
3 you know, the simplest method that most of our  
4 institutions in the study used is they lined all  
5 of the discharges up, the numbers up in a row,  
6 and then just used a random number generator to  
7 select 25.

8 DR. STOCKWELL: So in terms of the  
9 feasibility of automation, I think we should  
10 think about the question that we had earlier in  
11 terms of how many of the hospitals were fully  
12 electronic. Just like the answer to that  
13 question was there are many that are in  
14 transition from paper to automation, that  
15 certainly is some of the challenge as you work  
16 towards automating a full list of -- of triggers.

17 However, it can be done on --  
18 certainly done on an institutional level. That  
19 is where I had gotten my start with looking at  
20 automated triggers. We had run reports from --  
21 we have Cerner here in town at Children's  
22 National -- from Cerner reports that would -- we

1 would do daily pulls that would identify the  
2 specific data elements, Naloxone in Chris's  
3 example, or there are also organizations that can  
4 help to extract those data files from any  
5 organization with things like HL7 fees or flat  
6 file extractions, things like that.

7 So it certainly is feasible. It is  
8 typically a one-time organization to -- to have  
9 the local hospital prepare their data to be  
10 extracted, and then once that -- once that is  
11 done, those things are -- are pretty much in  
12 place. So it is fairly feasible.

13 CO-CHAIR BROOKEY: Jeff?

14 MEMBER MILLER: I guess I am wondering  
15 on the magnitude of that. Anything is feasible  
16 with electronic health records. You know, for  
17 example, when we try to take algorithms from  
18 other children's hospitals that we have learned,  
19 it is, you know, many days of a programmer to  
20 actually put that up and actually make it live,  
21 and so it adds significant burden when you start  
22 talking of that programming fee ahead. Did you

1 in your -- in your tests, did you actually kind  
2 of give those automated codes to someone and then  
3 measure how long it took them to build that out  
4 in their own system de novo?

5 I know you have done a lot of work on  
6 this with D.C. Children's, so you have had the  
7 benefit of kind of developing this gradually over  
8 time. I am very interested if there was a de  
9 novo institution that got the automated codes,  
10 and how long did it take them to really get it up  
11 live, and what were the FTE costs?

12 CO-CHAIR BROOKEY: So Marlene, I  
13 wonder if we can just hold that thought until we  
14 get to feasibility since we are focused now on  
15 just getting through the evidence question, and  
16 we can come back to that if that would be -- if  
17 that would be okay.

18 MEMBER MILLER: Sure.

19 CO-CHAIR SUSMAN: Jeff, did you have  
20 a --

21 MEMBER MILLER: Sure, that --

22 CO-CHAIR BROOKEY: -- question?

1 MEMBER MILLER: -- would be fine.

2 MEMBER SCHIFF: I think this is an  
3 evidence question. I am curious about -- and I  
4 have been trying to -- I looked at this list  
5 yesterday, and I can't seem to find it at the  
6 moment, but I am curious about what you -- what  
7 is not on the list that you thought had high --  
8 that you could not capture through the triggers?

9 And then I am also curious about --  
10 specifically, I am curious about the diagnostic  
11 errors, which I think are harder to capture, and  
12 whether or not they --

13 DR. LANDRIGAN: Sure.

14 MEMBER SCHIFF: -- whether or not  
15 there is anything to say about the importance of  
16 those versus some therapeutic errors.

17 DR. LANDRIGAN: Yes. So in terms of,  
18 you know, what -- what's on the list and what's  
19 not on the list, we -- we went through a pretty  
20 extensive process when we started -- started  
21 developing this measure to, you know, really  
22 review the literature and get broad input and



1 consider I think kind of everything under the sun  
2 that was possible.

3 We looked at both published lists as  
4 well as, in speaking with developers, things that  
5 they used individually in their own institutions  
6 and so forth, and tried to develop a sense of,  
7 you know, what were going to be good triggers,  
8 what were going to be bad triggers, and then, as  
9 part of our RAND process, got folks to -- to vote  
10 on these, and then sort of subsequently tested  
11 them one by one to see which ones played out.

12 So I think that, you know, at the end  
13 of the day, the list that we have here is not  
14 terribly different than the list that exists in  
15 the adult world or some of the prior kind of  
16 pilot pediatric tools that were developed, but it  
17 is streamlined. It is things that I think have  
18 been more extensively tested where we developed  
19 more evidence on the performance of each of these  
20 individual triggers, and we are pretty confident  
21 that it is a good list that is going to give a  
22 really broad picture of what is going on in the

1 hospital.

2 I completely agree with your sentiment  
3 that there are some -- you know, there are some  
4 limitations to this method. It does not capture  
5 everything, even though it is pretty broad, and I  
6 think one of the areas where it does tend to miss  
7 things is diagnostic errors. I don't think it's  
8 a great tool for picking that sort of thing up.

9 This is really a much better measure  
10 of errors of commission, where there is an  
11 explicit thing that is done wrong that causes  
12 harm in a patient, than -- than a measure of  
13 omission, like a diagnostic mistake, for example.  
14 It does at least capture some of those as well --

15 (Simultaneous speaking.)

16 CO-CHAIR BROOKEY: So Marlene, did you  
17 have another question about evidence?

18 MEMBER MILLER: Me? No.

19 CO-CHAIR BROOKEY: Oh, okay. I think  
20 we should move on. I think that we are -- we are  
21 really answering the question of whether or not  
22 there is one outcome related to this particular

1       measure, and the outcome would be improve patient  
2       safety.

3                   And I am going to call on myself as a  
4       discussant, since this is one of my two measures  
5       to review, and just to make a comment that in  
6       Kaiser, we have had some experience using trigger  
7       tools, so we -- we have been collaborative with  
8       data classing and so forth, and so I have a  
9       little bit of -- of firsthand knowledge of how  
10      good it could be, and how difficult it may be.

11                   But as a pediatrician, I would have to  
12      argue that we probably should have started these  
13      studies with pediatrics instead of adult medicine  
14      because the opportunity for error and medication  
15      error is just far greater with dose-related  
16      dosing of medication, so this is really, as a  
17      pediatrician, something that I think is, you  
18      know, really fabulous for improving patient  
19      safety, even though we are inferring it from the  
20      adult data, from what I understand, what you said  
21      here.

22                   So the question for the group is do we

1       -- does this particular outcome measure have a  
2       relationship to a desired outcome, which would be  
3       inferred here to be improved patient safety, I  
4       would guess? And are there any other questions  
5       about whether there is sufficient evidence for  
6       this outcome measure before we vote?

7                       (No audible response.)

8                       CO-CHAIR BROOKEY: Are we ready to  
9       vote? Okay.

10                      MS. JUNG: The voting for Measure 3136  
11       for evidence is now open. Option 1, pass; option  
12       2, not pass. And just to note, we will have a  
13       total of 22 votes for this because we have one --

14                      CO-CHAIR BROOKEY: We have one  
15       recusal.

16                      MS. JUNG: Yes.

17                      (Pause.)

18                      MS. JUNG: Voting is now --

19                      CO-CHAIR BROOKEY: Press really hard.

20                      MS. JUNG: -- now closed.

21                      (Laughter.)

22                      MS. JUNG: The results are 95 percent

1 pass, with 21 votes, and one vote -- or 5 percent  
2 for not pass, with one vote. The measure has  
3 passed for evidence.

4 CO-CHAIR BROOKEY: Okay. Very good.  
5 So we are going to move on to gap. And who would  
6 like to start, either Jill or Karen? Karen.

7 MEMBER HARPSTER: So I think as we  
8 kind of talked about, there is a gap. We don't  
9 have a pediatric tool of the measure at this  
10 point, so this would be the first, you know,  
11 taking a stab at it. The one thing again I  
12 mentioned before, the number of adverse events,  
13 but in the sample of the 16 hospitals that they  
14 looked at, there -- they identified 414 events,  
15 and 50 percent of them were preventable, so that  
16 is, again, a pretty large number, so I think that  
17 they have established that there is a gap.

18 And they also had -- they talked about  
19 disparities, too. I should mention that, and a  
20 gap in the disparities of racial ethnicity, and  
21 the number of chronic conditions had a number of  
22 input in the number of adverse events too.

1 CO-CHAIR BROOKEY: Jill, anything to  
2 add?

3 MEMBER MORROW-GORTON: No.

4 CO-CHAIR BROOKEY: And I have nothing  
5 to add. Any comments from the group, questions?

6 (No audible response.)

7 CO-CHAIR BROOKEY: Anyone on the  
8 phone?

9 (No audible response.)

10 CO-CHAIR BROOKEY: Are we okay to vote  
11 on gap? All right.

12 MS. JUNG: The voting for performance  
13 gap for Measure 3136 is now open. Option 1,  
14 high; option 2, moderate; option 3, low; and  
15 option 4, insufficient.

16 (Pause.)

17 MS. JUNG: Voting is now closed. The  
18 results are 73 percent voted for high, with 16  
19 votes; 27 percent for moderate, with six votes; 0  
20 percent for low, with zero votes; and 0 percent  
21 for insufficient, with zero votes. The measure  
22 has passed for performance gap.

1 CO-CHAIR BROOKEY: Great. So we are  
2 going to move to reliability, and I think we  
3 actually touched on some of these points in the  
4 earlier discussion, but I will look to Jill to  
5 see if you want to just comment on reliability.

6 MEMBER MORROW-GORTON: I -- I think  
7 there was a question about whether or not the  
8 RAND methodology does empirical validity, and I  
9 would like to hear a little more about what that  
10 -- how that works, and -- and how you used that.

11 CO-CHAIR BROOKEY: That's a question  
12 for the developer.

13 DR. LANDRIGAN: Sure. So, you know,  
14 our approach to trying to come up with a valid  
15 and reliable tool really took a few steps.  
16 Obviously, we started with a literature review,  
17 as I mentioned, and then sort of moved from there  
18 to taking things that were extracted from that  
19 literature review to a review by -- by a RAND  
20 appropriateness panel.

21 And really what that was is we had a  
22 group of nine organizations, professional

1 organizations from around the U.S., nominate  
2 members to consider these -- these measures,  
3 where we essentially put before them trigger by  
4 trigger what -- what we thought the relationship  
5 was between that particular trigger and risk of  
6 an adverse event, and had them rate, do they  
7 think that this thing is a valid measure of that,  
8 and then do they think it would be feasible to  
9 extract it from the medical record if it went  
10 live?

11 That generated for us really this list  
12 of 54 draft triggers, but the ultimate  
13 measurement of -- of validity and reliability of  
14 the measure went forward a step, where in the  
15 national field test, we -- we really looked at  
16 how well each of these recommended things had  
17 performed, and so I think of it, in this case, it  
18 is not the RAND method sort of operating in  
19 isolation, but for us, it was really a first step  
20 to getting towards more robust measures of  
21 reliability and validity that really were based  
22 on a direct assessment of the data.



1                   MEMBER MORROW-GORTON: And I think the  
2 other -- the other piece that probably needs a  
3 little clarification here is that -- that your --  
4 your data showed high specificity but low  
5 sensitivity for all of the reviewers, whether  
6 they were physicians, or, you know, your -- you  
7 considered some of them to be novices and some of  
8 them to be experts --

9                   DR. LANDRIGAN: Sure.

10                  MEMBER MORROW-GORTON: -- and they --  
11 and they all had sort of low sensitivity, and as  
12 well, they had -- they may have identified  
13 similar numbers of events, but they didn't  
14 identify the same events, so -- so the question  
15 is are there really more events there, and why is  
16 the sensitivity low?

17                  DR. LANDRIGAN: Sure. So, you know --  
18 you know, we tried to cross-check this in several  
19 different ways to look as carefully as we could  
20 at the reliability and validity of the measure,  
21 and our primary measure was really within an  
22 institution, how consistently can both nurses at

1 the primary review stage and then physicians at  
2 the secondary review stage rate these events?  
3 How frequently do they come to the same  
4 conclusions about what is going on, in other  
5 words, was there an adverse event in a particular  
6 chart, and then if so, was it confirmed  
7 preventable, what the severity level was, and so  
8 forth?

9 And in doing that, you know, we -- we  
10 found that -- that there was really high  
11 reliability at that stage, with -- with 92  
12 percent agreement at both the primary and the  
13 secondary stage with event identification. Then,  
14 as sort of a -- a secondary check of robustness,  
15 we then took those reviewers and put them to a  
16 pretty difficult standard, I think, which was  
17 comparing their reviews against the reviews of  
18 experts who had been doing this stuff for many  
19 years, and what we found in doing that is that  
20 the specificity of what our newly trained  
21 hospital-based reviewers found was quite high,  
22 you know, sort of in the 90 percent range.

1                    Their sensitivity as compared with  
2                    expert reviewers who had been doing this for many  
3                    years tended to be low. They missed, you know, a  
4                    relatively large proportion of the total events  
5                    that were there. And just as you're suggesting,  
6                    that to us indicated that there's probably more  
7                    in the chart. Sometimes it goes, you know,  
8                    undetected, and that experience makes some  
9                    difference.

10                   And we did take -- in trying to kind  
11                   of further delve into that and understand well  
12                   what are the limitations in our method for that,  
13                   we looked at what happened over the course of the  
14                   study as our reviewers gained more experience and  
15                   found that their sensitivity actually improved  
16                   significantly over the course of the study, and  
17                   furthermore, that those institutions that had  
18                   done this before -- you know, remember, again, we  
19                   were a mix of community and academic centers.  
20                   Some of them had used trigger tools before, some  
21                   of them had not.

22                   When we subdivided and looked at those

1       that had a little bit more experience, their  
2       sensitivity as well looked much better as  
3       compared with the expert reviewers than did the  
4       notices', and so we walked away from the process  
5       thinking that -- that really what we need to do  
6       is have a slightly more extended training  
7       program, which we developed. We actually created  
8       a series of five videos as the program ended to  
9       try to get people to a more expert level to  
10      begin. And then -- and then recognize that we  
11      think we do need a ramp up period once people  
12      begin to really use this where there is some  
13      feedback that happens as they begin to go through  
14      this process to get them up to that expert level  
15      of sensitivity before this really goes live.

16               CO-CHAIR BROOKEY: Karen?

17               MEMBER HARPSTER: I have nothing to  
18      add.

19               CO-CHAIR BROOKEY: So that does affect  
20      the reliability, though, if there is a learning  
21      curve or a -- I mean, that is obvious.

22               DR. LANDRIGAN: Right.

1 CO-CHAIR BROOKEY: So I think --

2 DR. LANDRIGAN: Right.

3 CO-CHAIR BROOKEY: -- we have to just  
4 understand that that is kind of a threat to  
5 reliability, right? Any other questions or  
6 concerns about reliability?

7 MEMBER AGORATUS: This is Lauren. I  
8 had a -- I understand that the rationale is to  
9 prevent events once someone is admitted, except  
10 that I was concerned that there was no follow-up  
11 for those that were in the ER and not admitted  
12 because sometimes lack of treatment could lead to  
13 an adverse event. Also, a question as to whether  
14 or not this includes mental health, and lastly, I  
15 looked at the -- it was a fairly comprehensive  
16 trigger list, but it was unclear whether UTIs  
17 from prolonged catheterization, which is a fairly  
18 common event, was included.

19 DR. LANDRIGAN: So I will -- I will  
20 answer the last question first. Yes, UTIs are  
21 included. Any type of a hospital-acquired  
22 infection would be included, or an infection

1       acquired as a consequence of healthcare  
2       intervention would be one of our captured types  
3       of events.

4               In terms of mental health admissions,  
5       the way that -- the way that the -- the tool is  
6       -- or the measure is structured, we are  
7       measuring, you know, again sort of really acute  
8       hospitalizations where patients are emergently  
9       coming into the institution, and that could  
10      include coming in for an overdose, you know, a --  
11      a psychotic break, for example. Any type of a  
12      really severe mental health condition that led to  
13      an acute hospitalization would be included here.  
14      It does not include sort of more chronic  
15      psychiatric care, if you will, rehab care,  
16      newborn nurseries, those types of not-quite-  
17      acute-care admissions, even though you might be  
18      in a facility for those.

19              And then I think there may have been  
20      a third facet to your question that I am  
21      forgetting. Did I miss something?

22              MEMBER AGORATUS: The -- the ER, the

1 people that are not admitted --

2 DR. LANDRIGAN: Oh yes.

3 MEMBER AGORATUS: -- and that lack --  
4 yes.

5 DR. LANDRIGAN: Yes, and again, I  
6 agree with that comment, that those are certainly  
7 an important population to consider as well. It  
8 really wasn't quite within the scope of what we  
9 were trying to do here, but I certainly agree  
10 with you that that is an important patient safety  
11 arena as well.

12 CO-CHAIR BROOKEY: John?

13 MEMBER BOST: James.

14 CO-CHAIR BROOKEY: I am sorry, Jim.

15 MEMBER BOST: Obviously, most hospital  
16 systems have a self-reporting like RL Solutions  
17 or something like that for adverse events. Was  
18 that data consulted at all when doing any of  
19 these reliability or validity assessments?

20 DR. LANDRIGAN: Not -- not for this  
21 specific study, no. There have been a number of  
22 studies in the past that have tried to cross-

1 check those things against one another, and they  
2 have found that those types of voluntary  
3 reporting systems really only pick up a fraction  
4 of what this tool picks up, something in the  
5 ballpark of 2 to 10 percent depending on which  
6 study you look at.

7 In fact, there was one study by David  
8 Classen that I am thinking of now that I think it  
9 picked up 1 percent of what their trigger tool  
10 picked up, so we really do think that this is a  
11 much more robust way of capturing that. Not to  
12 say that those systems are not valuable; I think  
13 that what those systems provide is a really  
14 detailed focused insight I think into the nature  
15 of -- of harms that occur in hospitals and help  
16 to focus institutional attention on trying to  
17 prevent these things, but if you are using it as  
18 a measure to try to track epidemiologically over  
19 time the frequency with which adverse events are  
20 occurring, I think this is much stronger than  
21 that sort of approach.

22 MEMBER BOST: Yes. I mean, I agree.



1 I was just wondering, just in the sense of --  
2 just in the sense that -- did they maybe happen  
3 to just pick up any that the testing process  
4 didn't?

5 DR. STOCKWELL: So I had an earlier  
6 study that predated the GAPPS work where we did  
7 look at that. A very common number that seems to  
8 come out in the adult and pediatric literature  
9 for the overlap is about 8 to 10 percent, and the  
10 six hospital study that -- that we performed,  
11 then the overlap was 9. And so that -- as Chris  
12 is saying, I think that the way to -- to look at  
13 these two approaches to harm identification is  
14 that what we are presenting today is patient  
15 safety outcomes, and many of the voluntary admit  
16 reporting events are near-miss events, so have  
17 not reached the patient yet.

18 You need both. I mean, as a -- for  
19 operations in a hospital, you need -- you need  
20 both so that you can get those two lenses on  
21 patient safety, but we feel like this is the --  
22 the more robust, as Chris said, more reliable way

1 to measure patient safety outcomes.

2 CO-CHAIR BROOKEY: Any other questions  
3 about reliability before we go to vote?

4 (No audible response.)

5 CO-CHAIR BROOKEY: Are we ready to  
6 vote? I wanted Suzanne to talk a little bit  
7 about -- going to your algorithm for evidence,  
8 this can only get a moderate, and so that is why  
9 you can't vote for high, and I want her just to  
10 explain that for us for this and future measures.

11 MS. THEBERGE: Sure. So for this, the  
12 reliability testing is at the data-element level  
13 only, which, according to our algorithm, the  
14 highest eligible is moderate. To be eligible for  
15 a high, we would need the measure score testing  
16 as well.

17 CO-CHAIR BROOKEY: Okay. Should we  
18 vote?

19 MS. JUNG: Voting for Measure 3136 for  
20 reliability is now open. Option 1, moderate;  
21 option 2, low; and option 3, insufficient.

22 (Pause.)

1 MS. JUNG: Voting is now closed. The  
2 results are 73 percent for moderate, with 16  
3 votes; 27 percent for low, with six votes; and 0  
4 percent for insufficient, with zero votes. The  
5 measure has passed for the reliability criterion.

6 CO-CHAIR BROOKEY: Great. We can move  
7 on to validity. Either Jill or Karen want to  
8 volunteer any comments about validity?

9 MEMBER HARPSTER: I think some of the  
10 comments that I had we discussed already. So,  
11 you know, one of the comments I had was about the  
12 lower sensitivity which we had already talked  
13 about.

14 They go on to talk about how we don't  
15 have a gold standard that exists, so we don't  
16 have that to use for that. But, they do talk  
17 about the base validity with the RAND methodology  
18 which they have discussed with us here today.

19 Other than that, I'm trying to see if  
20 I have any other comments here. I feel like we  
21 talked about a lot of the comments that I had on  
22 validity.

1 CO-CHAIR BROOKEY: Yes, I think we  
2 kind of blended these two together a little bit.

3 MEMBER HARPSTER: Yes. So, I think we  
4 -- and the length of stay of 24 hours, we kind of  
5 talked about already, too.

6 CO-CHAIR BROOKEY: Yes.

7 MEMBER HARPSTER: I think we're good  
8 as far as all the comments I had.

9 CO-CHAIR BROOKEY: Jill?

10 MEMBER MORROW GORTON: I agree, I  
11 think we've covered a lot of this.

12 CO-CHAIR BROOKEY: I think we did.

13 Jeff?

14 CO-CHAIR SUSMAN: So, this is a  
15 question for the developers. It seems that this  
16 tool, I'm sure will be helpful. But, that you  
17 have equated relatively minor events with some  
18 things that are relatively major or egregious.

19 And, to me, that's a little threat to  
20 your face validity as a clinician. And, thinking  
21 about some of the apples and oranges sort of  
22 gives you a fruit cocktail.

1                   So, when you're reporting rates at an  
2                   institutional level, I mean, maybe people are  
3                   dying like flies at one institution and they're,  
4                   you know, electrolyte imbalances or something in  
5                   another.

6                   DR. LANDRIGAN: Sure. And, so, we do  
7                   have a means of rating the severity of these  
8                   events as well. We use the NCC MERP scale where  
9                   these things are put on this fairly standardized  
10                  now five-point scale that gets you right from the  
11                  electrolyte disturbances up to preventable death.

12                  And, as really a submeasure of this,  
13                  those would be reported as well. I agree with  
14                  you, I think it's very important.

15                  DR. STOCKWELL: And, the other point  
16                  I might make is that the focus of the measure is  
17                  decidedly preventable adverse events.

18                  And, so, as is often the case, when we  
19                  discuss patient safety or patient harm from those  
20                  -- from the patient perspective, from the family  
21                  perspective, if -- those more serious events can  
22                  be just as unsettling to the patient or the

1 family as those that may resolve.

2 And, so, the scope of all of those  
3 events is something that we feel like we should  
4 be able to track and hopefully identify, improve  
5 and, at one point, eliminate.

6 CO-CHAIR SUSMAN: Yes, fair enough.

7 CO-CHAIR BROOKEY: I think that -- I  
8 mean, it goes -- it may get into the usability or  
9 not so much a feasibility but the usability of  
10 the measures in terms of any unintended  
11 consequences of trying to compare hospitals  
12 because the rates may or may not truly be telling  
13 the same story.

14 And, I think we may have to put that  
15 aside if we think there's still benefit for  
16 trying to get this to happen in hospitals.

17 And, I think we have to understand  
18 that that's going to be a threat. But, I guess  
19 we would have to deal with it like we do with any  
20 other measure that it's -- especially if it  
21 becomes publically reported.

22 I think we all intuitively understand

1       that this is going to be challenging to compare  
2       hospitals, even with a really solid measure.

3                   CO-CHAIR SUSMAN: Can I just ask one  
4       other question?

5                   When you looked at your community  
6       hospitals and the academic referral centers, it  
7       appeared that there were greater rates, if I  
8       remember correctly, at your academic centers, as  
9       you sort of expect.

10                  And, do you have any way that you've  
11       corrected for severity of illness de novo that  
12       might help tell more of a story about rates of  
13       adverse events?

14                  DR. LANDRIGAN: Well, when we did our  
15       initial analyses, we did adjust for the presence  
16       of chronic complex conditions. So, you know,  
17       adjusting in a sense for chronicity of illness  
18       and longstanding problems.

19                  And, while certainly, those things  
20       occurred more frequently in the academic medical  
21       center, it did not, by any stretch, explain all  
22       the differences between the academic and the

1 community.

2 I image a lot of that is due to the  
3 fact that the academic centers are receiving the  
4 sickest patients from the community hospitals and  
5 so there's a real disparity there in the types of  
6 patients that they're seeing and that that really  
7 is an apples and oranges type of a comparison.

8 Our recommendation at the end was  
9 that, really, community hospitals and academic  
10 hospitals should, for purposes of comparison, be  
11 stratified. They really are sort of in different  
12 buckets and I don't think at some level it's  
13 appropriate to compare, you know, a large  
14 children's hospital with a smaller community  
15 center that is seeing a very different population  
16 of patients.

17 CO-CHAIR SUSMAN: Okay. So, you do  
18 recommend stratification?

19 DR. LANDRIGAN: Yes.

20 CO-CHAIR SUSMAN: That's probably --  
21 okay, thanks.

22 CO-CHAIR BROOKEY: Any other comments



1 about validity before we go to vote? Okay.

2 MS. JUNG: As with the previous  
3 criterion, for validity testing this is only the  
4 highest eligible rating is for moderate, just to  
5 note, since it is a patient-level data element.

6 The measure -- the voting for Measure  
7 3136 is now open for validity testing. Option 1,  
8 moderate; option 2, low; and, option 3,  
9 insufficient.

10 Voting is now closed. The results are  
11 73 percent with moderate with 16 votes, 6 percent  
12 -- I mean, 27 percent for low with 6 votes and 0  
13 percent for insufficient with 0 votes.

14 The measure has passed for validity.

15 CO-CHAIR BROOKEY: Okay, moving on to  
16 feasibility, I think that we clarified one  
17 concern we all had about the number of physicians  
18 that would be involved in the review.

19 But, they're secondary reviewers, so  
20 the first level of review are by RNs and then the  
21 follow-ups would go to clinicians or physicians  
22 in the hospital, which can present challenges

1 unless they're staff physicians paid for by the  
2 hospital or for the medical group or whatever.

3 So, that would be the one comment  
4 about feasibility.

5 The other issue would be in terms of  
6 having electronic system, maybe SPOE or,  
7 hopefully, most hospitals are going electronic  
8 and so they would be able to use electronic  
9 triggers.

10 But, that certainly would be a threat  
11 if that wasn't available.

12 Jill, do you want to go ahead and make  
13 your comments about feasibility?

14 MEMBER MORROW-GORTON: Yes, and I  
15 think I talked about this earlier when we were  
16 talking about evidence, so I probably put it in  
17 the wrong place.

18 But, just kind of looking at what was  
19 available in some places and not in others, what  
20 was in an electronic record, what was not in the  
21 electronic record, what was able to be gained by  
22 a manual review.

1                   But, I think you've really touched on  
2                   that.

3                   Can you give us a little sense of the  
4                   cost, both time and money, related to training  
5                   the reviewers, both the -- because you would have  
6                   to train both your nurse reviewers and the  
7                   physician reviewers?

8                   DR. LANDRIGAN: Sure. So, the -- in  
9                   terms of the training, the program that we have  
10                  is really, it's five one-hour videos that we ask  
11                  folks to go through that requires a little bit of  
12                  homework in between, where, particularly, towards  
13                  the end of that video series, they're going into  
14                  their own real charts extracting, you know,  
15                  practicing extracting some cases and then coming  
16                  back to the training with, you know, really the  
17                  opportunity to vet questions amongst themselves  
18                  and sort of think through how these types of  
19                  events should be rated.

20                  So, it's -- I think it's not -- it's  
21                  certainly not cost-free in terms of time, but I  
22                  don't think it's enormously burdensome. And, the

1 hospitals that participated in this did not find  
2 it to be too difficult.

3 Do you want to add to that, David?

4 DR. STOCKWELL: I do. Just, and also,  
5 to tie in a little bit about the physician piece.  
6 I think that -- I appreciate that we've been able  
7 to clarify that, because there was clearly some  
8 confusion around how much intensive physician  
9 work there was to do this.

10 And, if this relied on physicians  
11 digging around in charts, we all know this  
12 wouldn't go anywhere. Right?

13 DR. LANDRIGAN: Right.

14 (Laughter.)

15 DR. STOCKWELL: So --

16 DR. LANDRIGAN: Unless we pay them.

17 DR. STOCKWELL: All the nurses in the  
18 room are like, yes, I know that's right.

19 (Laughter.)

20 DR. STOCKWELL: So, this time spent by  
21 a physician by reviewing these events is  
22 incredibly valuable. And, I'll tell you this

1 from experience at my own organization, when I  
2 was leading safety and quality at Children's  
3 National, I was often the physician authenticator  
4 for this process.

5 That process itself was some of the  
6 most valuable time that I ever spent learning  
7 about how the practice of medicine was executed  
8 at our organization.

9 And, so, we've estimated four hours a  
10 year at a minimum of physician time. But, I  
11 would argue that that time is some of the best  
12 that you can spend of learning where your  
13 vulnerabilities are. Where are the problems that  
14 the organization needs to address?

15 And, so, I think it's incredibly  
16 valuable time and, as we've constructed it, it's  
17 actually a minimal impact on physicians as well.

18 MEMBER MORROW-GORTON: Do you offer  
19 CME and CEUs?

20 (Laughter.)

21 DR. LANDRIGAN: That's a great idea.

22 DR. STOCKWELL: That's a good idea.

1 DR. LANDRIGAN: That's a great idea.

2 (OFF MICROPHONE COMMENT AND LAUGHTER)

3 CO-CHAIR BROOKEY: Do you have any  
4 comments for --

5 MEMBER HARPSTER: The only other  
6 comment or question I might have is that, you  
7 know have these videos and so, you know,  
8 hopefully, that after watching the videos they're  
9 really good at looking for what they need to look  
10 for.

11 But, do you have some kind of process  
12 that's set inside if you have a reviewer that is  
13 maybe not where you want them to be after your  
14 training period and what that looks like?

15 DR. LANDRIGAN: Yes, and I think it's  
16 a great question.

17 In the study itself, we didn't have  
18 really any problems with our reviewers and with  
19 the training videos and a little bit of coaching  
20 as they were getting started, things worked out  
21 fine.

22 I think that, as this rolls forward

1 going forward, I do think it would be important  
2 for institutions to keep an eye on how their  
3 reviewers are performing.

4 We typically recommend that they hire  
5 at least two people to fill this role and they  
6 each have a bit of an opportunity to do both the  
7 primary reviews as well as the secondary reviews,  
8 which obviously allows for some diffusion of  
9 work, but also gives us the chance to make sure  
10 that they're well-calibrated with each other and  
11 that one person is not problematic, for example.

12 DR. STOCKWELL: The other point that  
13 may be useful to bring up is that, in addition to  
14 the videos, we have standardized charts that  
15 really have guides that walk you through the  
16 process and, if you miss this, this is what you  
17 missed and the nature of the event itself and  
18 describing those sort of things.

19 And, we recognize that there will  
20 certainly be flux in the reviewers' core team  
21 from -- for any organization. So, keeping that  
22 calibration, as Chris has mentioned, is, I think,

1 a very important aspect of it.

2 CO-CHAIR BROOKEY: So, tagging on to  
3 Marlene's earlier question, you know, my  
4 experience is that not all hospital electronic  
5 health records are the same. And, things that  
6 are very important may be missing in terms of  
7 like, for instance, we had an issue for a period  
8 of time where ABGs were not connected.

9 So, there was not -- we could not  
10 create a concurrent review of triggers based on  
11 ABG until we had that integrated into the system.

12 And, so, I guess my question is, is  
13 this going to be highly reliant on integrated,  
14 very sophisticated systems or is it going to be  
15 different from hospital to hospital in terms of  
16 being able to utilize the tool?

17 DR. LANDRIGAN: Yes, you know, it  
18 doesn't have to be. Obviously, if you have a  
19 well-coordinated, easy to read electronic health  
20 system, it makes life easier for the nurse  
21 reviewers.

22 But, this is really designed around



1 the idea that you could just be going through an  
2 old paper record where, retrospectively,  
3 everything is printed out and stuck into a chart  
4 to make it work.

5 CO-CHAIR BROOKEY: Okay.

6 DR. LANDRIGAN: It speeds things if  
7 you don't have to do that, but it works  
8 regardless.

9 CO-CHAIR BROOKEY: Okay. So, I think  
10 that we talked about feasibility. I think we  
11 understand it requires people.

12 So, I mean, when we talk about --  
13 that's usually what we're talking about. It's  
14 not something that we can just pull out of the  
15 system, administrative data.

16 So, I think we all recognize that.  
17 And, so, I think the question will be whether the  
18 group feels this is -- meets feasibility. And, I  
19 guess we can rate it high, moderate, low or  
20 insufficient.

21 And, David, you wanted to make a  
22 comment before we vote?

1                   MEMBER KELLER: Only the, you know,  
2 all of this discussion of relying on the -- on  
3 institutional integrity brings to mind several  
4 learning collaboratives that we've been involved  
5 in where we've found ourselves to be holding  
6 ourselves to a much higher standard than our  
7 peers.

8                   And, I'm wondering if you considered  
9 the unintended -- potential unintended  
10 consequences of, well, I think the process that  
11 you're describing is exactly the right one that  
12 should be undertaken within an institution by  
13 making it a measure.

14                   And, you know, are we setting  
15 ourselves up for an unintended consequence of  
16 some folks gaming the system and then not having  
17 adequate external controls to be able to look for  
18 that kind of variation in implementation when we  
19 take this sort of a measure out into the field?

20                   DR. LANDRIGAN: Yes, I think it's an  
21 important point. And, depending on where this  
22 goes in terms of public reporting and so forth, I

1 mean, I think there may very well be a role for  
2 having occasional random audits of institutions  
3 by external reviewers as well as the internal  
4 folks.

5 We certainly, even in the context of  
6 study, use that to make sure that we had good  
7 reliability within the institutions and what they  
8 were detecting and reporting and so forth.

9 And, you know, I think if there's fear  
10 as time goes by about gaming the system here and  
11 there's consequences that are associated with  
12 having certain rates of reported adverse events  
13 using this measure, then I would think that some  
14 type of a check might be important.

15 CO-CHAIR BROOKEY: Okay, I think we  
16 all understand the feasibility of this measure.  
17 Are we ready to vote?

18 (NO RESPONSE)

19 CO-CHAIR BROOKEY: Okay.

20 MS. JUNG: Voting on feasibility for  
21 Measure 3136 is now open. Option 1, high; option  
22 2, moderate; option 3, low; and, option 4,

1       insufficient.

2                   Voting is now closed. The results are  
3       5 percent for high with 1 vote, 68 percent for  
4       moderate with 15 votes, 23 percent for low with 5  
5       votes and 5 percent for insufficient with 1 vote.

6                   The measure has passed the criterion  
7       for feasibility.

8                   CO-CHAIR BROOKEY: Great. So,  
9       usability follows feasibility and I think we kind  
10      of touched on some of those issues including  
11      unintended consequences if this gets out as a  
12      publically reported measure.

13                   I think that we have also talked about  
14      this is probably an important thing to do to look  
15      at potential harm in pediatric population.

16                   So, I'm going to ask either Jill or  
17      Karen if you have any specific comments about  
18      usability?

19                   MEMBER HARPSTER: I think we touched  
20      on them. I guess the only thing I would say is  
21      that, you know, it's not currently being used  
22      now. So, they mention that, you know --

1 CO-CHAIR BROOKEY: For children?

2 MEMBER HARPSTER: For children,  
3 exactly.

4 But, that there's a potential for it  
5 to be used.

6 MEMBER MORROW GORTON: So, I had two  
7 questions. One is, what's the experience of  
8 adult hospitals using this?

9 And, the second question is, and you  
10 talked a little bit about differences between  
11 hospitals, but my question would be, is this as  
12 or more useful as an internal quality improvement  
13 measure versus being compared across hospitals?

14 DR. STOCKWELL: So, my review of the  
15 adult literature and just from some of the  
16 experiences that I've had in working with David  
17 Classen and understanding where many adult  
18 organizations have been, there are -- there is  
19 extensive use of, obviously, not gaps, but the  
20 IHI Global Trigger Tool itself.

21 And, there is not necessarily national  
22 use of the results of that, but there are many

1 organizations, large hospital organizations that  
2 will compare hospital to hospital within those  
3 organizations and they, by their accord, have  
4 found that quite useful.

5 And, so, I think that the same thing  
6 could be extrapolated to the pediatric  
7 environment with the caveats that we've already  
8 discussed.

9 DR. LANDRIGAN: And, with respect to  
10 your second question about its use as a  
11 benchmarking tool versus a quality improvement  
12 measurement, I think it certainly fulfills both  
13 roles.

14 I think that most institutions that  
15 began using early versions of this were primarily  
16 using it for quality improvement purposes. And,  
17 I think that's kind of the history of this in  
18 many respects.

19 But, you know, now, as we've begun to  
20 demonstrate some reliability and validity and so  
21 forth to the measure --- excuse me --- you know,  
22 our hope is that it could be used in a broader

1 sense as well for hospitals to benchmark against  
2 one another.

3 CO-CHAIR BROOKEY: Okay, Jeff?

4 MEMBER SCHIFF: I just want to speak  
5 to this from the point of view of a state program  
6 because I don't think we could ever use this  
7 successfully at the state program without getting  
8 skewered.

9 (LAUGHTER)

10 MEMBER SCHIFF: No, I mean, I'm just  
11 being really honest about it. I think that this  
12 is exactly what needs to happen at the hospital  
13 level for the basis of quality improvement at the  
14 hospital.

15 And, what we could do at the state  
16 program, we do this sometime is insist that  
17 institutions put themselves through these  
18 processes and we just have to, at the state  
19 program, know that the process is happening.

20 So, in terms of usability, this is  
21 probably more a comment for NQF than for the  
22 developers is, I think there needs to be a place

1 for measures that we can endorse that are usable  
2 at the -- as a process measure that we should  
3 understand are being done so we, at the state  
4 level or the national level endorse them as  
5 confidential process measures or quality  
6 improvement measures that we don't ever ask for  
7 the results of but we know that they're actually  
8 happening.

9 CO-CHAIR BROOKEY: Yes, your point  
10 it's exactly mine that I'm more interested in  
11 this hospitals doing this rather than reporting  
12 it. That's why I struggle with this as a measure  
13 because I'm much more interested in the process  
14 because of the potential harm that could happen  
15 if these results are shared publicly without  
16 really good interpretation.

17 And that's the issue that I have in  
18 terms of usability. But I would love to see this  
19 happen at every hospital that admits children.

20 Amy?

21 MEMBER HOUTROW: I basically have that  
22 same concern, especially with overlay. So,



1       there are certain health systems that are really  
2       invested in doing exactly this sort of thing in  
3       potentially a very robust way.

4               And, then there are high -- hold  
5       themselves a very high standard. Then there are  
6       others for which the systems they have in place  
7       would be very difficult to actually use this.

8               And so, we have a spectrum of  
9       potential usability and I'd like to ask the  
10      developers about the overly issue and  
11      duplication that might occur for some systems  
12      that are already pretty advanced in their --

13              CO-CHAIR BROOKEY: And I'm going to  
14      ask for a brief discussion because we're running  
15      a little bit over time on this topic. Okay?

16              DR. LANDRIGAN: You know, sure. I  
17      think that certainly is the case that, if you can  
18      do this in an automated fashion, it becomes a  
19      little bit easier for the institution.

20              But, we really did design this with  
21      the notion that it should be able to work in  
22      hospitals that have minimal resources along those

1 lines and minimal electronic health records to  
2 try to make it as easy as possible.

3 CO-CHAIR SUSMAN: So, it's sort of  
4 like rape reporting on campus, those that are  
5 really diligent are punished because their rates  
6 are higher. And, you know, it may be an apt  
7 analogy in some ways.

8 So, this idea of dissociating  
9 accountability from process measures, I think, is  
10 really important for NQF to get a hold of. So,  
11 I'm talking to this corner of the room because I  
12 think, frankly, there are many measures that are  
13 ready, just wonderful for improving internal  
14 processes and identifying issues quality  
15 improvement, but really aren't ready for prime  
16 time at a national accountability level.

17 CO-CHAIR BROOKEY: Jim?

18 MEMBER BOST: I just want to make sure  
19 that somewhere in they are you're really saying  
20 it's for system improvement and not any type of  
21 punitive use.

22 CO-CHAIR BROOKEY: Yes, I think that's

1       what we're talking about.

2                   You can go ahead.

3                   MEMBER MILLER:   This is Marlene, could  
4       I chime in?

5                   CO-CHAIR BROOKEY:   Go ahead, Marlene.

6                   MEMBER MILLER:   I agree with this  
7       whole conversation and I just have had experience  
8       of many other measures that get put forth saying  
9       they're not ready for accountability and we don't  
10      think they should be used there and then they  
11      still get used there.

12                   And, so, I just have a lot of  
13      trepidation because there are no safeguards, no  
14      processes to prevent that from happening and  
15      using measures that aren't ready for  
16      accountability in such a punitive way.

17                   CO-CHAIR BROOKEY:   Go ahead.

18                   DR. AGRAWAL:   So, very quickly, I  
19      think you've tapped into a conversation that  
20      we're having actively right now in the  
21      background.

22                   I certainly, in discussions with our

1 stakeholders, see this as a gap or a need. Lisa  
2 and Marcia are well aware of this.

3 I think we have to think through what  
4 that means for, you know, our -- the public  
5 agencies that are involved in the work, what  
6 means for the evidentiary base behind these  
7 measures.

8 Because, of course, we also know there  
9 are gaps in measures with an extensive  
10 evidentiary base that we want to be able to  
11 elevate for accountability purposes.

12 So, if we're not doing that, I think  
13 we have to be really thoughtful about it. But,  
14 you know, in the spirit of being responsive, I do  
15 think this is a really important topic.

16 DR. STOCKWELL: Can I clarify one  
17 thing? I think that the rape analogy is an  
18 interesting one, although, I think it's more akin  
19 -- the rape reporting is more akin to voluntary  
20 reporting.

21 And, the vulnerabilities that are --  
22 that we've talked about with voluntary reporting.

1                   What we're trying to present to you is  
2                   a more systematic, reliable process to review  
3                   patient records in a way that you can actually  
4                   decrease a lot of that variability from hospital  
5                   to hospital in terms of just the reporting method  
6                   itself.

7                   CO-CHAIR SUSMAN: It's really the  
8                   element of gaming and assiduous review along the  
9                   specified pathway that you have defined. I  
10                  mean, I think your measure is really quite robust  
11                  in many ways.

