

NATIONAL QUALITY FORUM
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POPULATION HEALTH ENDORSEMENT MAINTENANCE
PHASE II
STEERING COMMITTEE MEETING

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WEDNESDAY
MAY 30, 2012

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The Steering Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Paul Jarris and Kurt Stange, Co-Chairs, presiding.

PRESENT:

PAUL JARRIS, MD, MPH, Co-Chair
KURT STANGE, MD, MPH, Co-Chair
RON BIALEK

SARAH LINDE-FEUCHT*
LINDA KINSINGER*
MADELINE NAEGLE
ROBERT PESTRONK
SUE PICKENS
MARY PITTMAN*
AMIR QASEEM

SARAH SAMPSEL
JASON SPANGLER
MATT STIEFEL
MICHAEL STOTO

NQF STAFF:

HELEN BURSTIN, MD, MPH

KRISTIN CHANDLER, Project Analyst

ANGELA FRANKLIN

ELISA MUNTHALI, MPH, Senior Project Manager
for Population Health

ROBYN NISHIMI, NQF Consultant

ALSO PRESENT:

DAWN ALAYON, NCQA

SAM AMIFAR, New York City Department of Health
and Mental Hygiene*

MARY BARTON, NCQA*

SEPHEEN BYRON, NCQA

IAN CORBRIDGE, HRSA*

ERIN GIOVANNETTI, NCQA

IRENE HALL, CDC*

SHARON HIBAY, Quality Insights of Pennsylvania

PEGGY HONORE, Office of the Assistant

Secretary for Health, HHS

DAWN JACOBSON, Public Health Institute*

BOB REHM, NCQA

ALFONSO RODRIGUEZ, CDC*

AMISHI SHAH, Office of the Assistant Secretary
for Health, HHS

DON WILSON, Quality Insights of Pennsylvania

PASCALE WORTLEY, CDC*

*Participating via teleconference

C-O-N-T-E-N-T-S

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

9:02 a.m.

CO-CHAIR JARRIS: Good morning everyone. This is Paul Jarris. I'm here with Kurt Stange and Helen Burstin and Elisa Munthali for the day. And we have a number of people in the room we'll introduce in a moment.

Thanks for the traveling. And for those of you who were unable to travel, thank you for joining us by phone. So we do have about a day and a half or so of meeting to go over.

Like in the past, the first meeting will begin with looking at some of the measures that we received. And very importantly, I think, this is an opportunity to look at what we received as compared to perhaps our expectation, as well as compared to the NQF population health measures criteria.

And then tomorrow we'll have more

1 discussion to talk about. For the status
2 check where we are, the progress we've made,
3 and compare that to our expectations to what
4 we received.

5 And really have a more in depth
6 discussion, both with measures developers as
7 well as the committee on the steps going
8 forward. How should we continue? What types
9 of things should we do to really increase the
10 participation in this process, and in the
11 yield on the measures?

12 So I think it should be a very
13 fruitful discussion. And it could be very
14 important tomorrow to provide guidance, both
15 to the committee, the workgroup, as well as
16 NQF in moving forward on population health
17 measures. Kurt? Okay. Well go ahead, Elisa.

18 MS. MUNTHALI: Good morning
19 everyone. This is Elisa Munthali. I'm the
20 senior project manager for population health.
21 And I just wanted to welcome and thank you
22 again for joining us today.

1 I just have a couple of
2 housekeeping items before we continue with our
3 introductions. As you can see, our meeting is
4 being taped and transcribed. So we do ask
5 that whenever making a comment or posing a
6 question, that you make sure you turn on your
7 microphones and speak into the mics so we can
8 capture your comments.

9 And as for the restrooms, a very
10 important item for all of you that are here.
11 They're just in the hallway, just beyond the
12 elevators to the right.

13 And so what we're going to do are
14 introductions of everyone who's in the room.
15 And for everyone we ask that you state your
16 name and your organization. And for the
17 steering committee, we also ask that you give
18 us a little bit more about your role within
19 the organization.

20 As you recall during our first in
21 person meeting, you did publicly announce your
22 disclosures. We're also asking now if there

1 are any updates to that disclosures, that you
2 do that as well. And that includes any
3 changes in employment. I think that is it
4 with regards to the disclosures.

5 I wanted to bring up also the
6 measures that are under consideration. And
7 part of the disclosure update is to consider
8 these measures and to see if you've had any
9 involvement in measure development. And so as
10 you go around, if you can please indicate so
11 if you've had that. So I think we'll start to
12 my left with Paul.

13 CO-CHAIR JARRIS: I'm Paul Jarris,
14 Executive Director of the Association of State
15 and Territorial Health Officials. And I have
16 no conflicts on either current or past to
17 announce. Thanks.

18 CO-CHAIR STANGE: Kurt Stange.
19 I'm a professor at Case Western Reserve
20 University in Cleveland, and also working for
21 the year with the implementation science team
22 at the National Cancer Institute. I have no

1 new disclosures. I have been involved in some
2 measure development in the remote past. But
3 nothing related to this topic.

4 DR. BURSTIN: Good morning. Helen
5 Burstin, NQF.

6 MEMBER STOTO: Good morning. I'm
7 Mike Soto from Georgetown University. I don't
8 have any conflicts to mention.

9 MEMBER NAEGLE: Good morning. My
10 name is Madeline Naegle. I'm a professor at
11 New York University. There my primary focus
12 is on substance related disorders programming
13 development.

14 I serve as a Deputy Director on
15 our Center for HIV and Drug Use Research. I'm
16 also a co-investigator of Project SARET, which
17 is substance abuse research training and
18 education for our students. Good morning.
19 I've no disclosures.

20 MEMBER BIALEK: Good morning. Ron
21 Bialek, President of the Public Health
22 Foundation. And I have nothing new to

1 disclose. As far as measure development, I
2 had some discussions with the Legacy
3 Foundation regarding the tobacco measures.

4 MEMBER SAMPSEL: Good morning.
5 Sarah Sampsel with WellPoint. My position has
6 changed at WellPoint. I'm now Business Change
7 Director for our Clinical Quality Division,
8 which is a group that's actually trying to
9 improve performance measures across WellPoint.
10 And I should disclose that I was lead staff at
11 NCQA for the development of measure 0024 and
12 1690.

13 MEMBER PESTRONK: I'm Bobby
14 Pestronk, the Executive Director of National
15 Association of County and City Health
16 Officials. My position hasn't changed since
17 the last meeting or disclosure. I don't have
18 any conflicts to report. And I have not been
19 a contributor to the development of any
20 measures under consideration.

21 MEMBER SPANGLER: I'm Jason
22 Spangler. I'm the Chief Medical Officer of

1 Partnership for Prevention. I don't have any
2 disclosures. Are we supposed to just talk
3 about the measures there that we've possible
4 worked on?

5 MS. MUNTHALI: Any of the measures
6 under consideration. So also in Workgroup B.

7 MEMBER SPANGLER: Yes. I haven't
8 worked on any of those. But kind of like Ron,
9 I don't lead our tobacco efforts. But I work
10 with the people on some tobacco measures.

11 MEMBER STIEFEL: Matt Stiefel from
12 Kaiser Permanente. Senior Director in the
13 Care Management Group for population health.
14 I haven't worked on any of these measures in
15 previous groups. And no disclosures.

16 MEMBER QASEEM: Amir Qaseem,
17 American College of Physicians. No financial
18 conflicts of interest. But non financial, I'm
19 on various boards and committees, just like
20 everyone. And a bit of work with CDC and all
21 of that. I don't think that's something.

22 MS. CHANDLER: Kristin Chandler,

1 NQF project analyst.

2 MS. NISHIMI: Robyn Nishimi, NQF
3 consultant.

4 MS. ALAYON: Good morning. I'm
5 Dawn Alayon. I'm from the National Committee
6 for Quality Assurance.

7 MS. HONORE: Peggy Honor, Office
8 of the Assistant Secretary for Health, HHS.

9 MS. SHAH: Amishi Shah from Office
10 of the Assistant Secretary for Health at HHS.

11 MS. FRANKLIN: Angela Franklin,
12 staff NQF.

13 MS. MUNTHALI: Sarah, on the
14 phone, and Linda.

15 MEMBER LINDE-FEUCHT: Yes. Hi,
16 this is Sara Linde-Feucht. I'm the Chief
17 Public Health Officer at the Health Resources
18 and Services Administration with HHS. And I
19 have no disclosures, and have not worked as a
20 developer of any measures.

21 MEMBER KINSINGER: And good
22 morning. this is Linda Kinsinger. I'm the

1 Chief for Preventive Medicine for the Veterans
2 Health Administration. And have no
3 disclosures to report, and have not worked on
4 any of the measures.

5 MS. MUNTHALI: Thank you. Is
6 there any other steering committee members on
7 the phone? Okay. Thank you everyone. And so
8 before we turn the meeting over to the
9 committee and to the co-chairs, we do have a
10 few introductory slides, some reminders.

11 We just wanted to first tell you
12 why we're meeting today. And during this
13 meeting the steering committee will evaluate
14 endorsed and newly submitted clinical body
15 mass index measures and population level
16 measures against NQF's criteria and guidance
17 for population health, to determine their
18 suitability for endorsement recommendations.

19 They will also identify related
20 and/or competing measures to determine if
21 there's need for harmonization or selection
22 for best in class.

1 And finally, they'll participate
2 in discussions about outreach efforts for our
3 recent call, provide feedback on improving
4 response to future calls for measures, and
5 ways in which to strengthen NQF's population
6 health portfolio.

7 The committee will review and vote
8 on nine submitted measures that are under
9 endorsement consideration. Developers are
10 present, as we noted earlier. And they will
11 briefly introduce the measures at the start of
12 each topic area. And they're also available
13 to respond to questions from the committee.

14 The committee in turn will discuss
15 and vote on each of the measures using the
16 four major criteria, importance to measure and
17 report, scientific acceptability of the
18 measure properties, usability and feasibility.

19 Our members and the public will
20 have several opportunities during the day to
21 provide comment. During Day 2 the committee
22 will participate in several discussions,

1 including a facilitated conversation with
2 invited developers on how NQF could improve
3 future response to call for population health
4 measures.

5 Later on in Day 2 the committee
6 will look at NQF endorsed population level
7 measures, and offer input on how to address
8 the measurement gap.

9 And finally they will look at the
10 recommendations from the commission paper to
11 see if there are any they would like to adopt
12 as committee's recommendations.