12                 CO-CHAIR BROOKEY: Thank you.

13                 I'm going to try to move us along. I  
14                 think that we have good conversation here. This  
15                 is not a must pass element, usability.

16                 But, I think that when you're voting  
17                 for usability and overall, individually, you'll  
18                 have to consider all of these points about  
19                 accountability, and, so, that'll influence your  
20                 vote for the overall voting for this measure.

21                 Are there any other points about  
22                 usability that haven't been made already or

1 should we move to vote?

2 (NO RESPONSE)

3 CO-CHAIR BROOKEY: Vote? Okay, so,  
4 we're voting for usability.

5 MS. JUNG: Voting for Measure 3136 for  
6 usability and use is now open. Option 1, high;  
7 option 2, moderate; option 3, low; and, option 4,  
8 insufficient information.

9 Voting is now closed. The results are  
10 0 percent with 0 votes for high, 45 percent for  
11 moderate with 10 votes, 50 percent for low with  
12 11 votes and 5 percent for insufficient with one  
13 vote.

14 The measure has not met the criterion  
15 for use and usability. Oh, consensus not  
16 reached, apologies.

17 CO-CHAIR BROOKEY: Okay. Are there  
18 any other points before we go to overall?

19 (NO RESPONSE)

20 CO-CHAIR BROOKEY: Okay, so, we're  
21 going to vote for overall suitability for  
22 endorsement.

1 Oh, I'm sorry, Carol.

2 MEMBER STANLEY: Just one minor  
3 correction. I was wondering --

4 CO-CHAIR BROOKEY: Can you use your  
5 mic?

6 MEMBER STANLEY: I was wondering, I  
7 noticed you have no exclusions and that comes  
8 during the process. But, I think one question  
9 that would come up is, why aren't patients who  
10 are transferred from another facility excluded,  
11 you know, if they're admitted with a UTI already  
12 from another institution?

13 DR. LANDRIGAN: Sure.

14 So, because that would get into, if  
15 this were to go to public reporting, those  
16 institutions that get a lot of transferred  
17 patients would essentially be punished.

18 DR. LANDRIGAN: Right. Yes, we do,  
19 again, as a submeasure of this, track which of  
20 these preventable adverse occurred within the  
21 studied facility as opposed to having come in  
22 from outside. So, it's easy to exclude that for

1       measure purposes.

2                   CO-CHAIR BROOKEY:   Jeff?

3                   MEMBER SCHIFF:   I just want to be  
4       clear of the question, if we're voting for  
5       suitability for endorsement, is that under the  
6       overall open accountability framework of NQF?

7                   CO-CHAIR BROOKEY:   Yes.

8                   MEMBER SCHIFF:   Okay.   Can we abstain?

9                   (LAUGHTER)

10                  MEMBER SCHIFF:   I hate to cause a  
11       rebellion, but I just think it's really -- I  
12       don't want to disrespect the developer, but I  
13       don't think this is appropriate for that kind of  
14       measurement.   So, I guess the answer would be we  
15       should vote against it.

16                  DR. NISHIMI:   You are voting for  
17       accountability.

18                  MEMBER SCHIFF:   Okay.

19                  CO-CHAIR BROOKEY:   So, if that is a  
20       concern, you would vote no.

21                  MEMBER SCHIFF:   Okay.

22                  CO-CHAIR BROOKEY:   Okay?



1 Are we all clear what we're voting  
2 for?

3 (NO RESPONSE)

4 CO-CHAIR BROOKEY: Okay. So, let's  
5 vote for overall suitability.

6 MS. JUNG: Voting for overall  
7 suitability for Measure 3136 is now open. Option  
8 1 is yes; option 2 is no.

9 Voting is now closed. The results are  
10 64 percent with 14 votes for yes, 36 percent with  
11 8 votes for no.

12 The measure is recommended for NQF  
13 endorsement.

14 CO-CHAIR BROOKEY: Great.

15 Well, I think we're warmed up now, so  
16 that was a great discussion.

17 (LAUGHTER)

18 CO-CHAIR BROOKEY: Congratulations.

19 (APPLAUSE)

20 CO-CHAIR BROOKEY: Thank you.

21 So, we're going to take a break for  
22 how long?

1 MS. THEBERGE: Fifteen minutes.

2 CO-CHAIR BROOKEY: Fifteen minutes, be  
3 back in your seat in 15 minutes. Thank you.

4 MS. THEBERGE: 10:45 folks.

5 (Whereupon, the above-entitled matter  
6 went off the record at 10:30 a.m. and resumed at  
7 10:46 a.m.)

8 CO-CHAIR BROOKEY: Okay, we need to  
9 keep on schedule, so if I could ask everyone to  
10 return to their seat and we'll get started.

11 And, Rita, do you want to introduce  
12 yourself and your team member and we'll get  
13 started?

14 DR. MANGIONE-SMITH: Hi, I'm Rita  
15 Mangione-Smith and I am the Director of the  
16 Center of Excellence on Quality of Care Measures  
17 for Children with Complex Needs at Seattle  
18 Children's Research Institute.

19 And, this is one of our Center members  
20 and research team members, Kim Arthur.

21 MS. ARTHUR: So, I will be presenting  
22 Measure 3153, Continuity of Primary Care for

1 Children with Medical Complexity. Good morning.

2 We began our measure development  
3 process by creating a conceptual framework to  
4 identify care coordination processes that are  
5 related to short and long-term health outcomes  
6 for children with medical complexity.

7 Continuity of care emerged as  
8 foundational to care coordination because a  
9 continuous relationship with a single primary  
10 care provider or a small group of providers with  
11 in depth knowledge of a patient and family's  
12 needs could potentially increase efficiencies in  
13 care coordination, reduce avoidable utilization  
14 and improve health outcomes.

15 We conducted a literature review of  
16 continuity of care, defining continuity as the  
17 extent to which a patient's visits are  
18 concentrated in a single provider or a small  
19 group of providers. And, we were focused on  
20 primary care, to clarify that.

21 We found that the association between  
22 continuity of care and better outcomes has been

1 observed in multiple pediatric studies.

2 Better outcomes include lower ED  
3 utilization, lower risk of ambulatory care  
4 sensitive hospitalizations and greater primary  
5 care provider involvement and care coordination  
6 activities such as communication with other  
7 providers.

8 All of these studies use the Bice-  
9 Boxerman Continuity of Care Index which I will  
10 refer to today as the Bice-Boxerman COC Index.

11 This Index has multiple advantages  
12 over other measures of continuity of care.  
13 First, it is sensitive to continuity with a small  
14 group of providers if a patient sees a few  
15 providers frequently.

16 Whereas, other existing measures  
17 assess continuity with only one main provider.

18 Second, it uses administrative data.  
19 The Bice-Boxerman COC Index is, therefore, more  
20 feasible than parent reported measures and is not  
21 subject to recall bias.

22 All of the studies from our literature

1 review were Level II evidence according to the  
2 Oxford Center for Evidence-Based Medicine Levels.

3 We presented our literature review to  
4 a multistakeholder Delphi panel of nine panelists  
5 which included representatives of state Medicaid  
6 agencies and caregivers of children with medical  
7 complexity, among others.

8 The continuity of care measure we're  
9 reviewing today met face validity criteria. So,  
10 it was then operationalized and it underwent  
11 field testing in a sample of nearly 1,500  
12 caregivers.

13 Those caregivers were children of  
14 medical -- with medical complexity and they were  
15 from two state Medicaid programs and that was  
16 using 2012 data.

17 We had compelling results at that time  
18 showing an association between higher continuity  
19 and lower emergency department utilization as  
20 well as greater likelihood of caregivers  
21 reporting that their child's care coordination  
22 needs had been met during the prior 12 months.

1                   So, we then conducted the analyses  
2                   that you have seen in our measure submission  
3                   documentation to assess validity and reliability  
4                   using 2008 Medicaid analytic extract for MACs  
5                   data from 17 state Medicaid agencies.

6                   We found that our measure had  
7                   excellent reliability in this larger sample.  
8                   And, in our empirical validity testing, we found  
9                   that children who passed our COC quality measure  
10                  had lower odds of having an emergency department  
11                  visit which was consistent with our previous  
12                  findings.

13                  I look forward to discussing this  
14                  measure with you today and addressing any  
15                  questions you may have.

16                  Thank you.

17                  CO-CHAIR BROOKEY: Great, thank you.

18                  And, this measure is a structure  
19                  measure, if you're following your algorithm.

20                  And, I will ask, let's see here, we have Jill  
21                  again, no, different, Marlene, I'm sorry.

22                  Marlene, you're on the line, do you want to go

1 ahead and kick off?

2 MEMBER MILLER: Sure, focusing on the  
3 evidence, I think this measure correctly cites  
4 seven different articles linking the continuity  
5 of care to better outcomes.

6 I think the one thing -- I don't think  
7 even beyond these seven articles, if you just  
8 talk about, you know, gestalt and wisdom and what  
9 makes sense, there is a lot of also logic there  
10 behind the more that you are connected, the more  
11 you are less likely to have other inadvertent  
12 outcomes like unnecessary ED visits, et cetera.

13 The more you are actually connected  
14 and counseled and made sure you're, you know,  
15 compliant on your therapies, et cetera.

16 So, I think it has a lot of evidence  
17 going for it.

18 In addition, I think the one thing  
19 that is interesting is that all of the evidence  
20 behind it of this particular tool which, it was  
21 interesting to me, that it was something  
22 developed back in 1977.

1 All the evidence of those seven  
2 articles uses this one tool. And, so, you know,  
3 it did raise some questions of, you know, are  
4 there other better ways, maybe easier ways?

5 You know, should we look at other  
6 evidence other than a lot of this research, not  
7 only using the one tool, but came from one group  
8 about this link on continuity of care.

9 And, I say that, while in the  
10 meantime, I'd say that, you know, I think even on  
11 a -- whether you'd call it evidence or just pure  
12 face validity, I think everyone agrees that this  
13 one should make sense.

14 I guess the one thing that gave me  
15 pause in the evidence was using this rather older  
16 published tool and that all of this cited  
17 evidence uses only this one tool and it's  
18 predominantly from one research group in terms of  
19 the breadth of the evidence on it with this  
20 particular tool from 1977.

21 CO-CHAIR BROOKEY: Okay, good points.

22 I should mention that Jeff Schiff is



1       recusing himself from this particular measure.

2               David, do you have comments?

3               MEMBER EINZIG: Yes, just a couple  
4       comments.

5               I agree that, on the surface level,  
6       this absolutely makes sense.

7               Just a couple of questions that I  
8       would raise, though, would be can it be a direct  
9       correlation that seeing one provider or a small  
10      group of providers, is that a direct correlation  
11      with improved patient outcomes?

12              And, then second thought is, if you're  
13      in the world of shared care and collaborative  
14      care now, if you're in a large pediatric practice  
15      where that one patient may not see that one or  
16      two providers, if they're in the same office or  
17      in the same location, they may not bill. But, if  
18      they're still present, that's not -- they may not  
19      get accounted for with looking at the claims  
20      data.

21              So, those --

22              CO-CHAIR BROOKEY: Do you want to put

1       that into a question for the developer?

2               MEMBER EINZIG:   So, how would -- yes,  
3       so how would -- yes, so a question would be,  
4       direct correlation with improved care?

5               And, the second question is, how would  
6       that get picked up if they're not scheduled with  
7       that provider but that provider is still there?

8               CO-CHAIR BROOKEY:   Go ahead.

9               MS. ARTHUR:   Should I address the  
10       previous comments as well or --

11              CO-CHAIR BROOKEY:   I would focus on  
12       his questions ---

13              MS. ARTHUR: --- start here?

14              CO-CHAIR BROOKEY: --- yes.

15              MS. ARTHUR:   Okay.   So, it is true  
16       that the studies we found were studies of  
17       association and not causation.   But they were  
18       consistent across multiple studies.

19              And, in terms of, let's see, the  
20       second question about, if the provider was  
21       present, but it wasn't billed for that provider,  
22       it's true that this measure would not capture

1       that.

2                   I think that would be a reason to be  
3       trying to make sure that the billing reflected  
4       the provider who was -- the providers who were  
5       there.

6                   CO-CHAIR SUSMAN:   So, I guess in  
7       follow up, some of the most advanced systems are  
8       providing continuity based on team, maybe a nurse  
9       or other care coordinator and at least, as I  
10      understand this index, it's really focused, isn't  
11      it, on physician or is there a broader  
12      definition?

13                  MS. ARTHUR:   We define primary care  
14      clinician as a physician, nurse practitioner or a  
15      PA.

16                  CO-CHAIR SUSMAN:   But, a nurse who  
17      might be very well qualified to do care  
18      coordination who's not an NP or advanced practice  
19      nurse wouldn't be included, is that correct?

20                  MS. ARTHUR:   Oh, a nurse practitioner  
21      would.

22                  CO-CHAIR SUSMAN:   Good, but one who is

1 not?

2 MS. ARTHUR: No.

3 CO-CHAIR SUSMAN: One who is not would  
4 not be included as a continuity provider?

5 CO-CHAIR BROOKEY: Or a social worker  
6 or a therapist?

7 MS. ARTHUR: This measure isn't  
8 looking at that continuity.

9 CO-CHAIR BROOKEY: Right, right,  
10 right, right.

11 CO-CHAIR SUSMAN: Right. So, I mean,  
12 again, I'm just thinking about, and maybe it's  
13 better discussed when we talk about validity,  
14 that this is a threat where some system, a Kaiser  
15 for example, that might have advanced systems of  
16 care might be poorly represented by this measure?

17 MS. ARTHUR: One thing to say is that  
18 that, if you're looking at social workers or  
19 nurses, a healthcare plan would not be unfairly,  
20 like would not be punished for that because  
21 that's not measured in this measure, like, we're  
22 not looking at that.

1 CO-CHAIR BROOKEY: Right. Well, I  
2 guess the question would be, so the evidence  
3 here, and we're talking about evidence right now,  
4 the evidence and all the research that has been  
5 done is looking at this relationship with these  
6 providers and not with the extended team.

7 So, we're looking here at a very  
8 limited range in terms of providers. But, that  
9 is what you're evidence is suggesting leads to  
10 better outcomes even though intuitively know that  
11 all these others are important as well. Is that  
12 a fair statement?

13 DR. MANGIONE-SMITH: I think part of  
14 what the measure is getting at is the idea of the  
15 quarterback, right? That you have a team, but  
16 you should have one consistent person who's  
17 coordinating not only care for that child but  
18 also the team that's caring for that child.

19 CO-CHAIR BROOKEY: Okay.

20 DR. MANGIONE-SMITH: So, I think like  
21 Kim was saying, you're not going to get penalized  
22 by having that team in place. What you'd be

1 penalized for is the child seeing somebody  
2 different every time they come in --

3 CO-CHAIR BROOKEY: Right.

4 DR. MANGIONE-SMITH: -- as a primary  
5 care provider.

6 The one other thing I wanted to add in  
7 relation to Marlene's question about the  
8 evidence, we did review evidence more broadly.  
9 We looked at several different types of measures  
10 of continuity of care that have been used and  
11 trialed.

12 We ended up staying with Bice-Boxerman  
13 because it does actually give you credit for  
14 seeing the same two people several times as well  
15 as giving credit for seeing the same one person  
16 every time.

17 CO-CHAIR BROOKEY: Right, right.

18 DR. MANGIONE-SMITH: The other  
19 measures that are available strictly look at your  
20 continuity with a single provider. So, you get  
21 no credit if there's like a team of providers,  
22 maybe they both work part-time and you always see

1 one of those two, you will have a higher score on  
2 Bice-Boxerman than somebody who is seeing those  
3 same two providers using one of the other  
4 measures.

5 CO-CHAIR BROOKEY: Okay, understood.

6 Tara, do you have any comments?

7 MEMBER BRISTOL-ROUSE: Yes, you know,  
8 I think one thing that stuck out for me is the  
9 issue of, you know, communication being such a  
10 vital part of continuity from certainly the  
11 parent perspective that I have.

12 So, I know that there's, you know,  
13 this relationship between the two. But, just in  
14 thinking about practical lived experience, I  
15 think, you know, so much of it is less about, I  
16 mean obviously, I would love to see the same  
17 providers all the time, but it's also, even if  
18 it's a different provider, if it's a provider who  
19 knows my child and is able to speak competently  
20 with me, like, that's just as important as having  
21 someone I've seen before, maybe even more  
22 important if it's someone I've seen before who's

1 not a great communicator or is not really engaged  
2 with my family.

3 So, just, I guess that point in terms  
4 of the communication piece of continuity.

5 CO-CHAIR BROOKEY: Good comment.

6 David?

7 MEMBER KELLER: I will apologize if  
8 I'm just reading this wrong, but I want to make  
9 sure I'm clear on the denominator, because, in  
10 the version I have, it says --

11 MS. ARTHUR: It's wrong.

12 MEMBER KELLER: Okay. So, could --  
13 okay, good. Because, I read that like 15 times  
14 trying to figure out what I was missing.

15 MS. ARTHUR: Yes, it's oh boy, we're  
16 going to really trip people up with that.

17 MEMBER KELLER: Okay, so, it's  
18 supposed to be the most complex kids, not the  
19 other two categories with the lesser --

20 MS. ARTHUR: Right.

21 MEMBER KELLER: -- two? Okay. Thank  
22 you for that.



1 CO-CHAIR BROOKEY: That's why you're  
2 on the group, Jeff, very good.

3 So, Jill?

4 MEMBER MORROW-GORTON: Did I read  
5 right that they have to have five or more visits,  
6 sort of more than --- four or more? And, I guess  
7 my question is, where did you come up with that  
8 number?

9 And, in thinking about kids that have  
10 lots of complexities, if they don't need -- so,  
11 adding more visits just for the purpose of  
12 getting credit for this would not be -- would not  
13 necessarily be a quality thing to do when you're  
14 talking about primary care visits. So, just a  
15 question of where that all fits?

16 MS. ARTHUR: Thank you for the  
17 question.

18 So, the minimum of four visits was  
19 based on the research that was done by  
20 Christakis, et al, and he found that the Bice-  
21 Boxerman Index was less stable if you had fewer  
22 visits.

1                   So, just like with any calculation, if  
2                   you have a small denominator, whatever you  
3                   calculate is going to be -- not going to be  
4                   stable and it's going to be highly variable. So,  
5                   that's where the four visits came from.

6                   Also, I think it's important to think  
7                   about, if you think about this population of  
8                   children with medical complexity and you  
9                   establish that four visit minimum, these are the  
10                  children who are going in to primary care  
11                  frequently compared to others and there's more  
12                  opportunity to build that continuous relationship  
13                  with those children who are going in more  
14                  frequently.

15                  And, I'll also say that, in our  
16                  sample, the mean number of primary care provider  
17                  visits was 4.63. So, the kids in our sample were  
18                  coming in just over four visits and this was kids  
19                  age 1 to 17, so across the age range, that was  
20                  what our mean was if that helps give a sense.

21                  CO-CHAIR BROOKEY: And, that was sort  
22                  of stable across the age range, even with the

1 older?

2 MS. ARTHUR: No, older kids had fewer.

3 CO-CHAIR BROOKEY: Yes, yes.

4 MS. ARTHUR: Yes.

5 CO-CHAIR BROOKEY: Okay. I thought I  
6 saw somebody, oh, go ahead, Deborah.

7 MEMBER FATTORI: I'm just curious, as  
8 you looked at your evidence, did you look at  
9 generational differences with parents?

10 One of the things that we're  
11 struggling with, maybe struggling is too strong a  
12 word, but certainly being thoughtful about is, in  
13 our millennial parents, where seeing the same  
14 provider isn't as important to them as seeing a  
15 provider when they want to.

16 And, I'm just curious how that -- how  
17 this measure will impact that as long, I think to  
18 your point, Tara, as the communication is good,  
19 if they can use telehealth, if they can come in  
20 an evening or see the provider when they want, it  
21 might not be as important to them that they see  
22 the same provider.

1 MS. ARTHUR: That's an interesting  
2 question and I can't say that the evidence that  
3 we were looking at looked at generations. So, is  
4 there anything else I can address for you?

5 MEMBER FATTORI: No, I was just  
6 curious if that came up. It is one of the things  
7 that we're seeing more and more with our younger  
8 parents.

9 MS. ARTHUR: Yes.

10 MEMBER FATTORI: And, needing to meet  
11 the needs of those parents in our primary care  
12 settings to -- as far as when they want to be  
13 seen and have their children seen.

14 CO-CHAIR BROOKEY: Yes, so coming back  
15 to this particular measure, we're looking at the  
16 evidence to support this approach to continuity  
17 of care with better outcomes to refocus our  
18 discussion for future vote.

19 So, David?

20 MEMBER KELLER: I'm sorry, the other  
21 question that I had which I forgot because I was  
22 so obsessed with that other thing --

1 (LAUGHTER)

2 MEMBER KELLER: -- I was sure it was  
3 -- I was reading it wrong.

4 Is the question of primary care  
5 visits, and how do you -- how to identify primary  
6 care visits? At least in our state Medicaid  
7 agency, we are -- state Medicaid database, we are  
8 unable to differentiate a subspecialty visit from  
9 a primary care visit within our system because we  
10 bill a single provider code.

11 So, I think that would lead to some  
12 challenges if you were trying to apply it in our  
13 state.

14 MS. ARTHUR: Sure. And, it's an  
15 excellent point. We had the good fortune to have  
16 the data programming and analysis people that  
17 work with Jeff sitting next to you in development  
18 of the specifications as well as the Washington  
19 State Medicaid data and analysis people.

20 And, in working with them, we tried to  
21 come up with this comprehensive list of codes as  
22 we could to capture these visits appropriately.

1                   And, by doing the combination of the  
2                   NPI, the provider identifier and the place of  
3                   service, you can be pretty confident that it's  
4                   primary care because providers are, by their NPI,  
5                   there are ways to get at whether they're  
6                   subspecialty or primary care.

7                   So, by limiting the type of provider  
8                   by NPI that we allowed in, we were hoping that we  
9                   would avoid some of the problem that you're  
10                  alluding to in terms of if you were just to use E  
11                  and M codes for the type of visit.

12                 MEMBER KELLER: Right, I mean, and I  
13                 would have thought that would have been easy,  
14                 too. But, I've been told --

15                 MS. ARTHUR: It's not easy.

16                 MEMBER KELLER: -- because I was going  
17                 to say --

18                 MS. ARTHUR: And, we would never  
19                 purport that it's easy.

20                 MEMBER KELLER: Okay.

21                 MS. ARTHUS: But, it is --

22                 MEMBER KELLER: Good, because, yes.

1 MS. ARTHUR: We found that it is  
2 doable.

3 MEMBER KELLER: It's doable?

4 MS. ARTHUR: Yes.

5 MEMBER KELLER: Our state Medicaid  
6 agencies struggles with that and we struggle with  
7 them around that.

8 MEMBER AGORATUS: This is Lauren, just  
9 to tag team on that, I'm not sure if there's a  
10 way to capture if the primary care physician is a  
11 specialist, for example, for a transplant  
12 patient. Your PCP might be the nephrologist.

13 DR. MANGIONE-SMITH: Right. So, this  
14 measure would not look at subspecialty medical  
15 homes, it would only look at primary care medical  
16 homes.

17 And, so, if it were a child who is  
18 getting most of their care including their  
19 primary are from a subspecialist, which certainly  
20 does happen, they would very likely not be  
21 included in this measure because they wouldn't  
22 meet the threshold of having had four primary

1 care visits in a measurement year.

2 MEMBER AGORATUS: Thank you for  
3 clarifying.

4 DR. MANGIONE-SMITH: Sure.

5 CO-CHAIR BROOKEY: Okay. So, we have  
6 a number of questions and comments and, remember,  
7 we're talking about evidence for the measure.  
8 So, I'm going to --

9 Marlene, did you put your flag down or  
10 did you not have a comment?

11 MEMBER EDIGER: I found --

12 MEMBER MILLER: Oh, I didn't know it  
13 was up.

14 MEMBER EDIGER: Oh, sorry, it's  
15 Maureen.

16 CO-CHAIR BROOKEY: I'm sorry, Maureen.

17 MEMBER EDIGER: Similar names.

18 MEMBER MILLER: Sorry.

19 MEMBER EDIGER: That's all right.

20 My question was about emergency room  
21 visits and I think I found my answer in the  
22 report.



1 CO-CHAIR BROOKEY: Okay.

2 MEMBER MODAK: Just briefly to address  
3 the concern about team based care and about an RN  
4 care coordinator.

5 We actively use those for our  
6 medically complex patients. And, that has  
7 actually, I think it aligns well with this  
8 because we've found it increases continuity with  
9 the same provider or we have a dyad of providers  
10 who take care of patients in case one is not  
11 there.

12 CO-CHAIR BROOKEY: So, you don't have  
13 any concerns if they're not included?

14 MEMBER MODAK: I don't think so, I  
15 think it actually -- it's totally aligned with  
16 this, yes.

17 CO-CHAIR BROOKEY: Yes, okay.

18 Carol?

19 MEMBER STANLEY: Yes, I was wondering  
20 if you could speak to not having separate  
21 stratification for age categories since you're  
22 putting adolescents with the younger population

1 and the recommendation for primary care visits  
2 through AAP is vastly different for adolescents  
3 versus younger and how that bodes with the  
4 requirement of four or more visits?

5 DR. MANGIONE-SMITH: Right. So,  
6 there's not a requirement that you have four  
7 visits, we only put you in the denominator if  
8 you've had four visits.

9 So, if you're an adolescent who's not  
10 requiring much primary care, even though you're  
11 medically complex, you wouldn't even make it into  
12 the denominator for this measure.

13 That's why the majority of our  
14 population was in that younger age group because  
15 those are the kids who are coming in over and  
16 over again to primary care and those are the kids  
17 we want to be sure are having good continuity.

18 MS. ARTHUR: Right. I just was going  
19 to add, if you are an adolescent patient coming  
20 in at least four times, then we'd want to make  
21 sure you have continuity just like a younger  
22 patient is going to.

1 CO-CHAIR BROOKEY: Okay. I'm just  
2 trying to think through that just a little bit.  
3 So, you're trying to give better outcomes and  
4 you're probably looking at complex children,  
5 whether they're young or adolescents that are  
6 likely coming in more often.

7 So making them and having them come in  
8 four is probably reasonable to look at improved  
9 outcomes of decreased ED utilization and so  
10 forth. Is that right?

11 MS. ARTHUR: That's correct.

12 CO-CHAIR BROOKEY: Okay. Is everyone  
13 clear about what we're trying to measure? And,  
14 again, we're looking at the evidence for this  
15 measure and its relationship to outcome.

16 Are we ready to vote for evidence you  
17 think? Anybody on the phone have any other  
18 concerns before we move on?

19 DR. MANGIONE-SMITH: We did want to  
20 point out one thing in the review was that we did  
21 actually evaluate the quality of the evidence  
22 using the Oxford Center for Evidence-Based

1 Medicine criteria. It was one sentence in the  
2 evidence review and I think it just got missed.

3 CO-CHAIR BROOKEY: Yes.

4 DR. MANGIONE-SMITH: They were all  
5 Level II cohort studies.

6 CO-CHAIR BROOKEY: I think we're good.  
7 Okay, you want to vote?

8 MEMBER MILLER: Can you remind the  
9 scales?

10 MS. JUNG: Oops, sorry, hold on just  
11 one moment. No, we didn't start yet.

12 Voting for Measure 3153 is now open  
13 for evidence. Option 1, high; option 2,  
14 moderate; option 3, low; and option 4,  
15 insufficient.

16 Voting is now closed. The results are  
17 14 percent for high with 3 votes, 77 percent for  
18 moderate with 17 votes, 9 percent for low with 2  
19 votes and 0 percent for insufficient with 0  
20 votes.

21 The evidence has passed -- or the  
22 measure has met the criteria for evidence.

1 CO-CHAIR BROOKEY: Great, so now we're  
2 going to move on to gap. And, what page am I on  
3 here? I don't see a discussion on gap. Here it  
4 is, okay.

5 So, David, do you want to start out?

6 MEMBER EINZIG: Gap exists, I don't  
7 think that there was much else to add from other  
8 committee members comments.

9 CO-CHAIR BROOKEY: Okay.

10 Marlene?

11 MEMBER MILLER: Yes, I agree, gap  
12 exists. I think one question I had is, there was  
13 a substantially large sample size, I think it was  
14 like over 11,000 cases.

15 And, so, there was a lot of  
16 significance, but I wonder if the developers can  
17 comment about the clinical significance?

18 So, for example, there was, you know,  
19 a different pass rates of 67 percent continuity  
20 of care versus 62 percent. And, is that  
21 sufficient? Is that clinically meaningful is  
22 what I was lost on because it's such a large

1 sample size, I was worried if we lost sight of  
2 clinical then there's just statistical  
3 significance?

4 DR. MANGIONE-SMITH: Hey, Marlene.  
5 Yes, so, I think looking at the pass rates by age  
6 range or some of the other criteria, the P values  
7 are certainly being influenced by the large  
8 sample size.

9 I think what was striking to us was,  
10 when you look at the range of scores across the  
11 states, the 23 percent to 96 percent indicating  
12 that there's huge variation in performance across  
13 state Medicaid plans that we looked at in the 17  
14 different states.

15 That's where I think we're really  
16 seeing what would probably be considered more  
17 clinically significant differences in scores.

18 CO-CHAIR BROOKEY: Let me ask Tara to  
19 go next. Tara, do you have any comments?

20 MEMBER BRISTOL-ROUSE: No, nothing  
21 additional.

22 CO-CHAIR BROOKEY: Okay.

1 Jeff?

2 CO-CHAIR SUSMAN: It stretches my  
3 credulity that there's a 96 percent at a  
4 statewide level? I mean, I just -- I have almost  
5 -- is that right?

6 DR. MANGIONE-SMITH: Yes, it's right.

7 CO-CHAIR SUSMAN: Might just miss it  
8 on me. Because some of you work on the plan  
9 level, state level all the time. It just -- wow.

10 CO-CHAIR BROOKEY: Is that correlated  
11 to density and population or density of providers  
12 or --

13 DR. MANGIONE-SMITH: So,  
14 interestingly, the variation available sample  
15 size across the states was there was a big  
16 variance, but this was actually one of our states  
17 with a bigger sample size to draw from.

18 So, they had 450 eligible children.  
19 So, it was not that it as a tiny sample size and  
20 they just did really well on a few kids.

21 CO-CHAIR SUSMAN: Yes, no, just wow.

22 DR. MANGIONE-SMITH: You know, I guess

1 I could out them but I'm not going to.

2 CO-CHAIR SUSMAN: So, that's your  
3 secret sauce?

4 DR. MANGIONE-SMITH: Right.

5 CO-CHAIR BROOKEY: Let's see, Carol?

6 MEMBER KELLER: Actually, I do know  
7 that sample because there was a -- Massachusetts  
8 has a specific program for its sickest kids  
9 that's called CCM and my wife was the medical  
10 director for it during that period of time.

11 And, if that's the sample that they're  
12 drawing from, those kids have incredible  
13 continuity of care. So, I do believe.

14 CO-CHAIR BROOKEY: Okay, Carol?

15 MEMBER KELLER: She wasn't the one  
16 seeing them, but she supervised the program.

17 CO-CHAIR BROOKEY: Okay, let's see,  
18 Ricardo?

19 MEMBER QUINONEZ: Did you -- was there  
20 a correlation between that gap and primary care  
21 and the outcomes you're trying to prevent so that  
22 the states that have the lowest follow up have



1 the highest rates of emergency visits, for  
2 example?

3 DR. MANGIONE-SMITH: So, the analysis  
4 controlled for state. We did not look at ED use  
5 by state. But, in the overall analysis, the  
6 states that passed the measure that had higher  
7 pass rates had lower ED utilization.

8 MEMBER QUINONEZ: Okay.

9 CO-CHAIR BROOKEY: Jon?

10 MEMBER FINKELSTEIN: So, I, too, am  
11 the breadth of the variability by state makes me  
12 a little skeptical. So, because these are events  
13 that are happening at the provider group level  
14 being rolled up to a state and it's not -- it  
15 seemed implausible to me that one state has only  
16 wonderful provider groups, you would expect some  
17 regression to the mean as you combine different  
18 groups.

19 So, I just wonder, is there -- did you  
20 look for other kind of data quality explanations  
21 for this? So, people billing under a single NPI  
22 number in one clinic or any other things that

1 could have introduced funny things to make a  
2 state look better than it is or worse than it is?

3 DR. MANGIONE-SMITH: So, we  
4 deliberately included both states that had  
5 strictly fee-for-service, states that had a  
6 combination of managed care and fee-for-service.  
7 And, we know from working over the past five  
8 years with our Medicaid state partners in  
9 Washington and Minnesota that the managed care  
10 data is questionable at best many times and not  
11 complete.

12 We also know that the 2008 MACs data  
13 suffers terribly from incomplete managed care  
14 data. So, I would not be at all surprised if we  
15 looked at the states with lower performance, they  
16 probably have higher managed care penetration in  
17 terms of this population of children.

18 And, the ones that are mainly covering  
19 their kids with fee-for-service are probably the  
20 high performers because their data is much more  
21 complete.

22 So, I would say that that's probably

1 the biggest culprit here. We did try to use the  
2 states with Jeff Silber's help, we got a lot of  
3 information about which states have the higher  
4 quality data in the MACs data and those are the  
5 ones we tried to target. But, I still think we  
6 ran into this issue.

7 CO-CHAIR BROOKEY: So, at this point,  
8 we're just trying to decide if there's a gap.  
9 So, if there's other --

10 (LAUGHTER)

11 CO-CHAIR BROOKEY: -- important  
12 questions about whether we have a gap, then I  
13 invite them.

14 So, David?

15 (NO RESPONSE)

16 CO-CHAIR BROOKEY: Oh, okay.

17 So, is everyone decided whether we  
18 have a gap or not? Can we vote for gap?

19 (NO RESPONSE)

20 CO-CHAIR BROOKEY: Okay, all right.

21 MS. JUNG: The voting for Measure 3153  
22 for gap is now open. Option 1, high; option 2,

1 moderate; option 3, low; and, option 4,  
2 insufficient.

3 The voting is now closed. The results  
4 are 41 percent for high with 9 votes, 59 percent  
5 for moderate with 13 votes, 0 percent for low  
6 with 0 votes and 0 percent for insufficient with  
7 0 votes.

8 The measure has passed for performance  
9 gap.

10 CO-CHAIR BROOKEY: Okay, we can move  
11 on to reliability. And, can I get a volunteer  
12 from Marlene, David or Tara to go first?

13 (NO RESPONSE)

14 CO-CHAIR BROOKEY: Hearing none, I'll  
15 go with Marlene.

16 (LAUGHTER)

17 MEMBER MILLER: Great, I get the short  
18 straw, right?

19 I had no concerns about the  
20 reliability. They're pretty much all based on  
21 algorithms and they're well executed out the  
22 code.

1                   What I wasn't clear on, and I think  
2                   it's in there, but I just wanted to ask  
3                   specifically was how much of this was done  
4                   exclusively on ICD-10 which, obviously, we all  
5                   know greatly expanded the coding.

6                   I saw some wording there that there  
7                   was ICD-10, but I just wanted to be sure that  
8                   this was tested with ICD-10.

9                   DR. MANGIONE-SMITH: So, the current  
10                  testing that was done was done on the 2008  
11                  medical extract file which is all ICD-9. So, it  
12                  has not been testing in ICD-10, although the  
13                  algorithm to get the denominator, the pediatric  
14                  medical complexity algorithm will be released,  
15                  the ICD-9, ICD-10 combined version will be  
16                  released at the end of this month.

17                  So, and that has been tested using  
18                  both ICD-9 and ICD-10 coded data and validated  
19                  with both.

20                  So, we're confident that, at least in  
21                  terms of identifying the denominator population,  
22                  that should not be an issue.

1                   MEMBER MILLER: Okay, so I thought I  
2 was because I was -- that's why I was confused.  
3 I know is saw ICD-10 in some places but the  
4 bigger bulk of it has not been tested yet in 10?

5                   DR. MANGIONE-SMITH: Yes, the testing  
6 in this document was all done with ICD-9, but we  
7 wanted to make clear that the ICD-10 version is  
8 on the brink of being available.

9                   MEMBER MILLER: Okay.

10                  CO-CHAIR BROOKEY: David or Tara, any  
11 comments?

12                  (NO RESPONSE)

13                  CO-CHAIR BROOKEY: I should note, I  
14 think it's six eligible individuals per state  
15 Medicaid agency for necessary, that's not very  
16 many.

17                  DR. MANGIONE-SMITH: We're just .7.

18                  CO-CHAIR BROOKEY: For --

19                  DR. MANGIONE-SMITH: Yes, if you have  
20 up to 20 -- we recommend up to 25 because that  
21 pushes your reliability up to .9.

22                  CO-CHAIR BROOKEY: Right, right.

1 DR. MANGIONE-SMITH: Yes.

2 CO-CHAIR BROOKEY: So, any concerns  
3 about reliability? I think this is clearly  
4 described here.

5 Jim?

6 MEMBER BOST: Maybe it's not a concern  
7 but from what I -- I see that it was only done on  
8 Medicaid, and yet, your unit is health plan. So,  
9 I guess just a little concerned that reliability  
10 wasn't assessed at commercial plans.

11 DR. MANGIONE-SMITH: Right. So, we  
12 only looked from state to state in terms of the  
13 Medicaid health plans, that's correct.

14 Many of the states did have managed  
15 care products, so there was some commercial  
16 health plan in there.

17 But, you're right, we did not look at  
18 commercial health plan -- compared to commercial  
19 health plan.

20 CO-CHAIR BROOKEY: So, just for my  
21 benefit, because I'm very California-centric,  
22 when you say Medicaid health plan, you're

1 including both fee-for-service and managed care?

2 DR. MANGIONE-SMITH: Yes.

3 CO-CHAIR BROOKEY: Okay. Okay. Any  
4 other questions or concerns?

5 MEMBER AGORATUS: Yes, this is one  
6 from Lauren.

7 In terms of the continuous coverage,  
8 what happens if they switch plans?

9 MS. ARTHUR: We --

10 MEMBER AGORATUS: Is that in the  
11 report?

12 MS. ARTHUR: Sure, thanks for the  
13 questions.

14 So, to clarify, we were looking at  
15 continuous enrollment in order to be eligible.  
16 And, continuous enrollment in a single plan and  
17 they could have no more than a 30-day gap.

18 And, so, if a child switched plans,  
19 they wouldn't be eligible.

20 MEMBER AGORATUS: Thank you.

21 CO-CHAIR BROOKEY: If they went from  
22 fee-for-service to managed care, they would not



1 be eligible.

2 MS. ARTHUR: No, that would be a plan  
3 switch.

4 CO-CHAIR BROOKEY: Okay.

5 Carol?

6 MEMBER STANLEY: So, a little while  
7 ago, you mentioned that disparity between the  
8 numbers, one of your hypothesis is that in  
9 managed care, the data's not being captured as  
10 well possibly as it is in fee-for-service.

11 And, so, with health plans being the  
12 level of analysis, why would there be -- why  
13 would you use claims and not use a hybrid  
14 methodology for this measure if you're finding  
15 that with health plans there may be data  
16 integrity issues?

17 DR. MANGIONE-SMITH: Right. So, let  
18 me clarify.

19 There are issues with the managed care  
20 data in the MACs file, which is what we used.  
21 Our understanding, at least from our Medicaid  
22 partners in Washington State, now that almost all

1 children are on Medicaid managed care, there's  
2 almost nobody on classical fee-for-service  
3 anymore, their data that they're getting from the  
4 health plans is far more complete than it used to  
5 be.

6 So, and the testing we did in our two  
7 states, the 1,500 that we did for part of our  
8 measure development, we saw, you know, very  
9 similar performance to what we're seeing here,  
10 but did not have -- we did not have the same  
11 concerns with data being absent in that run that  
12 we did in the MACs file.

13 So, I don't -- I do think these source  
14 health plans have the data that's needed to do  
15 this. But, the states, at least back in 2008 in  
16 the, you know MACs file, we're not getting  
17 complete data from them.

18 CO-CHAIR BROOKEY: Any other comments  
19 about reliability or should we vote?

20 (NO RESPONSE)

21 CO-CHAIR BROOKEY: Vote? Okay.

22 MS. JUNG: The voting for Measure 3153

1 for reliability is now open. Option 1, high;  
2 option 2, moderate; option 3, low; and, option 4,  
3 insufficient.

4 The voting is now closed. The results  
5 are 23 percent for high with 5 votes, 64 percent  
6 for moderate with 14 votes, 9 percent for low  
7 with 2 votes and 5 percent for insufficient with  
8 1 vote.

9 The measure has passed for  
10 reliability.

11 CO-CHAIR BROOKEY: Okay, so let's move  
12 on to validity.

13 David, do you want to lead this one?

14 MEMBER EINZIG: If there are any other  
15 members who are more of a numbers person, that'd  
16 be great. Otherwise, it appears valid and I  
17 don't have much else to add.

18 MEMBER MILLER: This is Marlene, I can  
19 chime in, if that's all right.

20 Can you hear me?

21 CO-CHAIR BROOKEY: Yes, go ahead,  
22 Marlene.

1 MEMBER MILLER: Okay, great.

2 So, I think there's a lot of evidence  
3 presented both for empiric and face validity. I  
4 think the main concern I had with validity was  
5 the fact that the continuity of care with this  
6 scale all the ways you can measure and all the  
7 variability we just talked about and reliability,  
8 between states, for examples, they put down to a  
9 simple dichotomization of pass/fail.

10 And, I really worried about that  
11 having real validity in terms of -- because we  
12 know continuity of care is much more complex than  
13 that. It's either not a pass/fail, black or  
14 white.

15 So, I was wondering if the developers  
16 could comment on that in the methodology.

17 DR. MANGIONE-SMITH: Right, so, this  
18 score is pass/fail based on whether your COC  
19 index ranges from .5 or higher.

20 So, COC index can go from 0 to 1, all  
21 of the studies that we reviewed, you know, when  
22 they were looking at relationship to outcomes,

1 they were looking at different levels of the  
2 Bice-Boxerman Continuity of Care Index and how  
3 that related to outcomes.

4 The vast majority of them, in fact, I  
5 think all of them found that the better outcomes  
6 started happening right around .5.

7 So, we wanted to give credit to any  
8 case that was included in a state sample, in the  
9 Medicaid sample where that child's Bice-Boxerman  
10 Continuity of Care Index was .5 or higher rather  
11 than saying, you know, we want to know the  
12 continuous value or the mean value of Bice-  
13 Boxerman COC for your state.

14 We could have done it either way, but  
15 we felt that the evidence was really suggestive  
16 that there were these clear cut points where  
17 outcomes were better.

18 And, that's -- and it also, I think,  
19 makes it a more straightforward measure to  
20 interpret and potentially to improve on.

21 So, if you know that the bar you're  
22 trying to make is I just I need to get my

1 population at least up to .5 if I want to see  
2 improved outcomes, it's just a little bit more  
3 straightforward, we felt.

4 MS. ARTHUR: Also, I can add that the  
5 mean COC in our study in this analysis was .65  
6 actually. And, in those previous studies that  
7 looked at improvements stating at the .4 or .5  
8 five level, the mean COC was actually around .4  
9 or .5.

10 DR. MANGIONE-SMITH: So, they're  
11 pretty similar.

12 CO-CHAIR BROOKEY: Carol? I meant  
13 Jon.

14 MEMBER FINKELSTEIN: We get confused  
15 all the time.

16 (LAUGHTER)

17 MEMBER FINKELSTEIN: So, in looking at  
18 your data on ER visits, the outs ratio was in the  
19 .9 range which is a 10 percent lower rate of  
20 people hitting the ED who have good continuity  
21 compared.

22 Were you happy with that? Was that the

1 magnitude you were -- as a guy who kind of  
2 philosophically believes in continuity, I was a  
3 little disappointed, but maybe that's the  
4 magnitude of effect you'd expect. I was just  
5 wondering about that.

6 DR. MANGIONE-SMITH: Yes, actually, I  
7 think it is the magnitude we would expect. There  
8 are very few interventions that can drag down ED  
9 rates by 10 percent.

10 So, if we could even get that far  
11 down, I think we'd be accomplishing something.

12 MS. ARTHUR: Also, there was a study  
13 that we hadn't mentioned today that looked at  
14 costs avoided with ED visits. And, they actually  
15 found, this was a study by McBurney and  
16 colleagues, and they found that increasing  
17 continuity of care by ten percent points yielded  
18 a decline in expected ED visits from around 1,300  
19 -- 1,362 to 1,290. And, there was a cost savings  
20 of almost \$20,000.

21 So, I mean, you'd love to see more,  
22 but it's meaningful.

1 CO-CHAIR BROOKEY: Well, there is one  
2 intervention that's effective, it's called co-  
3 payments. I don't think any of these states have  
4 co-payments, do they?

5 MS. ARTHUR: The grand health  
6 experiment.

7 CO-CHAIR BROOKEY: Yes.

8 Jill?

9 MEMBER MORROW-GORTON: So, they might  
10 have co-payments, depending on the state.

11 But, anyway, my question --

12 CO-CHAIR BROOKEY: This is true, there  
13 are some states that have Medicaid co-payments.

14 MEMBER MORROW-GORTON: Yes, there are  
15 a few that have --

16 CO-CHAIR BROOKEY: Yes.

17 MEMBER MORROW-GORTON: -- co-payments  
18 for various things, yes. It's like a dollar or  
19 \$3 or something like that.

20 But, for a poor family, that could be  
21 meaningful.

22 (OFF MICROPHONE COMMENTS)



1                   MEMBER MORROW-GORTON: Yes, so my  
2 question, as you looked at ED visits, and it  
3 could be that they are pushing not going to the  
4 ED, going to their primary care doc and then  
5 getting direct admitted from the primary care  
6 doc, which you would not capture in ED visits.  
7 Did you look at hospitalizations?

8                   So, you've got ED visits savings, but  
9 you might, you know, you might not really have  
10 gotten any savings because we wouldn't have paid  
11 for that ED visit if they got admitted. We would  
12 have just paid for the admission.

13                  DR. MANGIONE-SMITH: In this  
14 particular analysis, we did not look at  
15 hospitalizations. We felt we would have to look  
16 at ambulatory care sensitive hospitalizations.  
17 And, in pediatrics, at least, that is not -- they  
18 are not well defined.

19                  There is only one study that we were  
20 able to find that had any outlining of codes that  
21 you might use for it.

22                  And, the quality of the MACs data was

1 such that we just felt we couldn't adequately  
2 look at that outcome in that data. So, it's two  
3 incomes late.

4 CO-CHAIR BROOKEY: Any other questions  
5 about validity?

6 (NO RESPONSE)

7 CO-CHAIR BROOKEY: On the phone?

8 (NO RESPONSE)

9 CO-CHAIR BROOKEY: Okay, should we  
10 vote?

11 MS. JUNG: Voting for Measure 3153 for  
12 validity is now open. Option 1, high; option 2,  
13 moderate; option 3, low; and, option 4,  
14 insufficient.

15 Voting is now closed. The results are  
16 5 percent for high with 1 vote, 77 percent for  
17 moderate with 17 votes, 18 percent for low with 4  
18 votes and 0 percent for insufficient with 0  
19 votes.

20 The measure has passed for validity.

21 CO-CHAIR BROOKEY: Okay, so for  
22 feasibility, let me just, before I turn it over

1 to the discussants, just to ask you to clarify a  
2 comment you made about getting data for managed  
3 care, and so, in terms of how it relates to  
4 feasibility. Is that going to be an issue from  
5 state to state?

6 DR. MANGIONE-SMITH: So, I think for  
7 state Medicaid agencies, as they have moved away  
8 from fee-for-service and towards Medicaid managed  
9 care, my understanding, at least from our  
10 partners, and I can only talk about my NF2 which  
11 is Minnesota and Washington, that it is getting  
12 better.

13 They are -- their data is more  
14 complete than it was, say, five years ago and  
15 they have much more confidence that it's  
16 complete.

17 Having said that, there will probably  
18 be states where there is not complete data. And,  
19 I, you know, I don't, unfortunately, have like,  
20 you know, fact-base to go on because I don't have  
21 direct contacts at all 50 states, so I don't  
22 know.

1 CO-CHAIR BROOKEY: Okay, David or Tara  
2 or Marlene, any comments about feasibility?

3 MEMBER MILLER: No, I mean, I had some  
4 concerns, I don't know whether -- where to kind  
5 of go with them that this would require anybody  
6 who wanted to do this to reach out to the  
7 developer's website and get the SAS code.

8 You know, it's not something that they  
9 could run independent of their own shop and then  
10 they always worry about accessibility and will  
11 that always be there kind of thing.

12 MEMBER EINZIG: It's electronic claims  
13 data, so it's feasible.

14 CO-CHAIR BROOKEY: Yes, it's feasible.  
15 Tara, any comments?

16 MEMBER BRISTOL-ROUSE: No, I mean,  
17 obviously, one of the benefits is, you know, as  
18 opposed to parent report data is that it comes  
19 from claims data.

20 CO-CHAIR BROOKEY: Any other comments  
21 about feasibility? Go ahead.

22 MEMBER FEI: My question's probably

1       rather general, but any thought to the  
2       feasibility, but also being able to implement it  
3       within commercial claims?

4               I mean, I know, in a commercial PPO  
5       world, perhaps the volume is less, but we would  
6       be interested to know if we could actually take  
7       that SAS code and like apply it to our warehouse?

8               DR. MANGIONE-SMITH: Absolutely. So,  
9       one, actually, two of the studies were done in  
10      commercial data.

11              MEMBER FEI: Okay.

12              DR. MANGIONE-SMITH: One was done by  
13      Jeff Tom who actually used the exact same code  
14      that we used for this study in the Hawaii, I  
15      think it's Blue Cross, it's the -- they cover  
16      like 80 percent of the privately insured lives in  
17      Hawaii.

18              So, he ran his analysis and actually,  
19      interestingly, back -- the question about  
20      ambulatory care is sensitive hospitalizations, he  
21      was able to look at that because we have this  
22      very complete data and his was the one study that

1 did show that, as your COC went up, your  
2 ambulatory care sensitive hospitalizations went  
3 down and children with at least one chronic  
4 condition.

5 CO-CHAIR BROOKEY: Okay, another other  
6 comments or should we vote on feasibility?

7 (NO RESPONSE)

8 CO-CHAIR BROOKEY: Okay, we'll vote.

9 MS. JUNG: Voting for Measure 3153 for  
10 feasibility is now open. Option 1, high; option  
11 2, moderate; option 3, low; and, option 4,  
12 insufficient.

13 Voting is now closed. The results are  
14 36 percent for high with 8 votes, 64 percent for  
15 moderate with 14 votes, 0 percent for low with 0  
16 votes and 0 percent for insufficient with 0  
17 votes.

18 The measure has passed on feasibility.

19 CO-CHAIR BROOKEY: Okay, so then we'll  
20 move to usability and use. Any of the  
21 discussants want to lead?

22 David?

1                   MEMBER EINZIG: So, just a few  
2                   comments on usability and use. So, it says MAP  
3                   imbedded, I'm curious, this might be in here, but  
4                   a small group of providers, does that define what  
5                   is the number for a small number of providers?

6                   MS. ARTHUR: What we really were  
7                   intending to say with that was that the Bice-  
8                   Boxerman Index, as we mentioned before, is  
9                   sensitive to detect continuity with more than one  
10                  provider.

11                  So, perhaps it wasn't clear that we  
12                  define -- you know, we define small group. But,  
13                  it really was just that concept that it's more  
14                  than one and it can still detect continuity.

15                  MEMBER EINZIG: And, then, just final  
16                  comment, you know, I think parent perspective is  
17                  really valuable here, too, that if we're using  
18                  this -- planning to use this measure, I think it  
19                  would be useful to get more parent and family  
20                  feedback in terms of from the family perspective  
21                  if it's ongoing -- of ongoing value in current  
22                  day terms.

1 MS. ARTHUR: So, I'm actually wearing  
2 two hats here today. I am the proud mother of  
3 medically complex twins who are three, so I can't  
4 resist putting on that hat for just a minute to  
5 say that my -- in my experience, I've been doing  
6 pretty much all the care coordination. That's  
7 been my personal experience with my end of one  
8 hat on.

9 But, what I also will say is that I  
10 have very rarely seen the physician who is  
11 supposed to be my primary care provider because  
12 every time my girls are sick, we see whoever can  
13 see them right away or whoever can see them to  
14 follow up from the ED.

15 And, so, to sit here and see this  
16 measure and think, wow, if there was -- if it was  
17 a priority for me to actually see that person who  
18 really, truly does know our history, although  
19 now, it's been over a year since I've seen him,  
20 it would have made a difference.

21 So, I can just -- if you're asking for  
22 a parent and family opinion, I can't keep quiet.



1 DR. MANGIONE-SMITH: And, the other  
2 thing I'll add, the process that our center used,  
3 Carolyn Allshouse, who's the person who directs  
4 Family Voices of Minnesota, as part of our  
5 center.

6 And, she brought in a whole group of  
7 parents into our measure development process.  
8 So, every measure that's come out of our center  
9 was, the literature reviews are read by the  
10 parents, the measures were commented on by the  
11 parents.

12 And, we really took their feedback and  
13 quite, quite seriously. They were involved from  
14 the beginning to the end.

15 In fact, Carolyn's an author on many  
16 of our papers that have come out of the center  
17 work.

18 So, we are very cognizant of the  
19 importance of parent input on this particular  
20 population. And, really tried very hard to have  
21 serious incorporation of that view.

22 CO-CHAIR BROOKEY: Comments about

1 usability?

2 MEMBER BRISTOL-ROUSE: Yes, I think,  
3 you know, I would just reiterate my comments  
4 about communication being so key because I can  
5 think very specifically about one provider who we  
6 had never seen before from our practice who was  
7 as good if maybe even not better than our primary  
8 care provider.

9 So, I guess what I am struggling with  
10 this is that I think this measure is necessary,  
11 but it just may not be sufficient.

12 CO-CHAIR BROOKEY: Yes.

13 So, Jill?

14 MEMBER MORROW-GORTON: And, I just  
15 want to piggyback on that. You're measuring both  
16 sort of well visits and continuity visits and  
17 sick visits and if you only have sick visits, the  
18 likelihood you're going to be able to see the  
19 same practitioner is going to be small because  
20 they can't work 24 hours a day 7 days a week 365  
21 days a year.

22 But, I guess my question is, where is

1 the quality? Is the quality in any visit? Is  
2 the quality in those regular, not your sick, we  
3 have a problem, but those regular how are things  
4 going, what do we need to fix, those sort of, you  
5 know, the kids with ADHD that you see four times  
6 a year because that's how you keep track of  
7 what's going on versus, you know, they have a  
8 sore throat and they get it checked because they  
9 happen to see the same doc.

10 And then, my second comment is from  
11 the vantage point of a payer, what this says to  
12 me is we should just pay docs to see kids more  
13 when I'm -- I mean, not more money, but we should  
14 just pay them for more visits.

15 When, you know, David's comment about  
16 the CCM program, well the reason the CCM kids get  
17 to the doc as frequently as they do is because  
18 they have a nurse case manager who they're  
19 talking with on a probably weekly, if not  
20 multiple times a week. And, it's that person  
21 that's driving things.

22 So, my concern is, you know, is this

1 capturing what is driving or is this sort of a  
2 proxy for that?

3 DR. MANGIONE-SMITH: So, a lot of  
4 things in there.

5 (LAUGHTER)

6 DR. MANGIONE-SMITH: Where can I  
7 start?

8 So, I think your point that the, you  
9 know, sort of the biannual, quarterly, whatever,  
10 continuity visit, right, where you're trying to  
11 see that same person who's doing the care  
12 coordination and thinking about how do we tune up  
13 your care plan? How do we do all the  
14 coordination things that are needed?

15 You know, do I want you to see that  
16 same person or no more than two people who are  
17 focusing on that?

18 Yes, I think it's -- those visits,  
19 it's probably more important than the strep  
20 throat visit.

21 That's part of the reason the measure  
22 takes you down to .5 and still says you pass

1       because we know you're going to have to see other  
2       people when you're sick a lot of the time.  
3       You're not, I don't want to work 365/7, you know,  
4       7 days a week, you know, whatever. And nobody  
5       can do that.

6               I don't think this measure  
7       incentivized seeing more visits. I want to be  
8       clear or pushing people to have more visits.

9               This measure is looking at those  
10      people who are naturally already doing that and  
11      saying we want to make sure you're having decent  
12      continuity if you're coming in a lot and  
13      accessing care a lot.

14              Because that's a signal that things  
15      are not under good control. And, one of the  
16      tenants, at least in our conceptual framework,  
17      the way you get things under control, is to have  
18      it just a couple of people who are trying to  
19      figure out why are things breaking down? Why  
20      aren't things going well? What do we need to  
21      change so that your child does better?

22              CO-CHAIR BROOKEY: So, just sort of

1 backing into the evidence, I think that we agree  
2 that the evidence was strong for this measure.  
3 But, speaking as a pediatrician that only sees  
4 patients one day a week, every time a patient  
5 sees me, it's a failure of the system because I'm  
6 seeing somebody else's patient because I don't  
7 have a panel. Okay?

8 So, what I try to do is communicate as  
9 well as I can, to Tara's point, because I know  
10 that I may never see this patient again.

11 But, we do and if you have an  
12 organized system, and not everyone does for  
13 Medicaid, then you have to incentivize your  
14 medical groups and so forth to make a priority  
15 for PCP bonding and having the patients only  
16 primarily see one particular provider or a small  
17 group of providers.

18 So, I think there is an action that  
19 can come out of this, but it's not an easy one,  
20 especially when the primary goal of most Medicaid  
21 providers is not bonding, it's access in general.

22 MS. ARTHUR: I think it's important to

1 keep in mind, too, though, we are talking about  
2 like six percent of the U.S. child population and  
3 that we've focused this on children with medical  
4 complexity.

5 And, I think that that's an important  
6 distinction to make.

7 CO-CHAIR BROOKEY: I'm just saying  
8 that it's still not easy to do, but I think there  
9 has to be some energy and leadership around it to  
10 make it happen.

11 So, David?

12 MEMBER KELLER: No, I share Jon's love  
13 of continuity and I think it's important and I  
14 share your problem as a one day a week person who  
15 actually does have a panel because we all have to  
16 have a panel and it's very challenging.

17 I spend a lot of time talking with my  
18 colleagues who see patients the days I'm not  
19 there.

20 Actually, I had a difference question,  
21 though, which is, you've proposed this as a plan  
22 level or a sort of system level. Has there given

1 much thought to making this a healthcare system  
2 level measure in addition to being a plan  
3 measure?

4 I can -- I think there is one of the  
5 problems in our large multispecialty  
6 organizations that we have, the Kaisers of the  
7 world, the children's hospitals of the world, is  
8 that we don't value continuity within our own  
9 organization and I can see value in pushing out a  
10 measure like this to be used at an organizational  
11 level as well as a plan level.

12 DR. MANGIONE-SMITH: Not something,  
13 obviously, that we tested, definitely something  
14 of interest. I think with accountable care  
15 organizations, this sort of thing should be at  
16 this, you know, should be very central to what  
17 they're trying to do.

18 CO-CHAIR BROOKEY: Okay, so, I'm going  
19 to take a comment from Maureen. We do have lunch  
20 here if you want to try to wrap up a little  
21 earlier, we can get there a little earlier.

22 So, Maureen?



1                   MEMBER EDIGER: That's a lot of  
2 pressure to be concise.

3                   (LAUGHTER)

4                   MEMBER EDIGER: So, you asked for the  
5 parent opinion, so just really quick. When I  
6 think about the times when it was most important  
7 that I had the continuity of our pediatrician who  
8 knows our family so well that she's had our  
9 twin's birthday party at her house.

10                   Unfortunately, when you have a  
11 medically complex kid, you end up making these  
12 relationships that are outside of the sort of  
13 normal.

14                   And, so, I feel really lucky to have  
15 those and I know I have a couple of nurses that  
16 have just given me their cell phone number and  
17 said, just text me, don't bother coming into to  
18 the ER.

19                   So, this doesn't capture all of the  
20 work arounds that parents have done who have very  
21 complex kiddos. But, I think it's important to  
22 acknowledge that not all parents have the ability

1 to make those relationships, that they're not  
2 going to be assertive enough, they're not going  
3 to speak the same language, they're not going to  
4 be able to forge those kind of relationships.

5 So, I just feel like it's important to  
6 acknowledge that you get into a little bit of --  
7 there's not all families are playing the same  
8 system. And, the goal is that, you know, my goal  
9 is to stay out of the office and the hospital as  
10 much as possible and I wish 2017 Maureen could go  
11 and talk to 2009 Maureen and tell her that that  
12 would be goal because it took me a while to get  
13 there.

14 (LAUGHTER)

15 MEMBER EDIGER: So, that's why I think  
16 there's something really important about parents  
17 being able to mentor and help other parents find  
18 those skills, not just about asking questions,  
19 but being assertive and finding a way to kind of  
20 work around some of the systems.

21 That's all. Lunch.

22 CO-CHAIR BROOKEY: Not quite, but any

1 other comments before we vote?

2 (LAUGHTER)

3 CO-CHAIR BROOKEY: All right, good  
4 discussion. Let's go ahead and vote.

5 MS. JUNG: The voting for Measure 3153  
6 for use and usability is now open. Option 1,  
7 high; option 2, moderate; options 3, low; and,  
8 option 4, insufficient.

9 The voting is now closed. The results  
10 are 5 percent for high with 1 vote, 73 percent  
11 for moderate with 16 votes, 23 percent for low  
12 with 5 votes and 0 percent for insufficient with  
13 0 votes.

14 The measure has passed for usability  
15 and use.

16 CO-CHAIR BROOKEY: Okay, and before we  
17 vote for overall, any additional comments?

18 (NO RESPONSE)

19 CO-CHAIR BROOKEY: Okay.

20 MS. JUNG: The measure is now open for  
21 overall suitability for endorsement. Option 1,  
22 yes; option 2, no.

1 CO-CHAIR BROOKEY: People are pointing  
2 all over the room.

3 (LAUGHTER)

4 MS. JUNG: Voting is now closed. The  
5 results are 77 percent for yes with 17 votes, 23  
6 percent for no with 5 votes.

7 The measure is recommended for  
8 endorsement.

9 CO-CHAIR BROOKEY: Thank you.

10 All right, so, before we break, do we  
11 have any NQF member of public comments?

12 OPERATOR: At this time, if you would  
13 like to make a comment, please press star then  
14 the number one.

15 And there are no public comments from  
16 the phone lines.

17 CO-CHAIR BROOKEY: No comments, okay.

18 All right, are there any comments from  
19 you before we break?

20 (NO RESPONSE)

21 CO-CHAIR BROOKEY: Okay. So, we have  
22 -- we're a little ahead of schedule and I'd like

1 to keep us ahead of schedule if that's okay. So,  
2 we're supposed to get how much time for lunch?  
3 Twenty minutes, so, let's say at ten after, even  
4 if you have food in front of you, we'll get  
5 started again, is that all right?

6 Okay.

7 (Whereupon, the above-entitled matter  
8 went off the record at 11:49 a.m. and resumed at  
9 12:15 p.m.)

10 CO-CHAIR SUSMAN: Okay, folks, I'd ask  
11 you to gather around and we're going to restart.  
12 Please feel free to get your dessert or fruit, we  
13 have some healthy options here today.

14 And, we're going to start with rate of  
15 emergency department visit use for children  
16 managed for identifiable asthma, visits per 100  
17 child years. And, our measure developers are  
18 calling in, so let's see if they're on the phone.

19 Oh, one person's here. Okay. I'm  
20 glad you're here, welcome.

21 DR. KLEINMAN: I'm here, too.

22 CO-CHAIR SUSMAN: Okay, Suzanne, it

1 is?

2 MS. LO: Yes.

3 CO-CHAIR SUSMAN: Okay, Suzanne, you  
4 can go ahead or your colleague and provide us an  
5 overview.

6 MS. LO: We have Dr. Kleinman on the  
7 phone so he's --

8 CO-CHAIR BROOKEY: You'll need to use  
9 your mic.

10 DR. KLEINMAN: Hi, thank you, Suzanne  
11 and thank you to the committee at NQF.

12 This is Larry Kleinman, y'all can hear  
13 me okay?

14 CO-CHAIR SUSMAN: Sounds good.

15 DR. KLEINMAN: Okay, great.

16 So, I'm very pleased to present this  
17 measure which is a result of work from the  
18 Collaboration for Advancing Pediatric Quality  
19 Measures, one of the CHIPRA Centers of  
20 Excellence.

21 And, we were asked to measure on  
22 emergency department asthma and overuse was the

1 whole suite of things that we did.

2 We felt first, we needed a good  
3 measure of emergency department use, that's what  
4 this is an attempt to do. We feel very  
5 comfortable with it.

6 We -- there was a question in the --  
7 that we received, what is the overall rate in the  
8 state? So, I can tell you that it was 20.65  
9 visits per 100 child years and in the various age  
10 groups, it ranged from a low of 15.08 in teens to  
11 a high of 29.7 in the younger children.

12 And, we think that there are  
13 biological and behavioral differences in age that  
14 it's better to report it as a stratified measure  
15 than as a single measure. It's a more accurate  
16 reflection.

17 But, we're open to whatever the  
18 committee would direct us towards.

19 We were not able to come up with a  
20 statistical summary of reliability appropriate  
21 for this distribution. We tried, we looked and  
22 we consulted with statisticians who thought our

1 best idea was to do either a Poisson or a zero-  
2 inflated Poisson or a hurdle model.

3 We've done all of them, they all come  
4 up with very similar results which suggests that  
5 we get good confidence intervals with many plans  
6 and many counties being different from one  
7 another.

8 I have some specific data I'd be happy  
9 to share. We shared it with staff this morning.  
10 I'm sorry we weren't able to get it in advance.  
11 We had IRB issues that prevented me from doing  
12 the analysis until over the weekend and I'm home  
13 with a newborn baby, so it's been a little bit of  
14 an administrative challenge and a personal  
15 challenge to get some of the responses all done.

16 But, we do have data that's now been  
17 shared with the committee and I can discuss it  
18 with you.

19 There was a question about some codes.  
20 We omitted some codes in terms of our  
21 denominator. We didn't add any, so I can explain  
22 that if there's questions about it.



1                   And, I know there's going to be some  
2                   interest in risk adjustment and I'm happy to  
3                   discuss that at some length.

4                   But, let me just say, I think this is  
5                   a really good measure. It is a true  
6                   epidemiological rate. It was developed by a  
7                   systematic process that involved stakeholders and  
8                   an expert, a RAND expert panel.

9                   I know you've had discussion about the  
10                  RAND panels earlier in the day and I'd be happy  
11                  to answer questions and respond to what the  
12                  committee would like to know.

13                  CO-CHAIR SUSMAN: Thank you.

14                  Suzanne, any further comments?

15                  Okay, so, we will go to our lead  
16                  discussants. Karen?

17                  MEMBER DORSEY: Do you want to talk a  
18                  little bit of overview or do you want to focus on  
19                  evidence?

20                  CO-CHAIR SUSMAN: Why don't we, if you  
21                  have key concerns that you can foreshadow those,  
22                  but let's stick with the evidence since that's

1 where we'll have to start.

2 MEMBER DORSEY: So, the developer  
3 already brought up on of the concerns which is  
4 really, you know, how to interpret and think  
5 about the analysis that they provided for  
6 reliability of the measure. So, I think we'll  
7 get to that when we get to that component.

8 You know, the other, you know, this  
9 measure looks at ED utilization for children who  
10 have persistent asthma. And, the developers  
11 provide a lot of explanation about how they came  
12 up with the definition of persistent asthma and I  
13 sort of recognize the challenge of coming up with  
14 a sort of robust and well accepted definition.

15 And, I think that they, you know, sort  
16 of did jump through all the hurdles to make sure  
17 that they had a decent one.

18 But, you know, the measure sort of  
19 rests on your belief in that to a great extent.  
20 And, so, it may be worthwhile hearing directly  
21 from them a little bit about that process of  
22 developing the definition and sort of their --

1 the evidence that supports it.

2 And, other than that, the evidence  
3 linking, you know, ED visits as a poor outcome  
4 and the fact that hospitals can -- and health  
5 plans and providers can take interventions to  
6 reduce ED visits. I feel they are on very solid  
7 ground there as an outcome measure.

8 So, I don't think there's any issue  
9 with the evidence for this measure.

10 CO-CHAIR SUSMAN: And, Jonathan?

11 MEMBER FINKELSTEIN: So, I agree,  
12 sticking to the evidence frame, I have no  
13 problems seeing the ED visit as an outcome for  
14 childhood asthma and the link to evidence that we  
15 can do something about that is broad, deep and  
16 well summarized by the developers.

17 I think there will be issues about the  
18 specifications that I'd like to have clarified,  
19 but on the evidence, I'm good.

20 CO-CHAIR SUSMAN: So, what I'll do is  
21 I'll go through our discussants and then I'll ask  
22 the developers to talk a little bit about the

1 specifications so we all know what we're talking  
2 about to begin with.

3 So, Carol?

4 (NO RESPONSE)

5 CO-CHAIR SUSMAN: Carol Stanley?

6 MEMBER STANLEY: Yes?

7 CO-CHAIR SUSMAN: Do you have any  
8 comments?

9 MEMBER STANLEY: No, I don't have any  
10 comments actually.

11 CO-CHAIR SUSMAN: Okay, well, yes.

12 (LAUGHTER)

13 CO-CHAIR SUSMAN: Much ado about  
14 nothing.

15 And, Ricardo?

16 MEMBER QUINONEZ: I agree that the  
17 evidence for what they are saying which is that  
18 the evidence that high utilization of ERs is a  
19 sign of poor quality and asthma is there.

20 My only concern, and it does go to  
21 evidence, is our ability to diagnose asthma down  
22 to two years of age.

1                   And, so, I, you know, I know that they  
2                   stratify by age, but the -- I don't know of any  
3                   convincing evidence that we can diagnose  
4                   effectively asthma at that young of an age.

5                   So, there may be some consideration as  
6                   to the actual age groups that are included. I  
7                   think three or above or four and above would be  
8                   way more precise than including children with two  
9                   years of age in which you're probably including  
10                  kids who have diagnosed with asthma but they  
11                  actually don't have it.

12                  That's probably recurrent wheezing due  
13                  to viral infections and the evidence for efficacy  
14                  of treatments there is just not as robust.

15                  CO-CHAIR SUSMAN: Good and, Carol,  
16                  immediately decided she had to talk.

17                  (LAUGHTER)

18                  MEMBER STANLEY: I did decide that.

19                  And backtracking through some notes,  
20                  I did want to ask about the evidence of how  
21                  you're factoring in environmental factors given  
22                  urbanization and quality of air and quality of

1 home environment, which is really out of the  
2 realm of the health plan and the provider.

3 So, how would you explain that these  
4 visits to the ED are solely attributed as an  
5 outcome to the provider or the health plan?

6 CO-CHAIR SUSMAN: Okay. So, I've  
7 heard that comment, a comment about the  
8 definition, how persistence was defined and the  
9 issue about including the youngest aged children.

10 So, perhaps the developers could help  
11 us with those before we talk about voting?

12 DR. KLEINMAN: Sure, happy to, thank  
13 you.

14 So, the first thing I would say is  
15 that what we did and the way we defined the age  
16 groups, both how we grouped ages and how we  
17 decided who was in and who was out was through a  
18 RAND modified Delphi process of national experts  
19 that included pediatricians, family physicians,  
20 ER docs and pediatric ER docs, all of whom  
21 through an open, transparent process.

22 The group felt that two was the lowest

1 age at which one might think about asthma. I  
2 would say if the committee, in its judgment, said  
3 three, I would disagree, but not argue and be  
4 happy with that.

5 What they tried to do, and this now  
6 relates to the definition, the idea was which  
7 children, keep in mind that in order to get an  
8 enumerator, you have to have an asthma as first  
9 or second diagnosis in the emergency room.

10 So, with that as the requirement of  
11 having some form of signal, the question that the  
12 attempt to identify persistence or identifiable  
13 asthma as it's evolved to, was which children  
14 should the practice and/or the health plan be  
15 aware of sufficiently? They should be managing  
16 their child for the wheezing illness in an effort  
17 to try to prevent them from coming to the  
18 emergency room.

19 So, I think it was -- I think there  
20 was a bit of agnosticism on whether the diagnosis  
21 itself was asthma. As you can see, recurrent  
22 bronchitis is a part of the specification. If

1       there's enough of them, depending on the age  
2       group.

3                   And, there need to be more illness in  
4       younger children under five to consider that  
5       asthma was identifiable than there did in  
6       children over five because of this diagnostic  
7       uncertainty.

8                   Now, with regard to -- does that  
9       answer the question about age, first of all?  
10      And, then I'll take identifiable asthma with some  
11      numbers that may help you understand it a little  
12      bit.

13                   CO-CHAIR SUSMAN:   Ricardo?

14                   DR. KLEINMAN:   What was that?   I'm  
15      sorry, I didn't understand.

16                   CO-CHAIR SUSMAN:   Okay, I think the  
17      group -- it is what it is.

18                   DR. KLEINMAN:   It is what it is,  
19      that's a fair point.   Okay.

20                   So, with regard to this, we wanted  
21      something that would be less stringent in  
22      identifying asthma than the HEDIS persistent



1     asthma definition which was very restrictive and,  
2     in New York State, only identified 3.1 percent of  
3     children as having persistent asthma which we  
4     know, based on clinical and other information in  
5     the state health plan and Medicaid in New York,  
6     it is low.

7             We had about 15 or 16 percent of New  
8     York Medicaid children who would answer -- a  
9     parent would answer a survey that they've never  
10    been told they had asthma. That number was too  
11    high for what we were looking for because we did  
12    want a more select group.

13            And, if you look at anybody who had an  
14    asthma claim, it was somewhere around 11 or 12  
15    percent in a given year.

16            And, this measure, when we applied it,  
17    identified 8.6 percent.

18            So, we think that there is some  
19    construct validity by the virtue of the fact that  
20    it is a targeted population. It's less than if  
21    you look at anybody who has an asthma definition  
22    or asthma diagnosis in the course of the year.

1 But it is less restrictive that the HEDIS  
2 definition which was looking at hospitalizations  
3 for children with persistent asthma.

4 We also have some other evidence that  
5 doctors actually managed to this. Because when  
6 we, as part of our other measures, something  
7 that's under consideration now in your  
8 coordination of care, the NQF coordination of  
9 care call, we have a measure as to whether  
10 children after their ED visit get inhaled  
11 corticosteroids within two months following the  
12 visit.

13 And, in that, using that metric, we  
14 find that children who are seen in the emergency  
15 room without this identifiable asthma  
16 classification received an ICS prescription about  
17 13 and a half percent of the time.

18 While those with the identifiable  
19 asthma classification receive it 34 and a half  
20 percent of the times.

21 That's almost a threefold increase  
22 which suggests that this construct has meaning in

1 the real world and there's just not an artifice  
2 of an expert panel to put it together.

3 With regard to environmental factors,  
4 this measure is not able to account for them. We  
5 are using readily available data in order to be  
6 feasible, so we're not going into the chart. We  
7 can't look at things like asthma action plans or  
8 environmental triggers.

9 But, we can say that one of the points  
10 of the National Heart, Lung and Blood Guideline  
11 is that children in more challenging  
12 circumstances need to be managed more aggressive  
13 and that asthma control, which implies no ED  
14 visits for because of exacerbations is the goal  
15 of treatment for all children. So, we think it's  
16 consistent with that.

17 And, we also would say that, like any  
18 measure, it's not perfect, and some judgment may  
19 need to be applied because these are all proxies  
20 for the real world.

21 But, we think it's a really good  
22 measure in that regard.

1 CO-CHAIR SUSMAN: Okay, so, are there  
2 any other questions that are directly around  
3 evidence?

4 Yes, Jill?

5 MEMBER MORROW-GORTON: Just a quick  
6 question: did you look at matching ED diagnoses  
7 of asthma to, say, primary care or -- or pharmacy  
8 or some other measure that might have validated  
9 that?

10 DR. KLEINMAN: I -- we looked at  
11 visits to primary care docs before and after, but  
12 I am not sure -- I am not seeing the connection  
13 that you're asking, and maybe we did look at it,  
14 if you could clarify, as a validating construct  
15 in this regard. So what were you thinking of?

16 MEMBER MORROW-GORTON: I have reviewed  
17 lots of ED records, and the diagnoses don't  
18 always make sense.

19 (Laughter.)

20 MEMBER MORROW-GORTON: Just -- just  
21 the thought, if the ED doc, maybe not even a  
22 pediatrician, saw a child who was wheezing, said

1       asthma, was that borne out after? I mean, was  
2       that something that was known before? Did the  
3       primary care know that? Was that -- or was that  
4       something that was sort of proposed at the time  
5       of the ED visit, and -- and the child went on to  
6       never have another wheezing episode?

7               DR. KLEINMAN: These are claims data,  
8       so that -- that is actually beyond the scope of  
9       what we could have done, but keep in mind that in  
10      order to qualify for the denominator, they had to  
11      have had a number of indicators prior to the ED  
12      visit that this was asthma. That is where this  
13      definition -- that is why restricting to only  
14      those with identifiable asthma comes into play.

15             As part of the -- the validation for  
16      the appropriateness measure which is coming up,  
17      we did look in charts, and -- but we didn't -- we  
18      did not cross-reference claims and charts. We  
19      did not have those for the same children, so we  
20      couldn't do that.

21             CO-CHAIR SUSMAN: Jeff?

22             MEMBER SCHIFF: This is probably maybe

1 more of a comment than a question, but some of  
2 the ED visits are preventable only with social  
3 service interventions, you know, adequate  
4 housing, less social chaos, those kind of things,  
5 and I don't -- I don't think you -- you didn't do  
6 any literature -- I guess my question is there is  
7 no real literature -- literature review about  
8 that, on that being -- I just want to -- I -- I  
9 think that the challenge of this measure is how  
10 much to hold health plans or providers  
11 accountable for things that are outside of that  
12 scope.

13 MEMBER DORSEY: And can I just -- just  
14 I think a point of clarification: the developers  
15 do present data on disparities that I think we're  
16 going to get to, which I think speaks to this  
17 issue, but I don't believe that they stratify the  
18 results by -- they do by race and ethnicity, but  
19 not -- I don't believe, and I would like some  
20 clarification there, about whether they stratify  
21 looking at any of these types of SES indicators  
22 or, you know, how they thought about that.

1 DR. KLEINMAN: Sure. I mean, we -- we  
2 provide an opportunity but don't require  
3 stratification by both level of urbanicity, using  
4 the Department of Agriculture's Urban Influence  
5 Codes, and by the degree of poverty in the county  
6 of residence of the mother, so -- or of the  
7 caregiver.

8 We do have something that looks, but  
9 one I would suggest -- and the appropriate  
10 measure is an attempt to capture this, and keep  
11 in mind, this is a suite of measures that  
12 sometimes it's not because they are sick, but  
13 because --

14 CO-CHAIR SUSMAN: You are really  
15 breaking up, and we can hear about every third  
16 word.

17 DR. KLEINMAN: Okay. I am going to  
18 take you off the speaker, then.

19 What I was saying is the -- we have  
20 created a suite of measures. This is -- this is  
21 one of the core measures, as it quantifies the  
22 amount of ED use, but the appropriateness measure

1 looks at whether the children themselves were  
2 actually sick or in the emergency room, perhaps  
3 for other reasons, and the -- and -- and there --  
4 there is going to be a background of failure.  
5 There is going to be a failure rate that every  
6 plan has. While in theory it should be zero, in  
7 practice, it is never going to be.

8 And again, we would hope that these  
9 are used by people who are thoughtful and -- and  
10 able to -- to identify that there is a tremendous  
11 amount of signal here, but it is -- it is not  
12 without some noise, and -- and we hope that we  
13 have demonstrated that through the -- through our  
14 analysis. I would think if -- if the idea was  
15 everything had to be attributable to the health  
16 plan, we couldn't even use immunizations as a  
17 measure because really that is there as well.

18 CO-CHAIR SUSMAN: Okay. Ah yes,  
19 please.

20 MEMBER FINKELSTEIN: So I just think  
21 this suite of measures is complicated, and we  
22 should stay focused. My understanding is if we



1 say this is an outcome measure, all we have to  
2 decide on is that the actions of the healthcare  
3 setting can move that needle, and I am -- I think  
4 that is -- that is really clear from the  
5 literature. If I know a kid has asthma, I own  
6 whether or not he shows up into the emergency --  
7 I can't prevent everyone, but I own it, and if  
8 there are cockroaches in the home, I own that, to  
9 the extent I can do something about it.

10 CO-CHAIR SUSMAN: We will make sure  
11 you get cockroaches on every visit.

12 (Laughter.)

13 CO-CHAIR SUSMAN: I think that is well  
14 stated, and unless there are others who would  
15 like to comment or have pressing questions, why  
16 don't we move on to a vote?

17 (Pause.)

18 CO-CHAIR SUSMAN: And this is  
19 evidence.

20 MS. JUNG: The voting for Measure 3189  
21 for evidence is now open. Option 1, pass; option  
22 2, not pass.

1 CO-CHAIR SUSMAN: This is an easy one.

2 (Pause.)

3 MS. JUNG: Still waiting for one more.

4 CO-CHAIR SUSMAN: Do you have your  
5 people from on the line?

6 MS. JUNG: Okay.

7 CO-CHAIR SUSMAN: Okay.

8 MS. JUNG: Oh. The voting is now  
9 closed, but --

10 CO-CHAIR SUSMAN: Voting is closed,  
11 but -- .

12 MS. JUNG: Let's try that again. Yes.  
13 Just --

14 CO-CHAIR SUSMAN: Okay. We're going  
15 to have to re-vote, so if you will get your  
16 clickers?

17 MS. JUNG: Try that one more --

18 CO-CHAIR SUSMAN: I thought it would  
19 be --

20 MS. JUNG: -- time please.

21 CO-CHAIR SUSMAN: -- easy, I mean --  
22 yes, no.

1 (Laughter.)

2 CO-CHAIR SUSMAN: Are we ready yet?

3 MS. JUNG: Yes. It is open now.

4 CO-CHAIR SUSMAN: Okay, open, so  
5 please.

6 MS. JUNG: It is not working.

7 CO-CHAIR SUSMAN: Vote early, vote  
8 often.

9 DR. KLEINMAN: I am from Jersey. That  
10 works for me.

11 (Laughter.)

12 MS. JUNG: Let's see. It is still not  
13 working.

14 CO-CHAIR SUSMAN: Yes. I don't know  
15 if it is acceptable to do a hand-vote, or --

16 PARTICIPANT: Yes, for this one right  
17 now.

18 CO-CHAIR SUSMAN: Okay. Well, while  
19 we try to sort out the mechanical, why don't we  
20 do a hand --

21 PARTICIPANT: Close your eyes.

22 CO-CHAIR SUSMAN: Yes, close your

1 eyes, raise your hands. We will close our eyes  
2 too, and we'll just go with the Force.

3 (Laughter.)

4 CO-CHAIR SUSMAN: Okay. So --

5 DR. KLEINMAN: Do you want me to count  
6 from here?

7 CO-CHAIR SUSMAN: Pardon me?

8 DR. KLEINMAN: I can count from the  
9 phone if everybody's eyes are closed.

10 (Laughter.)

11 CO-CHAIR SUSMAN: Yes, right, yes,  
12 thank you.

13 Okay. So all those who vote 1 for  
14 pass? And I will rely on our --

15 PARTICIPANT: 1, 2, 3.

16 CO-CHAIR SUSMAN: -- what is that?  
17 Okay.

18 PARTICIPANT: 7, 8, 9, 10, 11, 12, 13,  
19 14, 15, 16, 17, 18, 19, 20, 21.

20 CO-CHAIR SUSMAN: Okay. And all those  
21 who are voting 2 for not pass? Okay. We've got  
22 one, so we have one not pass, the rest pass. It

1 passes.

2 Okay. Let's talk about gap.

3 MEMBER DORSEY: So although it was --  
4 it wasn't in the place that I am used to finding  
5 the performance distribution, the -- the  
6 developer did provide that, and there is a  
7 distribution across measured entities, and they  
8 also provided some analysis looking at rates  
9 among different racial and ethnic groups and in  
10 the different age ranges, and so there is  
11 evidence of both gap and disparities presented in  
12 the materials.

13 CO-CHAIR SUSMAN: Jonathan?

14 MEMBER FINKELSTEIN: Yes, I agree.  
15 Nothing to add.

16 CO-CHAIR SUSMAN: Okay. Carol,  
17 anything to add?

18 (No audible response.)

19 CO-CHAIR SUSMAN: Okay. And Ricardo?

20 MEMBER QUINONEZ: Nothing to add.

21 CO-CHAIR SUSMAN: Okay. So other  
22 comments or questions? I think we heard a few

1 questions about other dimensions that might  
2 influence this measure, degree of urbanness, for  
3 example. All potentially important to consider.

4 (No audible response.)