13 As with Day 1 our members and the
14 public will have an opportunity to comment.
15 We just wanted to remind everyone about the
16 project goal and scope.

17 The population health project
18 sought to expand NQF's current portfolio,
19 preventive services and immunization members,
20 which we did in Phase I. And healthy
21 lifestyle behaviors and broader population
22 health measures in Phase II.

1 And while we're doing this we
2 wanted to also foster harmonization of these
3 measures at all levels of analysis, including
4 the provider and population level. And as a
5 reminder, this project is being conducted in
6 two phases. And this is just an outline of
7 our endorsement process.

8 And as you can see, we're in this
9 third stage of the process where the committee
10 is reviewing and evaluating measures, and will
11 render recommendations for endorsement. And
12 so we wanted to go over the endorsement
13 maintenance process with you.

14 And actually we have done this.
15 So we're going to skip through these two
16 slides, and just go through the measurement
17 evaluation process with you.

18 Before turning over the meeting,
19 we wanted to tell you what we did with the
20 measure. We divided the measures into two
21 workgroups. There's Workgroup A, which is the
22 clinical body mass index measures. And

1 Workgroup B that's looking at the population
2 health measures.

3 Several committee members have
4 been assigned to each measure. And they will
5 lead discussion today on those measures.
6 However, we wanted to stress that all
7 committee members will evaluate all measures.

8 The committee will also discuss
9 and vote on each measure by criterion. And
10 then if a must pass criterion, like importance
11 to report, measure on report is not met, then
12 the decision and discussion for that measure
13 ends.

14 If the measure meets all of the
15 criteria the committee will vote on the
16 suitability for endorsement. We do have a
17 cautionary note.

18 If they're related or competing
19 measures, the vote is not final until there's
20 review of whether or not harmonization is
21 needed, or a selection of best in class is
22 needed. And so I'll turn it over to Kristin

1 who is going to go over our electronic voting
2 process.

3 CO-CHAIR JARRIS: Elisa, can I ask
4 a question?

5 MS. MUNTHALI: Sure.

6 CO-CHAIR JARRIS: The clinical BMI
7 seems to me to be back to the Phase I. Is
8 there a reason it was considered here in Phase
9 II, rather than in Phase I?

10 MS. MUNTHALI: Because it's
11 suggesting healthy lifestyle changes. And
12 that was part of the call for measures.

13 DR. BURSTIN: And I think actually
14 our hope was that we were going to get
15 measures in at the population level on
16 obesity, that we would logically want to look
17 at together with these.

18 So we actually had these already
19 earlier on, but wanted to at least have them
20 reviewed. We were surprised we didn't get
21 anything in this area population wise.

22 CO-CHAIR JARRIS: Yes. That's why

1 -- Because the measures don't appear to be
2 population wise, they are clinical. That's
3 what I thought they were back in Phase I,
4 which is fine. It's just they're really not
5 population measures. But we'll talk about
6 that when we get there I think.

7 MEMBER QASEEM: Sorry. You may
8 already mention it to the committee. Where do
9 the Phase I measures stand? I think the
10 members have already voted now, right?

11 MS. MUNTHALI: They have. And
12 actually they're in appeals right now. And so
13 they have been endorsed. Nineteen measures
14 were endorsed. I think 11 immunization
15 measures and eight preventative services
16 measures.

17 Those were the screening measures.
18 And the appeals process will end on January 1.
19 I mean, sorry, June 1. So we actually
20 haven't, knock on wood, received any appeals
21 so far.

22 MEMBER QASEEM: So then it will go

1 --

2 MS. MUNTHALI: But we'll let you
3 know. Yes.

4 MEMBER QASEEM: And then it will
5 go to CSAC, right?

6 MS. MUNTHALI: It's already gone
7 to CSAC.

8 MEMBER QASEEM: Oh, it's already
9 gone to --

10 MS. MUNTHALI: It's gone to the
11 board.

12 MEMBER QASEEM: Oh, okay.

13 MS. MUNTHALI: Once it's gone
14 through board ratification they're endorsed.
15 Yes.

16 MEMBER KINSINGER: Elisa, for
17 those of us on the phone, are the slides
18 available somewhere?

19 MS. MUNTHALI: Yes. Kristin is
20 going to send them to you. Is this Linda?

21 MEMBER KINSINGER: Yes.

22 MS. MUNTHALI: Okay.

1 MEMBER KINSINGER: Thanks very
2 much.

3 MS. MUNTHALI: And she'll send
4 them to you as well, Sarah.

5 MEMBER LINDE-FEUCHT: Many thanks.

6 MS. CHANDLER: So very briefly,
7 most of you should remember the voting process
8 from Phase I. But all of you should have
9 received a voting remote when you walked in
10 the door. If you didn't, please let me know.

11 I will begin the voting on each of
12 the criteria for each measure. I will begin
13 the timer and you'll have 20 seconds to
14 indicate your response. You should point your
15 remote towards this computer right here.

16 A green light indicates your vote
17 was received. A red light indicates there's
18 a problem with the remote. And in that case
19 we'll need to exchange it out for a new one.

20 If you need to change your vote
21 for any reason, just simply press the number
22 that correlates with your answer. Only the

1 second, or last vote will count towards your,
2 towards the total tallies.

3 So any questions? Yes. And for
4 those on the phone, if you would like to
5 verbally indicate your responses for each of
6 the criterion as we go through the measures,
7 we will record those here.

8 OPERATOR: To ask a question press
9 star and the number one on your keypad.

10 CO-CHAIR STANGE: And Kristin,
11 we're just voting on the four summary kind of
12 measures, not the individual ones?

13 MS. CHANDLER: No. We will be
14 voting on each of the major criteria.

15 MS. MUNTHALI: And Kristin will go
16 through an example so we can get a hang of it.

17 MS. CHANDLER: So real quickly, if
18 everyone could pick up their remotes. I'm
19 going to start the timer now. And please
20 enter any response. This is just a practice.
21 Towards this computer. I think we're --
22 Okay. All righty? Okay.

1 MS. MUNTHALI: Great. So we will
2 start in reverse order. We're going to start
3 with the Workgroup B measures. The first on
4 is Measure 2014. This is Place of Birth.

5 This is from the CDC. It's a new
6 measure. The measure developer, Alfonso
7 Rodriguez, is on the line. Operator, can you
8 make sure that Alfonso's line is open? Anika?

9 OPERATOR: His line is open.

10 MS. MUNTHALI: Okay. Alfonso?

11 DR. RODRIGUEZ: Yes. Hello. Can
12 you hear me?

13 MS. MUNTHALI: Hi. How are you?

14 DR. RODRIGUEZ: I'm very good, how
15 are you?

16 MS. MUNTHALI: Fine, thank you.
17 If you could go ahead and provide
18 introduction? You can do the introduction for
19 Measure 2018 as well. About three to five
20 minutes?

21 DR. RODRIGUEZ: Yes. And thank
22 you very much for the opportunity to propose

1 about these measures, this measure. I work
2 for the Center for Disease Control and
3 Prevention. And the first measure is place of
4 birth.

5 And we are proposing this measure
6 from three different point of view. One, we
7 consider that country of birth is an important
8 determinant of health. Because it's
9 associated with barriers to access to care.

10 Are different in the various
11 experience by the general population of the
12 U.S. Also foreign born and migrant
13 populations experience legal barriers to
14 access to care, language barriers, and social
15 isolation.

16 And a higher potential for
17 discrimination and xenophobia than the general
18 population or other minority populations in
19 the U.S. And also they tend to suffer more,
20 experience more health literacy challenges.

21 So we consider it's an important
22 determinant of health. Also we're looking at

1 these variables from the vulnerable
2 populations, sub-populations' point of view.

3 Foreign born populations, by
4 definition, have experienced multi-national
5 exposures. They come, many of them come from
6 developing countries where the burden of
7 disease is different than the one in the U.S.

8 And as a consequence they also
9 show different health conditions, or a
10 different prevalence of health conditions than
11 the general population of the U.S. They also
12 have different behaviors, attitudes and
13 beliefs about diseases and access to care.

14 But also have different on the
15 general, maybe different on the general
16 population. The foreign born population is an
17 increasing minority in the U.S. Thirteen
18 percent of the U.S. population is foreign
19 born.

20 Currently it's a highly diverse
21 population. But also the children of the
22 foreign born, who are born in the U.S., can be

1 also vulnerable population.

2 And the parents are the ones
3 obviously who are making decisions about
4 access to care and treatments, et cetera. And
5 this is an increasing population, the children
6 of the foreign born.

7 And finally, we believe that the
8 country of birth is an important -- And this
9 has been demonstrated in the literature. It's
10 an important variable to measure to better
11 assist and identify health disparities.

12 It will help to identify some
13 groups within the race/ethnic groups that are
14 more vulnerable for specific health
15 conditions, including -- Or health issues,
16 including health care, health insurance and
17 quality of care.

18 There are many disparities in
19 access to health services experienced by the
20 foreign born, including infectious disease
21 testing, like HIV testing, cancer screening.

22 Prevalence of the infectious

1 disease like tuberculosis and HIV are good
2 example, hepatitis B. Chronic conditions,
3 like certain types of cancer, like cervical
4 cancer and others.

5 So we think it's a very important
6 variable to help us to go deeper within the
7 race/ethnic. So that would be to identify
8 race/ethnic groups who have increased
9 disparity for a specific health condition.

10 There are some -- This variable
11 has been validated, has been collected by
12 census in other, a number of national data
13 sources for a number of years.

14 It's a highly valuable, reliable
15 measure used to comply with international
16 recommendations to increase in monitoring of
17 the health of foreign born and migrant
18 populations.

19 It's been collected, as I said, by
20 a number of national surveillance and data
21 sources in the U.S. But not by all. So one
22 of the committee members mentioned about the

1 importance of standardizing, you know, the
2 collection with national data sources.

3 And we believe that it's important
4 to have these variables in every national
5 information data source. So I don't know if
6 there's any questions. I don't know how much
7 time -- Hello?

8 CO-CHAIR JARRIS: Any questions?

9 OPERATOR: To ask a question,
10 press star then the number one on your
11 telephone key pad.

12 CO-CHAIR JARRIS: Anyone here in
13 the room have questions? Amir, I think this
14 was -- Or no, Alfonso's --

15 OPERATOR: At this time there are
16 no questions.

17 CO-CHAIR JARRIS: Oh, Bobby? Was
18 this --

19 MEMBER PESTRONK: So our job is to
20 share with the rest of the committee the
21 discussion that the subgroup has had. It is
22 on, yes. Our job is to share with the rest of

1 the committee the discussion that the subgroup
2 of us had about this particular, this
3 submitted measure.