5 CO-CHAIR SUSMAN: Seeing no hands, I  
6 think we can go on to vote. Now, whether we will  
7 be able to vote electronically will --

8 MS. JUNG: I think we will for this  
9 one. So for Measure 3189, voting for gap is now  
10 open. Option 1, high; option 2, moderate; option  
11 3, low; and option 4, insufficient.

12 CO-CHAIR SUSMAN: I see the numbers  
13 running. It looks like it is working.

14 (Pause.)

15 PARTICIPANT: This is the most  
16 important part.

17 CO-CHAIR SUSMAN: Yes.

18 MS. JUNG: Voting is now closed. The  
19 results are 39 percent for high, with nine votes;  
20 57 percent moderate, for -- with 13 votes; 4  
21 percent for low, with one vote; and 0 percent for  
22 insufficient, with zero votes. The measure has

1 passed for gap.

2 CO-CHAIR SUSMAN: Okay. Moving right  
3 along, we have the issues of reliability, and  
4 maybe it could be clarified by the NQF staff what  
5 additional materials were sent and the  
6 sufficiency of such analysis, because it sounded  
7 to me a little bit like there was a Poisson  
8 distribution assessment, and I wasn't clear  
9 exactly what the -- we had.

10 DR. NISHIMI: The original analyses  
11 that came in spoke more to the issue of  
12 meaningful differences, so we did follow up with  
13 the developer, who did provide some, a couple  
14 hours, just, so we haven't had time, as we sat  
15 here, to then look at those, so we have asked the  
16 developer -- and we told the developer that, and  
17 so we have asked them to summarize what they  
18 found.

19 CO-CHAIR SUSMAN: Okay. Maybe in a  
20 minute, or very very briefly, the developer could  
21 remind us what you did and found with that so we  
22 have a basis --

1 DR. KLEINMAN: Sure.

2 CO-CHAIR SUSMAN: -- that we --

3 DR. KLEINMAN: So we -- happy to do  
4 that, thank you. We have done the model three  
5 different ways, all of which are theoretically  
6 coherent, and the results of which are coherent  
7 Poisson, zero-inflated Poisson, and hurdle.

8 In the Poisson model, which is what we  
9 shared just because it is easier to -- to  
10 present, we ran it with a number of different  
11 plans as the index plan, which you can -- you can  
12 control in SAS with a little bit of data  
13 manipulation, and this is a -- this is a typical  
14 finding, so I have got one, two, three, four,  
15 five, six, seven, eight, nine, ten of the -- of  
16 18 plans have a -- a different p-value of less  
17 than 0.001. Using chi-squared, we have one that  
18 is 0.873 from the index plan, one at 0.516, so  
19 you're -- one at 0.58, so you are seeing that  
20 some plans are similar, some plans are different,  
21 which is what you would want to see.

22 The standard errors are typically



1 small relative to the -- to the estimates, so a  
2 coefficient of 0.34, with a standard error of  
3 0.05, 0.65, and 0.05, so you are seeing what you  
4 would like to see to be able to show that there  
5 are tight confidence intervals, but that not  
6 every plan is different from every other plan.  
7 And that is what we were able to do. This --  
8 this model does not produce an s-statistic, which  
9 means we can't calculate in the standard way the  
10 -- the variability -- oh, not the variability,  
11 the reliability, but -- and this model is  
12 adjusted for age group because that is how we are  
13 recommending that it be -- it be done.

14 CO-CHAIR SUSMAN: I know that we are  
15 perhaps at some slight disadvantage, not having  
16 the data, but as a non-statistician, I am not  
17 sure that would help a whole lot. But let me  
18 invite the lead reviewers to make comments, and  
19 then the group to weigh in.

20 MEMBER DORSEY: Right. So I mean,  
21 it's a little bit difficult for me. I am also a  
22 non-statistician, but it's a little difficult for

1 me to really conceptually grasp what -- what you  
2 all are providing. It still sounds more in the  
3 realm of -- of sort of model validity for  
4 constructing the measure score and not a  
5 precision estimate, which is really making sure  
6 that if you repeat a measurement, that at the  
7 level of the attributed entity, you are getting  
8 the same value.

9 And -- and so it -- that makes it  
10 difficult for me to make recommendations or -- or  
11 think about how to vote on this, and I don't know  
12 if, you know, there is a role for digesting the  
13 information that was sent a little bit more here  
14 at NQF and then revisiting this -- the vote on  
15 reliability, but it is really hard for me to  
16 figure out how to go forward without better  
17 understanding whether this -- this testing really  
18 represents a test for reliability.

19 MEMBER FINKELSTEIN: So --

20 CO-CHAIR SUSMAN: Jonathan.

21 MEMBER FINKELSTEIN: Yes, so let me  
22 just say, and maybe there is guidance from NQF:

1 the whole notion of -- this is a claims-based  
2 measure. The whole notion of reliability, inter-  
3 rater reliability, test/retest reliability, does  
4 not really hold in the same way for a claims-  
5 based measure.

6 If you run it, if you run a SAS code  
7 on claims, and two days later, you run it again,  
8 you will get the same result. That is  
9 test/retest. It is not like -- it is not like  
10 asking somebody and then asking them three days  
11 later. It is -- also inter-rater reliability has  
12 no meaning, so the best you can do are these  
13 quirky mathematical things that most of us who  
14 are not PhDs in statistics don't really  
15 understand the nuances of.

16 So to me, reliability and validity for  
17 these claims-based measures blur somewhat, and I  
18 think there are some issues that we should --  
19 should talk about with regard to whether you are  
20 measuring with precision the thing you want to  
21 measure, that is, validity. Whether you are  
22 measuring it with precision is the reliability,

1 and for me, they boil down to several things.

2           Number one is the issue -- I would  
3 love the developer to explain the issue of the  
4 denominator time. My understanding is that if I  
5 had an ED visit in -- in February, the time for  
6 me to be qualified as having asthma is 13 months.  
7 It is the prior year plus January of that year.  
8 If I have an ED visit in December that is in the  
9 numerator, I have actually 12 plus -- through  
10 November, I have like over 20 months in order to  
11 be qualified as -- as having asthma, and I am  
12 worried about what bias that introduces given the  
13 seasonality of asthma, so that is one.

14           A second one is the developers made  
15 some interesting choices based on their expert  
16 panel to exclude a class of medications that is  
17 usually included as asthma medications,  
18 specifically --

19           CO-CHAIR SUSMAN: Jonathan, I am going  
20 to interrupt just a moment --

21           MEMBER FINKELSTEIN: Yes.

22           CO-CHAIR SUSMAN: -- because it sounds

1       like a lot of these are more validity issues --

2               MEMBER FINKELSTEIN:   So do you want me

3       to --

4               CO-CHAIR SUSMAN:   -- as opposed --

5               MEMBER FINKELSTEIN:   -- hold them to

6       --

7               CO-CHAIR SUSMAN:   -- to --

8               MEMBER FINKELSTEIN:   -- validity?

9               CO-CHAIR SUSMAN:   -- to the --

10              MEMBER FINKELSTEIN:   That is fine.

11              CO-CHAIR SUSMAN:   -- precision, the  
12       issues of reliability --

13              MEMBER FINKELSTEIN:   Okay.

14              CO-CHAIR SUSMAN:   -- at this point,  
15       yes.

16              MEMBER FINKELSTEIN:   Yes.

17              CO-CHAIR SUSMAN:   We have a hard  
18       enough time doing reliability without mixing it  
19       with validity, but good comments, for sure.

20              Now just to presage what we can vote  
21       on, one option that will come up is to say that  
22       it is insufficient because we just have not had

1 the opportunity to digest the material, or the  
2 material ultimately was not provided, so, you  
3 know, frankly, I find it difficult to be able to  
4 vote on something with any validity when it is  
5 not present. But that is my own bias.

6 So I am looking for further comments  
7 here about reliability, if any.

8 DR. KLEINMAN: May I make one comment,  
9 two comments, quickly in response to things that  
10 have been said that are related to reliability,  
11 not the other component?

12 CO-CHAIR SUSMAN: Sure.

13 DR. KLEINMAN: Okay. Thank you. One  
14 thing, in response to what I believe it was Karen  
15 was saying, we actually have provided a precision  
16 analysis. So when I say that the estimate is  
17 0.34 and the standard error is 0.05, that tells  
18 us the 95 confidence interval is between 0.25 and  
19 0.45, and we have that for each plan, and we also  
20 have that for every county. So the -- and the  
21 confidence intervals are narrow enough that plans  
22 differ and are outside of one another's

1 confidence interval, so that is the precision  
2 analysis.

3 The other, again, I apologize that we  
4 didn't get this to you sooner. It was actually  
5 an impossibility because I left -- I moved from  
6 Mount Sinai to Case Western, and when our IRB --  
7 and I remained the PI because I am an adjunct at  
8 Mount Sinai, our IRB did not know how to figure  
9 this out. It took them four months to grant our  
10 renewal, or our continuation, of the IRB, so I  
11 was literally not able to touch the data --

12 CO-CHAIR SUSMAN: Yes. You know, that  
13 is --

14 DR. KLEINMAN: -- so --

15 CO-CHAIR SUSMAN: -- certainly  
16 understandable, and we certainly appreciate your  
17 explanation. We do have an option of asking for  
18 the data, and then being able to reconsider this  
19 during our phone call, so I think, as I am  
20 looking around the room, that there is a fair  
21 amount of head-nodding around trying to be able  
22 to look at all the expounded information that you

1 are discussing, but let me get Jim.

2 MEMBER BOST: So what you added with  
3 your Poisson analysis gets more -- gets as well  
4 to the meaningfulness by providing additional  
5 data, but it didn't sound like it actually gets  
6 at what you would call a typical definition of  
7 reliability. I mean, I could see you potentially  
8 doing some chart reviews to see if your claims  
9 algorithm matched up with the chart reviews, but  
10 I didn't see that, or if -- if you have a -- a  
11 program that runs this, you could have tested  
12 that program at a variety of different entities  
13 to see if it runs, so I guess I was looking more  
14 for those kind of things for reliability here  
15 that I did not see.

16 DR. KLEINMAN: I -- I think we did  
17 provide a literature review that took the claims  
18 to the constructs under the validity section, so  
19 that part, we do have, and we did -- we looked at  
20 various plans, and we looked at counties and  
21 found that it worked in both all within a single  
22 data set, which is what we had available. Thank



1       you.

2                   CO-CHAIR SUSMAN: I am wondering if a  
3       vote on reliability, and if we indeed vote that  
4       it is insufficient, there will be the opportunity  
5       for the developer to provide all the information  
6       that has been asked for, some of it provided, and  
7       we can take a look at that at our leisure. So  
8       unless there are objections, I would suggest that  
9       we would vote on reliability.

10                  CO-CHAIR BROOKEY: Which would mean we  
11       would discuss it in the phone call meeting, is  
12       that correct?

13                  CO-CHAIR SUSMAN: Which would mean we  
14       would discuss it on the phone call meeting.

15                  DR. NISHIMI: Post-comment call.

16                  CO-CHAIR SUSMAN: The post-comment  
17       call, thank you.

18                  Okay. So let us move to voting on  
19       reliability.

20                  MS. JUNG: The voting for Measure 3189  
21       for reliability is now open. Option 1, moderate;  
22       option 2, low; and option 3, insufficient.

1 (Pause.)

2 MS. JUNG: Still waiting on one more  
3 vote.

4 (Pause.)

5 CO-CHAIR SUSMAN: Everybody might want  
6 to -- quick, again, we have our offsite person.

7 MS. JUNG: Oh, there we go. Voting is  
8 now closed. The results are 4 percent for  
9 moderate, with one vote; 17 percent for low, with  
10 four votes; and 78 percent for insufficient, with  
11 18 votes. The measure did not pass for  
12 reliability.

13 CO-CHAIR SUSMAN: And with it not  
14 passing reliability, do we continue on, or do we  
15 stop there?

16 Okay. So we will stop there. I think  
17 my sense from the group here is that this is a  
18 very viable measure, but having to conform to the  
19 NQF procedure, we just need a little bit more  
20 data, and you might likewise consider the  
21 information that was provided for validity  
22 testing, making sure that all our potential

1       answers at the post-comment call will be  
2       provided. So thanks very much. Yes?

3               DR. NISHIMI: It might be useful for  
4       the developer to hear some of the concerns about  
5       validity that Jeff wanted to raise just so that,  
6       although the committee won't vote, it will be  
7       useful feedback in anticipation of the post-  
8       comment call.

9               CO-CHAIR SUSMAN: Great, great point.  
10       So let's take this opportunity then to focus on  
11       validity, or any other really core questions, but  
12       validity is also a must-pass element, so Jim, did  
13       you have a comment still, or -- okay. Jon.

14               MEMBER FINKELSTEIN: So -- so I will  
15       try to be -- I will try to be really succinct.  
16       The three issues -- I think this is really useful  
17       because then the developer can bring us back  
18       information. The three issues that stood out to  
19       me are the variable ascertainment period for who  
20       is an identifiable asthmatic and how that varies,  
21       especially seasonally throughout the year, that  
22       is number one.

1                   Number two was the exclusion of Beta  
2 agonists, short-acting Beta agonists as an asthma  
3 medication, which I understand is a -- is just a  
4 decision that the expert panel made, but I did  
5 not see any analysis of how that does or does not  
6 affect the measure performance. And the third  
7 one, again, a decision the expert panel made to  
8 include the diagnosis of bronchitis, and in the  
9 asthma research I know, that does not affect  
10 things very much, but -- but if that is just a  
11 decision the expert panel made, I am wondering if  
12 they did any analysis of whether including or not  
13 including those diagnosis codes makes any  
14 difference at all. So those were my three  
15 validity issues.

16                   CO-CHAIR SUSMAN: Thank you so much.  
17 Karen, do you have any additional comments there?

18                   MEMBER DORSEY: No. I agree that the  
19 denominator definition is the one that I am --  
20 that I focused most on, so a little bit of more  
21 clarity there I think is really helpful.

22                   CO-CHAIR SUSMAN: And again, you may

1 well have provided this, but if you can make it  
2 absolutely crystal so at our post-comment call we  
3 can address this, it would be very useful.

4 The rest of the group, other comments  
5 that our measure developer should be considering  
6 for a resubmission at the post-comment, or the  
7 ongoing submission, if you will? Okay, yes,  
8 Dave. Dave?

9 MEMBER KELLER: Well actually, the  
10 only -- only -- just a question for the Chairs:  
11 the next measure we're about to consider sort of  
12 builds on this measure, and the fact that we  
13 deferred decision on this measure, does that  
14 impact our ability to consider the next measure?

15 DR. NISHIMI: No. You should -- you  
16 should judge the next measure with what you have  
17 in front of you. If you judge that it is  
18 similarly insufficient, then we would stop and  
19 provide the developer feedback, but we wouldn't  
20 just set it aside.

21 MEMBER KELLER: Got you.

22 CO-CHAIR SUSMAN: God has spoken.

1 (Laughter.)

2 CO-CHAIR SUSMAN: All right. We  
3 appreciate the hard work and the very interesting  
4 and useful concepts here and look forward to  
5 reconsidering that at our post-comment call, and  
6 we will move forward then to another very related  
7 measure and allow our developers to discuss the  
8 broad overview of that one.

9 DR. KLEINMAN: Sure.

10 CO-CHAIR SUSMAN: This is a --

11 DR. KLEINMAN: Thank you very much.  
12 I am sorry. Go ahead?

13 CO-CHAIR SUSMAN: I was just saying  
14 this is the appropriateness measure.

15 DR. KLEINMAN: So thank you, and I  
16 appreciate your feedback on the other, and this  
17 is a part of our suite of asthma measures. As I  
18 indicated, some are being considered by Care  
19 Coordination, some by Pediatric.

20 This measure was an attempt to  
21 recognize that there are various reasons for use  
22 of the emergency room, one of which is a clinical

1 outcome failure which is generally discussed and  
2 which that first measure was designed to  
3 identify. Another may be failures of the primary  
4 care system or other aspects of the -- of the way  
5 that care is delivered, as has been demonstrated  
6 dating back to the Three City Study in the 1980s,  
7 I believe, early 90s.

8 And so we wanted to know, if a child  
9 was in the emergency room, was that the  
10 appropriate level of care for that child? And  
11 our expert panel gave us several -- several key  
12 reasons for them to be there, some of which would  
13 require patient-centered information, which we  
14 can't collect, and -- in this measure, which is a  
15 chart review measure, but most of which are in  
16 the chart.

17 And so we set this up as either  
18 appropriate or of questionable appropriateness.  
19 It should be clear we are not using the word  
20 "inappropriate," in part because of that. We --  
21 we think this is an important measure. It is a  
22 measure both of overuse and a measure which

1 allows for interpretation of other data, such as  
2 the -- the frequency of ED use, whether you count  
3 it with our measure or some other, and it also  
4 can help to drive improvement as well as being an  
5 accountability measure.

6 Anyway, I am happy to take questions  
7 and to address the -- the concerns and interests  
8 of the committee.

9 CO-CHAIR SUSMAN: Okay. Thank you  
10 very much. Anything further, Suzanne?

11 (No audible response.)

12 CO-CHAIR SUSMAN: All right. Well,  
13 let's go down to our leads with Ricardo.

14 MEMBER QUINONEZ: Well so I understand  
15 we will be discussing the evidence --

16 DR. KLEINMAN: I can't --

17 MEMBER QUINONEZ: -- first --

18 DR. KLEINMAN: -- hear.

19 MEMBER QUINONEZ: We will -- we will  
20 be discussing the evidence, correct? And since  
21 this is an outcome measure, we would consider  
22 whether there is any modifiable process that can



1 influence the outcome, and so based on that very  
2 narrow definition, I would say there are  
3 processes of care that can influence the outcome.  
4 There's -- there's other concerns that I have,  
5 but not related to this narrow definition of  
6 evidence for outcome measures.

7 CO-CHAIR SUSMAN: Okay. Let's go down  
8 the list: Marlene?

9 MEMBER MILLER: Yes, I mean, while I  
10 agree with that, I think this does bring up some  
11 of the same issues as the other measure.  
12 Obviously, for example, this measure predisposes  
13 that everything is modifiable by the health plan,  
14 but there is no ability to account for a simple  
15 issue such as compliance, some of the -- you  
16 know, medication compliance in the home setting,  
17 the social stressors, et cetera, so it gets very  
18 blurry for me when we try to say the evidence.  
19 The evidence is that we can impact those rates,  
20 but this measure to me the way it is constructed  
21 suggests that you would impact all of it, and  
22 because there is no accounting for these other

1 factors which are, you know, likely beyond full  
2 control of the health plan, i.e. for example  
3 compliance of medication use at home.

4 CO-CHAIR SUSMAN: Okay. Thank you.  
5 My issue probably revolves around calling this  
6 "appropriateness" because you don't know who  
7 doesn't go to the ER, and while it may well be a  
8 very small number that don't appropriately end up  
9 in the ER when they should, all we know are the  
10 people who go.

11 So it is in some ways I guess more of  
12 an overuse measure, potentially, but it is just  
13 as important to think about underuse, so when I  
14 think about outcomes, I mean, maybe it would be a  
15 far worse outcome to have a child not sent  
16 appropriately to the ER, so even though it might  
17 be very infrequent, differences that are  
18 meaningful might be very important to capture.

19 I see a lot of now hands up, if you  
20 will. Let me go to James to give final comments  
21 from the primary reviewers, and then we will get  
22 to the further comments and questions.

1                   MEMBER BOST: Sure. I think there was  
2 certainly evidence that -- of -- of  
3 appropriate/inappropriate overuse in the ED for  
4 asthma. When I was looking at the measure and  
5 its definitions, so if -- if the rate is low,  
6 that is telling me that there are a lot of kids  
7 coming who could be taken care of by a PCP or  
8 specialist that are not. So, you know, I guess  
9 at a health plan level, you could be working to  
10 make sure those kids get assigned to a  
11 specialist. Not sure at an individual hospital  
12 whether you could do that, but maybe you can.

13                   If -- if the rate is at like 100  
14 percent, let's say, then, you know, in essence,  
15 that is great in terms of that being assigned to  
16 a PCP, but if over time, that stays really high,  
17 but your denominator is going up, then that means  
18 that there are more kids coming where the PCP is  
19 not doing a good job of taking care of them, so  
20 they are having more crisis events. So it got a  
21 little confusing in my head how you -- how that  
22 rate, standing alone, could be used to gauge

1       whether improvement is done.

2                   CO-CHAIR SUSMAN:  Yes, and it -- at  
3       the developer, it seems to be in some ways that  
4       you meant this to be a sort of paired measure,  
5       even though we do have to look at this on its own  
6       as submitted?

7                   DR. KLEINMAN:  Yeah, I would say it  
8       should -- it would best be paired with some  
9       estimation of how commonly ED is used.  It  
10      improves interpretation.  But I do think -- I  
11      think the point that was just added, I am not  
12      sure who that third reviewer was, I am sorry, I  
13      didn't hear your name, actually hits the bull on  
14      the head.

15                   This is -- it is a challenging measure  
16      because if it is high, it means one thing, if it  
17      is low, it means something else, but they both  
18      have important meaning potentially for  
19      improvement, and context matters.  So this is an  
20      attempt to actually bring a little bit of nuance  
21      into the measurement we have done, and in part,  
22      it is definitely an overuse measure.

1                   And it was also done because we did  
2                   not want the assumption that emergency room use  
3                   meant overuse of the emergency room at the  
4                   clinical level, because we were concerned about  
5                   the potential policy implications of that. We  
6                   don't want those services cut when it's a safety  
7                   net for children who need it. So this is -- this  
8                   is really -- it is a rich and nuanced measure  
9                   that comes out of a -- a rich tradition in terms  
10                  of appropriateness, but also access and  
11                  coordination of care. It sort of brings them all  
12                  together.

13                 CO-CHAIR SUSMAN: Okay. We have a  
14                 number of questions and comments. I will start  
15                 with Jon.

16                 MEMBER FINKELSTEIN: So my -- and this  
17                 is maybe definitional, but I think important. So  
18                 when I was going through this measure, the other  
19                 measure I totally saw as an outcome measure. I  
20                 did not see this as an outcome measure. Getting  
21                 to the ER is an outcome, but this to me is -- is  
22                 -- the question is is an overuse measure --

1       because I agree that is exactly what it is -- a  
2       process measure or an outcome measure? I  
3       generally think of -- of overuse -- that is just  
4       definitional.

5               DR. KLEINMAN: So Jon, when I  
6       originally submitted this measure, and it was  
7       submitted initially to the pulmonary group, I  
8       submitted it as a process measure, and the  
9       committee and staff told us it would be better  
10      considered as an outcome measure. So I think in  
11      terms of a formal academic framework, it is  
12      probably more process, but in the way that  
13      operationally these things are used, it would be  
14      -- it is an outcome measure. I have become  
15      convinced of that, but I share your -- your  
16      initial reaction to it.

17             DR. NISHIMI: I just want to reinforce  
18      what Larry said. The committee did come back and  
19      recommend to him that he submit it. It is  
20      splitting hairs, you know, ten ways, but they  
21      came down on it being an outcome measure, so when  
22      you apply our criteria, it becomes a pass/no

1 pass.

2 CO-CHAIR SUSMAN: Okay. Let's go down  
3 the row. David?

4 MEMBER KELLER: Jeff actually had his  
5 up first, but mine -- mine just is an observation  
6 that as was said, this -- what this reminds me of  
7 as an outcome measure is looking at readmissions,  
8 where you can change the rate by altering either  
9 the numerator or the denominator, and in this  
10 case, the way -- which of those combination of  
11 things changes matters. We found in a number of  
12 our readmissions work that as we reduced the  
13 number of unnecessary admissions, we had some  
14 hospitals that actually would increase their  
15 readmission rate because all that was getting  
16 admitted was the complicated patients, and that  
17 ended up hurting them in some of the schemes.

18 So I think that is -- the question to  
19 the developer is had -- was there consideration  
20 of looking at the rate as you did in the previous  
21 measure of unnecessary ER use per 1000 child  
22 years of children with asthma rather than per --

1       than using emergency room visits as the  
2       denominator?

3               I think the other piece to that is  
4       that this -- the way it is constructed, I could  
5       see this as a measure that would be perceived as  
6       a problem for the emergency room to solve, and  
7       this is not a problem for the emergency room to  
8       solve. They -- they have to take anyone who  
9       shows up, and so the real question is work that  
10      goes on outside the emergency room, and this is  
11      clearly a measure of system function rather than  
12      of emergency room function, but -- but I could  
13      imagine this measure being used, and, you know,  
14      on the dashboard of our emergency room at the  
15      hospital --

16              DR. KLEINMAN: Yes.

17              MEMBER KELLER: -- and then -- but the  
18      emergency room docs would have very little to be  
19      able to do about that other -- except in  
20      retrospect.

21              CO-CHAIR SUSMAN: Okay. And then  
22      finally, Jeff?



1                   MEMBER SCHIFF: I -- just to echo one  
2                   thing David said, I would like to hear from the  
3                   developer why they wouldn't use this numerator in  
4                   their previous denominator, because that would be  
5                   a measure of the severity of -- that would give  
6                   you a measure, a better measure of severity of  
7                   the folks who show up in the ER.

8                   To me, the -- I have a comment and a  
9                   question. The comment is that in this measure, a  
10                  high percent may be a measure of -- of  
11                  insufficient care prior to the emergency room,  
12                  because somebody would not -- you would say that  
13                  they -- they should have been treated so they  
14                  didn't have a low PO2 or S saturation. A low  
15                  percent may be a measure of bad triage, which is  
16                  I think what the developer was getting at.

17                  My question though, just, it is  
18                  probably more the evidence question, is in the  
19                  criteria for explicit criteria, there's a lot of  
20                  variation in that, and especially the last one,  
21                  there -- it says there is clear documentation  
22                  that prior to arrival in the ED, any of the

1 following occurred, and I just want to -- I  
2 wanted to -- was curious about how that final  
3 component was developed, you know, because it  
4 seems like that is -- there are some of these  
5 that are pretty hard, you know, 2 saturation  
6 below 90 percent, a blood gas was obtained, even  
7 though labored breathing I think is maybe  
8 subjective, I just want to know how they -- how  
9 they -- where is the validity or the evidence for  
10 that?

11 DR. KLEINMAN: Should I respond? Is  
12 that -- is there --

13 CO-CHAIR SUSMAN: Yes, please --

14 DR. KLEINMAN: -- a question?

15 CO-CHAIR SUSMAN: -- if you will.

16 DR. KLEINMAN: Sure, of course. So I  
17 think in response to the last -- not the last  
18 comment, but the last commenter, and also to  
19 David's comment about sort of creating a  
20 population measure that integrates  
21 appropriateness and the count measures, this is  
22 something we have thought about. We just were

1 not there. We did not have the resources to do  
2 it. That was -- we thought that was a --  
3 potentially a later stage of development.

4 We only had the resources to assess  
5 this in one hospital. I agree it's a system  
6 measure, but chart reviews are difficult and  
7 expensive and time-consuming, and given the --  
8 the constraints that existed from AHRQ and CMS  
9 regarding this measure, this is what we were able  
10 to do, but I do think that is a future direction  
11 that is -- is worth doing and worth thinking  
12 about.

13 In this metric, some of the criteria  
14 that the committee suggested such as previous  
15 history of rapid deterioration were not  
16 operationalized into this measure, and that is  
17 why I say some of those are things that require a  
18 -- talking to the parent. And since we were  
19 restricting ourselves here to chart review data,  
20 that is one of the reasons we don't ever call it  
21 inappropriate. We say "questionable  
22 appropriateness," and that is one of the ways

1       that that question could be answered.

2               We do have -- I have one of my former  
3       fellows in New York who is currently seeking  
4       funding to expand work on this and also to  
5       develop a patient-centered survey in the ED that  
6       would help to complement these data, but we are  
7       not --

8               CO-CHAIR SUSMAN:   Okay.

9               DR. KLEINMAN:   -- implementing those  
10       here.

11              CO-CHAIR SUSMAN:   Okay.   I am going to  
12       move things along.   John?

13              CO-CHAIR BROOKEY:   Yes, I just want to  
14       make a couple comments in terms of being a health  
15       plan measure.   We do know there is a pretty good  
16       correlation with asthma medication ratio and ED  
17       utilization.   It is probably the one thing that  
18       you can do from a health plan perspective to  
19       really change ED utilization is to improve the  
20       compliance with medication, as well as to provide  
21       access in primary care, so those are the two sort  
22       of actionable things a health plan could actually

1 do.

2 But having looked at this pretty  
3 extensively in Kaiser in California, we know a  
4 couple of things. We are -- our Medicaid  
5 utilization is double commercial for ED  
6 utilization, but if you look at hospitalization,  
7 it is not so different, and as I mentioned  
8 earlier, our access in the ER is very very good  
9 with no copay, and so that kind of confounds your  
10 analysis of the data, and I -- I don't look at ED  
11 utilization as being an index of severity of  
12 illness, but rather access.

13 And I would look at hospitalization  
14 differently, and I think that is kind of what  
15 this measure is getting at, is trying to figure  
16 that out, and I agree that maybe the denominators  
17 need to be switched or something, but I like  
18 where it is going. I am not sure the group will  
19 say this is the right measure at the right time,  
20 but -- but trying to get at severity illness I  
21 think is a very important thing.

22 CO-CHAIR SUSMAN: Well, this has been

1 a very robust discussion. Does anybody have  
2 anything new about evidence?

3 (No audible response.)

4 CO-CHAIR SUSMAN: And if not, let's  
5 make the vote.

6 MS. JUNG: Okay. Voting for Measure  
7 2816 for evidence is now open. The option is  
8 option 1, pass; option 2, not pass.

9 PARTICIPANT: What happens if you vote  
10 3?

11 CO-CHAIR SUSMAN: If you vote 3, we  
12 will make you serve on three more NQF panels.

13 (Laughter.)

14 MS. JUNG: Voting is now closed. The  
15 results are 55 percent pass, with 12 votes; 45  
16 percent not pass, with -- I am sorry, with 10  
17 votes, and then the pass -- 55 percent pass, with  
18 12 votes; 45 percent not pass, with 10 votes.

19 PARTICIPANT: And what does it have to  
20 be to --

21 MS. JUNG: It has to be at 60 percent,  
22 so this does not pass -- I am sorry --

1 CO-CHAIR SUSMAN: This is a --

2 MS. JUNG: -- I keep saying that.

3 Consensus is not reached for this.

4 CO-CHAIR SUSMAN: And we continue to  
5 go on then? Yes, okay.

6 So thank you. We now get to look at  
7 gap, and let's have our primary reviewers comment  
8 briefly about gap.

9 MEMBER QUINONEZ: I think the  
10 reviewers definitely showed evidence that there  
11 is -- there is a gap, particularly I think  
12 similar to the prior measure, that there is also  
13 a lot of disparity in ED utilization with asthma,  
14 so it -- I mean, it -- the evidence that ED  
15 utilization varies for patients with asthma I  
16 think is definitely there.

17 CO-CHAIR SUSMAN: Okay. Marlene?

18 MEMBER MILLER: I do think there is  
19 obviously evidence for inappropriate use. I  
20 still have trouble that we -- there is not  
21 evidence into the parsing of the reason behind it  
22 in terms of access, non-compliance, et cetera,

1       which obviously influence the ability to move  
2       that needle, if you will, on appropriate use of  
3       the ER.

4                   CO-CHAIR SUSMAN:  I don't have  
5       anything new to contribute.  And Jim?

6                   (No audible response.)

7                   CO-CHAIR SUSMAN:  Nothing?  Questions  
8       or comments?

9                   (No audible response.)

10                  CO-CHAIR SUSMAN:  And if not, let's  
11       vote on gap.

12                  MS. JUNG:  The voting for gap for  
13       Measure 2816 is now open.  Option 1, high; option  
14       2, moderate; option 3, low; and option 4,  
15       insufficient.

16                  (Pause.)

17                  MS. JUNG:  Lauren, we -- oh, there it  
18       is.

19                  (Pause.)

20                  MS. JUNG:  One more vote.

21                  CO-CHAIR SUSMAN:  Folks, please vote  
22       again just to make sure we captured them all.



1 Oh, one has stepped out.

2 MS. JUNG: Snuck out.

3 CO-CHAIR SUSMAN: Uh-oh.

4 MS. JUNG: Voting is now closed. The  
5 results are 9 percent for high, with two votes;  
6 82 percent for moderate, with 18 votes; 9 percent  
7 for low, with two votes; and 0 percent for  
8 insufficient, with zero votes. The measure does  
9 pass for gap.

10 CO-CHAIR SUSMAN: Okay. Let's move on  
11 and talk about our validity issues -- or  
12 reliability issues. I am trying to really move  
13 us along.

14 MEMBER QUINONEZ: So following the --  
15 the script that we were given for discussing  
16 reliability, here we considered the numerator  
17 statement, the denominator statement, and I think  
18 this is -- this is where a good discussion of the  
19 developer's criteria for appropriateness may be  
20 -- may be in order. I have a lot of difficulty  
21 with that because I think there is -- you know,  
22 since we're looking at appropriate ER visits, and

1 I realize that the -- they used a RAND/UCLA  
2 Appropriateness criteria method to get at these  
3 criteria, but I think there's a lot of  
4 opportunities here to game the system.

5 You know, I think for example, all of  
6 the reliability criteria are "or," and -- and so  
7 passing any of those would -- would give you --  
8 would tell you that -- that the -- the visit is  
9 appropriate, so, you know, for -- one example is  
10 recorded oxygen saturation below 90 percent. Is  
11 that on presentation, or is that at any time  
12 during the ER visit? When you get three back-to-  
13 back doses of Albuterol, many children drop below  
14 90 percent. It does not really mean much. And  
15 so -- but by these criteria, you would meet that  
16 -- that appropriateness criteria.

17 And so I -- you know, and I think  
18 there's -- there's several things in this. The  
19 subjectivity of -- of the physical exam in  
20 respiratory distress, I think there's a criteria  
21 when an ABG was obtained, so I would basically --  
22 you know, I could get an ABG on every single kid

1       that shows up to the ER because I want to meet  
2       this criteria, and so I could game the system  
3       that way. So I have a lot of concerns about the  
4       appropriateness criteria that worried me in this  
5       specification.

6               CO-CHAIR SUSMAN: And it sounds like  
7       at least some of this is about the validity --  
8       face validity of the measure.

9               MEMBER QUINONEZ: Yes, except the  
10      script really wants to talk about that.

11              DR. NISHIMI: Right, but it does --

12              CO-CHAIR SUSMAN: It also -- yes.

13              MEMBER QUINONEZ: Yes.

14              DR. NISHIMI: It goes to the  
15      specifications, which is the first element.

16              MEMBER QUINONEZ: Right.

17              DR. NISHIMI: So it's both.

18              MEMBER QUINONEZ: Yes.

19              DR. NISHIMI: Yes, no, it's both.

20              CO-CHAIR SUSMAN: Okay. Did you want  
21      to make a comment, Robyn, about how we're going  
22      to handle the reliability and actually not vote

1 on that, as I understand it.

2 DR. NISHIMI: So one element of the  
3 reliability is what Ricardo spoke to, which are  
4 the specifications. So you need to keep that in  
5 the back of your mind. But the developer has  
6 claimed data element level validity, unlike the  
7 measure you just discussed where we were looking  
8 at actual scores.

9 So in this case the developer has  
10 relied on the literature for the identification  
11 of the denominator and then has done some empiric  
12 testing, which is described. He had ten charts  
13 at the facility against -- the gold standard was  
14 the transposition and the other two abstractors.  
15 So that would be the empirical testing of  
16 validity against a gold standard at the data  
17 element level. And that would be appropriate for  
18 reliability as well. So you won't vote on  
19 reliability testing because we're going to rely  
20 on the validity testing.

21 CO-CHAIR SUSMAN: So as you're  
22 thinking about that -- I think your comments are

1 very appropriate for at least both of those.

2 We have a bunch of questions here.

3 MEMBER DORSEY: I just had a question  
4 about that guidance specifically. You want me to  
5 hold it?

6 CO-CHAIR SUSMAN: Yes. No, no.

7 MEMBER DORSEY: So I was just curious  
8 whether there's any requirements when we think  
9 about data element validity testing about a  
10 facility. So it's just one facility, but is that  
11 -- that's up to us? There's no specific guidance  
12 from the staff about that?

13 DR. NISHIMI: No, whether you feel  
14 that is sufficient. The validity calculation  
15 also asks you questions about meaningful  
16 differences. Can't do that with only one. But  
17 again, that's just one element and the Committee  
18 members have to judge where to weight all these  
19 different issues.

20 CO-CHAIR SUSMAN: Jim?

21 MEMBER BOST: So when I was reading  
22 the guidance, it says, was empirical -- and this

1 is on the reliability. It says, was empirical  
2 validity testing of patient-level data conducted?  
3 Well, this is item level, isn't it? So I don't  
4 see patient level. So I would have said that  
5 then goes to insufficient.

6 DR. KLEINMAN: May I respond to that?

7 CO-CHAIR SUSMAN: Yes.

8 DR. KLEINMAN: The overall  
9 appropriateness score would be the patient level.  
10 The items are sort of supporting data --  
11 information for that, but overall appropriateness  
12 is at the patient level.

13 CO-CHAIR SUSMAN: But aren't there the  
14 assessment and an element level?

15 DR. KLEINMAN: It's element level  
16 building up to patient level, and overall  
17 appropriateness is at the patient level, not at  
18 the element level.

19 CO-CHAIR SUSMAN: So there --

20 MEMBER BOST: So how would we assess  
21 that if it's only one institution and --

22 CO-CHAIR SUSMAN: Well, I think that's

1 certainly an important point. I mean, if we're  
2 supposed to be looking at differences and the  
3 testing is only at one place, even if we give  
4 them a pass on validity, it's hard for me to get  
5 too excited about that being an adequate  
6 demonstration.

7 Okay. We are sort of continuing to  
8 talk about both reliability and validity because  
9 of the interrelationship here. Are there other  
10 comments or key issues around this that will  
11 ultimately influence our voting?

12 Yes, I see some hands, so I'm going to  
13 get Jim first and then we'll go down.

14 MEMBER BOST: So it should also be  
15 mentioned that in the item testing all items  
16 could not be tested because a couple of them were  
17 not actually collected at that institution. Now  
18 the institution did say that it really wasn't  
19 needed, that the other items in the list were  
20 sufficient to do that. And they did talk to nine  
21 other institutions and showed them the list of  
22 items. And they thought it was okay to get what

1       they're needing. But again, we didn't get an  
2       item-level analysis on every item.

3               CO-CHAIR SUSMAN: And just to add to  
4       that, the pharmacy data was variably accessible.

5               So, okay. From our --

6               DR. KLEINMAN: And --

7               CO-CHAIR SUSMAN: Just a moment.

8       Let --

9               DR. KLEINMAN: Oh, sorry.

10              CO-CHAIR SUSMAN: Yes.

11              DR. KLEINMAN: I was just asking if it  
12       was time. Okay. Great.

13              MEMBER EDIGER: I'm just confused.  
14       Since it didn't pass on evidence, I just think --  
15       (Simultaneous speaking.)

16              MS. JUNG: Consensus was not reached.

17              CO-CHAIR SUSMAN: Consensus was not  
18       reached and per the NQF protocol we continue on.

19              MEMBER EDIGER: Okay.

20              CO-CHAIR SUSMAN: Yes.

21              MEMBER EDIGER: Okay.

22              CO-CHAIR SUSMAN: So, sorry for the



1 confusion.

2 MEMBER EDIGER: That's all right.

3 CO-CHAIR SUSMAN: Okay. Other  
4 comments? Jim and Jon.

5 MEMBER BOST: To its credit, it was  
6 designed like a HEDIS measure so that  
7 specification stuff I thought it was well  
8 designed in terms of assessing whether it could  
9 be reliably collected. And the kappas that were  
10 collected on the item level for most were pretty  
11 good, although they really needed a lot of  
12 practice because the kappas were much better  
13 after they were doing it for a while.

14 CO-CHAIR SUSMAN: Jon?

15 MEMBER FINKELSTEIN: So the criteria  
16 for the appropriateness of the ED visit -- some  
17 of them are incredibly objective whether a blood  
18 gas was ordered, although I'm guessing that  
19 happens a very small percentage of the time  
20 anywhere. Others are so subjective and much more  
21 frequent, and I'm concerned would drive the  
22 measure. So I'm talking about referral by a PCC.

1 I understand why they thought about  
2 that, but I'm not sure that makes it appropriate.  
3 It just could make it an inappropriate primary  
4 care provider. And I'm guessing that that's  
5 going to be a much more common occurrence and  
6 could drive the measure.

7 CO-CHAIR SUSMAN: Or if you've got a  
8 busy office, just go to the ED.

9 (Laughter.)

10 CO-CHAIR SUSMAN: Kerri?

11 MEMBER FEI: Thanks. Kind of along  
12 the lines of what Jon said, a lot of the things  
13 in this list you -- would be tough to test  
14 because you don't expect to find all of them all  
15 of the time. So getting that type of testing, of  
16 testing all of the data elements that are listed  
17 here I think would be tough. And again, there's  
18 going to be some you're going to find a lot and  
19 there's going to be some that you aren't going to  
20 find very often. And a lot of them are pretty  
21 subjective, which would be tough.

22 CO-CHAIR SUSMAN: Okay. So are there

1 other -- did you have another comment, too?

2 (No audible response.)

3 CO-CHAIR SUSMAN: No? Okay.

4 Are there any other new questions,  
5 concerns or comments from the panel?

6 (No audible response.)

7 CO-CHAIR SUSMAN: Okay. So we're  
8 actually going to be voting on validity.

9 DR. KLEINMAN: May I respond to some  
10 of the comments because I think I can help  
11 clarify some of the things.

12 CO-CHAIR SUSMAN: Okay. If you could  
13 keep your comments very brief.

14 DR. KLEINMAN: I will do it. There  
15 are nine criteria the panel endorsed, only six of  
16 which are specified here. All the specified  
17 criteria were tested. There were 1,000 or so  
18 charts that were looked at, so while I was at one  
19 institution it was fairly robust. O2 saturations  
20 rarely fell below 90. That was not a major  
21 reason for appropriateness.

22 ABGs I think it's unlikely to game

1 because if you remember what was talked about  
2 earlier, when appropriateness is very high, it  
3 suggests you're doing a worse job of asthma  
4 management. Low is a worse job of access. So  
5 there is a balance intrinsic to the measure that  
6 ought to work against gaming. I'll leave it at  
7 that.

8 CO-CHAIR SUSMAN: Thank you. Thank  
9 you very much.

10 Okay. Let us go ahead then and vote  
11 for validity.

12 MS. JUNG: Okay. The voting for  
13 validity for Measure 2816 is now open. Option 1,  
14 moderate, option 2, low, and option 3,  
15 insufficient.