4 And based upon our understanding
5 of the rules of review, it is essential for
6 the measure to pass these, this first group of
7 criteria in the impact opportunity and
8 evidence section in order to move on and
9 consider the other aspects of the measure.

10 And I think following the
11 discussion and review, the group's consensus
12 is that this is an important demographic
13 characteristic, which is useful to know about
14 certain populations.

15 But it doesn't rise to the level
16 of a population measure specifically. It may
17 be important data to collect as an aspect of
18 some other measure. But it would be difficult
19 to see this particular proposed measure on its
20 own in the context of opportunities for
21 improvement.

22 One wouldn't necessarily only want

1 to know whether place of birth, or the numbers
2 of people, or the rates of people born in
3 certain places had changed over time.

4 So understanding how the measure
5 as proposed itself could help to, help with an
6 understanding of a particular performance gap,
7 I think there was not enough information, not
8 enough explanation that accompanied the
9 materials to have us pass that particular
10 criterion.

11 And I think that because in those
12 first two areas of impact and opportunity for
13 improvement, the recommendation or the -- I
14 don't know whether we're recommending to the
15 rest of the committee, or just sharing with
16 your our review and analysis. Is that this
17 doesn't meet the criterion to have, to accept
18 the measure as a population measure.

19 DR. RODRIGUEZ: If I may? Because
20 I'm confused. In the instructions for the
21 call for measures it talks both about -- I
22 definitely agree that this is not a health

1 outcome type of measure.

2 But the call for measures
3 specifically refers to two groups of measures
4 that the committee is looking for. One is the
5 health outcomes. And within the health
6 outcomes measure, that health must serve the
7 health of a subset of the population.

8 And this is one of the areas where
9 we consider that country of birth is an
10 important variable to be able to identify. To
11 observe the health of the sub-population in
12 the U.S., many that are foreign born, because
13 of the disparities.

14 And, but also, we believe that
15 this variable complied with the second type of
16 measure that the committee is looking for as
17 a determinant of health.

18 Because again, foreign born
19 experience a number of quantifiable
20 socioeconomic and environmental determinants
21 of health.

22 And I believe that those are very

1 important to, you know, to be able to collect
2 and to identify, you know, to implement a
3 specific intervention. And also specifically
4 to target interventions to the population
5 suffering specific health disparities.

6 So I'm not totally sure I
7 understand. I mean, I agree that this is not
8 a health outcome. But definitely it's a
9 measure of this population health and
10 disparities. And it's a determinant of
11 health. And so I'm not sure the rationale for
12 not accepting this variable, or this measure.

13 CO-CHAIR JARRIS: Mike?

14 MEMBER STOTO: Thanks. I mean, I
15 wasn't able to be on the call, but I agree 100
16 percent with what Bobby said. I think one
17 thing that has not been said, but needs to be
18 said --

19 In fact it just answers that last
20 question. Is that we're interested in
21 performance measures. We often don't use the
22 word performance. We use it in key places.

1 But when you look at the criteria
2 and so one, it's performance. So which means
3 a modifiable risk factor I think. And you
4 can't --

5 So this is just like race or
6 education or income, and so on. Clearly those
7 are determinants of health. But you can't
8 imagine anybody doing anything to change those
9 things as a way of improving health.

10 And I think that's, you know, it's
11 so ingrained in the health care setting it
12 doesn't always carry over into the population
13 health setting. But I think it's important
14 point to make.

15 CO-CHAIR JARRIS: Amir?

16 DR. RODRIGUEZ: Mike, what's so
17 bad -- Sorry.

18 CO-CHAIR JARRIS: Was it directly
19 in response to what Mike said?

20 DR. RODRIGUEZ: Yes. My points
21 that I have is how does the committee plan to
22 identify disparities in sub-populations, all

1 of the sub-populations, if we don't have a
2 state of standard, you know, we'll call it
3 demographic or social measures, like
4 race/ethnicity, country of birth, poverty
5 level, et cetera?

6 CO-CHAIR JARRIS: You know, I
7 think you're making a valid point. But I
8 still agree with what Mike and Bobby said, in
9 that we do need to understand the population
10 being served.

11 And that's important for social
12 determinants as well as other determinants of
13 health. But those aren't -- They might be,
14 could be very useful in sort of a risk
15 modification.

16 Looking at one community versus
17 another community. And what is the potential
18 burden of illness in that community, based on
19 immigration status, race, ethnicity,
20 socioeconomic and unemployment? So we have to
21 get our hands around that.

22 MEMBER STOTO: You might even want

1 to have different interventions depending on
2 the nature of the community.

3 CO-CHAIR JARRIS: Right. But it's
4 different from something that is a modifiable
5 measure. For example, we certainly wouldn't
6 want a community to say, in order to improve
7 our health status we're going to limit the
8 number of foreign nationals we allow in our
9 community.

10 Or the opposite. We're going to
11 increase, you know, the amount of foreign
12 nationals, as opposed to U.S. born people of
13 that group.

14 So, you know, I think that's what
15 I'm struggling with. This is a very important
16 thing. But it may not be a modifiable
17 measure. Amir, please.

18 MEMBER QASEEM: Just to follow up.
19 I completely agree. And that's the first
20 thing that I was looking at in trying to
21 figure out what does it mean.

22 It actually applies for 2018. And

1 there's some other ones as well. I just
2 couldn't figure out what are we improving in
3 terms of performance measures.

4 Second thing I was going to say
5 was, don't we have this information available?
6 Maybe it's just a dumb question. But U.S.
7 census, don't they get this information in
8 there?

9 Or a lot of places you can get
10 this information? So what are we really going
11 to add? What is CDC going to add with this
12 measure? I just couldn't even find the --

13 DR. RODRIGUEZ: Yes. There is a
14 number of, including the census, there is a
15 number of data sources, or national data
16 sources that collect country of birth.

17 But there are all the important
18 data sources like behavioral risk factors in
19 the system. And especially clinical kind of
20 data, like hospital discharge data, et cetera,
21 that do not collect that information.

22 And therefore, it doesn't allow us

1 to identify this specific vulnerable
2 population, social population, that we could,
3 you know, then target this specific
4 intervention to those populations.

5 So I totally understand in terms
6 of the not being a performance measure. But
7 again, from the instructions it's not very
8 clear to me, you know, if you're asking for a
9 determinant of health.

10 And country of birth cannot by
11 itself be modified. I totally agree on that.
12 But it's a very good proxy for a number of
13 legal and social and other type of barriers
14 and exposures.

15 And, you know, exposure that can
16 be very helpful in terms of, you know,
17 targeting and identifying health disparities.
18 Even though by itself it's not a modifiable
19 measure.

20 MEMBER QASEEM: So but you're
21 trying to get the information at the -- With
22 the census data you can get it literally at

1 the zip code level. That how many folks are
2 born outside U.S.

3 So why can't that information be
4 utilized? I'm just trying to figure out why
5 do we need a new measure? You're just trying
6 to find out in a certain population area, how
7 many are foreign born?

8 And the second question is like
9 that one. That information, there is very
10 good data available. I'm just trying to
11 figure out the utility of adding another thing
12 is there's already information already out
13 there.

14 DR. RODRIGUEZ: The data is
15 collected by the census. Again I totally
16 agree with that, you know, how many people are
17 foreign born in a specific area.

18 But the data, the country of birth
19 is not collected in a number of key health
20 information sources in the U.S. Like, you
21 know BRFSS and different behavioral reflectors
22 used in the BRFSS. Country of birth is not

1 collected.

2 So you cannot identify issues for
3 a foreign population. If you're interested in
4 hospital discharge data, clinical data,
5 country of birth is not collected. So it's
6 collected in a number of data sources in the
7 U.S., national data sources. By half of them
8 probably. But not collected in the other
9 half.

10 And so that creates a number of
11 gaps in our understanding of the health issues
12 and disparities of these, you know, increasing
13 foreign born populations in the U.S. And then
14 it creates, you know, limitations in being
15 able to, you know, identify those disparities
16 and target the interventions.

17 We're seeing that there is a
18 tremendous diversity within the different
19 race/ethnic groups. And country of birth is
20 one of the variables that can help you to
21 understand, you know, to get more in depth
22 into those disparities and diversity within

1 the race/ethnic groups.

2 Now I understand, you know, if the
3 committee's looking for different kinds of
4 measure, you know, I completely understand
5 that. But again, I see it as a determinant of
6 health. And so --

7 CO-CHAIR JARRIS: Thank you. Ron?

8 MEMBER BIALEK: Yes. I think the
9 measure in and of itself is an important
10 measure, as we talked about. And the role of
11 NQF is endorsing existing measures, whether or
12 not those measures can ultimately be used to
13 make a difference, have an impact.

14 And I think what we're really
15 missing here is how can one use this
16 particular measure, which is a determinant of
17 health, how you can use that measure to make
18 a difference within the community in terms of
19 health.

20 And I think it's important for us
21 to note the problems that were cited with the
22 clarity of instructions for the developer of

1 the measure. So unfortunately you're one of
2 our, I guess guinea pigs here.

3 But it's important for us to note
4 that clarity is an issue. And the question
5 then becomes, you know, could this measure --
6 Not right now.

7 But could this measure be tied to
8 specific evidence based interventions that can
9 be impacted by knowing about this particular
10 measure within the community? And if the
11 answer is yes to that, that might be something
12 worthy for further consideration.

13 DR. RODRIGUEZ: And the answer to
14 that is absolutely yes. I mean, on the one
15 side I totally agree that it's not performance
16 measure.

17 But on the side, if you're asking
18 for a measure that we can use, or how it can
19 be used, it certainly can be used for that.
20 It can be used to identify a specific sub-
21 population that have the main disparities in
22 health or specific disparities in health.

1 They can be extremely helpful,
2 especially when we are in the times of limited
3 resources, where you're going to target your
4 interventions. And to put specific, you know,
5 a specific population as possible to be
6 effective.

7 So there is no doubt in my mind,
8 and there is a very, very good literature
9 right now in terms of how this variable can be
10 used to identify those populations. And to
11 implement intervention that are culturally and
12 linguistically appropriate.

13 Again, the country of birth is a
14 proxy for a number of additional variables
15 that can truly help you to tune into those and
16 to focus into those populations who have the
17 greatest disparities.

18 At the same time foreign born
19 population have very good indicators for all
20 their measures of health. And is more, you
21 know, the children of the foreign born, or is
22 people who have, you know, different

1 race/ethnic groups born in the U.S.

2 Again, this variable allows you to
3 make that differentiation, not to have this,
4 you know, broad race/ethnic groups that we're
5 finding that are less and less useful because
6 they're too broad in terms of targeting public
7 health measures. So I totally, I mean, I
8 would say a complete yes in terms of that this
9 measure is a useful measure for public health.

10 CO-CHAIR JARRIS: Thank you,
11 Alfonso. Let's get a couple more committee
12 members. Kurt and Matt, I think you're next.

13 MEMBER STIEFEL: This seems like a
14 feature of the measures in one of the
15 evaluation criteria that we called for, for
16 the measures.

17 And we asked for a summary of
18 measures of disparity by population group,
19 which seems like that would be appropriate to
20 address in the measures that were called for,
21 as a feature of those measure. As opposed to
22 a measure in and of itself.

1 In the commission paper they made
2 the distinction of population subgroups, or
3 sub-populations. And it seems like this is a
4 sub-population as opposed to a measure.

5 DR. RODRIGUEZ: I totally agree.
6 I completely agree. And that's probably my
7 point from the beginning. It's not a
8 performance measure. It's a population, sub-
9 population, or health disparity type of
10 measure.

11 But again what's not totally clear
12 is how can we include that? This is what it
13 sounds like. This call for measure is asking
14 for how can we include those determinants of
15 health in this initiative, if they are not
16 considered performance measures? I'm not
17 clear about that. If it's including
18 socioeconomic, social norms --

19 CO-CHAIR STANGE: So this is Kurt
20 Stange. I have a question for our NQF
21 colleagues. There's clearly consensus that
22 this is important to know about To stratify

1 other measures of health and other health
2 determinants.

3 There's no question that it is a
4 health determinant, and that it's useful thing
5 to know. The question is whether it meets
6 this kind of one beat performance gap thing.
7 Because it's not, as Mike and Ron pointed out,
8 it's not a performance measure.

9 So the question for the NQF
10 colleagues, is there precedent within your NQF
11 measures for a measure like this? Something
12 that's useful to help interpret other
13 measures, but maybe isn't a performance
14 measure in itself?

15 And the other question is, with
16 the disparities or any qualities group, how
17 are they handling this? Because I imagine
18 there would be a lot of issues like this,
19 things that you would like to look at across
20 many different measures of quality. Or in our
21 case health and health determinants. And is,
22 did we learn anything from how they've

1 approached this?

2 DR. BURSTIN: Yes. I'll speak
3 first. And Robyn may want to weigh in on
4 disparities. We don't have anything exactly
5 like this.

6 I think the one thing that it
7 raised for me, that was somewhat analogous, is
8 the exercise we've recently gone through
9 bringing in measures of research use and
10 costs, which none of us agree in and of
11 themselves are measures of quality. But when
12 paired with other measures become very
13 powerful building blocks of quality measures.

14 So that was the one big picture
15 analogy I could potentially see to measures
16 like this. As part of the disparities
17 project, we didn't get anything along these
18 lines that I recall. Rather more so measures
19 that are assessing cultural competency. Not,
20 you know, tools, patient surveys.

21 We did have some measures that
22 came in on child health that perhaps get

1 closer. But again this issue of mutability
2 isn't necessarily a requirement either.

3 There's significant variation in
4 the population. There's differences in
5 outcomes they have clearly demonstrated, based
6 on the criteria we wrote in terms of outcomes
7 for those patients. I wouldn't get as hung up
8 on that.

9 But, you know, we have endorsed,
10 for example, some of the CATI surveys that
11 look at issues like children who attend
12 schools perceived as safe, children who live
13 in communities perceived as safe.

14 In and of themselves, the question
15 is, what is the performance measure. I guess
16 that is the performance measure of the
17 community.

18 And I guess I'd be curious about,
19 you know, Paul and Bobby's perspective on a,
20 you know, how in some ways are a measure like
21 that inherently different than a measure like
22 this. But Robyn, anything from the

1 disparities perspective that you want to add?

2 MS. NISHIMI: No, we didn't, as
3 you said, get any measures along this line at
4 all. And so then the focus was, in that
5 project, what elements do you use to stratify
6 reporting for other measures?

7 CO-CHAIR JARRIS: It was my
8 understanding when we discussed that health
9 disparities group though, that in fact, it was
10 limited to health care, within the health care
11 setting. So a measure like this wouldn't
12 enter.

13 DR. BURSTIN: The call for
14 measures wasn't limited. All we got in was
15 health care. So we could have gotten
16 something broader, it just didn't come in.

17 MEMBER STOTO: I wanted to second
18 the point that the developer and Ron made
19 about the documentation. There's two things.
20 One is that the current criteria and the form
21 for filling it out are the ones that NQF has
22 always used for its health care measures.

1 And really hasn't been modified to
2 represent the population health. We put the
3 change in the criteria, but the form hasn't
4 been modified. And I think that's an
5 important issue that has to be addressed.

6 And I also think that the
7 background paper doesn't do a good enough job
8 at this. And we probably want to address that
9 too. And I think these are really issues for
10 tomorrow's discussion. I think they really
11 have a lot to do with the relatively small
12 number of measures that we've gotten in moving
13 forward.

14 MEMBER KINSINGER: Hi. This is
15 Linda. If I could jump in? It's hard being
16 on the phone, not being able to raise my hand.
17 I just, I also reviewed this measure, and want
18 to concur with everything that's being, that's
19 been said already.

20 That it doesn't measure a gap in
21 quality performance. The information that was
22 presented spoke eloquently towards the reason

1 why place of birth is, you know, leads to
2 disparities.

3 But didn't talk about what's
4 currently measured, how this could help inform
5 interventions that could address that. So
6 just to concur with everything that's been
7 said.

8 MEMBER PESTRONK: Now Helen, just
9 in thinking about the example that you gave,
10 perceived safety, children's perceived safety.
11 There one can clearly see how that kind of
12 measure could lead to performance, on the face
13 of it.

14 Because levels of perceived safety
15 could change. And activities or steps taken
16 to decrease, increase perceived safety in this
17 case, would be a change in performance in the
18 direction desired. And one would be able to
19 determine whether the activities themselves,
20 in fact, produce that change in performance.

21 And I think that's the distinction
22 that we're trying to make here. Just on the

1 face of it, knowing the place of birth tells
2 one nothing.

3 Or it doesn't tell one nothing,
4 because I think the explanation that has been
5 provided about it suggests how it might be
6 used. On the face of it, it isn't a measure
7 of performance.

8 CO-CHAIR JARRIS: Can I make a
9 suggestion? I'm wondering if this very
10 important measure is a denominator, as opposed
11 to a complete measure.

12 So for example, if we looked at
13 foreign borns in a community, and the
14 numerator was something like the percentage of
15 foreign borns with early access to prenatal
16 care, with access to a medical home, with
17 complete vaccinations, with high school
18 graduation rate within three years of ninth
19 grade.

20 Then we would have a real
21 population health measure. But I think we're
22 talking now about a denominator. And a very

1 important one.

2 MEMBER PESTRONK: Yes. Be
3 attached to something else.

4 MEMBER STOTO: A strata I think.
5 Just like race, ethnicity, education, income,
6 all those things.

7 MEMBER BIALEK: This may be
8 something for tomorrow's discussion. But I
9 pulled up the HHS consensus statement on
10 quality in public health. And I was looking
11 at the aims there.

12 And I'm thinking that if
13 developers of population measures consider
14 these aims, you know, is this measure
15 population centered? Yes, no. Does it work
16 toward achieving health equity? Yes, no.

17 Can it be used for formulating
18 policies, you know? Yes, no, and how for each
19 of these. And that could be quite helpful I
20 think for developers of measures to note the
21 population health impact. And, you know --

22 DR. RODRIGUEZ: And again, for all

1 those questions my answer would be yes. So
2 this is why I'm a little bit confused.
3 Because it's not a performance measure, but it
4 seems it fulfills many of the criteria, or the
5 questions that you are asking.

6 The question will be yes. It will
7 be, as variable it will be very useful to the
8 measure. And let me just give a very, very
9 simple example as in racial discrimination.
10 There is quite a lot, as you know, in terms of
11 discrimination in access to care and quality
12 of care.

13 And one of the criteria for
14 discrimination is discrimination to national
15 origin. And how, so how can you monitor
16 discrimination and access to care in the U.S.
17 related to national origin if you don't
18 collect country of birth.

19 That's one of the most critical, I
20 believe, uses of this variable. You cannot
21 identify that kind of discrimination based on,
22 or different quality of care based on

1 race/ethnicity or anything else. Or any
2 performance measure that you're looking at
3 would allow you to look at that important
4 determinant of health.

5 And the same thing, the quality of
6 care in health insurance. Again, country of
7 birth allows you to identify differences in
8 genetic background, behaviors, legal access to
9 care, language issues, cultural issues.

10 Many of those are modifiable.
11 They country of birth by itself is not
12 modifiable. But many of the factors
13 associated with being born in another country
14 and living in the U.S. are modifiable.

15 So this is where we think it's a
16 very useful measure for, you know, policy,
17 interventions, identifiable collections, and
18 monitoring disparities and reducing disparity
19 gaps in the U.S.

20 CO-CHAIR JARRIS: Okay. Why don't
21 we -- Matt and Bobby, and anyone who wants to
22 speak after that has to buy us breakfast on

1 Friday. Because we'll still be here.

2 MEMBER STIEFEL: Helen, you
3 mentioned impact is not a criterion. But I --

4 DR. BURSTIN: I said the fact that
5 it's mutable isn't necessary. Right.

6 MEMBER STIEFEL: But that a crux
7 of this issue I think. And it's I think quite
8 related to impact. It seems like this one
9 doesn't meet the impact criterion, the first
10 and fundamental criterion, in and of itself.
11 It's important. But, and so it's highly
12 related to mutability --

13 DR. RODRIGUEZ: If I could --

14 MEMBER STIEFEL: So it's an
15 important general point I think, that we'll
16 probably come back to for a lot of these
17 measures.

18 DR. RODRIGUEZ: Sure. Especially
19 impact.

20 DR. BURSTIN: Yes. And as you
21 just -- It's interesting. I feel like this
22 is just an important exercise for the next

1 measure as well. So I think it would be good
2 to just kind of get it done.