16 (Voting.)

17 MS. JUNG: One more. Is everyone in  
18 the room?

19 (Voting.)

20 MS. JUNG: Voting is now closed. We  
21 have the results. Four percent for moderate with  
22 one vote, 74 percent for low with 17 votes, and

1       22 percent insufficient with five votes.

2                   CO-CHAIR SUSMAN:   So this is a must-  
3       pass criteria and we did not reach the threshold,  
4       so we will stop there.

5                   Thank you very much again.   This is a  
6       really important work and I think a very  
7       important concept.   And I see everybody around  
8       the table -- which you can't see -- shaking their  
9       heads around that, and trying to address some of  
10      the, if you will, methodologic challenges here I  
11      think will be very useful for the field.   So  
12      thank you.

13                  DR. KLEINMAN:   Thank you.   Appreciate  
14      your time and your feedback.

15                  CO-CHAIR SUSMAN:   Okay.   We have  
16      another measure, and we're going to be talking  
17      about the informed coverage from Children's  
18      Hospital of Pennsylvania, CHOP.   And do we have  
19      the measure development -- walking up as we  
20      speak.   Thank you.

21                  So if you haven't figured it out, you  
22      can provide us your brief overview, introduce

1       yourself. And we appreciate your attendance.

2                   DR. SILBER: Thank you. It's nice to  
3       be here. I am Jeffrey Silber. I direct the  
4       Center for Outcomes Research at CHOP and I'm  
5       going to be talking about informed coverage.

6                   The measure is constructed to help  
7       states get a better sense of their participation  
8       rates of their children in Medicaid,  
9       participation rates meaning the denominator, the  
10      number of kids that are eligible and how many  
11      months they should be eligible during the study  
12      period, the observation period, and the numerator  
13      being of those that are eligible what's the -- or  
14      how many actually are enrolled. So we're talking  
15      about a fraction of that time period where the  
16      kids are enrolled when they're eligible.

17                  The measure fills a gap. Right now  
18      there's two kinds of measures that the states can  
19      use easily with their claims data. They can use  
20      a measure called duration, which is measured as  
21      after a gap in enrollment. You follow how long a  
22      patient -- once they're back on insurance -- how

1 long they stay on insurance.

2 That measure has a problem. That  
3 duration measure has a problem because if you  
4 don't have gaps, you don't show up in the  
5 measure. And we've talked to stakeholders and  
6 policymakers at the states who understand that  
7 that is a problem. If they're doing very well  
8 with a child who's always on during the study  
9 period, they don't get counted in the duration  
10 metric.

11 If you -- on the other hand, the other  
12 measure is the continuity ratio. It's in the  
13 literature. It hasn't been as formally developed  
14 as the duration metric. Continuity ratio looks  
15 at anyone during the study period who ever had  
16 insurance and then it says, well, that's -- then  
17 they should have been covered the whole time or  
18 participated with being enrolled the whole time.  
19 Then what fraction of their months were enrolled.  
20 So that's the continuity ratio.

21 So that has the opposite problem, and  
22 that problem -- the problem with the continuity

1 ratio is that there are kids that never are in  
2 the system at all. Those are the worst players,  
3 that they were eligible but you didn't know it  
4 and those don't show up in the continuity ratio.

5 So on the one hand you're penalizing  
6 states when they do a great job and then on the  
7 other hand with the second measure you're  
8 ignoring the very worst cases.

9 So we developed informed coverage to  
10 try to get at a better measure of this  
11 participation ratio. We developed it using a --  
12 what we wanted was an event that would be random  
13 that could tell us about participation. It  
14 wouldn't be related to your primary care. It  
15 wouldn't be related to any of the care that  
16 you've gotten.

17 And we thought, well, okay,  
18 appendectomies are random events. There's some  
19 literature about slight changes though with sex  
20 and with season, but appendectomies are very  
21 random. And then we can then check to see if you  
22 actually were enrolled before you came down with



1 your appendicitis and had your appendectomy.

2 And we know that you wouldn't show up  
3 in the MACs claims unless you were eligible. So  
4 we have a measure of eligible kids and then we  
5 can check going back in time to see if they were  
6 enrolled or not. And that's our measure of  
7 participation.

8 Now we bound this measure with two  
9 extremes. One extreme is -- we call the presumed  
10 eligible. These are looking at all the claims --  
11 not just an appendectomy, looking at all the  
12 claims and saying let's make an assumption that  
13 if we see you, you should have been eligible for  
14 the whole period. We make some modifications.  
15 That's similar to CO, but with some modifications  
16 for aging out.

17 And then there's presumed ineligible,  
18 which says, well, we presumed that if we didn't  
19 see you, you weren't eligible and therefore that  
20 gives you a higher participation rate. So we  
21 create two bounds, but we basically -- with this  
22 measure -- are using the appendectomy rate and

1 the percentage that had insurance prior to -- and  
2 were enrolled prior to getting their appendicitis  
3 event as our metric of participation in the  
4 states.

5 And then what we do -- and I'll finish  
6 up -- what we do is we compare our rates to the  
7 other two rates, to continuity and to duration.  
8 And we also go to what some consider a gold  
9 standard, which is the -- a survey method. So  
10 the American Community Survey, that is -- I'm  
11 saying it's often considered a good standard to  
12 look at. It surveys patients and families and  
13 asks them whether they're insured or -- whether  
14 they were on insurance or not. And so we present  
15 that data in our application as well. And we  
16 show that our metric is best -- better correlated  
17 with the ACS than is continuity or than is  
18 duration, and it also has less error than the  
19 continuity ratio compared to the ACS.

20 States can't get a hold of the ACS.  
21 In part, they can't link their data to the ACS  
22 and the ACS is -- varies over time and there's

1 even threats about whether that will be available  
2 in the same way. So for states that want to use  
3 their data to understand their participation  
4 rates, we think we have a good solution.

5 CO-CHAIR SUSMAN: Thank you very much  
6 for your succinct and clear explanation.

7 And we'll move on to Amy.

8 MEMBER HOUTROW: Yes, thank you. So  
9 as we heard, this is a measure of coverage over  
10 an 18-month period. And what we need to do here  
11 -- because this is an outcome measure -- is take  
12 the top part of our guidance for evidence, which  
13 is looking at whether this outcome measure has a  
14 relationship to at least one healthcare action.  
15 And they have provided evidence here that both  
16 for the individual who is insured, having health  
17 insurance improves their access to health  
18 services and outcomes.

19 And then in addition to the health  
20 plans perspective, the Medicaid plan, the  
21 disenrolled children who need to be re-enrolled  
22 is a very costly process. And so there's both

1 kind of the patient level related outcomes that  
2 they point to and then the systems level outcomes  
3 that they point to. And I would take those two  
4 as kind of the basic for how we would move  
5 forward in a decision about this outcome measure  
6 and the evidence for it.

7 CO-CHAIR SUSMAN: Okay. Kerri?

8 MEMBER FEI: I totally agree with what  
9 Amy said and I think there's plenty of evidence  
10 here to support that this is a measure that is  
11 needed.

12 CO-CHAIR SUSMAN: And what does the  
13 man from Ohio have to say?

14 MEMBER KNUDSEN: Agreed.

15 (Laughter.)

16 CO-CHAIR SUSMAN: And, David?

17 MEMBER KELLER: Yes, I actually not  
18 only agree, but I applaud them for their  
19 creativity. I think using appendicitis as a  
20 tracer into the system was a really interesting  
21 idea and I think will give some new -- a new way  
22 of looking at an old problem in the system.

1 CO-CHAIR SUSMAN: And the senator from  
2 Minnesota?

3 MEMBER SCHIFF: I didn't announce yet.

4 (Laughter.)

5 MEMBER SCHIFF: I think the approach  
6 is really novel. I -- my only comment was I just  
7 -- the presumed eligible and presumed ineligible,  
8 I had trouble with those terms and I was  
9 wondering if it could be something like coverage  
10 presumed maximally eligible and coverage presumed  
11 minimally eligible, because you really are  
12 cutting this differently and you're just making  
13 an assumption about that. And when I looked up  
14 presumed ineligible, I thought of all the reasons  
15 why people would be -- think about that as that  
16 folks somehow could not get coverage at that time  
17 when it's not that. It's just that they --  
18 they're just not on at that moment.

19 DR. SILBER: I think you're right. We  
20 could have better terminology. And you're right  
21 that they're supposed to be created to create a  
22 bound so that -- what's the worst case scenario

1 and the best case scenario for what your  
2 participation rate is. And we'll -- we could  
3 talk about the word maximum in there. I think  
4 you're right.

5 CO-CHAIR SUSMAN: So I'm not hearing  
6 a lot of controversy among the five primary  
7 reviewers. Are there any other questions or  
8 comments? Jon?

9 MEMBER FINKELSTEIN: So I guess --

10 CO-CHAIR SUSMAN: Wow.

11 MEMBER FINKELSTEIN: And this will be  
12 my last comment for the day.

13 (Laughter.)

14 CO-CHAIR SUSMAN: Okay.

15 MEMBER FINKELSTEIN: So I'm maybe  
16 being dense, but I, too -- I think the -- oh,  
17 thank you.

18 (Laughter.)

19 MEMBER FINKELSTEIN: Even better. I  
20 totally get the appendectomy thing. I agree it's  
21 -- that's really good. Are these guard rails  
22 that you've -- I don't quite understand the guard

1 rails, and are these guard rails that you've set  
2 up on either side to bound it just kind of  
3 theoretical and they're so extreme on either side  
4 that states would rarely hit them and what this  
5 really is is an appendectomy-focused measure, or  
6 are these guard rails guard rails that come into  
7 play a lot and people would be maxxed or minned  
8 all the -- frequently?

9 DR. SILBER: So the guard rails are in  
10 place for two reasons. So the first is that they  
11 create a bound and occasionally the appendectomy  
12 rate will be under or over the guard rails. So  
13 we didn't want -- we felt uncomfortable with  
14 that, so we bound it. It very seldom kicks in.  
15 It has a very slight effect, but occasionally  
16 you'll see that they're -- that it hits the  
17 bound.

18 The second reason that we have the PI  
19 and the PE is that when we look at strata --  
20 let's say we want to stratify by a region or by  
21 race. What we do is we work out for every state  
22 what the mixture of PE and PI would be to

1 replicate the appendectomy rate. And then we use  
2 for the strata -- we don't go getting  
3 appendectomy rates on a minority group or on a  
4 subset. We look at the actual PI and PE with all  
5 the thousands and thousands of patients in the  
6 state. And then we weight them according to what  
7 we learned from the overall state rate.

8           So we still see differences by race  
9 and other subgroups based on PE and PI and based  
10 on the mixture that was achieved when we first  
11 made the overall metric for participation based  
12 on appendicitis. So we didn't want to use  
13 appendicitis on subgroups where the ends might be  
14 too small.

15           So we use all the patients. We  
16 estimate a PI and a PE on everybody, but we --  
17 and so subgroups can be looked at, but how do we  
18 put PI and PE together? We use the overall  
19 tendency in the state to have PI and PE reflect  
20 what we believe to be the true rate, which is the  
21 appendectomy rate.

22           CO-CHAIR SUSMAN: Okay. Jill and



1       then Jeff.

2                   DR. SILBER: That's the purpose of why  
3 we have --

4                   CO-CHAIR SUSMAN: Thank you.

5                   MEMBER MORROW-GORTON: And I may have  
6 missed this, but a lot of the  
7 disenrollment/enrollment in Medicaid is kids that  
8 are eligible one month, not eligible the next  
9 month because of parental income. I mean, does  
10 this take into account what happens over time for  
11 a child versus, you know, your appendectomy rate  
12 is at one place in time.

13                   DR. SILBER: Okay, so the nice thing  
14 about this metric is it's actually a point in  
15 time. So if that child, when it -- when they  
16 came down with appendicitis and had their  
17 appendectomy, if at that point in time they were  
18 eligible, right, then we say that that patient  
19 was eligible and then we see if they did or  
20 didn't have insurance.

21                   Now how do we do this? We actually --  
22 and it's a little complicated in the description.

1 We go back four months because we know that kids  
2 that are eligible but not enrolled, they can be  
3 backdated and so that they can then get  
4 insurance. So we say -- we go back exactly four  
5 months from when the patient had their  
6 appendectomy, and when you ask -- we ask then  
7 were you insured or not? Did you have -- you  
8 were eligible.

9 We knew you were eligible four months  
10 later, so four -- exactly four months earlier --  
11 because no one thought about the kid coming with  
12 appendix when their parents did or didn't have  
13 insurance. We then ask, well, did you -- were  
14 you enrolled four months before? You might have  
15 dropped out the next month and the next month.  
16 That's not the case because we'll know that you  
17 could be backdated or not backdated.

18 MEMBER MORROW-GORTON: But you may not  
19 have been eligible four months before.

20 DR. SILBER: Right, you might --

21 MEMBER MORROW-GORTON: It's July. My  
22 parents do seasonal work. I don't qualify for

1 Medicaid in the summer.

2 DR. SILBER: Right.

3 MEMBER MORROW-GORTON: I don't qualify  
4 for Medicaid until November when their business  
5 closes for the winter. You go back your four  
6 months and that kid's going to be not eligible.

7 DR. SILBER: Right. The beauty is  
8 that it's random. So, in other words our  
9 estimate isn't going to be biased because we go  
10 back four months. It's a random event.

11 MEMBER HOUTROW: Well, I think this  
12 discussion is something we might need to look at  
13 a little more in a subsequent part of the  
14 discussion, because I think for the evidence part  
15 we have a very clear mandate on what we're voting  
16 on. And then there are some additional questions  
17 I think that will stem exactly from where you're  
18 coming from later on.

19 CO-CHAIR SUSMAN: That's a great  
20 point. Jeff?

21 MEMBER SCHIFF: Just a quick thing  
22 about presumptive eligibility and retrospective

1 coverage. I don't know the rules in every state.  
2 Do you know where that's at, because that would  
3 -- that -- this measure obviously hinges on that.

4 DR. SILBER: Right, so when we did our  
5 search and we talked to our stakeholders and did  
6 our literature search and talked to the  
7 authorities, we thought that four months should  
8 do it, that we don't think we have a problem  
9 going back four months. Three, two and one,  
10 states can vary, but no one goes back farther  
11 than four that we know of.

12 MEMBER SCHIFF: And do states -- do  
13 all states allow some amount of retroactive  
14 eligibility for kids?

15 DR. SILBER: My sense is they do.

16 MEMBER SCHIFF: Okay.

17 CO-CHAIR SUSMAN: Okay. So very  
18 interesting comments and questions, some to  
19 defer. Anything new before we take a vote on  
20 evidence?

21 (No audible response.)

22 CO-CHAIR SUSMAN: Seeing and hearing

1 none, let's move on to a vote.

2 MS. JUNG: The voting for Measure 3154  
3 for evidence is open. Option 1 is pass, option  
4 2, not pass.

5 CO-CHAIR SUSMAN: As a clinician this  
6 seems very arcane, but important.

7 (Voting.)

8 MS. JUNG: Voting is now closed. The  
9 results are 100 percent pass with 23 votes. The  
10 measure passes for evidence.

11 CO-CHAIR SUSMAN: Okay. Very good.  
12 So, let's move on. Amy, you want to carry  
13 forward? You did such a good time the first  
14 time.

15 MEMBER HOUTROW: So we're in the  
16 reliability section. And as you guys heard  
17 earlier, the numerator is the number of covered  
18 months in the denominator.

19 CO-CHAIR SUSMAN: Gaps.

20 MEMBER HOUTROW: Oh, gap. I'm sorry.  
21 I jumped ahead.

22 (Laughter.)

1 MEMBER HOUTROW: Okay. So --

2 CO-CHAIR SUSMAN: You tried to sneak  
3 that by us.

4 MEMBER HOUTROW: -- I'll save that  
5 thought.

6 So we have heard a little bit about  
7 the other methods by which there are ways to  
8 measure coverage and in the comparison that they  
9 did with those other measures. So they chose the  
10 ACS survey as the kind of gold standard to  
11 compare themselves to. And then two other  
12 measures of continuing coverage which they  
13 performed better than in their analysis.

14 And so I think this does help address  
15 a gap that they're seeing in the ability of  
16 states to actually demonstrate coverage in a more  
17 helpful way because we're getting at an issue  
18 regarding around whether children were  
19 appropriately covered when they could have been  
20 covered.

21 I do have a question. Very early in  
22 your -- you make a comment about good reasons

1       that people fall out of coverage and bad reasons  
2       that people fall out of coverage. So a good  
3       reason is that you're no longer eligible, but  
4       when you live on the very edge of eligibility --  
5       as you were just saying -- you can fall in and  
6       out of coverage and it is actually probably  
7       negative. And in fact your coverage levels when  
8       you did your analysis were much lower amongst the  
9       children who were in the higher parts of the  
10      income group than the kids in the lowest end.

11               And I'd like to hear about how we're  
12      going to get better at this issue regarding good  
13      reasons versus bad reasons for disenrollment.

14               DR. SILBER: So good and bad refer to  
15      what you would really want as a meaningful  
16      statistic when you're evaluating a state. So you  
17      don't want to punish a state for a parent winning  
18      the lottery and then no longer needing to be on  
19      Medicaid. And so that's what we consider a bad  
20      reason -- that's a good reason to leave. It  
21      would be a bad reason to punish the state.

22               So I think that's what I -- that's the

1 terminology that we were referring to. And a  
2 good reason to punish the state would be that the  
3 patient really was eligible and they were not  
4 enrolled and the state needs to be punished for  
5 that. So that the family forgot to -- or didn't  
6 re-enroll when they should have and then they're  
7 kicked off the rolls, etcetera. So, okay. That  
8 defines the good and bad as what we meant.

9 Now again, you're going back to this  
10 issue of, well, on the margin you're on and  
11 you're off and you're on or you're off. And so  
12 we are saying that we're taking a random event,  
13 which is the event of appendicitis, which has  
14 nothing to do with your healthcare or whether you  
15 were enrolled or not enrolled. Then we're just  
16 arbitrarily going back four months.

17 Now the reason we do is because we  
18 don't want any back enrollment to affect the fact  
19 that you -- we didn't want people to say, well,  
20 you were enrolled. Look, they were enrolled when  
21 they had their appendicitis, but that's because  
22 you back enrolled them and that wouldn't be fair.



1       You're giving the states credit to something they  
2       shouldn't.

3                   So we look at a random point in time  
4       four months before the random event and at that  
5       event you're either enrolled or you're not  
6       enrolled. So to us that is a measure of whether  
7       you had insurance or you didn't have insurance  
8       when you were eligible. So it might not be  
9       perfect, but at least it's random and there  
10      shouldn't be bias involved with that.

11                   MEMBER HOUTROW: If we're thinking of  
12      this in terms of the percentage of children who  
13      are covered or however the rates -- when we're  
14      thinking about what the quality mark is for that,  
15      we do have this issue of knowing where a  
16      threshold belongs, because you don't want to  
17      punish the states for families who make too much  
18      money, but you don't -- what you want is for kids  
19      who need to be on the service to be on the  
20      service.

21                   DR. SILBER: Well, I agree. I just  
22      don't think that this is punishing the states for

1 families that all of a sudden win the lottery in  
2 any way that's biased. Let's put it that way.

3 CO-CHAIR SUSMAN: So let's try to  
4 focus on gap. And, Kerri, do you have any  
5 further comments?

6 MEMBER FEI: No, I don't think I have  
7 -- I don't have anything else to add. I think  
8 what was presented to support the gap is  
9 sufficient.

10 CO-CHAIR SUSMAN: Kraig?

11 MEMBER KNUDSEN: Sufficient.

12 CO-CHAIR SUSMAN: David?

13 (No audible response.)

14 CO-CHAIR SUSMAN: Jeff?

15 (No audible response.)

16 CO-CHAIR SUSMAN: All right. Anyone  
17 else?

18 (No audible response.)

19 CO-CHAIR SUSMAN: So we're going to  
20 vote on gap.

21 MS. JUNG: The voting for Measure 3154  
22 for performance gap is now open. Option 1, high,

1 option 2, moderate, option 3, low, and option 4,  
2 insufficient.

3 CO-CHAIR SUSMAN: And it looks like  
4 Jon is absent, so --

5 (Voting.)

6 CO-CHAIR SUSMAN: He has a lapse in  
7 coverage here.

8 MS. JUNG: Voting is now closed. The  
9 results are 45 percent for high with ten votes,  
10 50 percent for moderate with 11 votes, five  
11 percent for low with one vote, and zero percent  
12 for insufficient with zero votes. The measure  
13 does pass for gap.

14 CO-CHAIR SUSMAN: Okay. And did you  
15 want to carry on since you were so enthusiastic  
16 with the reliability?

17 MEMBER HOUTROW: I'm excited about  
18 reliability specifications, so --

19 (Laughter.)

20 MEMBER HOUTROW: Okay.

21 CO-CHAIR SUSMAN: If you can get  
22 excited about it, it's all yours.

1                   MEMBER HOUTROW: Right. So produce  
2 consistent and then credible valid results. So  
3 this is all coming from administrative claims  
4 data, and you can look at the level of analysis  
5 at the state or potentially more regionally, and  
6 their interpretation as a higher score means  
7 better quality.

8                   And as we know, there are children who  
9 age out, and so when they did their testing they  
10 made sure that the children who were in the aged-  
11 out age groups were not included because they  
12 would -- anyone who is 16 could be aging out.  
13 Everyone who is 17 to 18 would age out. And then  
14 of course as they used their appendectomy, they  
15 were thinking about specifically very rare events  
16 in the children under the age of two.

17                   And we have heard a lot about how they  
18 have come to that, and this does require this  
19 related hospitalization. So we need to talk  
20 about whether we think this kind of use of the  
21 appendectomy is an appropriate surrogate. And I  
22 believe that it does help us get there.

1                   And in addition, we need to talk about  
2                   the relationship to the different things that  
3                   they tested. So the PE, the PI -- or the CI and  
4                   the Community Survey as their gold standard.

5                   And if there are any questions about  
6                   how the data elements are defined and if the  
7                   codes are appropriate and is the algorithm clear  
8                   -- I think we had a good presentation of that and  
9                   I'm feeling quite comfortable with this. And  
10                  again, my only issue is relating around the  
11                  children who are in the highest income group who  
12                  will change eligibility, and they will have lower  
13                  scores. And I don't know that that means  
14                  necessarily lower quality for them. And so  
15                  that's where I have an issue as the population of  
16                  very poor are always going to be income-eligible,  
17                  but those on the cusp are not, and I don't know  
18                  that a higher score means better quality for  
19                  those kids who are on the cusp.

20                  CO-CHAIR SUSMAN: Okay. Let's go  
21                  around to our primary reviewers first and then  
22                  I'll get everybody else.

1                   MEMBER FEI: Sure. So keeping in mind  
2                   that this measure would more than likely be used  
3                   for accountability, I'm not sure about the  
4                   ability to really tell -- compare states, tell  
5                   differences just because of the breadth of the  
6                   confidence intervals and the overlap that you  
7                   see.

8                   I don't know that you can really  
9                   discern state A is really doing better than state  
10                  B, than state C, than -- you know. I think that  
11                  would be a tough -- I think it might be tough to  
12                  do. I'm not saying you can't do it. I think it  
13                  would be tough to say somebody's really, really  
14                  doing better than someone else. So maybe --

15                  CO-CHAIR SUSMAN: It does seem like  
16                  that's an important issue as defined by the  
17                  algorithm, so if you have a comment --

18                  DR. SILBER: Sure. I'm not quite sure  
19                  why you're saying that it doesn't look like you  
20                  can see that states are different. If you look  
21                  on page 8 where we show the graph --

22                  MEMBER FEI: Not different, but

1 comparable.

2 DR. SILBER: Well, we're talking about  
3 confidence intervals that often for many of the  
4 states -- or half of the states aren't  
5 overlapping with the other half. So we lined  
6 them up in order of their informed coverage, and  
7 you can see that they're -- if you look at -- we  
8 gave you the confidence intervals. We thought  
9 that was very strong evidence that there's going  
10 to be states that are very different than other  
11 states. So I'm not quite sure.

12 I mean, these are -- there are some  
13 states that are very small and that the  
14 confidence intervals are wider. So Delaware and  
15 Hawaii. And some states that are somewhat funny  
16 like Nevada, which is the very last one. But the  
17 great majority of the states have tight  
18 confidence intervals and they are -- and if you  
19 look at the graphs, they're not overlapping with  
20 each other. In many, many -- at least half don't  
21 overlap with the other half.

22 But furthermore, you don't -- it's not

1 just that a confidence interval has to not touch  
2 each other. You can easily show significance  
3 when they're still touching each other or even  
4 overlapping to some extent. So we thought this  
5 was just obvious that it was reliable and that it  
6 showed that the hospitals were different.

7 We did have this -- I mean, you can  
8 interpret it that way. I don't quite understand  
9 the comment.

10 MEMBER HOUTROW: Well, I guess I want  
11 to follow up on that. So I'm thinking of a state  
12 like Alabama where people have very low incomes.  
13 And then I'm thinking of a state like -- I'm just  
14 going to say New Hampshire. And I think they  
15 probably have not as low incomes. And if the  
16 rates of income are different in those states and  
17 the rates of chronic health conditions among  
18 children are different in those states -- so two  
19 things that we demonstrated are -- you've showed  
20 in your data.

21 So let's say Alabama has a bunch of  
22 very, very poor kids and a bunch of very sick



1 kids, and New Hampshire has less poor kids and  
2 weller kids -- which actually I think is true.  
3 And so you could then make a statement that  
4 because Alabama's continuous coverage is higher -  
5 - which relates to the poverty status and their  
6 health status -- that they have better quality  
7 than New Hampshire?

8 DR. SILBER: Okay. So first of all,  
9 what I would say first of all is that they might  
10 show better informed coverage. That's the first  
11 thing, right? So there is a difference. When  
12 you talk about adjusting for income or adjusting  
13 for race or adjusting for other characteristics,  
14 you get into a philosophical question regarding  
15 how do you evaluate the states. We looked at it.  
16 From our perspective the reason why we didn't put  
17 in these adjustments, from our perspective it was  
18 because we thought that states have to do a good  
19 job for whatever population they have. And so,  
20 that's why we didn't do those statistical  
21 adjustments.

22 So we can get into a philosophical

1 debate about whether we should have adjusted or  
2 not or whether we should add adjustment, but I  
3 didn't think that it was appropriate for what we  
4 thought the goal was as -- when we were asked to  
5 help develop this measure from the PQMP, but  
6 maybe I'm not understanding your question.

7 MEMBER HOUTROW: Yes, so you would --  
8 you corrected me, and it's true -- and this is  
9 about informed coverage, right, so higher  
10 informed coverage. But the statement in this is  
11 that higher informed coverage is equal to better  
12 quality. And I think that's where we're  
13 struggling because as a quality measure, then not  
14 risk-adjusting for factors that we know influence  
15 it then makes it such that you can't successfully  
16 compare on quality between New Hampshire and  
17 Alabama. You can still assess them on their  
18 informed coverage, but not on the quality of  
19 that.

20 DR. SILBER: Well, put it this way.  
21 What I would do is say if I was a state that had  
22 a bad statistic on my informed coverage, I'd at

1       least want to study it and understand it. And if  
2       my excuse was that everyone was winning the  
3       lottery and somehow the statistic was off --  
4       which I don't believe is going to be the case --  
5       then okay. But at the very least it's a strong  
6       indicator that you might have a problem. And so,  
7       in our sense if I was a state, I'd rather have a  
8       high number than a low number.

9               And Illinois is an interesting  
10       example. We've looked at Illinois over time and  
11       then when they instituted a program about ten  
12       years ago that was strongly trying to increase  
13       their participation rates, they moved up by our  
14       statistic radically.

15              And so to me it is a measure of  
16       quality. Put it this way. Any time you have --  
17       you don't look good on a quality metric, you  
18       always have to examine it and ask, well, is it  
19       real, is it not real? But at least I think it  
20       lets the federal government and the states say  
21       what's going on there? At least we want to  
22       understand it.

1 CO-CHAIR SUSMAN: Okay. I'm going to  
2 try to move this on. First of all, let me ask  
3 for any of the primary reviewers who had further  
4 comments or questions.

5 MEMBER KELLER: Yes, only a comment --  
6 and I think this relates to the previous comment,  
7 I actually applaud you for including error bars  
8 because I always remember that every measurement  
9 that we take -- whether it is with one of our  
10 tools or with a ruler -- has error in it. And we  
11 forget that a lot. We tend to think these things  
12 are absolute numbers. They all have error, and I  
13 applaud you for making it explicit.

14 So I think that actually strengthens  
15 the measure's reliability, the fact that we can  
16 see what the error is depending on the size of  
17 the sample and various other things that we're  
18 working with. And I don't think that reduces its  
19 reliability at all. I actually thought that was  
20 great.

21 CO-CHAIR SUSMAN: Okay. Jeff?

22 MEMBER SCHIFF: Just a couple things.

1 I think that when I looked at the variation in  
2 states, I thought is this really a measure of the  
3 hassle to maintain coverage for individual kids  
4 and -- because every state has its way of doing  
5 eligibility, and I think that -- so in some ways  
6 my concerns are -- which was with the first term  
7 is about, presumed ineligible and -- it's almost  
8 like this is like the measure of the hassle of  
9 how much work it is to stay on coverage for  
10 families, because some states that may be -- we  
11 may think of as not having great coverage  
12 actually may make it easier for people to stay on  
13 or get enrolled, where other states -- and I'm  
14 looking at my state, which is in the lower end of  
15 this, aren't so -- maybe they aren't so good at  
16 that. So I think that's important.

17 It also may -- this is an editorial.  
18 It may be important if some of the proposals to  
19 reform the ACA about sticking to -- about if you  
20 lose coverage, you get penalized coming into  
21 effect.

22 So, and then the last thing to say is

1 it'll be really interesting -- and I'm not sure  
2 if you did this or not -- to look at this by race  
3 and ethnicity.

4 DR. SILBER: We did. That's in the  
5 appendix. And there are differences. In general  
6 what we're seeing is that blacks have a higher  
7 rate of coverage -- of informed coverage than  
8 whites in a lot of studies.

9 CO-CHAIR SUSMAN: Okay. Let's get the  
10 other cards, which seem to be proliferating.  
11 Jill?

12 MEMBER MORROW-GORTON: So I'm not at  
13 all surprised that blacks have a higher --  
14 because they have lower incomes in general. I  
15 mean, I think -- I still think I have concerns  
16 about the potential for missing a systematic  
17 error in the higher income families who are  
18 bouncing in and out, tends to be seasonal work,  
19 tends to be -- and for a state who might -- that  
20 might -- and I don't know even -- I can't see  
21 where Massachusetts is in there, and I don't  
22 really care in the sense that if you're a state

1       that has higher incomes in general or you have a  
2       bigger population in those higher incomes that  
3       would be bouncing in and out, that's never good.

4               But the reality is doing Child Find  
5       for those kids for the months that they're  
6       eligible versus the months that they're not is a  
7       lot of effort and may not be that -- so I think  
8       you need to think about should you be -- it's --  
9       this is not about winning the lottery. This is  
10      in fact about the guy that has a landscape  
11      business who makes \$50 too much this month and  
12      doesn't -- his kids don't qualify for Medicaid.  
13      That's what we're talking about.

14             DR. SILBER: All right --

15             MEMBER MORROW-GORTON: But I think  
16      that, one, you need to think about that because  
17      to tell a state that they're doing a really bad  
18      job at Child Find when it's that kind of an issue  
19      is a disservice in the sense that that doesn't  
20      help the state find kids that are not on Medicaid  
21      that should be on Medicaid.

22             CO-CHAIR SUSMAN: I'm going to ask

1       that we --

2                   DR. SILBER: May I respond?

3                   CO-CHAIR SUSMAN: Just a second. I'm  
4 going to ask would you really try to focus on the  
5 reliability issue here.

6                   Briefly please respond, but I want to  
7 try to bring this to a closure.

8                   DR. SILBER: I probably didn't make it  
9 clear enough, but bouncing in and out is not  
10 going to adversely bias our metric. It's a point  
11 in time. We don't bounce in and out for a point  
12 in time. The point in time is exactly four  
13 months before you got the random event of  
14 appendicitis. We don't look to see whether you  
15 did or didn't have enrollment on the day that you  
16 had appendicitis. A random point for that  
17 patient who we knew was eligible at some point.  
18 That random point is what we use and we simply  
19 ask were you enrolled.

20                   So I don't think that we're biasing  
21 the metric by using the point in time prior to  
22 the appendicitis. We could be adding some



1       variability, and what you're saying is maybe  
2       there's more variance, but I don't think we're  
3       biasing the metric.

4                   CO-CHAIR SUSMAN:   Okay.   I'm going to  
5       go over here.

6                   MEMBER DORSEY:   So, yes, I just wanted  
7       some guidance on the reliability vote in  
8       particular.   I noticed reviewing this that the  
9       sort of preliminary guidance about reliability  
10      voting on the sheets was low.   And my question  
11      was about the test that was used to assess  
12      reliability and whether that was the issue,  
13      right?   That this is about the tests had shown as  
14      point estimates for the states and the error bars  
15      around them and whether or not we're -- our  
16      discussion should be is that an adequate test of  
17      reliability?   That's a question to NQF.

18                  DR. NISHIMI:   So the PA focused on the  
19      ability -- because it was at the score level --  
20      to distinguish among the states, and the issue  
21      that Kerri or someone pointed out in terms of the  
22      overlap.   So for accountability purposes the

1       assessment was that the neighboring states that  
2       are clustered in the middle there -- the score  
3       may not be a reliable indication when you started  
4       making comparisons. And so that's what led to  
5       the low rating. But again, that's the staff's  
6       best assessment at the time and the Committee  
7       members need to make their own.

8               CO-CHAIR SUSMAN: Okay. With that  
9       explanation and further comment, anything else  
10      standing between us and voting?

11             (No audible response.)

12             CO-CHAIR SUSMAN: All right. Then  
13      let's go ahead on reliability.

14             MS. JUNG: The voting for Measure 3154  
15      for reliability is now open. Option 1, high,  
16      option 2, moderate, option 3, low, and option 4,  
17      insufficient.

18             (Voting.)

19             MS. JUNG: Voting is now closed. The  
20      results are four percent for high with one vote,  
21      48 percent for moderate with 11 votes, 39 percent  
22      for low with nine votes, and nine percent for

1       insufficient with two votes. So with that we did  
2       not reach the 60 percent threshold, so consensus  
3       has not been reached for reliability and we  
4       continue to vote.

5                   CO-CHAIR SUSMAN: We continue on,  
6       right? So we're in that intermediate range, if  
7       you will.

8                   Okay. So let's move on to validity.

9                   MEMBER HOUTROW: So in validity, as we  
10      had heard before, they used the ACS gold standard  
11      and that was highly correlated showing good  
12      numbers. And if you look on -- what page is  
13      this? There's a table. Table 2, which is their  
14      Pearson correlations of the continuity rate and  
15      the duration, as well as their own in comparison  
16      with the gold standard in each of the two. And  
17      you will see there informed coverage has -- with  
18      the continuity rate, appears in correlation of  
19      0.77. With duration it's lower, 52. And with  
20      ACS it's the highest, 46. And similarly they  
21      look good in comparison to the other measures  
22      against the gold standard of the ACA.

1                   We need to talk briefly about  
2                   exclusions. We've talked about the 18-month  
3                   period, which means you do need to do some  
4                   exclusion for some 16-year-olds and all 17-year-  
5                   olds. And in the appendectomy analysis that they  
6                   did, they actually dropped 15 percent of them.  
7                   And I would assume that most of those are the  
8                   older kids, not the under age two kids. But that  
9                   -- more than 15 percent is higher than a ten  
10                  percent rate, which would be something I would  
11                  feel a little bit more comfortable with.

12                 We need to talk about if they're --  
13                 these exclusions are consistent with the  
14                 evidence. I think from the perspective of you  
15                 need to not include people who are going to age  
16                 out and the under the age of two for appendectomy  
17                 that makes sense, and if there are any issues  
18                 regarding the impact of that exclusion. And I  
19                 think we don't need to do potentially any  
20                 additional empirical testing, although I would  
21                 ask is it mostly the older kids, that  
22                 appendectomy for that 15.6 that were excluded?

1 DR. SILBER: Yes.

2 MEMBER HOUTROW: Okay. We have  
3 already looked at the confidence intervals in the  
4 graph of informed coverage by state and the  
5 comparison there. And then the issue regarding  
6 missing data, which is 12 percent of the states  
7 weren't able to provide data.

8 So I think it's very straightforward  
9 to get appendectomy codes both in ICD-9 and ICD-  
10 10. That's good. It seems to be relatively  
11 clear. There are some issues with the states,  
12 but I think in general this looks quite good.

13 And then we've talked a little bit  
14 already about the variability in scores and the  
15 concern.

16 CO-CHAIR SUSMAN: Kerri?

17 (No audible response.)

18 CO-CHAIR SUSMAN: Okay. Any of the  
19 other reviewers have further comments on  
20 validity?

21 (No audible response.)

22 CO-CHAIR SUSMAN: Seeing none, anyone

1       else?

2                   (No audible response.)

3           CO-CHAIR SUSMAN:   Let us vote.

4           MS. JUNG:   Voting for Measure 3154 for  
5   validity is now open.   Option 1, high, option 2,  
6   moderate, option 3, low, and option 4,  
7   insufficient.

8                   (Voting.)

9           MS. JUNG:   Okay.   Voting is now  
10   closed.   The results are zero percent with zero  
11   votes for high, 74 percent for moderate with 17  
12   votes, 26 percent for low with six votes, zero  
13   percent for insufficient with zero votes.   And  
14   with that, the measure does pass the validity  
15   threshold.

16           CO-CHAIR SUSMAN:   Maybe I'll ask Kerri  
17   to start us off just to give you a break.

18           MEMBER FEI:   I don't want to steal all  
19   of Amy's thunder, you know?

20           CO-CHAIR SUSMAN:   Yes, I know.

21                   (Laughter.)

22           MEMBER HOUTROW:   I'm not so excited

1 anymore.

2 MEMBER FEI: Did you lose your  
3 excitement? You used it all up.

4 CO-CHAIR SUSMAN: Feasibility.

5 MEMBER FEI: Feasibility. I don't  
6 really see any real problems here. I think the  
7 problem isn't with the measure. It's with  
8 perhaps the data submitted to the MACs database,  
9 which is out of the control of the measure  
10 developer, so I don't want to make a big deal  
11 about that. I think if you were going to use  
12 this on a national level, efforts to improve the  
13 database would help this measure immensely, I  
14 would think. So, that's an aside.

15 But other than that, that's all I  
16 have.

17 CO-CHAIR SUSMAN: David?

18 MEMBER KELLER: Yes, I mean, I agree  
19 that the MACs database -- data set had some  
20 troubles that they clearly identified in their  
21 development of the measure. I think that it is  
22 in the interest of both the payers and the

1 providers to make sure that appendectomies are  
2 appropriately billed and paid for. So I think  
3 that there is an incentive to get that data in  
4 place that you should be able to get from within  
5 a state Medicaid agency if you were trying to  
6 report on it.

7 CO-CHAIR SUSMAN: Kraig?

8 MEMBER KNUDSEN: I was just surprised  
9 by the missing data, actually.

10 CO-CHAIR SUSMAN: Yes. Jeff, anything  
11 further?

12 MEMBER SCHIFF: Nothing specific,  
13 except I guess one of the questions I had is  
14 whether this will be a measure that the state  
15 officials will want their folks to do, which  
16 would require some technical assistance for when  
17 it's done nationally through the MACs or some  
18 other national set.

19 DR. SILBER: Well, a couple things.  
20 We actually have done the confidence intervals --  
21 which would have been the technical side of this  
22 -- two ways. We did bootstrapping, which we



1        didn't think the states could do. And then we  
2        did approximate formulas, which are in the  
3        appendix, which the states could just apply in a  
4        SAS program. And they are almost exactly the  
5        same. They give -- to the last second or third  
6        decimal point they give the same results. So we  
7        made this as user-friendly for the states as we  
8        could. That's why the appendix has the  
9        confidence interval formulas in there.

10                CO-CHAIR SUSMAN: Amy?

11                MEMBER HOUTROW: No, I'm good.

12                CO-CHAIR SUSMAN: Nothing to add?

13                MEMBER HOUTROW: One time ever.

14                (Laughter.)

15                CO-CHAIR SUSMAN: We know you're good,  
16        but we're -- okay. Jill?

17                MEMBER MORROW-GORTON: Okay. So a  
18        quick question. Knowing that the MACs data is  
19        often not great and you lost six states just  
20        based on this, is this something that could be  
21        done in a state MMIS system or a -- or so that it  
22        could be done at the state level maybe not using

1 the MACs data, but the state using their own  
2 data?

3 DR. SILBER: So to us the big issue  
4 was whether the managed care patients -- when  
5 they get appendectomies, do we see bills. And  
6 so, if the states know that they can see a bill  
7 from that, then -- and often they do have bills.  
8 So when they -- if we know that the bills will  
9 show up, then great. Then we can -- then a state  
10 can -- and if a state knows that, they can use  
11 that data. We have in the appendix the test that  
12 we use to see if the state had adequate managed  
13 care bills that were ending up with  
14 appendectomies.

15 So the way we did that -- and it's  
16 explained in the appendix -- is we looked at all  
17 the appendectomy cases and then we know whether  
18 they were managed care or not. And then we  
19 matched every appendectomy case to ten kids in  
20 the state, same age, same sex, who didn't have  
21 appendectomy. They just had a data set. They  
22 were just in the data set. And then we looked at

1 their managed care rate.

2 If we found that the managed care rate  
3 in the kids who weren't hospitalized but just  
4 were in the system was too much higher than the  
5 appendectomy rate kids, then we said the state  
6 had a problem. And that's how we -- so we had a  
7 filter to get rid of states that had inadequate  
8 -- that looked like they had problematic data.

9 So a state can try to figure that out.  
10 They can ask themselves whether their bills are  
11 ending up or they can run our filter which we put  
12 in the appendix.

13 CO-CHAIR SUSMAN: Thank you. Okay.  
14 Any other comments about feasibility?

15 (No audible response.)

16 CO-CHAIR SUSMAN: So if it's feasible,  
17 let's vote.

18 MS. JUNG: The voting for Measure 3154  
19 for feasibility is now open. Option 1, high,  
20 option 2, moderate, option 3, low, and option 4,  
21 insufficient.

22 (Voting.)