3 But we do specifically in our
4 population health guidance here say,
5 demonstrate a high impact of health effects.
6 A large population who has a substantial
7 impact for a smaller population is a source of
8 significant health disparities, leading cause
9 of mortality, morbidity, et cetera.

10 So I mean, it certainly seems like
11 it's potentially a source of healthcare,
12 significant healthcare disparity. So to me
13 it's not an issue of impact. I think it's
14 more a question of, I think it's a building
15 block of a measure.

16 And the question is, is it on its
17 own standalone? Or is it really something
18 that's a building block? And I guess the
19 question is, since we did specifically call
20 for social determinants, I think it's helpful
21 for us to at least think through what we meant
22 by that.

1 And maybe that's more for
2 tomorrow. Because certainly this is a social
3 determinant of health, which has a significant
4 source, you know, that leads to significant
5 health disparities.

6 Certainly somebody who practiced
7 in a, you know, refugee clinic for ten years,
8 this is a huge issue. I just think it's
9 important for us to at least think it through.
10 Because we did specifically indicate that
11 would be high impact.

12 It is a source of disparities. It
13 is a social determinant of health. I'm not
14 sure exactly how it would be used. But I
15 think that's been a question all along.

16 DR. RODRIGUEZ: But again, that's
17 what I'm a little bit confused. You're saying
18 that you're now asking for social
19 determinants. But in the call for measures it
20 says that you're asking for health outcomes
21 and determinants of health.

22 So you're asking for it. So

1 that's where I'm really confused. If you were
2 telling me we only looking for performance or
3 health outcome measures, I would totally agree
4 with you that this is not a pertinent measure.

5 But if you were asking for health
6 outcomes and determinants of health -- And
7 like everybody seems to be agreeing that this
8 is a determinant of health, then I think it's
9 totally relevant. So that's what I am really
10 confused with the rationale.

11 CO-CHAIR JARRIS: So I think we
12 want to thank the developer for helping us to
13 clarify the call and the criteria here. Just
14 as a footnote, if anybody read the newspaper
15 this morning. There is some question about
16 the mutability of place of birth. But I think
17 that's a specific case that relates to the
18 political context.

19 DR. RODRIGUEZ: Yes. So that
20 would very helpful clarification. And then so
21 that the determinant of health are included in
22 these call for measures, or not. And if yes,

1 you know, how you compose determinants of
2 health, without being a performance measure.

3 CO-CHAIR JARRIS: Alfonso, I want
4 to thank you. This has been very helpful.
5 And as you can tell, we're really in still a
6 developmental phase here. And your confusion
7 is something we created inadvertently.
8 Because we're all confused ourselves.

9 And what you put forth is a very
10 important measure. The question is, you know,
11 and we've struggled with this about the NQF
12 criteria. And does your important measure fit
13 into this NQF process? Or would it be
14 considered a building block within this
15 process?

16 But I'd like to -- I think to
17 punish you, we should put you on the committee
18 for doing good work. But thank you for what
19 you've done. And I hope you continue to work
20 on this. And we need to go now probably to
21 the voting process and move along. All right.
22 You're buying lunch?

1 MEMBER SPANGLER: I had a question
2 you may want to answer. I mean, he asked
3 about what social determinants. Should we
4 have social determinants? And I think we kind
5 of answered that.

6 I don't know if he heard, but
7 there are social determinants that are
8 modifiable, and that we can try to improve on.
9 This just isn't one of those. So maybe -- I
10 don't know if that answers your question,
11 Alfonso.

12 CO-CHAIR JARRIS: It's not one
13 we'd want to modify. And I have to say I have
14 a little sensitivity to that, given some of
15 the anti-immigrant sentiment in this country.

16 And parts of it I would want to be
17 very careful about putting place of origin up
18 as some kind of a quality issue. That's why
19 I would get back to, this is an important
20 denominator. And we need a numerator on top
21 of it.

22 DR. RODRIGUEZ: Okay. Thank you

1 very much.

2 CO-CHAIR JARRIS: So why don't we
3 turn it over to Elisa and Kristin to go
4 through the voting process?

5 MS. MUNTHALI: Okay. Thank you.
6 I just wanted to remind everyone that
7 importance to measure and report is a
8 threshold criterion that must be met in order
9 to recommend a measure for endorsement.

10 And so all three sub-criteria must
11 meet, must be met to pass this criterion. So
12 the first one is 1A, impact. And I don't know
13 if you can see it.

14 Addresses a specific national
15 health goal priority or data demonstrated a
16 high impact aspect of health care, numbers
17 affected, resource use, severity and
18 consequences.

19 And so the rating scale is one for
20 high, two for medium, three for low, four for
21 insufficient evidence. And so Kristin will
22 give you 20 seconds to rate 1A impact. And

1 make sure you're pointing towards this
2 monitor.

3 I think two people or three people
4 we still haven't received. So if you can just
5 -- Okay, we've got two more. One more. I
6 think we have nine out of ten. And Sarah and
7 Linda, if you can tell us your votes? High,
8 moderate, low or insufficient evidence.

9 MEMBER KINSINGER: This is Linda.
10 I would say insufficient.

11 MEMBER LINDE-FEUCHT: This is
12 Sarah. I agree, insufficient.

13 MS. MUNTHALI: Okay. So we have
14 two -- I think we have four for moderate,
15 five low, and 3 insufficient. Okay. So we
16 move on to 1B.

17 (Off microphone comment)

18 MS. MUNTHALI: I don't know if
19 they abstained or -- Okay. Make sure --
20 Would you like to -- We can do it again. And
21 make sure you're pointing to this monitor.

22 Okay. So that's it. Okay, we

1 have ten responses. Okay. Zero for high,
2 three for moderate, six low, and three
3 insufficient. Okay.

4 DR. BURSTIN: Basically this is a
5 must pass criterion. So you must pass all
6 three to meet it. So the first sub-criterion
7 is already not met. We could finish
8 importance if you like. But essentially --

9 If you think it would be a useful
10 exercise, just for the discussion tomorrow, to
11 actually see which of these sub-criteria are
12 not being met, it might be useful to continue
13 the next two. But, okay.

14 MS. MUNTHALI: So to 1B? Okay.
15 So this is performance gap. Data demonstrated
16 considerable variation or overall less than
17 optimal performance of cost providers and/or
18 population groups in disparities in care. And
19 so same rating scale.

20 And I think Kristin will give us
21 20 seconds again. I think we have four
22 people, one person missing. You can just step

1 -- That's it. Okay, Sarah and Linda? For
2 performance gap, 1B.

3 MEMBER KINSINGER: Insufficient.

4 MEMBER LINDE-FEUCHT: This is
5 Sarah. I agree.

6 MS. MUNTALI: Okay. So we have
7 zero high, one moderate, six low and five
8 insufficient. Okay. We'll go to the final
9 criterion, for importance to measure and
10 report. It's 1C.

11 And this is evidence. Health
12 outcome with rationale. Or quantity, quality,
13 consistency of body of evidence are met as
14 follows. Consistency, moderate or high. And
15 quantity and quality, moderate or low. Or low
16 with special circumstances.

17 And this is one for yes, two for
18 no, three for insufficient evidence. Okay.
19 Six missing in the room. I think we have two
20 missing in the room now. And we have all ten
21 in the room. And Sarah and Linda?

22 MEMBER KINSINGER: Linda. And

1 again, I think it's insufficient.

2 MS. MUNTHALI: Okay.

3 MEMBER LINDE-FEUCHT: Sarah.

4 Insufficient.

5 MS. MUNTHALI: Okay. So we have

6 one for yes, four no's, and seven

7 insufficient. And so the measure doesn't

8 pass. And we stop voting.

9 MEMBER STOTO: Can I just flag an
10 issue for later? I mean, there are two things
11 here really. One is, when we say the evidence
12 is sufficient or not, you know.

13 In the healthcare setting we mean
14 evidence that doing this process will lead to
15 the outcome that we want. It's not clear what
16 the appropriate evidence is here.

17 If you thought, what's the
18 evidence that place of birth is related to
19 outcome? Well that evidence is strong.
20 What's missing I think, in my view, is doing
21 anything --

22 Because we can't imagine what to

1 do, is there. So I think it's something
2 that's implicit in a known process. But needs
3 to be more explicit here.

4 CO-CHAIR JARRIS: Yes. So the
5 evidence should be that whatever is modified
6 or when an intervention occurs, actually
7 improves health.

8 MEMBER STOTO: Yes.

9 MS. MUNTHALI: Okay. This is also
10 from the CDC, the same developer, Alfonso. He
11 introduced this earlier. This is measure
12 2018, the year of arrival to the U.S. for
13 foreign born nationals. Alfonso, or -- I
14 think, Alfonso, did you have anything else to
15 add to your introduction?

16 CO-CHAIR STANGE: I guess, since
17 many of the issues are the same, focusing on
18 what's new in relation to the previous
19 measure.

20 DR. RODRIGUEZ: Yes, sorry. It's
21 a related variable, so a lot of the things
22 have been said about the previous variable are

1 relevant to this one.

2 It allows you to identify, you
3 know, recent arrivals versus people who have
4 been longer in the U.S. And again, the
5 purpose is to show that foreign born have been
6 longer in the U.S., their health gets worse
7 for a number of health indicators.

8 And again, allows you the
9 opportunity to identify new arrivals and the
10 opportunity to implement prevention services
11 and activities to, strategies to produce, to
12 prevent those, you know, health indicators for
13 becoming, getting worse.

14 Again, in terms of the, what can
15 you do with this information. If you know the
16 specific countries of birth, people from the
17 countries have experienced, they experience is
18 in disparities in access to care or in
19 specific health outcomes.

20 Then it allows you to use the
21 census or other health information to, or
22 information to know where those people are,

1 where the languages is, other issues related
2 to legal access to care, to culture, to
3 behaviors, and then to implement specific
4 intervention.

5 So this is what we think this
6 variables are important to identify those
7 disparities, and to target the populations to
8 review. So that you have the disparities,
9 without these variables it's very difficult to
10 do it.

11 CO-CHAIR JARRIS: Thanks. So I
12 was one of the folks that led to some of the,
13 who participated in this phone conversations.
14 And I think, rather than repeating much of
15 what we discussed, again, this could be an
16 important measure for a community.

17 But if it were -- To make it
18 actually an intervention or something that
19 made it a quality primer, we would need it to
20 be paired with something that you did.

21 So for example, again I go back to
22 it will be very important to measure the rate

1 of enrollment in early pre-natal care among
2 this population.

3 One community compared to another
4 as an indicator of how they are welcoming, how
5 they are reaching out to this population. But
6 just knowing the demographic characteristic
7 itself doesn't really identify or address the
8 performance gap.

9 DR. RODRIGUEZ: But I would make
10 the case that only having the quality measure
11 of the performance measure without having
12 these variable doesn't allow you either to put
13 aside these disparities.

14 So again, I really appreciate the
15 input from the committee. It's very helpful.
16 And I would be very interested in further
17 exploring with you, you know, how can we
18 incorporate some of these --

19 Not only the country of birth, but
20 all of the variables into these call for
21 measures. Because this population -- The
22 measure, the performance measure of the

1 quality measure by themselves aren't going to
2 allow you to do that. You need determinantal
3 health measures too. And this is one of
4 those.

5 So how can we incorporate those
6 measures within this call for measures? And
7 I would be very interested in, you know,
8 following up conversations. And looking for
9 opportunities to include those type of social
10 determinants.

11 CO-CHAIR JARRIS: It's an
12 important point. And I ask the NQF staff. Is
13 there ever a process in which you, if you
14 will, endorse a measure around the social
15 determinants of demographics of a population
16 as a building block, as opposed to --

17 Because it's true. If you had
18 this measure you could put something on top of
19 it, multiple interventions that would be
20 important. We don't have those interventions
21 in this proposal right now.

22 But is it worth taking, looking at

1 a two step process in which we say, okay, here
2 is a standardized, valid way of looking at
3 year of arrival to the U.S., number of foreign
4 borns, you name it.

5 Children living in poverty in this
6 community, or whatever it happens to be. And
7 then put that out there for other measure
8 developers to put on, you know, interventions
9 on top of them.

10 DR. BURSTIN: Never been done
11 before. But then again neither has population
12 health. So, you know, the inclusion of social
13 determinants of health on the call is
14 something that I think potentially, as we
15 discussed it up front, might be used in that
16 way.

17 DR. RODRIGUEZ: But again, to do
18 it is very confusing. Because the call for
19 measures, I'm looking at that right now,
20 talks, asks about both, health outcomes and
21 determinants of health. So those I am
22 confused about.

1 But again, I will be very happy
2 to, you know, to continue the discussion and
3 to look and see if there's any opportunities
4 to include some of these measures, and how to
5 do it.

6 Because I totally agree that, you
7 know, the background or the rationale that is
8 being asked doesn't allow to enter this kind
9 of determinant of health. Even though in the
10 call for measures, it's asking for them.

11 DR. BURSTIN: The call did say
12 modifiable socio-economic and environmental
13 determinants. And perhaps the sticking point
14 we're having here.

15 DR. RODRIGUEZ: But it talks about
16 -- It talks also about genetics. And it
17 talks about other -- So again, it's sort of
18 confusing.

19 CO-CHAIR JARRIS: Okay. Let's go
20 to Ron, Matt, Bobby, Madeline.

21 MEMBER BIALEK: I think the idea
22 of pairing a measure is an excellent one. And

1 I also think that there's another option,
2 which is for the developer of the measure to
3 demonstrate, with evidence, that knowledge of
4 that measure, knowledge of that information
5 leads to improvement in health in the
6 population.

7 And you can do that. I mean, the
8 guide to community preventive services uses
9 that type of an approach. In this instance,
10 again, it's a high impact for a population.
11 But it's a low impact in terms of any evidence
12 related to how one can make an improvement.

13 So again, a topic for tomorrow's
14 discussion is, if we deal with the social
15 determinant, does it have to be paired? Or
16 can a developer demonstrate evidence that
17 knowledge of that determinant can lead to a
18 change that improves health?

19 MEMBER STIEFEL: Just to make the
20 point that this is an evaluation criterion in
21 the call for measures. And evidence of
22 disparities by population group

1 So a good measure, if there are
2 significant disparities associated with place
3 of birth or date entered the U.S., then that
4 should be one of the components, one of the
5 strata of the measures that we endorse. That
6 was quite explicitly a part of our evaluation
7 criteria.

8 DR. RODRIGUEZ: But then again, it
9 sounds good to explore it again. Because it's
10 defiantly a strata that should be collected.
11 And there's plenty of information in the
12 literature that shows the disparities by
13 country of birth, after adjusting for many
14 other, like gender, poverty, health insurance,
15 many, many other variables.

16 Still the disparity on country of
17 birth persists. Even within the same
18 race/ethnic groups. Hispanics foreign born
19 versus Hispanics U.S. born.

20 MEMBER STIEFEL: So an example of
21 the measure. Say, take BMI. If place of
22 birth or date entered the U.S. is an important

1 stratum for BMI, then that should be an
2 element of the BMI measure.

3 DR. RODRIGUEZ: And the answer is
4 yes. The answer is a complete yes. This is
5 a complete yes in health.

6 MEMBER STIEFEL: But then the
7 measure is BMI. And this is a stratum of the
8 BMI measure.

9 CO-CHAIR JARRIS: So in other
10 words, would it be BMI as the numerator and
11 among this population? And the total of this
12 population as a denominator?

13 MEMBER STIEFEL: It would be BMI
14 as the measure. And then BMI would be
15 stratified by various important sub-
16 population.

17 DR. RODRIGUEZ: Yes. Completely
18 agree on that.

19 CO-CHAIR JARRIS: Okay, Alfonso,
20 let's let the other committee members speak.
21 And then we'll get, let you have a last word
22 before we vote. I think I had --

1 MEMBER PESTRONK: I like the fact
2 that this is pushing the discussion at NQF to
3 consider things that it hasn't considered
4 before. Because that's been the challenge for
5 the population health committee to begin with,
6 to introduce a different way of thinking about
7 measures.

8 I think that in the discussion
9 tomorrow, one way to perhaps address this is
10 to think about whether a separate evaluation
11 sheet for a proposed measure might be
12 proposed, to gauge the potential acceptability
13 for stratification type measures.

14 Rather than looking at them as
15 having to have the same kinds of
16 characteristicness as this worksheet requires
17 them to have.

18 Because it might be, it could be
19 useful down the road to have NQF endorsing
20 characteristics, like these two that we've
21 just considered, as a way to point out their
22 importance as means to stratify.

1 And perhaps even to say that these
2 are ways to pair traditional NQF measures with
3 other acceptable, with acceptable means of
4 stratifying those traditional measures.

5 Because it could push the issue
6 into the other domains where NQF has measures
7 also, where these stratification elements
8 should be considered, but aren't necessarily
9 considered.

10 CO-CHAIR STANGE: I'm interested
11 in having this discussion go forward beyond
12 the life of this committee, which might --
13 We'll see what our charge is tomorrow. But we
14 might be ending.

15 And I think that these two
16 measures are relevant, not just to population
17 health and population measures, but to
18 clinical measures as well. And they're quite
19 actionable.

20 I mean, a number of European
21 countries, for example, have measures of
22 social deprivation. And they pay differently

1 based on the social deprivation index.

2 And certainly everybody's talked
3 repeatedly about how these can be used to
4 stratify. And I think that's true for both
5 clinical and population measures.

6 So if we end up not going forward
7 as a group, but the disparities group is going
8 forward, I think this would be a wonderful
9 thing to ask them to take up. Because that
10 would be a way of really amplifying the impact
11 of the disparities group.

12 That they're not just looking
13 narrowly at measures of disparity and
14 equalities, or equity. But that they're
15 actually looking at how disparities can be
16 looked at across all the NQF measures.

17 MEMBER NAEGLE: Yes. And in that
18 way I just wanted to comment that I'm very
19 glad that we've moved in this direction. Both
20 in relation to thinking about disparities and
21 looking at the social determinants.

22 But I feel that in looking at

1 attributes or variables, it is so particulate
2 that it's not meaningful in terms of our going
3 forward and looking at measures.

4 So a number of important points
5 have been made about embedding those either as
6 strata measures, or creating a link between
7 those particular indicators and some types of
8 intervention.

9 And while we have quite a lot of
10 evidence about interventions related to social
11 determinants, that evidence is very
12 heterogenous.

13 And I think we are at the very
14 beginning of trying to figure out how to use
15 things like social determinants in creating
16 measures that are meaningful for performance.
17 But I'm glad we're moving that way.

18 CO-CHAIR JARRIS: Yes. So the
19 question will be, and Kurt, you raised this
20 issue about what is the future of this
21 committee? And is tomorrow our last day or
22 not? But this issue can't be lost.

1 And in Maryland, not far from
2 here, they took on a very important infant
3 mortality initiative. Set a goal to lower
4 infant mortality by ten percent within two
5 years. And they hit it slightly about, within
6 18 months into it.

7 But then they re-looked at their
8 data. And they had done nothing to close the
9 gap between African American and Caucasian
10 infant mortality. In fact, the decrease had
11 been in the Caucasian population. They
12 increased the gap.

13 They came back and set a specific
14 measure for African American infant mortality,
15 and actually hit it. And started to close the
16 gap. So I think that's the importance of
17 these sub measures, is to say okay, we've just
18 improved the health of this community.

19 But actually we did nothing for
20 the foreign borns or the people that have been
21 -- So we need to re-look at what we're doing.
22 So somehow we have to capture this an not lose

1 it.

2 DR. BURSTIN: Just to follow up on
3 that. Part of the work the disparities
4 committee has been doing has been updating our
5 criteria for what is disparity sensitive
6 performance measure.

7 And there is a set of criteria
8 about the prevalence of the condition in a
9 given population, the size of the quality gap,
10 evidence of what could be done to improve the
11 situation.

12 So we actually have a team that's
13 been going through the entire portfolio
14 particularly focused on outcome measures.
15 Indicating which one of them, including infant
16 mortality actually, which should always be
17 stratified explicitly, because we know there
18 are known disparities in those areas.

19 So maybe we'll try this. We'll
20 actually make sure we distribute that, those
21 criteria in the morning, just to help this
22 discussion further.

1 CO-CHAIR JARRIS: Are those people
2 -- Could they come and speak to us for a few
3 minutes tomorrow? Could we get them in here
4 for half an hour?

5 DR. BURSTIN: Robyn's the
6 consultant lead on it. She could certainly do
7 that, yes. On the disparities.

8 MEMBER KINSINGER: Hi. This is
9 Linda. If I could interrupt to make a
10 comment. I'd be interested in knowing the
11 reliability of reporting year of entry into
12 the U.S. No information about that was
13 presented.