1 MS. JUNG: Voting is now closed. The  
2 results, four high with one vote, 96 percent for  
3 moderate with 22 votes, zero percent for low with  
4 zero votes, and zero percent for insufficient  
5 with zero votes. And this measure does pass for  
6 feasibility.

7 CO-CHAIR SUSMAN: Usability. Kerri,  
8 why don't -- you did such a good job.

9 MEMBER FEI: Oh, sure. She gave me  
10 the easy part.

11 No, as far as usability I guess from  
12 a -- and my -- and it's addressed in the  
13 documentation using it for accountability I think  
14 is always the big discussion. Knowing that that  
15 hasn't been determined yet, I would like to see  
16 kind of an evaluation of how that could perhaps  
17 take place only because that is kind of the end  
18 result of where people are going to want to take  
19 this. And then I question if it really should be  
20 used in a traditional accountability fashion.

21 I don't -- I'm not sure this is a  
22 measure we should be either rewarding or

1 penalizing based on performance, but I think it's  
2 a necessary thing to know the results in order to  
3 improve the enrollment for kids on that for  
4 Medicaid. So I guess that's my struggle is  
5 whether -- it's an awesome -- it's a great  
6 measure. I think it's really innovative and  
7 novel. I don't know that using an accountability  
8 program would be best use of its results is my  
9 concern.

10 CO-CHAIR SUSMAN: Fair enough. Other  
11 comments? David?

12 MEMBER KELLER: Yes, I mean, it  
13 certainly would have -- I struggle with this with  
14 actually all of our measures is how they will be  
15 used, and I think that any accountability measure  
16 would require a state to develop a feeling for  
17 how this measure works and some time and energy  
18 to go into it.

19 That having been said, I actually  
20 think it should be an accountability measure  
21 eventually once they do get used to it, because  
22 the issue of continuous coverage and churn is

1       just -- is so important at the state level. So I  
2       think it's -- but I think it is -- in its current  
3       form the developer has made it as usable as  
4       possible and the question is, like all great  
5       power, will they use it for good or for evil?

6                       (Laughter.)

7                       CO-CHAIR SUSMAN: Wow. How could you  
8       possibly follow that? But I'll call --

9                       MEMBER KELLER: I have to quote  
10      Spiderman whenever possible.

11                      CO-CHAIR SUSMAN: Yes.

12                      MEMBER FEI: I mean, and that kind of  
13      echoes my concern as well. Yes, I think it needs  
14      to be used -- used the right way.

15                      CO-CHAIR SUSMAN: Kraig?

16                      MEMBER KNUDSEN: Working for the state  
17      government, comparing states, it's kind of like  
18      an art of sorts. People look at -- when we're  
19      looking at ourself and we go, oh, well,  
20      California is doing this or Hawaii is doing this.  
21      And then somebody always in the room is always  
22      saying, yes, yes, that's not us. So we're not

1 comparing ourselves to California or Hawaii. How  
2 about Michigan, or something like that? So it's  
3 useful in terms of a state -- your own state  
4 comparison from year to year, but not necessarily  
5 across all states.

6 CO-CHAIR SUSMAN: Jeff?

7 MEMBER SCHIFF: I think this would be  
8 an interesting measure to present to the National  
9 Association of Medicaid Directors to say what's  
10 going on?

11 I do think though that there's a  
12 marketing issue. I think it should be -- almost  
13 be called the Coverage During Random Appendicitis  
14 Measure, because I think that's where it really  
15 -- that's the strength of it and it gives people  
16 the sense then of whether or not they're -- what  
17 they're -- because it's really -- I don't want to  
18 go back to my hassle-of-coverage kind of issue,  
19 because I think that's where the accountable  
20 entity is the enrollment -- or the goal of doing  
21 enrollment in Medicaid.

22 CO-CHAIR SUSMAN: Amy and then I've

1 got a couple of other comments here about  
2 usability.

3 MEMBER HOUTROW: I think they've  
4 spoken to the things that I was concerned about.

5 CO-CHAIR SUSMAN: Okay. Jill?

6 MEMBER MORROW-GORTON: I just have a  
7 great -- this would be a great state self-  
8 assessment tool.

9 CO-CHAIR SUSMAN: Yes. Well said.  
10 Carol?

11 MEMBER STANLEY: Yes, so if I were to  
12 put my hat on in my previous role with the state  
13 Medicaid, I would see this as a valuable  
14 structural measure, especially measuring how good  
15 of coordination we have -- the Medicaid agency  
16 and Department of Social Services has in  
17 maintaining enrollment. And I could see the  
18 outcome of this measure being something to  
19 leverage getting more resources and coordination  
20 going.

21 But one of the questions I have  
22 relating to that is in Virginia if a child is



1 enrolled in Medicaid or CHIP, they have coverage  
2 for a full year regardless of any churning. And  
3 I don't know how that -- how it is in other  
4 states, if that's a federal law or if -- so --  
5 and then the -- another thing, now that I work  
6 for -- in a provider setting sometimes and have  
7 actually observed children coming in where their  
8 coverage has lapsed and the dilemma that the  
9 provider faces, this would be a valuable tool to  
10 pitch to the state. Look at how you're doing and  
11 how it's affecting us.

12 So one of the questions I have as far  
13 as usability are as far as churning between  
14 Medicaid and CHIP -- and we saw that a lot during  
15 the recession -- so when you factor in the  
16 calculations if a child moves between Medicaid  
17 and CHIP, is that counted as -- how does that  
18 come to fruition in your measurements?

19 DR. SILBER: So if we have evidence  
20 that they're eligible and they're enrolled, then  
21 they're in and the data sets -- to the extent  
22 that they pick up both of those, then we have

1       that information. So we're not -- it's -- again,  
2       it's a point in time --

3               MEMBER STANLEY: Right.

4               DR. SILBER: -- so we're not thrown  
5       off by a change as long as they have something.

6               MEMBER STANLEY: So if they're in  
7       Medicaid in your snapshot today, but they were in  
8       CHIP six months ago, they're still going to  
9       count.

10              DR. SILBER: That wouldn't make a  
11       difference, no. It would be a point in time.

12              CO-CHAIR SUSMAN: Jon?

13              MEMBER FINKELSTEIN: So what I'm going  
14       to say I'm not suggesting should be  
15       determinative, but I think it's important. So  
16       under use and usability for me a perfect quality  
17       measure is easily understandable by all  
18       stakeholders. So we read it ahead of time. I  
19       really delved into it. We've had 40 minutes with  
20       the developer. And if each of us was forced to  
21       take a whiteboard and explain it to five state  
22       senators, none of us would get it exactly right.

1 I'm not sure many of us would get it mostly  
2 right. I'm talking about myself. So that  
3 doesn't make it not technically great and  
4 worthwhile. And other things may outweigh this,  
5 but it is not an easily understandable measure.

6 CO-CHAIR SUSMAN: I mean, on the other  
7 hand, what I'm hearing from some of the folks who  
8 deal with these issues regularly on a policy or  
9 state level is that it makes sense to them. And  
10 I think that's important, because there are going  
11 to be different audiences for these sort of  
12 measures. And I would concur. I couldn't do a  
13 very good justice to this, but for someone who's  
14 running a Medicaid program it may be very  
15 valuable.

16 So, unless I see any other hands up or  
17 cards up, let's go ahead and vote on usability  
18 and use.

19 MS. JUNG: The voting for Measure 3154  
20 for usability and use is now open. Option 1,  
21 high, option 2, moderate, option 3, low, and  
22 option 4, insufficient.

1 (Voting.)

2 MS. JUNG: Voting is now closed. The  
3 results are four percent for high with one vote,  
4 74 percent for moderate with 17 votes, 22 percent  
5 for low with five votes, zero percent for  
6 insufficient with zero votes. And with that, the  
7 measure passes for usability.

8 CO-CHAIR SUSMAN: Okay. So any final  
9 comments before voting?

10 (No audible response.)

11 DR. NISHIMI: We don't vote on  
12 overall.

13 CO-CHAIR SUSMAN: Oh, we don't?

14 DR. NISHIMI: Because it didn't get --

15 CO-CHAIR SUSMAN: Oh, it didn't pass  
16 -- the one was indeterminate? Okay.

17 So what do we do? We pray.

18 DR. NISHIMI: So the developer will  
19 have the opportunity to bring additional  
20 information. You'll also receive comments from  
21 whoever chooses to comment on the measure. Those  
22 will come back to the post-comment call. You'll

1 consider the reliability issue, which is the  
2 criterion for which you did not achieve  
3 consensus. If you achieve consensus and it  
4 passes, then we will take an overall suitability  
5 for endorsement.

6 CO-CHAIR SUSMAN: If it doesn't?

7 DR. NISHIMI: If you don't achieve  
8 consensus or it fails, then it just stops.

9 CO-CHAIR SUSMAN: Okay.

10 DR. SILBER: Just a general question  
11 just for the process, because when we were  
12 talking to NQF, they instructed us that this was  
13 what we needed to do. And to us it showed  
14 clearly that some states were very different than  
15 others. So I would request as close guidance as  
16 possible.

17 I'll do whatever this Committee wants,  
18 but I just need to know exactly what it is that  
19 they want. And right now it's not clear to me  
20 because it still in my mind looks clear that some  
21 states look different than others, but maybe I'm  
22 missing the point. So I'd just request some help

1 if possible so that I can answer your questions.

2 DR. NISHIMI: I don't think it's a  
3 matter of analyses. I think it's a matter of how  
4 to interpret your graph. You -- we asked you for  
5 the graph and you produced exactly what -- and I  
6 think what we heard today -- and I don't want to  
7 put words in the Committee's mouth -- is that for  
8 purposes of accountability the fact that the  
9 states that were clustered around, you wouldn't  
10 be able to tell one better than the other. And I  
11 think that's --

12 DR. SILBER: For any distribution  
13 there's always going to be a cluster in -- you  
14 know, somewhere, and that's going to be ones that  
15 are different than others. So again --

16 DR. NISHIMI: Yes.

17 DR. SILBER: -- I don't understand it,  
18 but I will --

19 DR. NISHIMI: I think about --

20 DR. SILBER: -- work on --

21 DR. NISHIMI: -- half of them weren't  
22 and not.

1 CO-CHAIR SUSMAN: Yes, I mean, does  
2 the Committee want to weigh in on this question?  
3 Amy, you have -- your hand is --

4 MEMBER HOUTROW: I don't know if it's  
5 appropriate here, but I would have loved to see  
6 some potential risk adjustment for things that  
7 you knew influenced the rates.

8 CO-CHAIR SUSMAN: Yes, Jeff?

9 MEMBER SCHIFF: I don't know if it  
10 would -- I don't know if it's exactly the same  
11 thing, but it would be -- there seems to be such  
12 variability that I can't explain and why the  
13 cluster is where it is, but I wonder if there's  
14 some work that could be done to understand what  
15 the -- what explains the variation. I think  
16 that's -- that's not about the fact that it's not  
17 reliable. It's about the fact that there's some  
18 sort of special cause variation that I can't get  
19 at.

20 CO-CHAIR SUSMAN: Other comments?

21 DR. SILBER: Pardon me?

22 CO-CHAIR SUSMAN: Yes, sure. Please.

1 DR. SILBER: A clarifying question.  
2 When you say the cluster, what cluster -- or what  
3 figure are you referring to?

4 CO-CHAIR SUSMAN: It's on -- yes, page  
5 8.

6 DR. SILBER: So the cluster -- we've  
7 lined them up so that they'll look close next to  
8 each other, because they're --

9 (Simultaneous speaking.)

10 MEMBER SCHIFF: And I think what -- I  
11 guess what I would say is where the -- it's  
12 probably not a good -- cluster is not the right  
13 word. Where the confidence intervals maximally  
14 overlap is what I guess I would say is the  
15 cluster, but then there's the -- like the Nevada  
16 or whatever one is very low. So it's really  
17 about -- I guess it's really about trying to  
18 understand why there is that variation, maybe.  
19 But that's maybe beyond the scope of this.

20 DR. SILBER: And that's part of  
21 reliability, I guess. I'll try to answer that.

22 CO-CHAIR SUSMAN: I think --



1 DR. SILBER: That's part of validity  
2 I guess.

3 CO-CHAIR SUSMAN: -- there is clearly  
4 some use internally for a state to look at this  
5 sort of data. The question is if this is for  
6 accountability, can we reliably say that the  
7 state that is on the right is really better than  
8 the one next to it and the one next to it and --  
9 not necessarily that it's ordered or 100 percent,  
10 but you have to go pretty far along before -- and  
11 there's pretty wide confidence intervals. And of  
12 course that's going to happen in any distribution  
13 to a certain extent, but there are also a number  
14 of states that have very wide confidence  
15 intervals and it may well be just the number of  
16 incident cases that are there to analyze. But I  
17 think those are the sorts of issues that anything  
18 you can do to make the Committee more comfortable  
19 would be helpful.

20 And I'll leave the last comment to  
21 Jill.

22 MEMBER MORROW-GORTON: I just had a

1 couple of thoughts. One would be think about  
2 stratifying income levels and looking at what  
3 those numbers look like, because states look very  
4 different.

5 And the other thing you might think  
6 about is looking at eligibility at both of those  
7 two points in time to get a sense of how many of  
8 them are the same -- so those kids would have  
9 been eligible that whole time period -- and how  
10 many of them are different?

11 DR. SILBER: That question -- I'll  
12 have to explain it better in the next try. The  
13 question you're asking is -- I've already  
14 addressed and I thought I had. So it has to do  
15 with a random point in time and it's -- so I'll  
16 try to explain it better.

17 CO-CHAIR SUSMAN: Carol, did you have  
18 any final word or just -- okay. Well, I want to  
19 thank everybody, and particularly the measure  
20 developer who I think did a tremendous job of  
21 trying to make a somewhat difficult series of  
22 concepts well -- easily understood.

1                   And we have regressed to the mean.  
2       We're right on time. And we have scheduled a  
3       break. Then we'll reconvene at a quarter to.

4                   Do you want to give any guidance,  
5       John, about our next task or --

6                   CO-CHAIR BROOKEY: No, but we have  
7       five measures to do between now and going home,  
8       so just think about that. So see you back in 15  
9       minutes.

10                  CO-CHAIR SUSMAN: All right. Fifteen  
11       minutes. Make it sharp.

12                  (Whereupon, the above-entitled matter  
13       went off the record at 2:32 p.m. and resumed at  
14       2:45 p.m.)

15                  CO-CHAIR BROOKEY: So I first want to  
16       start out by getting a head count of those that  
17       are going to be able to stay the long haul. I  
18       know some of you have 7:00, 7:30 flights. We had  
19       asked people to stay until 5:30, but I know  
20       that's not possible for everyone, so let's just  
21       start out by asking how many can stay until 5:30,  
22       if necessary.

1                   So 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11,  
2                   12.

3                   Okay. And how many -- let's just say  
4                   if I said 5:00, how many can stay until 5:00?  
5                   How many more -- how many who said no could stay  
6                   until 5:00? Does that help anybody? That helps  
7                   one.

8                   So why don't we just see how it goes.  
9                   And these five measures have a lot of overlap,  
10                  and I think if we can get through the first one  
11                  or two, the remaining measures should be pretty  
12                  easy to do. And if -- worst case scenario we'll  
13                  do it on the follow-up call. We've already  
14                  committed to a phone call, so I don't think that  
15                  we should beat ourselves up if we have to leave  
16                  without getting them all completed, although last  
17                  year we got them all done before we left, and  
18                  that was a nice feeling.

19                  The developer is on the phone or in  
20                  person?

21                  MS. THEBERGE: On the phone.

22                  CO-CHAIR BROOKEY: On the phone?

1 DR. SOLLOWAY: Hi, this is Michelle  
2 Solloway, and I am on the phone, as is my  
3 colleague Naraa Gombojav.

4 CO-CHAIR BROOKEY: Okay. So let me  
5 just ask you before you get started, do we --  
6 first of all, do we have everybody in the room?  
7 Are we all here? I think we are.

8 So I would ask you to help us a little  
9 bit. We're not going to vote on these as a  
10 bundle of measures. We're going to vote on them  
11 individually. On the other hand, there are  
12 obviously a lot of commonality between these.  
13 And so, if you would give us a brief overview of  
14 sort of the set of measures and just very briefly  
15 touch on the points that are -- distinguish these  
16 measures in terms of why they're different one to  
17 the next. Just five minutes. But if you could  
18 touch on those topics, it would be really  
19 helpful.

20 DR. SOLLOWAY: Sure. Thank you so  
21 much, and thank you for inviting us on the call.  
22 And I first of all want to just express my thanks

1 to Suzanne and her staff for really helping us  
2 through this process. Christina Bethell -- who  
3 actually was the original developer of this --  
4 was not able to be on the call today, so I just  
5 wanted to first of all say thank you to everyone  
6 for all your help with this, because this is the  
7 first time I've gone through this process. So  
8 please bear with me if I don't understand all  
9 your procedures.

10 So I want to say that all of these  
11 measures -- 3219 to 3223 -- are all part of one  
12 tool, the Promoting Healthy Development Survey,  
13 which was previously endorsed by NQF. So these  
14 are different sections of the same tool. And the  
15 way this tool is used is it is a survey that is  
16 sent by providers to the families after a well-  
17 child visit to find out if the providers actually  
18 provided the well-child care in accordance with  
19 national guidelines.

20 And these different components,  
21 different measures, as you will, are -- represent  
22 different pieces of standard national guidelines

1 for well-child care. So anticipatory guidance,  
2 asking about parental concerns, family-centered  
3 care and family assessment for psychosocial  
4 screening and behavioral health and home safety.

5 So all of those are different aspects  
6 of national guidelines that are recommended by  
7 the American Academy of Pediatrics. They're all  
8 based -- all these measures are based on those  
9 recommendations. All these measures are  
10 recognized by the National Quality Measures  
11 Clearinghouse as being measures that meet basic  
12 criteria for use as standard indicators for  
13 healthcare quality for children.

14 Nothing has changed about these  
15 measures since they were endorsed as a -- in  
16 total as a tool, as the PHDS tool previously by  
17 NQF. So that's why they all -- that's why the  
18 applications kind of all look very similar.

19 So the specific details on the  
20 validity and reliability might be different  
21 because of how the different measures are  
22 constructed, but they're really all meant to be

1 part of and taken together as an assessment of  
2 whether children are receiving well-child care in  
3 accordance with national guidelines.

4 Also, several of the items are  
5 actually in national surveys, so all of the items  
6 in the Anticipatory Guidance Measure, 3219, are  
7 in the National Survey of Early Childhood.  
8 Asking about parental concerns and family-  
9 centered care are also in the National Survey of  
10 Children's Health.

11 So -- and I also just want to say that  
12 the development of the PHDS tool and all these  
13 different measures were -- there was a very, very  
14 rigorous process a number of years ago that  
15 really involved experts in measurement  
16 development and research and child health and  
17 quality measures that really all came together  
18 from expert panels. It was followed up with  
19 testing with providers and testing with parents.

20 And so the ways in which these  
21 measures were initially developed went through a  
22 very, very rigorous process in which the



1 reliability, validity and feasibility were all  
2 very much flushed out and really done in detail.  
3 And also these are measures about which providers  
4 can do something to improve the quality of their  
5 services. So nothing is included here that is  
6 not actionable. So it's all very actionable.

7 And I think I'll stop there and see if  
8 you have any questions for me at this point.

9 CO-CHAIR BROOKEY: I think that's a  
10 good introduction. And so we'll launch into this  
11 discussion. We're first going to talk about the  
12 evidence. This is an outcome measure.

13 And I think, Sue, are you going to  
14 kick off?

15 MEMBER KONEK: Yes.

16 CO-CHAIR BROOKEY: Okay.

17 MEMBER KONEK: This is for 3219,  
18 Anticipatory Guidance and Parental Education.  
19 And I'll say a little bit more since she did a  
20 brief overview.

21 This is a -- this measure is used to  
22 assess the degree to which pediatric clinicians

1 discuss key recommended anticipatory guidance and  
2 parental education topics. Necessarily,  
3 anticipatory guidance questions vary by child  
4 age, and of course we understand that.

5 This is an outcome measure. The  
6 measure proposes a method to determine how well  
7 the providers are meeting the goal of providing  
8 anticipatory guidance and parental education.

9 Through a survey of parents post-well-  
10 visit, parents will indicate whether their  
11 anticipatory guidance and parental education are  
12 met. Providers reviewing results of the surveys  
13 grouped in ten or more surveys will learn how  
14 effective they are in meeting this goal. Then  
15 they can be trained in AAP Bright Futures  
16 training that's available addressing this topic  
17 and subsequently improve the AGPE to better meet  
18 patient and family needs.

19 Do you want me to go more into  
20 evidence?

21 (No audible response.)

22 MEMBER KONEK: Evidence was presented

1       that both parents and clinicians felt that  
2       anticipatory guidance was the most important  
3       point of discussion at well visits. Evidence was  
4       also presented to demonstrate that by using a  
5       survey tool followed the -- I'm sorry, the PHD  
6       Survey -- following that they could use a PDSA QI  
7       work, do that work, providers are able to achieve  
8       statistically significant improvement in  
9       providing this AGPE.

10               Parents are more likely to report  
11       their needs for anticipatory guidance were met in  
12       follow-up assessments and surveys and to note  
13       that it's an ongoing process, so improvement can  
14       be measured. And that's the evidence.

15               CO-CHAIR BROOKEY: Before Jim goes --  
16       and maybe Jim can answer this question. I was  
17       looking for the actual survey instrument. I was  
18       --

19               MEMBER KONEK: Do you want me to --  
20       oh, do you want us to read that? I have it.

21               CO-CHAIR BROOKEY: Well, the question  
22       I had is as I recall this is --

1 MEMBER KONEK: It's a patient --

2 CO-CHAIR BROOKEY: -- it's the  
3 parent's recall of the --

4 MEMBER KONEK: Yes, the patient  
5 reported outcomes.

6 CO-CHAIR BROOKEY: -- conversation  
7 between the --

8 MEMBER KONEK: Yes, it's the patient  
9 reported --

10 CO-CHAIR BROOKEY: -- pediatrician --  
11 but was it a laundry list of anticipatory  
12 guidance items?

13 MEMBER BOST: So there's three  
14 questions. Well, it's -- there's three different  
15 age groups that have slightly different questions  
16 for this domain.

17 MEMBER KONEK: Different questions in  
18 each group.

19 MEMBER BOST: And there are three  
20 questions with sub-parts to them. So there can  
21 be a total of like 16 items.

22 And this particular domain -- in the

1 measurements and guidelines for it, they talk  
2 about a few different roll-up measures. What I  
3 believe we're talking about for this one is you  
4 look at all 16 items and you see whether or not  
5 for each of those items the parent said yes, I  
6 received some instruction or no, but I didn't  
7 need instructions. And then the measure for the  
8 physician is the percent of parents who said  
9 those two things for all the items.

10 DR. SOLLOWAY: Right, and I would just  
11 like to mention that there's really three  
12 sections, so there's five or six questions on  
13 physical health, there's six questions on  
14 behavior and language and learning, and then  
15 there's three questions on injury prevention. So  
16 you can actually just have scores by those three  
17 sections, if you want. But you are correct, the  
18 way you measure it is the percent of parents who  
19 said yes or I didn't need this information to all  
20 of the questions. So, yes, that's correct.

21 MEMBER BOST: So that's the way it's  
22 measured. And I don't really have anything more

1 to add to evidence, just some clarification on  
2 how the measure is actually done.

3 CO-CHAIR BROOKEY: So the evidence --  
4 well, the evidence is whether this is actionable  
5 by the pediatrician who gets the results. And  
6 theoretically, if I get kind of a report card  
7 back, I'm going to modify my approach to well-  
8 child care. Is that how we look at the evidence  
9 for this particular one?

10 MEMBER KONEK: That's it.

11 MEMBER BOST: And they do mention in  
12 one of their studies that it was actually done  
13 and they did like a training program at one of  
14 the institutions and it showed improvement.

15 CO-CHAIR BROOKEY: Yes, okay. Jeff?

16 CO-CHAIR SUSMAN: So just to clarify,  
17 let's say there are 15 measures -- just to make  
18 it easy -- and I do 12 of them, I will not meet  
19 the criterion. And it's also then supposing that  
20 if you do 15 and I do 14, that there's some  
21 difference in quality that is supported by  
22 evidence since this is what we're talking about,

1 the evidence.

2 MEMBER BOST: But that's not this  
3 measure, like you said.

4 There's another way you could do this.  
5 You could look at what was the percent of those  
6 15 items that the parent said yes and then take  
7 that average across all parents, but that's not  
8 what this is.

9 CO-CHAIR SUSMAN: Right. But I mean,  
10 it's suggesting that the outcome measure -- that  
11 this 15 out of 15 for argument's sake, is really  
12 a significantly better outcome than my doing 13  
13 out of 15, if I'm following correctly.

14 MEMBER BOST: Right. Absolutely.  
15 Yes.

16 CO-CHAIR BROOKEY: Do the doctors get  
17 an itemized report or do they just get that sort  
18 of pass/fail for each section?

19 MEMBER QUINONEZ: I mean, it seems  
20 like --

21 DR. SOLLOWAY: Okay. I was on mute.  
22 Sorry about that.

1                   MEMBER QUINONEZ:  -- the numerator and  
2 denominator, it means you just -- you either did  
3 it or not for all 16 items.

4                   CO-CHAIR BROOKEY:  That's kind of what  
5 I thought as well, but go ahead, developer.  Go  
6 ahead and clarify.

7                   DR. SOLLOWAY:  That's correct.  It is  
8 really about all of the age-appropriate items  
9 because all of them are recommended to be given  
10 as anticipatory guidance.  So that's the  
11 benchmark.

12                   The way the providers get the report,  
13 they send this out and then they can generate a  
14 report.  When they have at least ten surveys they  
15 can generate a report, but because we guarantee  
16 parent confidentiality, if for example there  
17 isn't enough data to maintain that  
18 confidentiality, it wouldn't show up as an item-  
19 by-item list.  If there is enough, we do show  
20 that.

21                   And actually, we -- what we do is we  
22 show in -- we have the three different domains,



1 physical health, behavior -- behavioral health  
2 and injury prevention. We show those three  
3 specifically, like what their percent in each of  
4 those domains, but then we also have a chart  
5 which is by age and by each of the questions.

6 And we put in red -- we show them in  
7 red which ones they didn't meet, but we can't  
8 give them the numbers unless there's really a lot  
9 of surveys. So they get the information to see  
10 what they're not doing well, but they don't  
11 necessarily get the metric on it if we can't  
12 guarantee parent confidentiality, if that makes  
13 sense. Does that make sense?

14 CO-CHAIR BROOKEY: So you're saying  
15 there's some volume threshold at which you would  
16 give them more specifics?

17 DR. SOLLOWAY: Right, because we're  
18 guaranteeing parent confidentiality in this  
19 report. So in other words, if they don't have  
20 enough surveys -- if they would know for example  
21 -- if they could remember what they did or go  
22 back in their records and look and they can

1 identify specific parents that they talked about  
2 specific things with, we have to make sure that  
3 we guard that confidentiality. So, yes.

4 CO-CHAIR BROOKEY: Yes, I get it, and  
5 I think it's a validity question, too.

6 DR. SOLLOWAY: Right.

7 CO-CHAIR BROOKEY: But it's also an  
8 evidence question as to whether you can actually  
9 act on the information, because that's really  
10 what we're looking for is an outcome --

11 DR. SOLLOWAY: Right.

12 CO-CHAIR BROOKEY: -- metric. And to  
13 say that --

14 (Simultaneous speaking.)

15 DR. SOLLOWAY: And we show them in  
16 red. Like, so we have a chart that has every  
17 item by age and by -- so that we highlight it in  
18 red if they didn't -- areas where they didn't  
19 make the cut, where they didn't ask those  
20 questions. So it gives them information about  
21 what they could do to improve.

22 Like for example, if they aren't

1        talking about car seat safety or burns or how to  
2        keep your child from getting burns, we can  
3        highlight that in red and then they could say,  
4        oh, we better get -- we better tell our people to  
5        ask about those questions.

6                    CO-CHAIR BROOKEY:    Yes.

7                    DR. SOLLOWAY:    Or make sure that they  
8        fill out some form where we've asked those  
9        questions, because it looks like we're not asking  
10       that enough.

11                   CO-CHAIR BROOKEY:    Yes.

12                   DR. SOLLOWAY:    So they --

13                   (Simultaneous speaking.)

14                   CO-CHAIR BROOKEY:    And just to help  
15       you out, when you say they, you're really saying  
16       you, because I'm a pediatrician.    So --

17                   DR. SOLLOWAY:    Oh, I'm sorry.    Yes.

18       Yes, you.

19                   CO-CHAIR BROOKEY:    So that's why I'm  
20       asking a lot of questions.    But let's move on to  
21       -- let's see.    Well, we have Rajiv and -- is  
22       Martha -- Martha's here, right?

1 Oh, there you are. We haven't heard  
2 from you. So do you want to comment?

3 MEMBER BERGREN: Yes, the only thing  
4 I was going to say was that there were several --  
5 and I'm repeating a little bit that there were  
6 identified ways to improve the quality that had  
7 been demonstrated. So that's it.

8 CO-CHAIR BROOKEY: Okay. So you're  
9 saying that that supports the evidence part of  
10 this is what you're saying?

11 MEMBER BERGREN: Yes.

12 CO-CHAIR BROOKEY: Okay. Rajiv?

13 MEMBER MODAK: Nothing more on that.

14 CO-CHAIR BROOKEY: Okay. Any other  
15 comments from the group about the evidence?  
16 David?

17 MEMBER KELLER: So this is actually by  
18 way of a question because within -- I know Bright  
19 Futures pretty well and I know the folks who are  
20 on your Advisory Committee, and one of the  
21 challenges is that within Bright Futures, it  
22 recommends that providers focus on three to five

1 of the possible items at each visit, the notion  
2 being that over time you will end up covering all  
3 of these things. And I've been hunting through  
4 because I didn't do a close review of this to see  
5 what time -- when you're asking these questions,  
6 are these questions related to a particular visit  
7 or to a series of visits over time?

8 CO-CHAIR BROOKEY: And I wonder if  
9 that's a feasibility question, but go ahead and  
10 answer the question briefly. I think that may be  
11 more to feasibility and usability, but,  
12 developer, you want to comment?

13 DR. SOLLOWAY: Sure. So really it's  
14 about the survey is sent out and they're asking  
15 about the last visit.

16 MEMBER KELLER: The last visit? Okay.  
17 Thanks. That's all I needed to know.

18 DR. SOLLOWAY: Yes.

19 CO-CHAIR BROOKEY: Yes, right.

20 DR. SOLLOWAY: Yes.

21 CO-CHAIR BROOKEY: Any other -- Jim?

22 MEMBER BOST: So the fact that they

1 get that itemized list of what's red and not,  
2 they -- a provider doesn't really need this rate  
3 to know where they need to improve. So I would  
4 ask the developer what other uses will this rate  
5 have?

6 DR. SOLLOWAY: Well, you mean the  
7 overall scoring rate?

8 MEMBER BOST: Right. I mean, you can  
9 use it to compare or benchmark yourself, or --

10 DR. SOLLOWAY: Yes.

11 MEMBER BOST: -- do you guys use a  
12 cutoff that you think means you need to do  
13 something or --

14 DR. SOLLOWAY: Well, what we do is  
15 when we provide the information back to the  
16 providers or to you, what we would give you is  
17 here's the national standard, here's the national  
18 average and here's your score. And then the idea  
19 is that you can use that in a PDSA quality  
20 improvement cycle for which you can get  
21 Maintenance of Certification Part 4 credit to --  
22 if you go through a process showing at two

1 subsequent time periods that you've implemented  
2 some activity to improve anticipatory guidance  
3 and that -- and then you have subsequent scores.  
4 So in other words you would use this survey at  
5 time one to get the baseline data, at time two  
6 and time three showing that you could improve  
7 over time.

8 CO-CHAIR BROOKEY: Okay, we don't want  
9 to talk about MOC though. That is a whole other  
10 discussion.

11 So, the question is about evidence,  
12 and it sounds like there is at least two or  
13 different things that can be done with this data.  
14 Does anyone have any other comments about the  
15 evidence for this particular measure or should we  
16 go to vote?

17 Jill.

18 MEMBER MORROW-GORTON: Just knowing  
19 that parents don't always hear what you say and  
20 they don't always remember, and depending on the  
21 timeframe between the visit and when they got the  
22 survey, do you have any evidence about or any

1 look at -- and maybe this is reliability, but  
2 look at what actually was talked about in the  
3 visit measured in some other manner and what  
4 parents remembered?

5 DR. SOLLOWAY: That is a really good  
6 question. And I have to say that I was not at  
7 CAHMRI at the time that this was developed. I  
8 would imagine and suspect that there may have  
9 been a little of that validity checking up on to  
10 see about that but I don't know. Naraa, do you  
11 know if that was done?

12 DR. GOMBOJAV: Yes, you know, I  
13 haven't seen at the time when the issue was up  
14 but I know from the previous literature using  
15 PHDS survey there are many literature searches  
16 being done to develop the survey. So we can -- I  
17 think we provided some of this literature found  
18 on these topics that --

19 CO-CHAIR BROOKEY: Okay, so it sounds  
20 like no. But I mean there are other things that  
21 are out there that depend on coding. So you can  
22 blow in a B code for dietary advice and



1 counseling about screen time and so forth,  
2 whether you did it or not, right, especially in  
3 Epic.

4 So this is getting to, really,  
5 hopefully what really happened or at least what  
6 the parent perceived happened. So you can decide  
7 yourself whether one is better than the other, I  
8 suppose.

9 Any other about evidence? David.

10 MEMBER KELLER: So just a quick  
11 question. How long until the families get the  
12 surveys? What's the timeframe?

13 DR. SOLLOWAY: The provider can send  
14 it out whenever they want. So, it's really up to  
15 the provider to make that decision. So they  
16 could do it at the end of every visit. You know,  
17 they could just have their staff send it out, or  
18 if it's available on a patient portal, because  
19 that is really up to the provider. We don't have  
20 any control over that.

21 CO-CHAIR BROOKEY: Okay, that may not  
22 affect the evidence discussion.

1                   Any other questions or comments about  
2 evidence? Okay, I would recommend that we go to  
3 vote.

4                   MEMBER EDIGER: I actually have a lot  
5 of thoughts about this.

6                   CO-CHAIR BROOKEY: I'm sorry. I  
7 didn't see you down there.

8                   MEMBER EDIGER: That's okay. So, I am  
9 one of the lead discussants on one that's further  
10 down so I am happy to save a lot of my thoughts  
11 but it seems --

12                  CO-CHAIR BROOKEY: No, go ahead and go  
13 now.

14                  MEMBER EDIGER: -- like they are  
15 relevant to all five.

16                  CO-CHAIR BROOKEY: Yes, go ahead.

17                  MEMBER EDIGER: So, I'm thinking about  
18 what you just asked about, like do parents hear  
19 what the checklist that the pediatrician's going  
20 through? And an example for me is, as I  
21 mentioned, I disclosed I have four kids. I had  
22 twins. I overshot. It's a long story.

1 (Laughter.)

2 MEMBER EDIGER: But so my pediatrician  
3 -- and we have gone to this same pediatrician.  
4 We love her more than oxygen. We've gone to her  
5 for over 16 years. And one of her standard  
6 questions is, do you have your own room? And  
7 every time, my kids are like, "no." Because I  
8 have four kids. And I always felt it always sat  
9 really uneasy with me. I always felt like it was  
10 a very judgmental question. Like, no, we don't  
11 have a house with five bedrooms but thanks for  
12 asking every single time I come in.

13 So, I finally asked her. I said can  
14 I just ask why you ask this question. And she  
15 said, "oh, well, I want to know if they feel like  
16 they have a place to go that is private. Like do  
17 they have space in the house to go to feel like  
18 they have their own space?" And I was like,  
19 well, then you should ask that. And I told her.  
20 I said I feel very judged when you ask my kids  
21 four times a year in front of me.

22 Anyway, so I think that is a really

1 good example of how good intentions -- she's  
2 going through her checklist, so I'm sure that  
3 question lines up in her mind with one of the  
4 questions on there, but with me it was salt every  
5 single time.

6 And I have other examples like that  
7 but just everything about reading about this  
8 survey, it didn't sit well with me because the  
9 parent gets nothing out of it except a report  
10 that says when you go back in 12 months for your  
11 next checkup, here's a list of things you should  
12 ask about: your car seat, if they have their own  
13 room -- yeah, 12 months later.

14 And I'll say, I'm specifically in the  
15 psychosocial screening so I'll save some of it  
16 specifically for that when we get there, but I  
17 have a lot of concerns about the intent of what  
18 this is supposed to do, and the people that do  
19 all the work actually filling out the 20-minute  
20 survey don't get anything out of it, in my  
21 opinion.

22 CO-CHAIR BROOKEY: You have to

1 disclose every time that you have guns in the  
2 house and things like that. So I appreciate your  
3 comments from a parent, because we do, we do  
4 survey -- we survey our patients all the time,  
5 whether they want to be surveyed or not. And  
6 there is very good reasons for doing that but I  
7 appreciate your perception of it.

8 And Tara?

9 MEMBER BRISTOL-ROUSE: So I feel a  
10 little bit differently, actually. So I work in  
11 quality improvement so there is an appeal to me  
12 that you can get the data back after ten  
13 responses so that you can make some  
14 semi-real-time changes in practice.

15 But I wanted to address the perception  
16 issue because I could see where that could be a  
17 sticky wicket for some providers, is that I think  
18 for parents or caregivers perception is reality.  
19 And so even if a parent is saying you never  
20 talked to me about breastfeeding, and this kind  
21 of gets to Maureen's point, like, you know, you  
22 have to look back and you go, as a provider you

1 might say, "I know I have talked about  
2 breastfeeding with everybody." So then it's  
3 like, "well, am I not talking about it in a way  
4 that is meaningful to the parent?"

5 And so I think regardless of how you  
6 look at it, the parent's perception is the  
7 weighty thing that should help you to improve  
8 your practice. So I just wanted to bring up that  
9 point about perception and what's meaningful.

10 CO-CHAIR BROOKEY: Good point.

11 Jeff.

12 CO-CHAIR SUSMAN: So, briefly, I am  
13 thinking about this in an accountability  
14 framework and trying to make a judgment about a  
15 provider's performance based on providing the  
16 whole haywagon-full of anticipatory guidance, 15  
17 questions, whatever it is, rather than  
18 potentially meting this out and focusing on maybe  
19 half of the questions or two-thirds of the  
20 questions and then following up later.

21 So I am not convinced that there is an  
22 evidentiary link between doing all this stuff and

1 an improved outcome. I mean, I believe that each  
2 of these individual things are probably good  
3 things to do and there is probably some evidence  
4 we could find for each of them, but the all or  
5 none aspect, I am not clear about.

6 And in fact I know there is good  
7 evidence around changes in behavior, preventive  
8 services, that suggests that you focus on a  
9 meaningful few, as opposed to everything, or you  
10 do some negotiation process. So that's where my  
11 dis-ease and looking at it from an evidence  
12 perspective.

13 CO-CHAIR BROOKEY: So, of course I  
14 agree with that, but I also just want to go back  
15 and say we're looking to see whether or not the  
16 measure, as written, could potentially lead to,  
17 in this case, a change in behavior in the  
18 provider. Does it have to be broken down into  
19 every element or would -- sort of three different  
20 answers, you basically have three different  
21 pillars of this.

22 So, is it sufficient for evidence to

1 say that, even if you don't get the detailed  
2 report, that a provider could look at that  
3 report, compare themselves to others, potentially  
4 change their behavior? That's the question about  
5 evidence.

6 So, we have a couple cards up. I will  
7 start with you, Rajiv.

8 MEMBER MODAK: So I think that what is  
9 the challenge is, I think there's a potential to  
10 change behaviors when performance is very low and  
11 you can improve those behaviors. But when you  
12 get to a certain point, I don't know how much you  
13 really impact meaningful behaviors that will  
14 improve outcomes for patients and will even  
15 improve their satisfaction.

16 So, speaking to going over the top  
17 with the questions that you are asking where I  
18 think there is some support for the idea that you  
19 can move people who are low performers to the  
20 middle.

21 MEMBER FINKELSTEIN: So, I was  
22 listening to what you were saying, John, and I



1 would have said it very differently. If this is  
2 -- if we are considering this an outcome measure  
3 -- are we considering this an outcome measure? I  
4 think the question is not whether the measure  
5 would result -- having the measure would result  
6 in provider behavior change. That's not the  
7 question. The question is, if this is an  
8 outcome, does provider behavior -- is there  
9 something the provider can do or not do -- affect  
10 this as an outcome?

11 So, from my perspective, I'm going to  
12 have other issues as we get into validity, but I  
13 think, if this is an outcome, I could do  
14 something to affect this outcome.

15 CO-CHAIR BROOKEY: Yes, just to read,  
16 there needs to be a relationship between the  
17 measured health outcome and at least one health  
18 care action, which is structure, process,  
19 intervention.

20 MEMBER FINKELSTEIN: Right.

21 CO-CHAIR BROOKEY: So it could be --  
22 so again, I mean, I think ultimately we want

1 better outcomes for the actual patient. But in  
2 this case, we are just looking for some change  
3 that could be -- some action that could result  
4 from this measure, the result of this measure.

5 So it's just the way that the  
6 algorithm is written. I would like there to be  
7 more evidence for actually improved patient  
8 outcome but that's not what we are looking at  
9 here.

10 Let's see. Carol, did you have your  
11 hand up?

12 Jim.

13 MEMBER BOST: I just want some  
14 clarification from staff. So it's my  
15 understanding that this survey was already  
16 approved. Is that true?

17 DR. NISHIMI: Well, not as a quality  
18 measure.

19 MEMBER BOST: Actually, what I'm  
20 trying to get at is, you have already signed off  
21 on the items in this instrument and the domains.  
22 So we're not really here to look at whether an

1 item is good or valid or reliable, just the  
2 roll-up measure itself. Or do I not get that?

3 DR. NISHIMI: There was an original  
4 survey instrument 0011. So the fact that it has  
5 number 11 means it was very old.

6 (Laughter.)

7 DR. NISHIMI: And it was done at a  
8 time when NQF considered instruments in their  
9 entirety. So the kind of review and the criteria  
10 have evolved and the types of testing required  
11 have evolved.

12 So in fact that's why these have new  
13 numbers because they have been split into  
14 specific performance measures based on those  
15 items. So previous endorsement doesn't really  
16 apply here. You're looking at this performance  
17 measure, which is the percent of, you know, blah,  
18 blah, blah.

19 MEMBER BOST: It sounded like the  
20 developers weren't ready to answer those kind of  
21 item analysis stuff that are previously published  
22 psychometric papers but were more here to focus

1 on the measure.