14 And I just wonder -- There are, I
15 think, people who come in and out. And so
16 what year would be the right year to report?
17 Are there reasons why people might report
18 something, you know, to gain some advantage
19 somehow?

20 I don't know what that would be,
21 you know. Just wondering whether there's,
22 whether this is actually even as reliable a

1 measure --

2 Certainly place of birth seems
3 pretty clear to me. But year of entry seems
4 like one that might be hard to be certain
5 about its reliability and validity.

6 DR. RODRIGUEZ: If I may respond
7 directly. It's a more difficult measure to
8 obtain. The developers have done a lot of
9 work in terms of how to ask that.

10 I mean the way that we're
11 proposing is actually to use the census
12 wording, where they have pointed when you came
13 to live in the U.S., not when you came to
14 visit or to stay for a period of time. When
15 you came to live.

16 It's still very some limitations
17 in the data. Especially when you have, you
18 know, anti-immigrant, you know situation,
19 political situation. It might be difficult to
20 get.

21 But it still doesn't mean that
22 it's not important to try to obtain. We know

1 that we have a lot of issues with the
2 race/ethnicity, you know, quality of the data
3 and the completeness.

4 That doesn't mean that it's not
5 important to collect. But there are
6 challenges in collecting this variable
7 compared to the country of birth. So I agree
8 on that.

9 CO-CHAIR JARRIS: Matt, and then
10 Madeline.

11 MEMBER STIEFEL: Paul, to your
12 question. There's a good example I think from
13 the U.K., the NHS. They don't have a life
14 expectancy goal.

15 But they do have a goal for the
16 disparity between the first and fifth
17 quintiles of the deprivation index for life
18 expectancy. So I think that's the kind of
19 thing that we're talking about.

20 CO-CHAIR JARRIS: So somewhere in
21 there, there were building blocks for
22 deprivation index that had to get started.

1 And I think that's our question. Do we look
2 at building blocks.

3 MEMBER NAEGLE: Yes. I wanted to
4 speak just a little bit to the comments you
5 made in your rationale about health literacy.
6 I'm just remembering that health literacy
7 among our mainstream population in this
8 country is relatively low.

9 So when you're trying to collect
10 this data, which we can see is relevant to
11 health status, explaining that to immigrant
12 populations, or having immigrant populations
13 understand the meaningfulness, or the
14 usability of this kind of information, it
15 would seem to me would even complicate our
16 collection of it.

17 And I think that's something that
18 CDC may want to think about in terms of how we
19 gather information which we see is very
20 relevant to the development of both measures
21 and targeting interventions. But really is
22 not a wide -- Well we're going to have some

1 difficulties getting reporting from the
2 public, for sure.

3 CO-CHAIR JARRIS: Any of the
4 committee members on the phone have a comment?
5 And if not, why don't we move on to the voting
6 process. Okay. Elisa?

7 MS. MUNTHALI: Okay. We will
8 start again with 1A, impact. The rating
9 scale. One high, two moderate, three low,
10 four insufficient. And I think time has
11 already started. Six people we're waiting for
12 in the room. One more person. Thank you.
13 Sarah, Linda on the phone?

14 MEMBER KINSINGER: I think I'd say
15 insufficient.

16 MS. MUNTHALI: Okay.

17 MEMBER LINDE-FEUCHT: This is
18 Sarah. I'd say low.

19 MS. MUNTHALI: Okay. So we have
20 three moderate, we have seven low and two
21 insufficient. For 1B, opportunity for
22 improvement. Performance gap. Sorry. Same

1 rating scale. And time has started. One more
2 person. Thank you. Linda and Sarah?

3 MEMBER KINSINGER: Low.

4 MS. MUNTHALI: Okay.

5 MEMBER LINDE-FEUCHT: And this is
6 Sarah. Low.

7 MS. MUNTHALI: Okay. So we have
8 one moderate, ten low, one insufficient. And
9 for 1C, evidence. This is one for yes, two
10 for no, three for insufficient evidence. And
11 time has started. Four more people in the
12 room we're waiting for. Three more. Two
13 more.

14 I think one more. Okay, I think
15 that was nine, right? No, ten. We got ten.
16 Linda and Sarah?

17 MEMBER KINSINGER: No.

18 MEMBER LINDE-FEUCHT: And this is
19 Sarah. No.

20 MS. MUNTHALI: So ten no's and two
21 insufficient. So the measure doesn't pass.

22 CO-CHAIR JARRIS: Well this was a

1 extremely helpful conversation. And I think
2 it's going to be very informative to this
3 process.

4 So although the measures did not
5 make it through the criteria as they exist
6 today, this has been a very valuable process.
7 And we want to thank you for the opportunity
8 to have this discussion, and really move our
9 thinking along significantly.

10 And we're looking forward to
11 figuring this out, so these measures can come
12 back to us in a way that meets the meaningful,
13 criteria set in a meaningful way. So thank
14 you.

15 DR. RODRIGUEZ: Well thank you
16 very much. I appreciate the comments from the
17 committee. I look forward to working with you
18 in the future.

19 CO-CHAIR JARRIS: So I believe we
20 actually are -- We can take a break now, a
21 little ahead of schedule. And then we can
22 come back in 15 minutes. So about 25 of the

1 hour. Does someone on the phone want to say
2 something?

3 MEMBER LINDE-FEUCHT: Yes. Paul,
4 this is Sarah Linde-Feucht. I actually have
5 to sign off for a little bit. I am not
6 positive I'm going to be able to rejoin today.

7 I do have one of my HRSA
8 colleagues, Ian Corbridge, on the phone. I
9 don't know if the procedures of NQF allow me
10 to give him my proxy vote in my absence.

11 But I just -- If so that would be
12 great. If not, I just wanted to say, if I'm
13 not answering, it's because I'm not on the
14 phone.

15 CO-CHAIR JARRIS: I suspect that
16 that, what we probably need to do is we will
17 send out a posse to find you if we fall below
18 a quorum. But otherwise we'll continue.

19 MEMBER LINDE-FEUCHT: Okay.

20 CO-CHAIR JARRIS: And hopefully
21 you'll be able to join us tomorrow. Because
22 I'd be very interested in your perspective

1 from, to the extent you can reflect a broader
2 HRSA perspective on the measures. And why we
3 might or might not have gotten more measures
4 from HRSA.

5 MEMBER LINDE-FEUCHT: Yes, okay.

6 CO-CHAIR JARRIS: Thanks. Break
7 time?

8 MS. MUNTHALI: Anika?

9 (Whereupon, the above-entitled
10 matter went off the record at 10:21 a.m. and
11 resumed at 10:40 a.m.)

12 CO-CHAIR JARRIS: Okay. So the
13 next measure we'll be discussing is 1999, late
14 HIV diagnosis, and 2020, adult current smoking
15 prevalence. And, Pascale, are you on the
16 line?

17 DR. WORTLEY: I am. Irene Hall is
18 -- I haven't been able to reach her. So she
19 may be just joining me at 11:00 a.m.

20 CO-CHAIR JARRIS: Very good.

21 Would you like to get started? Are you able
22 to?

1 DR. WORTLEY: You know, well
2 depending on the nature of the questions, it
3 probably would be good to have her here, since
4 she's, you know, more expert in the
5 surveillance system itself than I am. So it
6 kind of depends on the nature of the
7 questions.

8 CO-CHAIR JARRIS: Would you be
9 able to do an introduction? Or should we go
10 to the committee people who reviewed this?

11 DR. WORTLEY: An introduction as
12 in describing the measure?

13 CO-CHAIR JARRIS: Yes.

14 DR. WORTLEY: Yes, I could. I
15 wasn't really sure, you know. I didn't really
16 know how this was going to play out. But I'd
17 be happy to.

18 CO-CHAIR JARRIS: We're making it
19 up as we go.

20 DR. WORTLEY: Yes. I can do that.

21 CO-CHAIR JARRIS: Please do.

22 DR. WORTLEY: Oh, okay. I wasn't

1 sure if everybody could hear me at this point.
2 So I'm Pascale Wortley. And I work in the
3 division of HIV AIDS prevention.

4 And my colleague, Irene Hall, who
5 heads up the surveillance branch, will be
6 joining me shortly. So we proposed this
7 measure on late testing because it's something
8 that we would like to see change over time.

9 As described in the document that
10 you received, the late testers are those who
11 each year are diagnosed with HIV who are
12 essentially diagnosed at the same time with
13 Stage III HIV infection, that is, AIDS.
14 Generally based on a CD4 count under 200.

15 So obviously at this point in the
16 epidemic we would like to not be seeing such
17 a substantial chunk of people diagnosed late
18 in their course. And therefore not having
19 been tested earlier.

20 We are holding steady at around
21 just a little under 30 percent of new HIV
22 diagnoses every year, representing people who

1 are having a concomitant Stage III diagnosis.

2 We expect to see changes in this
3 measure as testing rates increase. Or as the
4 right people are tested. And I'm saying that
5 because routine opt out testing is recommended
6 for facilities where there is an undiagnosed
7 prevalence in HIV greater than 0.1 percent.

8 But that obviously doesn't apply
9 to everywhere in the country. But in lower
10 prevalence areas there's more of a target,
11 focus on targeted testing, that is, reaching
12 high risk people.

13 In any event, the result of
14 effectively applying these approaches should
15 result in a decrease in persons diagnosed late
16 in their course of illness. Does that cover
17 what you need out of an overview?

18 CO-CHAIR JARRIS: Yes. Thank you.
19 And Mike or Linda, did you want to speak to
20 this?

21 MEMBER STOTO: Can I do the -- Hi
22 Pascale. This is Mike Stoto. We worked

1 together on --

2 DR. WORTLEY: Yes.

3 MEMBER STOTO: -- unrelated issues

4 --

5 DR. WORTLEY: I remember you.

6 MEMBER STOTO: -- some time ago.

7 And I think this a really very interesting
8 proposal. And Pascale, in the earlier
9 discussions this morning we were confronting
10 some difficulties, I think with the
11 documentation with which we ask you to justify
12 these things.

13 And I think this one presents a
14 different set of problems on our end in what
15 we're asking for. I think that having worked
16 in this, in the field of HIV for a long time,
17 to me this actually makes a lot of sense.

18 Because what it really is, is a
19 way to measure whether or not people have been
20 tested, screened and tested early. It sounds
21 of course there is that you don't know how
22 many people are HIV positive for the

1 denominator.