2 DR. NISHIMI: And you will see we  
3 require item-level testing and score-level  
4 testing. And so they have looked at and reported  
5 certain focus group-related stuff, but they've  
6 also looked at item-level testing. And so that  
7 is why that is in there, because our requirements  
8 now are different. We're actually looking at the  
9 performance measure, not the instrument.

10 CO-CHAIR SUSMAN: Just briefly, one of  
11 the other factors in this is benefits of --  
12 benefits and harms. And I see what the sort of  
13 natural outcome of this is that the Epics of the  
14 world will have checklists, that people will  
15 dry-lab every one of those checklists because you  
16 want to get credit. Or if they are really  
17 honest, they will subject you to all 15 items  
18 every time you come in, or whatever the  
19 appropriate thing is.

20 So I think there are some potential  
21 harms here that we just need to be mindful of. I  
22 don't know whether that really shifts the

1 conversation fully one way or the other.

2 CO-CHAIR BROOKEY: David.

3 MEMBER EINZIG: So, nuances. So when  
4 we vote, are we voting -- I mean, I think it is  
5 easy to say that will change behavior, but if we  
6 don't think it will change behavior in a  
7 meaningful way, does that affect how we should  
8 vote?

9 CO-CHAIR BROOKEY: I think we're sort  
10 of blending our own personal experience with  
11 validity questions. We're questioning threats to  
12 validity. We're questioning unanticipated harm,  
13 unanticipated reactions from parents even  
14 perhaps. So there's a lot -- we're blending in a  
15 lot of this together. So I think we need to  
16 focus on the first question of evidence, which  
17 is, everybody, I refer you back to your  
18 algorithm, and just to say, whether you like it  
19 or not, the way the measure is created, whether  
20 you like the way it is reported back, it is not  
21 an item level unless you hit a certain volume  
22 threshold.

1           As it is written, do you believe that  
2           there is a relationship between the measured  
3           health outcome and at least one healthcare  
4           action, which could be a structure, process,  
5           intervention, or service, which means, in my  
6           mind, that the me getting this report will look  
7           at this and say, wow, I need to spend more time  
8           on this.

9           And so that's the question. That's  
10          what you have to wrap your head around to say  
11          whether or not you believe that is true or not.  
12          And that is what we are voting on. And kind of  
13          try to put aside all that other stuff for the  
14          moment because we are going to get to that.

15          So is everyone clear on what we are  
16          building on, I guess, is my question. So, it's  
17          not real satisfactory, is it, but it is what it  
18          is. So we're just going to have to go one step  
19          at a time.

20          So, let's go ahead and vote on  
21          evidence, pass or not pass.

22          MS. JUNG: The voting for Measure 3219

1 for evidence is now open. Option 1, pass; option  
2 2, not pass.

3 Okay, voting is now closed. We have  
4 68 percent for pass with 15 votes; 32 percent for  
5 not pass with 7 votes. And with that 68 percent,  
6 the measure passes for evidence.

7 CO-CHAIR BROOKEY: Okay, so let's talk  
8 about measurement or performance gap. Who's  
9 going to start this one?

10 MEMBER KONEK: Alright. So there  
11 appeared to be opportunity for improvement. The  
12 developers have provided three different  
13 well-designed research studies that show  
14 substantial variation in the measure across  
15 sociodemographic groups. And it showed there is  
16 room for improvement.

17 And we're going to hear more about  
18 those tests, those studies shortly. But there  
19 was clearly a demonstrated performance gap in  
20 providing AGPE, with rates varying from only 40  
21 to 60 percent. The review of the Promoting  
22 Healthy Development Survey results of the top

1 five providers -- and you are going to hear about  
2 them through the whole thing; they looked at the  
3 people that had the most surveys that came back.

4 And so they looked at them and the  
5 range was 46.8 to 84.8 percent was seen by the  
6 proportion of parents who reported discussion of  
7 all topics or reported no need to discuss them,  
8 such as people with a couple of kids. And the  
9 cited KPNW study showed a range of 22.2 to 67.7  
10 percent.

11 So, it looked like there was a big  
12 range in how well people -- the providers were  
13 providing this so that the family felt that they  
14 had their needs for the information met.

15 CO-CHAIR BROOKEY: So do you interpret  
16 that as a gap?

17 MEMBER KONEK: Well, that's how it was  
18 laid out. It seems they felt that there was a  
19 gap as far as performance for this. There was  
20 disparity shown with some groups, also, which  
21 were also discussed at length.

22 MEMBER BOST: Yeah, I mean, basically



1 the rates presented showed a lot of room for  
2 improvement. There were differences across  
3 socioeconomic groups, and, like you said, across  
4 physicians.

5 MEMBER KONEK: Right.

6 MEMBER MODAK: And I also just want to  
7 echo that that's the most important point, to me,  
8 was the disparity among ethnic backgrounds,  
9 socioeconomic backgrounds. And it's been  
10 reported that especially when there's language  
11 barriers there's a huge discrepancy. So I think  
12 there is a significant gap.

13 CO-CHAIR BROOKEY: Yeah, the use of  
14 interpreters and health literacy issues, all  
15 kinds of things can contribute to that, parents  
16 feeling like they weren't communicated to during  
17 the visit. Those are very important points.

18 Ricardo. Ricardo.

19 (Laughter.)

20 CO-CHAIR BROOKEY: Your flag is up.

21 MEMBER QUINONEZ: I have a virus.

22 Sorry.

1                   So, in the gap, in the evidence for  
2                   gap, just as a question, does the developer have  
3                   to show just that there's a gap or that gap means  
4                   there is a difference in quality? I mean, that  
5                   there's a gap in quality. So, meaning, yes, we  
6                   know that there's decreased performance if you  
7                   look across different providers, but I'm not sure  
8                   that necessarily correlates with worse quality.

9                   CO-CHAIR BROOKEY: Yeah, I think it's  
10                  not about that. I think it's about whether or  
11                  not this measure is going to -- if you measure  
12                  it, you are going to see a gap.

13                 MEMBER QUINONEZ: Big difference.

14                 CO-CHAIR BROOKEY: Right.

15                 MEMBER KELLER: I think that it's that  
16                  the evidence supposedly establishes that there's  
17                  something there and then the gap shows that  
18                  there's room for improvement.

19                 MEMBER QUINONEZ: No, but because we  
20                  only voted on whether the evidence can be  
21                  modified. We didn't actually vote on the merits  
22                  of the evidence. So, that's why I am asking.

1 CO-CHAIR BROOKEY: We voted to say --  
2 well, we did vote on evidence, which we defined  
3 in this situation as being something that could  
4 be acted on. And then the gap is that there is  
5 variation between providers and ethnic -- or  
6 there's socioeconomic or ethnic differences  
7 between the results.

8 So I think you have to kind of stretch  
9 it further to believe there is a quality gap but  
10 I don't think that is what we are voting on here.

11 Yes?

12 MEMBER DORSEY: So since this is a  
13 provider-level measure, the question that I want  
14 to see the answer to is either within do  
15 providers have differential quality for their  
16 higher-income/lower-income patients, or among  
17 providers who have a large proportion of certain  
18 vulnerable patients, do they tend to have lower  
19 scores? Rather than just the raw rate in the  
20 subgroups. That doesn't tell me much about the  
21 performance gap at the provider level.

22 CO-CHAIR BROOKEY: Right. So, John?

1                   MEMBER FINKELSTEIN: So I have a  
2 question really for the NQF staff. And I'm okay  
3 continuing down this road but this was a problem  
4 that came up at our last meeting. I will just go  
5 on record. This is not an outcome measure. It  
6 is a patient report of a process. And when you  
7 treat a patient report of a process -- this isn't  
8 "can I get up in the morning and go upstairs."  
9 That is a patient-reported outcome. When you  
10 take a patient report of a process and start  
11 treating it like an outcome, we get into funny  
12 problems.

13                   So, if that's the road you want us to  
14 go down because that's -- that's okay but I just  
15 want to call that out.

16                   CO-CHAIR BROOKEY: Okay, duly noted.

17                   Carol?

18                   MEMBER STANLEY: Yeah, a couple of  
19 things about gaps. One was this instrument -- is  
20 this sent out in Spanish to patients whose  
21 primary language is Spanish? Because if that's  
22 not the case, then I'm not so sure you can say

1       there's a disparity or what kind there is with  
2       ethnicity.

3               The other thing along those lines is  
4       I think I read where the instrument is written at  
5       the eighth or ninth reading level. So, that's  
6       pretty high, considering Medicaid population. So  
7       I'm not really sure how accurate this disparity  
8       presentation is.

9               And I also agree with the comment that  
10       if this is a provider-level measure, then I think  
11       we would need to see numbers that showed  
12       disparities between the providers and not looking  
13       at these aggregate numbers.

14              CO-CHAIR BROOKEY: So for the  
15       developer, is it sent out in either Spanish or  
16       any other threshold languages?

17              DR. SOLLOWAY: I don't believe it is  
18       because I don't think we had the money to develop  
19       the Spanish version, but I could be wrong about  
20       that. Naraa, do you know?

21              DR. GOMBOJAV: Yes, no Spanish version  
22       for now.

1 DR. SOLLOWAY: I don't think so. I  
2 don't think we had the money to develop it.

3 CO-CHAIR BROOKEY: Thanks for bringing  
4 that up, Carol.

5 DR. SOLLOWAY: Spanish, yeah, it's a  
6 very good point.

7 CO-CHAIR BROOKEY: Jeff?

8 CO-CHAIR SUSMAN: It just seems like  
9 a lot of issues that we are talking about are  
10 really tending toward more validity issues and we  
11 should make sure we come back to them.

12 CO-CHAIR BROOKEY: Yeah, don't forget  
13 that one. That's a major concern.

14 So let's see if we can talk about, or  
15 at least vote on, gap, now that we -- do we all  
16 know what gap is now for this purpose?

17 So, let's go ahead and vote on it.  
18 Let's close the gap.

19 MS. JUNG: Okay, the voting for  
20 Measure 3219 for performance gap is now open.  
21 Option 1 is high; option 2, moderate; option 3,  
22 low; and option 4, insufficient.

1                   Okay, voting is now closed. The  
2 results are 5 percent for high with one vote; 77  
3 percent for moderate with 17 votes; 5 percent for  
4 low with one vote; and 14 percent for  
5 insufficient with 3 votes.

6                   And with this, the measure does pass  
7 for performance gap.

8                   CO-CHAIR BROOKEY: Okay, so  
9 reliability. Who's going to kick that one off?

10                  MEMBER BOST: So reliability testing  
11 was done at three different studies, each that  
12 seemed to have adequate sample size and  
13 appropriate variability across socioeconomic  
14 status and age. The Cronbach's alphas were  
15 consistently in the 80 to 90 percent range for  
16 all items together and in the 70 to 80 percent  
17 range for the items within each of the three  
18 questions.

19                  Though it's really mentioned in  
20 validity, the items also had high factor loadings  
21 on each and acceptable interclass correlation  
22 coefficients.

1 I think, if anything, I might have  
2 liked to see some test/retest to see if parents  
3 would respond similarly a week apart or something  
4 like that. But other than that, I thought there  
5 was good reliability assessment.

6 CO-CHAIR BROOKEY: So, Carol, go  
7 ahead. I mean Sue. I'm sorry.

8 (Off-microphone comment.)

9 CO-CHAIR BROOKEY: So getting back to  
10 the question about language and getting to the  
11 question about the provider sending it out  
12 themselves and they may send it out the same day  
13 or a week later or further down the road, does  
14 that affect potentially both reliability and  
15 validity or not?

16 MEMBER BOST: Yeah, that's why I would  
17 have liked to see some test/retest to see if it  
18 is different. Because then if you're doing  
19 something like comparing across clinicians,  
20 should you be doing that consistently or not?  
21 And that kind of testing might help us understand  
22 that.



1                   MEMBER MODAK: So I think that that's  
2 a key point, especially with reliability, is when  
3 those surveys are getting sent out as well,  
4 because there is a huge difference in patient  
5 memory or parent memory from the day of the visit  
6 to three days later than after the visit. So, I  
7 don't think that has been vetted in this.

8                   CO-CHAIR BROOKEY: So are you  
9 suggesting that is a threat to reliability as  
10 well as validity?

11                  MEMBER MODAK: Yes.

12                  CO-CHAIR BROOKEY: Okay. Now Carol.

13                  MEMBER STANLEY: Yeah, and along those  
14 lines I think with needing to have six well-child  
15 visits by 15 months, if you are going by the  
16 HEDIS measure, and a parent gets the survey at  
17 month 16 and their child has had six well-child  
18 visits over the past 12 months with different  
19 providers, how do they know which provider  
20 they're evaluating if this is going to be a  
21 provider-specific report?

22                  CO-CHAIR BROOKEY: I will ask the

1 developer to answer, that but I'm guessing that  
2 the questionnaire will say during your last  
3 visit. Is that correct?

4 DR. SOLLOWAY: Yes, actually -- well,  
5 some of the questions ask in the last 12 months.  
6 Actually, these questions ask, "since your child  
7 was born did your child's doctors or other  
8 healthcare providers ask you about the  
9 following." So it really includes any of the  
10 providers you had. So it's really kind of a  
11 comprehensive measure of taken as a whole.

12 MEMBER STANLEY: How can that be  
13 provider-specific, then? If the report is going  
14 to a provider, how do you discern those -- that  
15 it's encompassing the providers from the last 12  
16 months?

17 DR. SOLLOWAY: Well, actually, I  
18 misspoke. These are not for the last 12 months.  
19 These are since your child was born did you get  
20 these questions.

21 And, you know, you're asking a very  
22 good question and I think there is probably some

1       assumption that they're staying with the same  
2       provider. But as I said -- oh, and actually in  
3       the injury prevention one it is in the last 12  
4       months.

5               And I know that these questions were  
6       really designed to really coincide with the way  
7       the questions were asked because they were tested  
8       for their validity and reliability in the  
9       National Survey of Children's Health. So I know  
10      that these questions were meant to align with  
11      those questions, which is why the wording is the  
12      same. But I understand your point.

13             CO-CHAIR BROOKEY: So -- and I want  
14      David to go. I just want to back up a notch,  
15      having this new information. Going back to the  
16      question of evidence and saying that I can look  
17      at my report and do something about it, now I'm  
18      hearing that this report may not reflect the care  
19      that I gave. Is that an accurate statement?

20             PARTICIPANT: You could come to me and  
21      tell me what to do better.

22             CO-CHAIR BROOKEY: I'm asking the

1 developer if that's accurate, that the report is  
2 not strictly speaking just based on what I did.  
3 It's the perception of the parent over all the  
4 care they've received, and it could be from  
5 numerous providers.

6 DR. SOLLOWAY: I think that's true,  
7 yes.

8 MEMBER HOUTROW: To speak to that in  
9 particular, we did some research several years  
10 ago which shows that children with more  
11 encounters, including ill visits, which tend not  
12 to be with your regular primary care doctor, in  
13 fact increase the likelihood that you will get  
14 anticipatory guidance, which is a good thing, but  
15 it means that attribution is related to all the  
16 care not just -- I mean the care to one provider.

17 CO-CHAIR BROOKEY: Okay, David, I  
18 think, is next.

19 MEMBER BOST: I have the actual  
20 question in front of us. And the first one is  
21 "since your child was born, did your child's  
22 doctor or other health providers talk with you

1       about." The second question is also since your  
2       child was born. The third one is in the last 12  
3       months.

4                   CO-CHAIR BROOKEY: So this is not  
5       attributable to any individual unless the child  
6       only saw one individual provider.

7                   MEMBER MORROW-GORTON: Or even a  
8       practice. Other healthcare provider could be the  
9       WIC clinic.

10                  CO-CHAIR BROOKEY: I think we may need  
11       to go back and re-vote on evidence. But let's go  
12       ahead and go around the room here.

13                  David.

14                  MEMBER EINZIG: Yeah, so, I mean, I am  
15       having a lot of trouble with this, along with a  
16       lot of people, I think, but I just can't remember  
17       what happened an hour ago.

18                  (Laughter.)

19                  CO-CHAIR BROOKEY: That is a different  
20       survey.

21                  MEMBER EINZIG: And so when you get  
22       these responses back, so that there is that

1 piece, and then there is the piece of this takes  
2 20 minutes for a family and this time consuming.  
3 How do you feel when you get a survey in the mail  
4 like that?

5 And then the issue of, I mean, just  
6 taking into consideration there are so many  
7 variable, if it's a family with a bunch of kids  
8 and they are stressed and they are struggling to  
9 pay rent and then there's this. And you're  
10 comparing those surveys with the other families  
11 who have one kid and have all the time in the  
12 world. So there's a lot of variables that don't  
13 feel right to me here.

14 CO-CHAIR BROOKEY: Could I ask that --  
15 could I entertain more comments about evidence?  
16 Would that be okay if we went back and talked a  
17 little bit about that, Helen?

18 DR. BURSTIN: Everybody, I'm Helen  
19 Burstin, Chief Scientific Officer. So apologies  
20 for not being here this morning.

21 I'm stuck on John's question because  
22 I think he's absolutely right. This is a process

1       measure. Just because it's a patient report  
2       doesn't mean it's an outcome. And in fact I was  
3       just pulling up, Lisa and I were just -- and some  
4       of you were actually here just for a behavioral  
5       health meeting just a couple of days ago -- and  
6       we in fact looked at measures from NCQA that were  
7       patient self-report of guidance about smoking  
8       cessation. You were here as well. That was a  
9       process measure. I just pulled it up.

10               So, to be consistent, unless it's  
11       actually an outcome or a patient experience, it  
12       would be a process measure.

13               And then just one other question.  
14       These measures, when they had come in before with  
15       the state level of analysis, and I wonder if when  
16       they've gone to the lower level of analysis, I'm  
17       not sure -- it would be helpful to hear from the  
18       developer of what additional work was done to see  
19       their applicability at this much lower level of  
20       aggregation.

21               CO-CHAIR BROOKEY: So, for the  
22       developer, did you hear the question?

1 DR. SOLLOWAY: Yes, Naraa, would you  
2 like to answer that?

3 DR. GOMBOJAV: Okay. So, based on the  
4 previous studies we have done, especially for the  
5 Kaiser study, we have tested the plan -- I'm  
6 sorry -- the provider, they will --

7 CO-CHAIR BROOKEY: Excuse me. I'm  
8 wondering if you could speak up a little bit. We  
9 are having a hard time hearing you.

10 DR. GOMBOJAV: I'm sorry. So we have  
11 done some low level analysis in the Kaiser study  
12 and also the peer review paper about PHDS testing  
13 being included. For plan levels, they were  
14 compared in different plans, so those --

15 MEMBER KONEK: Naraa, your voice is  
16 really muffled. We're having trouble hearing you  
17 in the room.

18 DR. GOMBOJAV: I'm sorry. Yes, I'm  
19 out of work today and I'm starting to cough. My  
20 voice is kind of hard. That's why and maybe you  
21 are hearing some difficulties. I'm trying to  
22 make it better.



1                   So I am just saying we have done some  
2                   analysis at the plan level, which was partly  
3                   involved in the Kaiser study, the initial study  
4                   we were testing the measures of survey measures.  
5                   So those are in a peer reviewed paper already  
6                   published.

7                   CO-CHAIR BROOKEY:   Okay.

8                   DR. SOLLOWAY:   And the other thing I  
9                   would just like to say is, so, initially, this  
10                  was designed to actually compare providers within  
11                  a practice and then the practices within the  
12                  plan.   So initially, it was done, and it was also  
13                  done at the state level.   So we have state, plan,  
14                  and practice and provider level.   And then we  
15                  kind of changed it to be just provider-specific  
16                  and not to compare providers against each other.

17                  CO-CHAIR BROOKEY:   Okay.

18                  DR. SOLLOWAY:   So we did do individual  
19                  provider levels as well.

20                  CO-CHAIR BROOKEY:   But these measures  
21                  are specifically meant to be at provider level  
22                  for individual provider feedback and for

1 individual provider action related to the  
2 feedback. Correct?

3 DR. SOLLOWAY: Yes, for individual  
4 providers. We have the capability on the back  
5 end to actually aggregate the providers within a  
6 practice because we know what practice they have.

7 CO-CHAIR BROOKEY: Well if you are in  
8 Kaiser Southern California, you can go all over  
9 Southern California.

10 DR. SOLLOWAY: That's exactly true.

11 CO-CHAIR BROOKEY: So I'm just  
12 clarifying the facts. It sounds like we started  
13 out by saying this was at an individual provider  
14 level, that we had concerns about it being in the  
15 sort of domains and not even individual items,  
16 but that this would be used for feedback, and,  
17 even further, it could even be used for financial  
18 incentives or all kinds of things that groups and  
19 health plans do with individual provider  
20 measures. But then we have discovered that in  
21 fact the questions do not necessarily relate to  
22 that individual provider.

1                   So I just want to clarify that those  
2                   are the facts.

3                   DR. SOLLOWAY: I would say yes, that's  
4                   true.

5                   CO-CHAIR BROOKEY: So I am going to  
6                   propose to the group that we revisit the evidence  
7                   question and we'll vote on a revote. And if we  
8                   vote to revote, we'll revote.

9                   So can I open it up for questions or  
10                  comments about the evidence? Okay, go ahead.

11                  MEMBER FATTORI: I don't know if this  
12                  is an evidence question but are we voting on this  
13                  as a process measure or an outcome measure?  
14                  Process?

15                  CO-CHAIR SUSMAN: We're going to  
16                  change it to process.

17                  MEMBER FATTORI: Okay.

18                  (Simultaneous speaking.)

19                  CO-CHAIR BROOKEY: So, let's just sort  
20                  of talk informally for just a little bit because  
21                  if they completely rewrote this to make it a  
22                  process measure, is it -- they are not going to

1 change the methodology of the measurement. So,  
2 is this going to be a measure that is going to do  
3 what it purports to do, which is to be an  
4 individual report card for an individual  
5 provider? Is it ever going to hit that mark, is  
6 my question?

7 MEMBER BOST: Well, it depends, also,  
8 on the instructions that you're given. Because  
9 if it comes up on the website and it says, please  
10 comment based on your visit on such and such a  
11 date, would you not think that they are talking  
12 about that provider?

13 CO-CHAIR BROOKEY: But they'd have to  
14 change the tool.

15 MEMBER BOST: I'm just asking.

16 (Simultaneous speaking.)

17 CO-CHAIR BROOKEY: I'm sorry. Jill,  
18 would you repeat what you said?

19 MEMBER MORROW-GORTON: So I think you  
20 could give those instructions, except the way the  
21 question is asked, at least the one that you gave  
22 us was, in the last 12 months, so that blows your

1 last visit, and your practitioner and all of your  
2 other healthcare practitioners. You know, people  
3 could have a PT that wasn't even related to the  
4 practice.

5 CO-CHAIR BROOKEY: So what is your  
6 conclusion?

7 MEMBER MORROW-GORTON: So my  
8 conclusion is that we could not use this to give  
9 feedback either to an individual clinician or to  
10 a physician practice because it's too open to  
11 other healthcare practitioner's input.

12 CO-CHAIR BROOKEY: Okay. John.

13 MEMBER FINKELSTEIN: So I just want to  
14 defend the measure for a minute and then raise a  
15 real concern. So I think when we flip to process  
16 it's a different pathway for evidence and a  
17 different level for evidence, so we are going to  
18 have to deal with that.

19 CO-CHAIR BROOKEY: Right.

20 MEMBER FINKELSTEIN: I think the most  
21 important question to me isn't the one we're  
22 talking about now. I get it, the attribution

1       isn't perfect. The evidence that this is based  
2       on comes from the evidence behind Bright Futures.  
3       And you can quibble with that evidence because  
4       the evidence for anticipatory guidance and  
5       well-child care in total is thin in some ways,  
6       but there was as much evidence to develop Bright  
7       Futures as those people could generate and we  
8       really have to look to that.

9               So here is the question, for me, for  
10       the developers, is I don't hear them talking  
11       about this as an accountability measure. I hear  
12       them talking about this as feedback to  
13       practitioners so that they can individually  
14       improve their care based on the last ten patients  
15       they saw and get MOC credit because that's a PDSA  
16       cycle. But do they ever think that this, at a  
17       practice level, that either individual  
18       practitioners or one practice to another to  
19       another, can be judged by these measures? I  
20       realize we are getting into validity, but do they  
21       even think about it as an accountability measure?

22               CO-CHAIR BROOKEY: I'm just going to

1 take all of your comments first. So go ahead,  
2 Carol.

3 MEMBER STANLEY: Along the lines of  
4 evidence, I'm not hearing anything that tells us  
5 that the scores wouldn't have improved anyway  
6 just at the mere fact, someone said it earlier, I  
7 think, that if you see a physician once and then  
8 twice and three, chances are you are going to see  
9 an increase and improvement in the scores because  
10 you are developing better rapport. So how has  
11 the developer sort of addressed that issue that  
12 is there evidence that using this tool is  
13 improving scores over time versus just the fact  
14 that the patient is seeing the same physician six  
15 times in 15 months?

16 CO-CHAIR BROOKEY: So I will let the  
17 developer answer that question. Basically, do  
18 you have data that shows actual improvement in  
19 individual provider scores?

20 DR. SOLLOWAY: Well, I would say yes  
21 to your question but no to the woman's question,  
22 because we haven't -- we didn't have research to

1 actually -- we didn't have the opportunity --  
2 well, no, that's not right.

3 What I'm saying is asking the  
4 question, was it because they used the tool or  
5 because they developed a better relationship,  
6 would be in and of itself a separate research  
7 question and a separate research project.

8 So what we did know from our focus  
9 groups with parents is that they really -- they  
10 liked being able to report back to the providers.  
11 They liked being able to give this feedback to  
12 the providers. And they did see improvement, but  
13 whether it was because there was a better  
14 relationship developed or did the tool help them  
15 develop a better relationship, I don't know that  
16 we can tease that out from the data that we have.

17 CO-CHAIR BROOKEY: Okay, thank you.

18 So, Rajiv, then Jeff, and then Jill.

19 MEMBER MODAK: Just, again, on the  
20 evidence, we voted about the evidence based on  
21 the idea that it was a question asked in the last  
22 visit, were all of these questions asked in the



1 last visit. Now we are changing it to were all  
2 these questions asked since you were born. Even  
3 with or without a relationship, obviously, if you  
4 have three visits, you're going to ask more  
5 questions, the potential to ask more question  
6 than at one visit. So this is completely  
7 different than we initially had voted for.

8 CO-CHAIR BROOKEY: So what are you  
9 concluding?

10 MEMBER MODAK: Well, we need to take  
11 a revote. But the question is, I mean, if we are  
12 changing it to a process outcome, then -- the  
13 question would be -- my question is, if we have  
14 them completely rejigger this to be a process, is  
15 it going to change that point about it not being  
16 an individual visit questionnaire; it's based on  
17 the past 12 months, which could be multiple  
18 providers.

19 So I'm just trying to just ask whether  
20 this can ever be an accountability measure at the  
21 individual provider level, which is a premise  
22 behind all of this.

1 Jeff.

2 CO-CHAIR SUSMAN: I mean, to answer  
3 your question, I think it's invalid. I don't  
4 think there is any validity. I think we will  
5 vote it down on validity if we were ever to vote  
6 on it. I think, at a minimum, what we need to do  
7 now is ask for the developer to reprocess the  
8 application as a process measure, consider it --  
9 pardon me?

10 DR. BURSTIN: Do a 511 analysis.

11 CO-CHAIR SUSMAN: Find the level of  
12 analysis, send it back to our comment meeting.

13 I still doubt very much whether it  
14 will pass because I think of the validity issue,  
15 but we'll see. We will have an opportunity.

16 CO-CHAIR BROOKEY: They have the other  
17 -- we can provide feedback to the developer, not  
18 only to redo the evidence review but to give them  
19 feedback that we don't think it is going to pass  
20 validity so you may want to think differently  
21 about how you are going to propose this measure.

22 CO-CHAIR SUSMAN: And moreover, it

1 applies to, I think, probably all the measures.  
2 If the unit of analysis is under question and we  
3 can't really determine that or need  
4 clarification, and if the process versus outcome  
5 measure issue, we're just going to be churning  
6 and not really accomplishing --

7 CO-CHAIR BROOKEY: It's not a good use  
8 of time.

9 Okay, Jill.

10 MEMBER MORROW-GORTON: I think the  
11 other thing we have to think about is, if this is  
12 in fact paralleled Bright Futures, Bright Futures  
13 does not say you should do 16 things at a visit.  
14 But the assumption in terms of the how do you  
15 improve your -- you know, it's an all or nothing;  
16 you had to have met the 16 and are we giving the  
17 wrong message to physicians -- if in fact we  
18 would say that you could measure an individual  
19 physician or a practice, are we giving them the  
20 wrong message that based on a single visit but  
21 using all the time that happened before, we  
22 should expect that all of those boxes would be

1 checked.

2 CO-CHAIR BROOKEY: So, we've been  
3 given the signal that the court will now recess  
4 for five minutes. So you can all stretch while  
5 we huddle in the corner. Okay?

6 (Whereupon, the above-entitled matter  
7 went off the record at 3:52 p.m. and resumed at  
8 4:01 p.m.)

9 CO-CHAIR BROOKEY: Okay, the court is  
10 back in session.

11 CO-CHAIR SUSMAN: Hear ye, hear ye,  
12 the Honorable John Brookey.

13 CO-CHAIR BROOKEY: We have a plan.

14 CO-CHAIR SUSMAN: It may not be a good  
15 plan but there is a plan.

16 CO-CHAIR BROOKEY: Is everyone pretty  
17 clear on what the issues are? Okay.

18 So we need to go back and revote --  
19 well, let me just ask for a show of hands. How  
20 many feel like it is appropriate to revote on  
21 evidence? Okay. Does anyone disagree with that?  
22 Okay.

1           We think, at this point, the way that  
2       it has been presented, it's not different than  
3       other measures that we've had that moving forward  
4       probably should turn into process measures. But  
5       in all fairness, they were asked to present it  
6       this way. And so we are going to vote on this  
7       measure as a self-reported outcome measure, which  
8       means that all the conversation we had earlier is  
9       still in play but we have new knowledge that this  
10      is not actionable at the individual practitioner  
11      level if the patient saw multiple providers.

12           So when we said this had an action as  
13      a result of the measure, we were all thinking  
14      that it was based on one visit, one provider and  
15      now we know that that is not true. So that may,  
16      in your mind, change the strength of the evidence  
17      for this measure.

18           Amy.

19           MEMBER HOUTROW: We are still in the  
20      green bar, which is that this measure -- there's  
21      a relationship between this measure and one  
22      actionable healthcare action: structure, process

1 intervention, or service, right?

2 CO-CHAIR BROOKEY: That's correct, but  
3 just to restate it, we were initially thinking  
4 that this would be -- I'm just going to  
5 paraphrase it -- this would be -- and I get  
6 these. If you're a practitioner, you get report  
7 cards. You get satisfaction report cards. We  
8 are used to this. We get feedback and we assume  
9 that feedback is attributable to me. And then we  
10 found out that it's not attributable to me, so I  
11 may not be able to use this data because I don't  
12 know if I'm the one who didn't give them the  
13 advice or not. So I think that's why we are  
14 revisiting this as an evidence measure.

15 MEMBER KELLER: I hear that, and I  
16 just wanted to make sure that we all understood  
17 that there's actually a number of outcome  
18 measures that are not rigged to look at the  
19 individual visit and look at the care provided by  
20 the system, even though they attribute that  
21 questionnaire to individual providers.

22 CO-CHAIR BROOKEY: That's correct and

1 that was mentioned earlier. It could just be at  
2 a state level. Could it be at a plan level?  
3 There's all different kinds of questions.

4 MEMBER KELLER: No, no, no. These are  
5 used at the -- so, within NCQA, one of the  
6 criteria for being a patient-centered medical  
7 home is that you regularly survey your patients  
8 and they give you extra points if you use the  
9 CAHPS survey.

10 The CAHPS PCMH survey, the questions  
11 are all about the care you have received in the  
12 last year, both the child and the adult, and they  
13 say by your regular doctor or another health  
14 provider. So the assumption there in that  
15 construct is that, as primary care provider who  
16 has a patient attributed to them, you are  
17 responsible for the totality of the care even if  
18 you don't directly deliver that care, and you are  
19 supposed to identify gaps that other people may  
20 have left out.

21 And we can think about whether that's  
22 right. I mean, that's actually, in that

1       construct of a patient-centered medical home, I  
2       don't think that that's wrong. I actually would  
3       argue that that's the right way to ask those  
4       questions.

5                   CO-CHAIR BROOKEY: So I thought CAHPS  
6       had a plan level.

7                   MEMBER KELLER: There is a CAHPS PCMH  
8       survey.

9                   CO-CHAIR BROOKEY: Okay, I wasn't  
10      aware of that.

11                  MEMBER KELLER: There's an individual  
12      provider level as well.

13                  DR. BURSTIN: But PCMH is not  
14      individual clinician. It's to the medical home,  
15      which I think would be different.

16                  MEMBER KELLER: It's to the medical  
17      home but in many constructs that is -- in  
18      Colorado, sometimes that's an individual  
19      physician because, you know, we still have solo  
20      practitioners.

21                  CO-CHAIR BROOKEY: So that's a good  
22      distinction.



1                   MEMBER STANLEY: But the CAHPS survey  
2 also requires 12 months of continuous enrollment.

3                   MEMBER KELLER: Correct, yeah, they're  
4 looking at your care over the last 12 months.

5                   CO-CHAIR BROOKEY: So this particular  
6 measure was presented to us as a measure at the  
7 individual provider level and it was presented to  
8 us as an outcome measure that would lead to some  
9 action, presumably by that individual provider  
10 believing this report is a reflection of the way  
11 they communicated with the parent.

12                   So I propose that we revote, based on  
13 the new information, that we revote on the  
14 evidence as written.

15                   Are there any other questions or  
16 concerns before we revote? On the phone?

17                   Okay, we all know what we are voting  
18 for, right? Okay, so let's open it up.

19                   MS. JUNG: Okay, voting for Measure  
20 3219 for evidence is now open. Option 1, pass;  
21 option 2, not pass.

22                   CO-CHAIR BROOKEY: I can see where

1 your thumbs are.

2 MS. JUNG: Okay, voting is closed. So  
3 we have the results are 36 percent for pass with  
4 8 votes; 64 percent for not pass with 14 votes.

5 CO-CHAIR BROOKEY: Okay.

6 MS. JUNG: And with that, we do not  
7 pass.

8 CO-CHAIR BROOKEY: So the question is,  
9 I believe that all five of these measures have  
10 the same situation, is that not true?

11 Go ahead.

12 MEMBER FINKELSTEIN: So just a  
13 clarifying question, because I was assigned one  
14 of the other measures.

15 The next measure is, "were you asked  
16 if you had any concerns." And that is  
17 appropriately for the last visit. It's only  
18 about what happened in the last visit. It's a  
19 very narrow measure. It's at the last visit were  
20 you asked if you had concerns.

21 CO-CHAIR BROOKEY: So, let's just go  
22 to the next measure, then, and if there are

1 differences in that, then we will call them out  
2 and we can move forward.

3 Okay, so this measure did not pass so  
4 we are going now -- to is it 3220? Is that  
5 right?

6 DR. SOLLOWAY: You know, I could just  
7 say that I'm looking at this survey and asking  
8 about parental concerns, family assessment for  
9 behavioral health and safety, and family  
10 assessment for psychosocial screening, they all  
11 ask in the last 12 months did your child's  
12 doctors or other healthcare providers ask you.  
13 So it's the same issue for all of them, except, I  
14 think, family-centered care.

15 CO-CHAIR BROOKEY: Is that Lauren  
16 speaking? Who is that speaking?

17 DR. SOLLOWAY: Oh, I'm sorry. This is  
18 Michelle Solloway speaking, the developer.

19 CO-CHAIR BROOKEY: Oh, okay.

20 MEMBER FINKELSTEIN: So I just want to  
21 follow the logic here. Ask about parental  
22 concerns is something that should happen, I would

1       argue, at every well-child visit. This is going  
2       out after a well-child visit.

3               So, if I'm sending it out because I  
4       did a well-child visit and then it goes to a  
5       family, they should be -- if asked the question  
6       "has anyone asked if you had concerns in the last  
7       12 months," if I don't get a yes on that  
8       question, that's a ding on me because I should be  
9       asking it -- because it should be asked at every  
10      well visit, it's different than "over the  
11      lifetime of your child has anyone asked you about  
12      blah, blah, blah."

13              CO-CHAIR BROOKEY: But if the answer  
14      is yes, it may not have been about you.

15              MEMBER FINKELSTEIN: Yes, I guess  
16      that's true.

17              CO-CHAIR BROOKEY: So is it  
18      actionable? So I don't see this as any  
19      different, personally.

20              So I'll just go around the room. Does  
21      anyone see this as different?

22              DR. SOLLOWAY: Can I just ask a

1 question about this? Because I think what the  
2 person who was just speaking is really asking  
3 that it sort of doesn't matter if it was, you  
4 know, someone else or not you; if you weren't  
5 asked about it, it is a problem.

6 CO-CHAIR BROOKEY: Correct.

7 DR. SOLLOWAY: And you should have  
8 been asking about it as a provider. So it still  
9 gives the information that you should have asked.

10 CO-CHAIR BROOKEY: Well, no, because  
11 if they answered yes and it wasn't about you,  
12 then it has nothing to do with your practice.

13 MEMBER FINKELSTEIN: I have to say,  
14 that's going to happen very rarely.

15 CO-CHAIR BROOKEY: Well, I know but --

16 MEMBER FINKELSTEIN: So there's some  
17 noise in the measure.

18 CO-CHAIR BROOKEY: You understand the  
19 logic.

20 MEMBER FINKELSTEIN: I understand the  
21 logic, but that's a rare event. So we're  
22 focusing on a problem now that that's only a

1 problem if the child was seeing someone else and  
2 recently came to my practice. And I agree,  
3 that's a problem, a serious problem. But it's a  
4 minority. If I did this on 30 kids, that would  
5 be a small minority of the kids.

6 CO-CHAIR BROOKEY: Okay, Ricardo.

7 MEMBER QUINONEZ: Yeah, I agree with  
8 you that the attribution problem is going to be  
9 the same for all. But isn't whether this is an  
10 outcome or a process measure going to be a  
11 problem for all, as well?

12 CO-CHAIR BROOKEY: Well, I think the  
13 question is -- so if we have them go back and  
14 rewrite this whole thing as a process measure, if  
15 the questions are the same, are we going to have  
16 questions with validity?

17 So I mean how far are we going to go  
18 down the road? We need to follow the process.  
19 So the process is we have to vote on evidence  
20 first. But as presented, and not just this  
21 measure, but other measures --

22 MEMBER QUINONEZ: But the evidence

1 level that we vote on is very different if it is  
2 an outcome or a process measure.

3 CO-CHAIR BROOKEY: That's correct.

4 MEMBER QUINONEZ: And we don't have  
5 the information. We are not going to --

6 CO-CHAIR BROOKEY: We don't have the  
7 information. So we had to make a decision as to  
8 whether -- because we are singling out this one  
9 but there have been others that we have gone  
10 ahead and voted on as an outcome measure, right?

11 DR. NISHIMI: Correct.

12 CO-CHAIR BROOKEY: So kind of changing  
13 the rules on the fly is probably not the best  
14 process for NQF. I think that the staff has  
15 gotten feedback and likely, there will be some  
16 changes. Probably not doing it in the middle of  
17 a meeting -- that is probably not appropriate.

18 So the proposal was to go ahead and  
19 vote for it as an outcome measure. And I am  
20 asking the question now is this problem any  
21 different with this particular measure or is it  
22 the same?

1 DR. NISHIMI: Can I have a show of  
2 hands of anyone who does not think it is the  
3 same?

4 MEMBER HOUTROW: Thinks it is  
5 different.

6 DR. NISHIMI: Thinks it is different.  
7 Thank you.

8 MEMBER HOUTROW: In the last 12  
9 months.

10 CO-CHAIR BROOKEY: David.

11 MEMBER KELLER: So again, the issue,  
12 if we are going to move this to a process  
13 measure, then you are right and anything I am  
14 going to say makes no difference.

15 If the issue, though, is whether there  
16 is evidence that this measure, as currently  
17 constituted, is changeable by an individual  
18 provider, I would argue that there is and it was  
19 presented to us. It makes -- even if somebody  
20 answered this question no: In the last year have  
21 any of your providers not attended to your needs?  
22 And I take special efforts in my practice to make



1       sure that I ask about the needs at every visit.  
2       Over time, that answer is going to change. We  
3       will have changed that outcome, even though I  
4       can't change what happened with another provider.

5               If it is an issue that they are going  
6       to see multiple providers within my practice, I  
7       can undertake a standardization effort to  
8       standardize that question so that it is always  
9       asked every time they walk into our office. And  
10      that will move that metric. It won't move it to  
11      100 percent but it will move the metric.

12             So I mean, again, I am sort of with  
13      John on this. I think this is different than the  
14      questions that are specific to the 15-month-old  
15      visit that I am not going to be able change those  
16      because by the time they come in for the next  
17      one, they are going to be asked a different set  
18      of questions. And whether I can change the  
19      15-month one or not is a different.

20             CO-CHAIR BROOKEY: Rajiv.

21             MEMBER MODAK: So I just was looking  
22      at the questions also. And I want to just point

1 out that it also says in the last 12 months did  
2 your child's doctor, or other health provider,  
3 including a nurse, ask if you have any concerns  
4 about your child's learning or development. So  
5 that is different also. That is no longer  
6 provider. You could -- okay.

7 MEMBER DORSEY: I think they phrase it  
8 that way because we fracture the way that we  
9 address these issues in clinical practice. Some  
10 of us have child life specialists who help the  
11 parents fill out development surveys, right? I  
12 think that is meant to bow to the structure of  
13 the way primary care is delivered differently in  
14 different settings. I don't think it is about --  
15 they are not really asking that an emergency  
16 doctor to do that.

17 I think we might feel better about  
18 this if we saw some data element validity. That  
19 came up in the earlier discussion of the previous  
20 measure that if we could see this checked against  
21 what actually happened in the practice so that we  
22 were confident parents weren't going back to a

1 visit they had, a WIC visit four months ago and  
2 that was what was populating the answer. I think  
3 we would feel better about the way it was phrased  
4 but I don't think we have all that information  
5 from the developer about all the testing that was  
6 done during the development of this survey.

7 So I think some of that is you know  
8 just a lack -- we just don't have that in front  
9 of us.

10 CO-CHAIR BROOKEY: Jill.

11 MEMBER MORROW-GORTON: But I do think  
12 that the wording that says or other healthcare  
13 providers, such as a nurse, confounds the this  
14 may not just be one practice. And it broadens  
15 that question to it could be the WIC nurse. It  
16 could be the school nurse. It could be -- you  
17 know it then takes it out of are we just  
18 measuring what is happening within a practice.

19 DR. NISHIMI: Excuse me. Can I ask  
20 what question you are seeing that on the thing  
21 about a nurse? Because I don't see it on the  
22 version of the survey that I have. So could you

1 direct me to where you are seeing that, please?

2 I see doctors or other healthcare  
3 providers but I don't see including a nurse.

4 MEMBER MODAK: I'm looking at the NCF  
5 Quality Measure ask about and address parental  
6 concerns Data Dictionary.

7 MEMBER FINKELSTEIN: So the two things  
8 are he is looking at the Data Dictionary --

9 DR. NISHIMI: Oh.

10 MEMBER FINKELSTEIN: And I am looking  
11 at the screen shots that are on page 32 of the  
12 attachment.

13 DR. NISHIMI: Okay, thank you. Yes,  
14 our tool doesn't have nurses in there.

15 CO-CHAIR BROOKEY: Oh, ok. Amy.

16 MEMBER HOUTROW: So I mean I just want  
17 to bring us back. This is not being changed to a  
18 process measure. It is staying as an outcome  
19 measure, for which the criteria to judge evidence  
20 is not a lot of criteria. We just have to say  
21 yes or no, do we think that an answer to this  
22 survey has something that is actionable at any

1 sort of level in the healthcare system. It  
2 doesn't even need to be the personal provider,  
3 really and certainly it is.

4 If no one is doing anticipatory  
5 guidance on a kid and they are in your practice,  
6 well then start doing some anticipatory guidance.  
7 I mean it is actionable.

8 And I feel like if we don't change --  
9 this is not moving to a process measure. I think  
10 we have to respect the fact that we have to vote  
11 on it as an outcome measure.

12 CO-CHAIR BROOKEY: So I don't know if  
13 there is anything new that can be said about  
14 this. I think we all understand exactly what we  
15 are talking about but this is an individual  
16 provider report card. So I just want to keep on  
17 saying that. This is going back as an individual  
18 --- they are going to open it up and look at this  
19 and think it reflects their care.

20 So unless there is something new, I  
21 would suggest that we vote on evidence, unless  
22 anybody disagrees with that.

1                   Okay, for number 2 -- 3220.

2                   MS. JUNG: This is for Measure 3220,  
3                   so that would be the second question in the set  
4                   of five or second measure.

5                   Okay, so voting for Measure 3220 for  
6                   evidence is now open. Option 1, pass; option 2,  
7                   not pass.

8                   Okay, voting is now closed. The  
9                   results are 45 percent for pass with 10 votes; 55  
10                  percent not pass with 12 votes. And with that,  
11                  consensus has not been reached.

12                  CO-CHAIR BROOKEY: So we move forward?

13                  MS. JUNG: We do.

14                  CO-CHAIR BROOKEY: Okay.

15                  So now let's talk about gap. And I  
16                  have lost track of who are the discussants. Is  
17                  it Lauren or it is Deborah?

18                  MEMBER AGORATUS: It's me. It's  
19                  Lauren.

20                  CO-CHAIR BROOKEY: Okay.

21                  MEMBER AGORATUS: So under the gap, it  
22                  is noted that, again the top five providers had

1 the range of 64.9 to 92.3 percent. Then they  
2 looked at the Kaiser study and it said  
3 approximately half, 53.3 percent of parents  
4 reported that they were asked whether or not  
5 there were any concerns. Disparities were race  
6 and ethnicity. And the level for risk for  
7 at-risk for developmental, behavioral, social  
8 delays and another study showed age and birth  
9 order as having an effect.

10 Let me just look here. I thought it  
11 was a little vague and I noticed some of the  
12 other folks also commented on this that you need  
13 to clarify this not just concerns but specific to  
14 learning development and behavior and that there  
15 also needs to be a response. So I think asking  
16 is one thing. What is the response or what  
17 resources are the parents being given after they  
18 are being asked this.

19 And that's it. That's all I have.

20 CO-CHAIR BROOKEY: Debbie.

21 MEMBER FATTORI: I think my only  
22 question goes back to the language issue. So

1       there was a disparity noted between Hispanics but  
2       I am curious to know how we can validate that or  
3       verify that if the survey isn't going out in  
4       Spanish.

5                   CO-CHAIR BROOKEY:   So is that -- that  
6       is sort of a question mark for a gap.

7                   MEMBER FATTORI:   Yes.

8                   CO-CHAIR BROOKEY:   That is also a  
9       question mark for validity, right?

10                  MEMBER FATTORI:   Right.

11                  CO-CHAIR BROOKEY:   Ok.

12                  MEMBER FATTORI:   Well, it could be  
13       both but for this segment of the conversation,  
14       the developer has listed this as a gap.  However,  
15       I am not quite sure how you can tell.

16                  CO-CHAIR BROOKEY:   I'm going to go  
17       ahead and let the floor make comments and then I  
18       will go around.

19                  So, John, I think you are next.

20                  MEMBER FINKELSTEIN:  I don't think I  
21       have anything to add.  I think they demonstrated  
22       some gap.



1 CO-CHAIR BROOKEY: Okay. And then  
2 Jeff?

3 CO-CHAIR SUSMAN: Gap.

4 CO-CHAIR BROOKEY: Okay. David?

5 MEMBER KELLER: I was just going to  
6 say that it is likely that a large number of  
7 Latino or Hispanic folks speak English. So you  
8 can, at least in our surveys, we often are able  
9 to identify a Hispanic population that is English  
10 speaking. I agree that it would be better to  
11 have also data on the Spanish-speaking Latino  
12 population but it is not essential.

13 MEMBER FATTORI: Agreed. We can't  
14 make that determination. That should be -- the  
15 survey they get should be based on their primary  
16 language, not necessarily race.

17 CO-CHAIR BROOKEY: Their preferred  
18 language, yes.

19 Any other questions about gap or  
20 should we vote on gap? Jill, I'm sorry.

21 MEMBER MORROW-GORTON: I just wanted  
22 to clarify that I read this right that this was

1 done, the gap was done only on five providers.  
2 Just the top five. Is that correct?

3 MEMBER FATTORI: It was the Kaiser  
4 Permanente Northwest study as well.

5 MEMBER MORROW-GORTON: Yes, well the  
6 Kaiser Permanente study just has one number.

7 MEMBER FATTORI: Right in that study  
8 about half didn't get it.

9 MEMBER MORROW-GORTON: Right.

10 CO-CHAIR BROOKEY: Okay, vote on gap.

11 MS. JUNG: Okay, the voting for  
12 Measure 3220 for performance gap is now open.  
13 Option 1, high; option 2, moderate; option 3,  
14 low; and option 4, insufficient.

15 Okay, voting is now closed. The  
16 results are 5 percent for high with one vote; 82  
17 percent for moderate with 18 votes; 14 percent  
18 for low with 3 votes; and zero percent for  
19 insufficient with zero votes.

20 And with that 82 percent for moderate,  
21 the performance gap passes.

22 CO-CHAIR BROOKEY: Okay, so let's go

1 to reliability. Is that Lauren or Debbie?

2 MEMBER AGORATUS: Yes, it's Lauren and  
3 I have under the specifications just a little  
4 reminder that the developer stated the missing  
5 data about the asked parental concerns questions  
6 were excluded from analysis but that NQF did not  
7 consider this as an exclusion.

8 Also under the reliability testing,  
9 the developer mentioned there were three  
10 different patient-centered strategies used. They  
11 did not report on the data element, the item  
12 level reliability. They did assess the  
13 difference between measured objects and  
14 inter-unit reliability. The ICC was 0.78, where  
15 0.74 is considered excellent.

16 And I think -- well, am I supposed to  
17 stop there or are we supposed to do all of  
18 validity? I'm sorry, I'm losing track of where  
19 we are.

20 CO-CHAIR BROOKEY: Reliability.

21 MEMBER AGORATUS: I'm sorry. Done.

22 Okay.

1 CO-CHAIR BROOKEY: Okay, Debbie.

2 MEMBER FATTORI: No, my comments were  
3 the same as Lauren's.

4 CO-CHAIR BROOKEY: Okay.

5 MEMBER FATTORI: I had nothing new to  
6 add.

7 CO-CHAIR BROOKEY: John.

8 MEMBER FINKELSTEIN: Just quickly, I  
9 think this goes under reliability. I understand  
10 they provided psychometric data but I think test/  
11 retest reliability in this case means it gets  
12 back to the concern raised earlier about the  
13 recall period. So if you send this out two days  
14 after the visit, after the index visit, I believe  
15 you will get different results than if you send  
16 it out three months after the visit. And since  
17 there is no limit on the time after the visit,  
18 you can send it out. I think that is a  
19 significant problem in reliability.

20 CO-CHAIR BROOKEY: So just to clarify,  
21 developer, what time period do we have? Is it  
22 unlimited or is there a three month, six month

1 window?

2 DR. SOLLOWAY: Well, we don't have  
3 control over when the providers send it out. It  
4 is sent out at their convenience. They decide  
5 when they are going to do that. That said, the  
6 studies that we did do were sent closely after  
7 the visit. So, it wasn't like -- I don't think  
8 it was a three-month time period. It was  
9 probably sent within a week or two. I don't know  
10 the exact time frame.

11 Naraa, do you know what the exact time  
12 frame might have been on that?

13 CO-CHAIR BROOKEY: But it sounds like  
14 there is no control over it.

15 DR. SOLLOWAY: Right.

16 CO-CHAIR BROOKEY: Probably most  
17 people will send it out soon.

18 MEMBER FINKELSTEIN: Right but the  
19 point is if this is for accountability and there  
20 is no control over when it gets out, I think  
21 there is a reliability problem.

22 CO-CHAIR BROOKEY: Okay, Jeff.

1 CO-CHAIR SUSMAN: Nothing to add.

2 CO-CHAIR BROOKEY: Open it up for  
3 committee.

4 So we are voting on reliability.

5 MS. JUNG: The voting for Measure 3220  
6 for reliability is now open. Option 1, high;  
7 option 2, moderate; option 3, low; and option 4,  
8 insufficient.

9 Voting is now closed. The results are  
10 zero percent for high with zero votes; 32 percent  
11 for moderate with 7 votes; 59 percent for low  
12 with 13 votes; and 9 percent for insufficient  
13 with 2 votes.

14 And with that, consensus has not been  
15 reached for reliability.

16 CO-CHAIR BROOKEY: So we do not move  
17 --

18 MS. JUNG: Oh, apologies. Yes,  
19 correct, it fails.

20 CO-CHAIR BROOKEY: We do not move  
21 forward.

22 Okay, 3221, Family Centered Care. And

1 I will just briefly ask the developer to mention  
2 if there is, in terms of the instrument as well  
3 as the evidence, are there differences with this  
4 measure compared to the previous two?

5 DR. SOLLOWAY: No, this asks in the  
6 last 12 months did your child's doctors or other  
7 healthcare providers and then there are seven  
8 items: take time to understand your needs,  
9 listen carefully, show respect, et cetera. So it  
10 is still asking about you and other providers.

11 CO-CHAIR BROOKEY: Where is Kraig?  
12 Oh, Kraig isn't here, is he? Oh, there's Kraig.  
13 Kraig, you are the primary discussant, right?

14 PARTICIPANT: No, I think it is Carol.  
15 Carol Stanley.

16 CO-CHAIR BROOKEY: I'm sorry. I'm  
17 looking on the wrong page.

18 MEMBER STANLEY: Yes, it's me.

19 CO-CHAIR BROOKEY: Carol, it is you.

20 MEMBER STANLEY: Yes, it's me.

21 CO-CHAIR BROOKEY: I believe that I am  
22 looking at the wrong, literally looking at the

1 wrong page. Okay, Carol.

2 MEMBER STANLEY: Yes, the comments  
3 that came up were identical to the issues we have  
4 raised regarding attribution to a single  
5 provider. And you know the same limitations are  
6 there.

7 CO-CHAIR BROOKEY: Okay, there was  
8 some distinction between the first measure and  
9 the second measure, some minor distinction.

10 MEMBER STANLEY: Right.

11 CO-CHAIR BROOKEY: What is your  
12 assessment of this third measure?

13 MEMBER STANLEY: I mean it has a  
14 12-month look back period when it goes to the  
15 parent and it seems very similar to the first  
16 question that we addressed.

17 This talks about whether the  
18 healthcare provider understands specific needs of  
19 the child and concerns of the parent, if the  
20 provider has helped build confidence in the  
21 parent, things are explained in a way that the  
22 parent can understand and if the provider shows



1       respect for a family's values, customs, and how  
2       they prefer to raise their child.

3                   CO-CHAIR BROOKEY:   Okay.   All right,  
4       I'm sorry, is it Tarra or Tara?

5                   MEMBER BRISTOL-ROUSE:   It's Tara.

6                   CO-CHAIR BROOKEY:   Tara, okay.

7                   MEMBER BRISTOL-ROUSE:   But I will  
8       answer to either, especially at this point in the  
9       day.

10                   You know I echo what Carol said. I  
11       think an additional concern for me is calling  
12       this kind of family centered care because family  
13       centered care is an approach to care.   So, it  
14       includes a lot more than is even represented in  
15       these five or seven items.

16                   And additionally, I think this maybe  
17       even more so than the other ones that we had  
18       issues with getting this and not knowing if it  
19       was specific to you as a provider will be very  
20       difficult to address for improvement.

21                   CO-CHAIR BROOKEY:   Okay, good  
22       comments.

1                   Let's see, we also had Jill on the  
2 group. I'm sorry.

3                   MEMBER STANLEY: And this is another,  
4 you have to answer at least four of the questions  
5 out of the seven, the seven areas it addresses.

6                   MEMBER MORROW-GORTON: Yes, and I was  
7 going to say that having seven areas and having  
8 them sort of they are not -- I mean they are sort  
9 of all in the same ballpark. I think it would be  
10 -- it might be difficult for people to answer  
11 them and there is seven. And then what do you do  
12 with -- you know do you get them as each  
13 individual one? Is that helpful? And how do you  
14 actually use that information.

15                  CO-CHAIR BROOKEY: Right but you may  
16 not get the item level result.

17                  MEMBER STANLEY: And the developer  
18 specifically says in here that there was no  
19 improvement among providers who participated in  
20 the study with these questions over time.

21                  CO-CHAIR BROOKEY: I don't have any  
22 additional comments. Amy, are you in this group,

1 too?

2 MEMBER HOUTROW: No, I was just going  
3 to make the point that in fact the family center  
4 care measures are conceptually very similar to  
5 the ask about parental concerns, which is a part  
6 of family centered care. So it is the same  
7 discussion that we would have for this set would  
8 be appropriate for the discussion that we just  
9 had on the previous one.

10 CO-CHAIR BROOKEY: Any other comments?

11 MEMBER AGORATUS: This is Lauren. I  
12 just have one clarifying question. On all of  
13 these, and I know we didn't get this far, but on  
14 all of these they discussed there was no  
15 automated reporting system and there was supposed  
16 to be a website launch in February 2017. Do we  
17 know if that happened?

18 DR. SOLLOWAY: It did not. We got a  
19 little bit delayed but it will happen this month.

20 MEMBER AGORATUS: Okay.

21 CO-CHAIR BROOKEY: All right.

22 DR. SOLLOWAY: The way -- okay.

1 CO-CHAIR BROOKEY: Any other questions  
2 or comments from the group?

3 Okay, so we will vote on the evidence  
4 as an outcome measure for 3221.

5 MS. JUNG: Okay, voting for Measure  
6 3221 for evidence is now open. Option 1, pass;  
7 option 2, not pass.

8 We're looking for one more vote. Did  
9 anyone step out? Oh, there we go.

10 Voting is closed. We have the results  
11 are 27 percent for pass with 6 votes and 73  
12 percent for not pass with 16 votes. And with  
13 that, the measure does not pass for evidence.

14 CO-CHAIR BROOKEY: So, I am going to  
15 preface this by saying that I don't want to rush  
16 through this. If we can't finish on time, we  
17 will finish on the phone call because I want to  
18 be sure that we get everyone's input and not just  
19 kind of try to get this done by 5:00. And if  
20 people need to leave and we don't have quorum, we  
21 will conclude early.

22 So having said that, this is a similar

1       measure. And Kraig, I think you are primary  
2       discussant on this one.

3               MEMBER KNUDSEN: All right. So this  
4       is Measure 3222: Assessment of Family Alcohol  
5       Use, Substance Abuse, and Safety.

6               In terms of evidence, again, this is  
7       the same issues that we have experienced with the  
8       other ones. This measure will evaluate the  
9       proportion of kids whose parents report being  
10      assessed for three items, alcohol use, substance  
11      abuse, and fire arms in the home. It can be used  
12      by providers to determine the level at which they  
13      discuss these issues with the parents.

14              The developer provided a logic model  
15      with all of the measures, the same thing, which  
16      connects the outcomes to provider behavior in  
17      terms of quality improvement.

18              In terms of this one, the developer  
19      indicated that the American Academy of Pediatrics  
20      and Child Health Bureau Bright Futures Guidelines  
21      include assessment of alcohol and drug use, the  
22      presence of guns, family violence, and other

1 safety issues in the family.

2 So, that's what they said.

3 CO-CHAIR BROOKEY: And your  
4 assessment, based on previous conversations, does  
5 this relate to this measure as well?

6 MEMBER KNUDSEN: Yes, it does.

7 CO-CHAIR BROOKEY: Okay.

8 MEMBER KNUDSEN: I believe it does.

9 CO-CHAIR BROOKEY: Okay. Let's see,  
10 Karen, I think you are the --

11 MEMBER DORSEY: I agree, it is the  
12 same.

13 CO-CHAIR BROOKEY: Okay, very good.  
14 And I agree. No more comments from me.

15 Any other comments from the group or  
16 on the phone? David.

17 MEMBER KELLER: One question for the  
18 provider or for the developers. I was wondering  
19 why you split this from the next measure that we  
20 are about to talk about, which is also about  
21 family well-being. It would seem to me that we  
22 actually ask these questions routinely as part of

1 a screener that we have but we have it all lumped  
2 together as a single thing because we are asking  
3 about home safety and basically how the parents  
4 are doing.

5 CO-CHAIR BROOKEY: Yes, developer, any  
6 rationale why these were split, 3222 and 3223?

7 DR. SOLLOWAY: I don't know what that  
8 is. I know there was one but I don't know what  
9 that is. I can't really speak to it.

10 Naraa, do you know if there is any  
11 rationale?

12 DR. GOMBOJAV: No.

13 DR. SOLLOWAY: It may have just been  
14 specific content. You know one is really about  
15 psychosocial screening and emotional well-being  
16 versus something outside of that.

17 CO-CHAIR BROOKEY: Okay, that's fair  
18 enough.

19 Okay, any other comments about the  
20 evidence on this particular measure? Any  
21 objection to moving to vote?

22 Okay.

1 MS. JUNG: Voting for Measure 3222 is  
2 now open for evidence. Option 1, pass; option 2,  
3 not pass.

4 Again, looking for one more vote. Do  
5 we have everyone in the room? There we go.

6 Voting is now closed. The results are  
7 32 percent for pass with 7 votes; 68 percent for  
8 not pass with 15 votes. And for that, it does  
9 not pass on evidence.

10 CO-CHAIR BROOKEY: Okay, thank you.

11 Why don't we go ahead and start 3223?  
12 If we can't finish, we will do it on the phone  
13 call but I suggest we go ahead.

14 I believe, David, you are -- are you  
15 able to stay for a few minutes?

16 MEMBER KELLER: Yes, no, I'm here.  
17 I'm tracking. I have got Google Maps set and I'm  
18 tracking how long it will take me to get to  
19 Dulles for my 7:00 plane and I can still make it.

20 CO-CHAIR BROOKEY: I should have put  
21 you out of order but go ahead.

22 MEMBER KELLER: I enjoy living close



1 to the edge. What can I say? To my wife's  
2 eternal regret, but still.

3 And actually this, given the last  
4 vote, I think this will take very little time  
5 because really this is the same. It is, as I  
6 said in my question, it is a parsing of similar  
7 questions that were aimed at family -- at  
8 parental well-being. We think they are important  
9 questions for assessing the environment in which  
10 a child is being raised. And they are part of  
11 Bright Futures. They are endorsed by the Academy  
12 of Pediatrics, as well as HERSA in its Bright  
13 Futures Manual.

14 And basically, but in the same way  
15 they ask over the last 12 months has your doctor  
16 or any other provider addressed these issues.

17 And so the evidence presented is  
18 really from the same surveys that we have already  
19 talked about in detail, I think. And I don't  
20 think I have anything else to add -- this really  
21 falls into that same bucket of similar surveys,  
22 the last four that we voted on.

1 CO-CHAIR BROOKEY: Maureen, do you  
2 have comments?

3 MEMBER EDIGER: In the interest of  
4 time, no. I will keep them to myself.

5 MEMBER KELLER: Well, we talked about  
6 this at the break a little bit, too.

7 MEMBER EDIGER: Yes.

8 MEMBER KELLER: Because we are just  
9 starting actually some -- you all know Maureen  
10 she is at our hospital. And we are starting now,  
11 in one of the clinics she goes to, to ask these  
12 questions routinely of every family that comes  
13 in.

14 She hasn't come in since we started  
15 doing that.

16 MEMBER EDIGER: But boy, will I!

17 MEMBER KELLER: I suspect she will  
18 have some feedback for us when she does.

19 MEMBER EDIGER: Yes, I think this is  
20 just -- I will do a plug for parents being  
21 involved in the process because I think the more  
22 that families are involved in the process,

1 families are going to raise their hand and go if  
2 you are doing something like this, what is in it  
3 for me as far as why would I spend 20 minutes on  
4 this if you are giving me a tool that is going to  
5 possibly bring up a lot of emotions.

6 Just having a child with a mental  
7 health diagnosis, if I sit down and I have to  
8 start kind of like regurgitating and telling  
9 somebody about how hard things are at home  
10 sometimes and then I hit send, I am going to be  
11 sitting there pretty emotionally raw. And it is  
12 like and then what.

13 So, that's all.

14 MEMBER KELLER: For the record, we did  
15 have parents involved. We just didn't have you  
16 involved.

17 MEMBER EDIGER: Right.

18 CO-CHAIR BROOKEY: Thanks, Maureen.  
19 Other David.

20 MEMBER EINZIG: I don't have anything.

21 CO-CHAIR BROOKEY: You have nothing to  
22 add? Okay, Karen.

1 MEMBER DORSEY: I have nothing to say.

2 CO-CHAIR BROOKEY: Okay. Any other comments from  
3 the group? You all look a little worn down.

4 PARTICIPANT: Bring us home, John.

5 CO-CHAIR BROOKEY: Yes, I feel kind of  
6 depressed after this whole string of measures we  
7 are not endorsing. But I hope that we field the  
8 process before we vote on the last measure. I  
9 guess after we vote on the last measure we can  
10 take one minute to get feedback about process.

11 So, I think we are ready for a vote,  
12 unless I am hearing any objections.

13 So this is the final measure, 3223.

14 MS. JUNG: Yes, the voting for Measure  
15 3223 for evidence is now open. Option 1, pass;  
16 option 2, not pass.

17 CO-CHAIR BROOKEY: Do we have member  
18 comment at the end?

19 DR. NISHIMI: Yes.

20 CO-CHAIR BROOKEY: Okay.

21 MS. JUNG: Voting is now closed. The  
22 results are 36 percent for pass with 8 votes; 64

1       percent not pass with 14 votes. And with that,  
2       it does not pass on evidence.

3                   CO-CHAIR BROOKEY: Okay, if you need  
4       to go to the airport, we are, at this point,  
5       going to open it up for member comment and then I  
6       would like it if people could stick around for a  
7       couple minutes just to talk about feedback.

8                   So, you are excused.

9                   MEMBER KELLER: Well may I make one  
10      comment --

11                  CO-CHAIR BROOKEY: Absolutely.

12                  MEMBER KELLER: -- as I pack up to  
13      head off to Dulles.

14                  Just I wanted to express my  
15      appreciation for the thoughtfulness of this  
16      committee and I wanted to thank CMMI for  
17      reconvening us and I hope that we continue these  
18      discussions because we really do need measures of  
19      these things and we need to be able to force them  
20      going forward.

21                  So, thanks to everybody for today. I  
22      appreciate your work.

1 PARTICIPANT: Sing it, sister!

2 CO-CHAIR BROOKEY: Thank you, David.

3 MEMBER FINKELSTEIN: John, do you want  
4 to excuse the developer?

5 CO-CHAIR BROOKEY: I'm sorry.

6 MEMBER FINKELSTEIN: Is the developer  
7 still on the line?

8 CO-CHAIR BROOKEY: I'm sorry, the  
9 developer, we are concluding these measurement  
10 discussions. So you can sign off, if you haven't  
11 already.

12 DR. SOLLOWAY: Okay, thank you so  
13 much. I appreciate your feedback and we will  
14 definitely take it and see what we can do. Thank  
15 you.

16 CO-CHAIR BROOKEY: Thank you.

17 Do we have member comments?

18 PARTICIPANT: Public also.

19 CO-CHAIR BROOKEY: Public comments?

20 OPERATOR: If you would like to ask  
21 any public comments, please press \*1. Press \*1  
22 to ask a public comment.

1 And there are no public comments.

2 CO-CHAIR BROOKEY: There are no  
3 comments? Okay.

4 I don't know if it was because I got  
5 up at 3:00 California time or it is just this  
6 meeting but I am kind of spent.

7 So I would like to first just ask for  
8 any feedback about the fairness of the process  
9 today, if there is any concerns about anything.  
10 These meetings are always very interesting. I  
11 just appreciate the group process because if we  
12 didn't have individuals on this group, we  
13 wouldn't have known as much as we know about  
14 these measures now. I don't think individually  
15 any of us are able to figure this all out. It  
16 took the group for us to figure this out. And so  
17 I appreciate everyone's contribution.

18 But let me just throw it back at you.  
19 Thoughts, comments, just for a couple of minutes,  
20 if we could.

21 Oh, John has his --

22 MEMBER FINKELSTEIN: So I would just

1 echo that I thought it was really a great day and  
2 people being thoughtful all around the table.

3 For this last set of measures, which  
4 was kind of an unusual circumstance, I think it  
5 is only fair to feedback to the developers that  
6 if they want to come back as a process measure  
7 with the caveats that -- bottom line is I think  
8 they might get through on evidence as a process  
9 measure but they have real validity problems as  
10 an accountability measure. So I just think there  
11 should be a discussion and counseling with them  
12 and they should be able to come back.

13 CO-CHAIR BROOKEY: So do you think  
14 that if they changed it, perhaps to a process and  
15 maybe changed the level of reporting maybe it  
16 might fly?

17 MEMBER FINKELSTEIN: Right and they  
18 would have to provide all the evidence that is  
19 behind the Bright Futures ---

20 CO-CHAIR BROOKEY: Right.

21 MEMBER FINKELSTEIN: --- elements in  
22 order for us to look at them. Anyway, I just



1 think we should give them a chance.

2 CO-CHAIR BROOKEY: I think they  
3 deserve our feedback and I agree with you. And I  
4 hope that we captured that.

5 Okay. So, Rajiv.

6 MEMBER MODAK: So I just wanted to say  
7 this is my first meeting and I really found it  
8 interesting and valuable and the discussions were  
9 right on.

10 And what I just want to express is  
11 that just even the discussions just gave me a lot  
12 of ideas to take back to my practice and to  
13 implement in my practice. So, I just want to  
14 give you that feedback that you will help my  
15 quality improvement.

16 CO-CHAIR BROOKEY: Alright, Jim.

17 MEMBER BOST: Yes, I think that for  
18 the last set of measures that if a rate is low,  
19 there is something you could do to improve. But  
20 I don't think these rates, with the questions the  
21 way they are written could ever be used for  
22 something like Pay-for-Performance or

1       accountability.

2                   CO-CHAIR BROOKEY:   Yes.   Amy.

3                   MEMBER HOUTROW:   My comment is just in  
4       general about this issue about the level of  
5       evidence that you need for an outcome measure  
6       versus a process measure, which is an NQF issue.

7                   But choosing a patient-reported  
8       outcome as a measure of a process of care is kind  
9       of a backdoor way to not to provide the rigorous  
10      amount of evidence that is required for a process  
11      measure and it makes me just a little bit  
12      uncomfortable.

13                  And then it also makes these  
14      discussions in the room really challenging  
15      because we are cognitively thinking about it in a  
16      way that is different than they are potentially  
17      presented to us.

18                  CO-CHAIR BROOKEY:   Yes, thank you.

19                  Let's go this way.   Debbie.

20                  MEMBER FATTORI:   So I am often accused  
21      of falling on the sword and I am going to do it  
22      now too, again, because I feel like I have some

1 personal accountability in this. Because I think  
2 that these were some of the questions in my head  
3 as I was reviewing this and I am just wondering  
4 if there is something that we can do as  
5 individuals or a team that we are kind of  
6 stopping the line, if you will, before we end up  
7 at this point in time.

8 I don't know if that makes any sense  
9 but I went through the process and some of those  
10 questions are nagging. Maybe I am not experienced  
11 enough in this work but I am just wondering if  
12 there is something that we can do before it gets  
13 to this point because we had this issue I think  
14 with a measure or two last time around.

15 CO-CHAIR BROOKEY: Yes.

16 MEMBER FATTORI: So, that is my only  
17 comment.

18 CO-CHAIR BROOKEY: I think all of us  
19 had the same thought, what could we have done to  
20 have prevented this. And again, I think that  
21 this was a situation that none of us really saw  
22 the huge big picture of what was going on here.

1 But I think it took the group process to figure  
2 that out. Unfortunately it was for five measures.  
3 So that is the unfortunate part.

4 Kerri.

5 MEMBER FEI: Yes, so back to those  
6 five measures, when it comes to putting on my  
7 health plan hat, I suppose, and if you are  
8 talking about use and accountability, what we  
9 also need to see is that I can know for a fact  
10 that an individual provider or a group is  
11 statistically worse, better, or the same as some  
12 type of benchmark. Right?

13 When we use them at the Association,  
14 that is how we look at accountability. The way  
15 it is now, we couldn't -- we would not be able to  
16 do that.

17 So, with always having this need of  
18 the NQF measures should have --- be appropriate  
19 for accountability, the way it is now, they will  
20 need to address that if they want them used for  
21 accountability as well.

22 So you will need to be able to see

1       that statistical significance that you can  
2       discern that, I think, between whether it is  
3       provider or group, or however they decide to do  
4       it, you need to see that back to the insured  
5       coverage measure as well.

6                   I feel bad I think he was a little bit  
7       upset with me.

8                   PARTICIPANT: I think he was upset  
9       with everybody.

10                  MEMBER FEI: And I feel terrible  
11       because that was not my intent. But from our  
12       perspective, I don't know with that chunk that  
13       this state is better --- statistically worse, no  
14       different, or better than the ones next to it.  
15       And that is what I was trying to get at.

16                  CO-CHAIR BROOKEY: From my seat --

17                  MEMBER FEI: I feel bad that he was  
18       mad. That was not my intent.

19                  CO-CHAIR BROOKEY: From my seat, that  
20       was a very unexpected but rich discussion and I  
21       think that he listened to the feedback. So I  
22       think --

1                   MEMBER FEI: Well and again, I think  
2                   it is one of those where maybe that measure isn't  
3                   right for that type of accountability but it  
4                   could be so fruitful and useful from other  
5                   perspectives.

6                   CO-CHAIR BROOKEY: Thank you.  
7                   Jill.

8                   MEMBER MORROW-GORTON: And I actually  
9                   wanted us to think about accountability from a  
10                  broader perspective. Because I think we had a  
11                  number, it wasn't just kind of the last set or  
12                  the last set plus the state measure but we had  
13                  this conversation even this morning in some of  
14                  the measures that were a little more  
15                  straightforward.

16                  Should we be adding accountability, or  
17                  a question about accountability, or does this  
18                  need an accountability criteria or something like  
19                  that as we are thinking about these? They are  
20                  likely to be used for accountability.

21                  CO-CHAIR BROOKEY: Yes.

22                  MEMBER MORROW-GORTON: And if they are

1 not designed for accountability and they can't  
2 distinguish, the people that are sometimes  
3 choosing them don't know that and don't  
4 understand that. And that is a piece of  
5 information that I think would be really helpful.

6 CO-CHAIR BROOKEY: Yes.

7 MEMBER FEI: That's absolutely true  
8 because I am the one that gets tagged with that.  
9 I have folks say to me I want to use this  
10 measure. No, you can't, it is not right for  
11 that. But I want to. But no, you can't. It's  
12 not right. It's not fair. So, not that  
13 everything is fair but they have meaning.

14 MEMBER MORROW-GORTON: Well at least  
15 try to be fair.

16 MEMBER FEI: Well absolutely,  
17 especially if someone is going to tie your money  
18 to it.

19 CO-CHAIR BROOKEY: Karen.

20 MEMBER MORROW-GORTON: Right and that  
21 is the biggest piece of it is tying money to it.

22 CO-CHAIR BROOKEY: Believe me, I would

1 have 9,000 doctors chasing after me if some of  
2 these got out of Kaiser. So, yes.

3 Karen.

4 MEMBER DORSEY: So just I want to  
5 thank you both for your leadership. I thought  
6 this was really as smooth as it could have been  
7 today, given what has already been said about  
8 some of these issues just coming out when we  
9 start to talk in groups. I appreciate that. And  
10 as usual, it was a wonderful experience to  
11 convene with this committee.

12 I think two things jumped out at me  
13 today. One is that I was a little hazy on the  
14 guidance around the reliability -- the  
15 statistical approach to assessing measure  
16 reliability for a couple of these measures. It  
17 came up with more than one of the measures. And  
18 you know I think we have had this experience this  
19 time and the last time where we have a lot of  
20 folks who are coming new to the NQF process, to  
21 the measure endorsement process, they are newly  
22 into measure development. That is just where we



1 are in pediatric measures right now. And I think  
2 the extent that we and NQF staff can really give  
3 people guidance about what we mean by a precision  
4 assessment and how they should approach it, I  
5 think that will be a good service to people.

6 Because I think there were some good  
7 measures that came forward but there were some  
8 questions about the specifics of the testing. So  
9 I think that is one thing that stood out to me.

10 And the other is that there is still  
11 a lot of haze. And I think this speaks to the  
12 last two comments about use and usability issues  
13 around these pediatric measures. They are  
14 attributed at all different levels. We think  
15 about their use in different contexts. We think  
16 about maybe assessment of managed care  
17 organizations, for the enrollment, and we are  
18 thinking about providers for some of these last  
19 measures we discussed. And I think that that  
20 creates a lot of sometimes confusion and issues  
21 for us to work out when we are talking about the  
22 measures around whether we think they are

1       valuable and if they can be used in ways that are  
2       going to be productive.

3               And because it is so complex, I just  
4       sort of long for us to have some structure, some  
5       conceptual structure around it. And I think I am  
6       hearing that from you all, too, around issues of  
7       accountability but it is a very different thing  
8       to think about parent reported survey information  
9       at the provider level and a plan that is going to  
10      be held accountable for how well it keeps  
11      continuity and enrollment. You know they are  
12      just totally different universes. Right? And I  
13      think, hopefully, as a standing committee, we  
14      will start to develop some guidelines around how  
15      we think about it.

16             CO-CHAIR BROOKEY: So, Karen, to your  
17      first point, and I am just going to get shot by  
18      the NQF staff here, but if there was an  
19      opportunity for those who were interested to have  
20      a little tutorial like an hour or two WebEx on  
21      how to interpret some of this stuff, do you think  
22      some folks would be interested in that? I mean

1 just some feedback to the staff.

2 I think your point is really well --  
3 I think the orientation was good but it probably  
4 is not deep enough for some of us. And so I  
5 think that might be helpful.

6 All right, did everyone have a chance?

7 Jeff, go ahead.

8 CO-CHAIR SUSMAN: Well first of all,  
9 let me thank all of you. You have just been  
10 splendid. As usual, I have learned a lot more  
11 from being here. I also want to thank the NQF  
12 staff who worked just incredibly to try to put  
13 these materials together.

14 In response to what I heard around the  
15 table, I do think that the NQF, as an  
16 organization, has to look at this issue of  
17 outcome versus process measures and really get it  
18 down better than we have now. It is difficult  
19 but we shouldn't be resolving these issues at the  
20 time of our meetings. It is not fair to the  
21 people who put a lot of energy and time into the  
22 development.

1                   Secondly, I think it really would be  
2                   very helpful to have some materials that really  
3                   define, as you have suggested, Karen, like  
4                   precision. Here are the three ways that we look  
5                   at this issue. This is what it means and this is  
6                   what we find acceptable. Or at least some  
7                   guidance, recognizing that each panel might have  
8                   certain nuances that need to be brought to bear.

9                   And then finally, the issue which I  
10                  talked to Shantanu is about the idea of  
11                  accountability and having wonderful measures,  
12                  which we all think would help improve health  
13                  within our systems, or within our states, but are  
14                  concerned about accountability. And having a  
15                  more nuanced approach to that issue, so that as  
16                  we vote, as we are trying to make some difficult  
17                  decisions, it is not a black and white situation  
18                  where we are either discarding measures which  
19                  could really help improve individual performance  
20                  or plan performance, what have you, or perhaps  
21                  really should be leading the way and pushing  
22                  people toward greater accountability.

1                   Again, overall, thank you so much. It  
2                   is really a pleasure to work with such smart and  
3                   dedicated people.

4                   CO-CHAIR BROOKEY: Robyn.

5                   DR. NISHIMI: The last word? On  
6                   behalf of NQF, I really want to thank you. Your  
7                   discussions today were spot on. You struggled  
8                   with the issues that I will tell you, having been  
9                   the founding chief operating officer, every  
10                  single committee struggles with these things  
11                  because there are no bright lines or firm  
12                  guidance.

13                  The first project we ever did at NQF  
14                  was the so-called Never Events List. Adverse  
15                  events that should be publicly reported. We  
16                  weren't even talking about payment then.

17                  So, it is the same conversations and  
18                  you shouldn't feel good or bad that you had to  
19                  have them. It is just the way the field is and  
20                  is evolving. So, I did want to mention that.

21                  The same thing with the PRO versus  
22                  PROP, patient reported outcome on a process. We

1 did recognize that this was the committee that  
2 raised this as an issue last year that there is  
3 something about the level of evidence that should  
4 be required for these that is different than a  
5 yes/no.

6 And so some internal processes have  
7 begun to discuss those. They just haven't been  
8 completed. We haven't landed on one place. And  
9 so to be consistent across projects, frankly,  
10 that is why you saw what you saw.

11 But I think we heard it again very  
12 loud and clear it is a struggle and the groups  
13 that are responsible internally for looking at  
14 our algorithm and our criteria and what we  
15 require, we are going to take it back and say it  
16 happened again and I had to sit there and listen  
17 to it again. So let's -- which is not to say that  
18 we shouldn't have or couldn't have moved faster  
19 but, again, it is the whole milieu we have felt  
20 the consistency. And so I did want to let you  
21 know that we had heard you the first time and  
22 there are people absolutely thinking about how

1 best to approach this.

2 And then the last thing I wanted to  
3 just stress because it peaked my interest was the  
4 use and usability. I congratulate you on the  
5 robustness of the discussions that you had  
6 because that is an often sort of set aside, kind  
7 of blow through the criterion discussion but you  
8 were very thoughtful there. And it is a  
9 struggle. And it is especially a struggle  
10 because all these measures, with the exception of  
11 the CAHMI and for them not for purposes of  
12 accountability, and at that level of analysis,  
13 but they haven't been in use. But you raised  
14 really good, thoughtful questions. I think they  
15 were good for the developer to hear and they were  
16 certainly good from the NQF staff point of view  
17 as we think about that whole criterion. So, that  
18 I was especially appreciative of and thank you  
19 for that.

20 That's it from me.

21 CO-CHAIR BROOKEY: So, I will just  
22 echo everything that Jeff said. You know this is

1 the second time that he and I have shared this  
2 meeting together and it is really a privilege to  
3 be able to do this and to interact with all of  
4 you. It is amazing to watch how things sort of  
5 go this way and that way and then back to some  
6 area that you didn't think it was going to go  
7 into. But at the end of the day, I think it is a  
8 good process and it has to be all of you  
9 together, including our parents in the back.  
10 They are sitting way in the back but next year  
11 you can be up here, okay? It is important to  
12 have you in the room and I appreciate that.

13 So, again, thanks, everyone and we are  
14 just going to go through a few points for coming  
15 up agenda items, our time line and then we will  
16 be dismissed.

17 So, go ahead.

18 MS. JUNG: I promise I will be brief.

19 Okay, so upcoming for the time line  
20 for our measures, we just have the comment period  
21 after this, which we will open to the public and  
22 to NQF members. Then we will have the NQF member



1 vote. And then after that, we will have the  
2 Consensus Standards Approval Committee or CSAC  
3 Committee vote for endorsement and that will be  
4 on June 27th. And after that, there will be a  
5 30-day appeals process.

6 Special dates for you to note is there  
7 will be a post-meeting call Friday, March 10th  
8 and that will be from noon to 2:00 p.m. That  
9 should be on your calendars. If any of these  
10 events aren't on those calendars --

11 DR. NISHIMI: Madison, we don't need  
12 to have that one.

13 MS. JUNG: Oh?

14 DR. NISHIMI: We went through all the  
15 measures today.

16 (Off-microphone comment)

17 DR. NISHIMI: Right but you need to get  
18 your comments back in and then you will -- yes.  
19 So we don't expect them to bring it back in the  
20 next week.

21 (Off-microphone comment)

22 DR. NISHIMI: That is correct, Gary,

1 we were much harder on you.

2 CO-CHAIR BROOKEY: So, cancel next  
3 week's meeting.

4 MS. JUNG: Yes, okay. You will also  
5 get a calendar invitation for that. So, congrats.

6 After the comment period, we will have  
7 a post-comment call and that will be Wednesday,  
8 May 31st and that will be from 2:00 to 4:00 p.m.

9 And with that, I just want to say  
10 there is our contact information and the  
11 SharePoint link and the meeting materials will be  
12 posted on the SharePoint for you all to find.

13 And with that, I would just like to  
14 say a huge thank you from the NQF team for your  
15 high level of engagement today. I know it was a  
16 very long day and a bit tedious but we thank you  
17 very much for all your hard work.

18 Thank you.

19 CO-CHAIR BROOKEY: All right, safe  
20 travels.

21 (Whereupon, the above-entitled matter  
22 went off the record at 5:01 p.m.)

A			
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Before: NQF

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