2 So what they do, like is done in
3 cancer, they look for people who are diagnosed
4 at a late stage, which is what this is all
5 about.

6 DR. WORTLEY: Right.

7 MEMBER STOTO: And so the
8 intervention that really is the focus of this
9 is screening. Spreading the spread and
10 utilization of screening.

11 So the evidence, questions about
12 evidence really ought to be about, what is the
13 evidence that screening makes a difference?
14 Both to the individuals themselves, in terms
15 of their outcomes. And in terms of preventing
16 spread to others.

17 And I think that the evidence
18 there is actually quite strong, and has been
19 for some time. And of course there are strong
20 recommendations from CDC about universal
21 screening and things like that.

22 So I think that if understood that

1 way, the evidence for the importance and the
2 impact of this is quite high. But I think
3 that because it really hasn't been written up
4 quite in that way, I think that presents a bit
5 of a difficulty to the committee.

6 DR. WORTLEY: Oh, in terms of what
7 we submitted.

8 MEMBER STOTO: That's right. And
9 I think --

10 DR. WORTLEY: Yes. And, you know,
11 to tell you the truth I felt like I was trying
12 to fit a little bit a square peg in a round
13 hole.

14 MEMBER STOTO: Well you were. You
15 were. And for a number of reasons. And I
16 think that this is, like I said, this is
17 something that we have to do at our end, is to
18 improve that documentation request process.

19 But I think that understood that
20 way -- And also the other thing I should say
21 is about disparities. I mean, they do, the
22 documentation does make a good case for

1 disparities, a number of dimensions,
2 performance gaps, and so on.

3 So I think that if understood that
4 way, the evidence is quite strong for this.
5 So I think it's a problem of documentation,
6 not of the merit of the measure.

7 The other thing I would say is
8 about the scientific properties, validity and
9 reliability, and so on. And here, and maybe
10 your colleague once she gets here, will have
11 something more to say about this.

12 But the, what the documentation
13 basically says is, this is all in the
14 surveillance system. And what it doesn't
15 address is, how does it get into the
16 surveillance system?

17 And, you know, there are issues
18 that I know have been thought, people have
19 spent a lot of time thinking very carefully
20 about.

21 Like suppose somebody is first
22 diagnosed in Arlington, Virginia. And then

1 has an AIDS diagnosis in a hospital near where
2 I work, from which you can see Arlington,
3 Virginia, but it's in D.C. Does anybody
4 really know that people are matched up the
5 right way, and so on. That's critical for
6 getting this right.

7 DR. WORTLEY: Right.

8 MEMBER STOTO: And I believe that
9 CDC has worked hard to get that as good as
10 possible. But I think that's the kind of
11 thing that we need to be thinking about here.

12 DR. WORTLEY: Yes. And Irene
13 discussed that on the last call. And I think
14 the example you're picking is the perfect
15 example of a tangled area. So, you know, she
16 can address that a lot better than I can.

17 I do tend to think that even
18 though on the last call we discussed using
19 this measure at different levels, because of
20 those challenges and some other reasons, I
21 think it's best used at a more macro level,
22 like a State, than trying to dive deeper.

1 MEMBER STOTO: Which is I think
2 fine for the population that we're talking
3 about. I think that's the appropriate level
4 too.

5 CO-CHAIR JARRIS: Can I ask, could
6 it be if the -- Is it possible to actually
7 look at the point of testing? Although --
8 And look backwards to say, is there evidence
9 or documentation that there was a referral
10 from, or a followup and a referral on the test
11 from the point of testing? I know, I think --

12 DR. WORTLEY: Well that would be
13 hard through the surveillance system.
14 Probably not really doable. It would require
15 different data sources.

16 CO-CHAIR JARRIS: Linda, did you
17 want to add anything.

18 MEMBER KINSINGER: Yes. So I was
19 -- HIV's not an area that I work in a lot.
20 So I may be coming at this not as well
21 informed as others.

22 But I couldn't understand the

1 rationale for changing the time frame from 12
2 months to three months, when in fact, the
3 documentation that was submitted says, almost
4 85 percent of persons diagnosed with Stage III
5 within 12 months of a diagnosis were in fact
6 diagnosed within three months.

7 So it seems like most everybody's
8 giving diagnosis in three months. But I
9 couldn't really tell from the justification
10 that was given how changing the measure from
11 12 to three months would improve reporting.
12 And perhaps would drive screening. I just
13 couldn't make those links together. So that
14 was my concern.

15 DR. WORTLEY: let me try to
16 clarify --

17 MEMBER STOTO: Can I just add one
18 more thing to that? I think that you might
19 argue that in fact many people -- I'm sure
20 it's true that many people are diagnosed with
21 AIDS at the same time they're diagnosed with
22 HIV. Not just three months or 12 months, but

1 simultaneously. So I wonder even why it
2 should be not zero, rather than --

3 DR. WORTLEY: Right. So the
4 reason -- Let me address that first. The
5 reason it's not zero is because we need to
6 allow some time for that initial CD4 count
7 report to come in. And somebody might --

8 Imagine somebody gets tested, gets
9 their test result today. And then they're
10 going to go see a provider. And that provider
11 will do a CD4 count, and lo and behold, it's
12 190.

13 But that doesn't happen the same
14 day. But we would expect that it would happen
15 within three months. So that's the reason for
16 that. But they are in fact -- Mike, you're
17 right. At the time that person was tested
18 they had AIDS, they just didn't have the
19 documentation of it.

20 MEMBER STOTO: So then moving to
21 12 months would --

22 DR. WORTLEY: But the 12 months is

1 what we're moving away from. So that is an
2 old measure that we're moving away from. And
3 if Irene is on the line now --

4 DR. HALL: Yes. I'm on.

5 DR. WORTLEY: Oh, she is. She may
6 want to address why we used to look at the 12
7 months and are now moving to the three months.
8 And just to clarify again, the reason we
9 didn't provide data for the three months, even
10 though that's the new thing, is because that
11 data is going to be released soon.

12 And we can't be releasing here
13 first. But I'm going to turn it over to
14 Irene. Because she's the best person to
15 address that.

16 DR. HALL: Yes. The problem with
17 the 12 month measure is that it really is a
18 combination of late diagnosis and if people
19 get treatment in time.

20 So it's really not a good measure
21 to determine what the stage of disease is at
22 diagnosis. So we are moving now to a measure

1 that we call stage of disease at diagnosis,
2 which is in line with our case definition.

3 And as --

4 I just heard a snippet here from
5 what Pascale was saying, that we define it as
6 a measure that we received in three months,
7 because the person gets diagnosed and they
8 need the care. And we need to get the lab
9 report in a certain --

10 We need to allow a certain amount
11 of time for people to go into care and get
12 that first CD4 measure. And we just define
13 that as three months.

14 I mean, in theory everybody should
15 be seen by care within 30 days. But as you
16 know, that doesn't always happen. So that's
17 our reason.

18 DR. WORTLEY: So it is meant to be
19 a measure of concomitant, of being Stage III
20 at diagnosis.

21 MEMBER STOTO: That makes a lot of
22 sense to me. Irene, I don't know if you heard

1 the earlier question about matching up people
2 who may have been diagnosed with HIV in one
3 State, with AIDS in another State, and so on.

4 DR. HALL: Yes. So we are --
5 Every six months we send out potential
6 duplicates that we find in a national data
7 base. And those thousands of those potential
8 duplicates, they go out to the State partners.
9 And they resolve whether these people are the
10 same as, or different than.

11 And they mark that in the
12 database, so that we at the national level
13 know which reports we need to combine as one
14 report, versus which reports are actually two
15 different persons.

16 MEMBER STOTO: Okay. I thought
17 that was done. Glad to hear that. Thank you.

18 CO-CHAIR JARRIS: Linda, was your
19 question addressed?

20 MEMBER KINSINGER: Yes, I think
21 so. Thanks.

22 CO-CHAIR JARRIS: Kurt.

1 CO-CHAIR STANGE: So it seems to
2 me that it is a population health measure.
3 And that interventions by probably multiple
4 stakeholders would primarily affect the
5 denominator. And the effect would be to
6 access to care.

7 And then what happens in care, as
8 far as how sensitive that is to early
9 detection. But also to screening programs.
10 There could be population or community based
11 screening programs. And then maybe indirectly
12 by mechanism --

13 I can't really quite do the logic
14 diagram in my head. Through prevention
15 programs. But it does seem like it has
16 multiple determinants that are more than just
17 what happens inside health care. So it does
18 seem like a population health measure.

19 MEMBER STOTO: Well counseling and
20 testing is one of the main HIV prevention
21 programs.

22 CO-CHAIR STANGE: Right.

1 CO-CHAIR JARRIS: Other comments,
2 questions? Amir?

3 MEMBER QASEEM: How is this
4 measure going to take into account home
5 measurement that's going to be coming?

6 DR. WORTLEY: The home test?

7 MEMBER QASEEM: Yes.

8 MEMBER QASEEM: You know, we don't
9 know. I mean, at this point we really don't
10 know what the uptake of the home test will be.
11 The idea is, is that somebody who was to test
12 positive at home would then present for care.
13 And then that provider would test them again.

14 CO-CHAIR JARRIS: So could I
15 hypothesize on that? Because this could very
16 well be a measure of what happens in the
17 clinical setting. But if we -- And so a
18 clinical measure.

19 But if we go to our second and
20 third sort of tiers, the behavior, healthy
21 behavior and lifestyles, they're messaging
22 around safe sex. But messaging around early

1 testing, you know, before you get engaged with
2 someone, make sure you're both tested.

3 All that kind of messaging can
4 affect this also. So as well as -- So maybe
5 the partners choose to home test. But if you
6 have an environment in which that means, I
7 better go get evaluated right away, and you've
8 created an environment where people can do
9 that in a welcoming and safe way, it will
10 happen.

11 So I think home testing should
12 feed people more in a early fashion into
13 clinical testing, you know, diagnostic testing
14 in a clinical setting. So what I like about
15 this is it affects the clinical setting. It
16 affects the healthy behaviors.

17 And also you can look at policy.
18 Do you have needle exchange programs that are
19 actively doing prevention counseling? That
20 are also doing HIV testing? That are talking
21 about safe sex? So it hits all three levels
22 of what the NPP call population health.

1 MEMBER STOTO: So I guess from a
2 measurement validity point of view, though,
3 the question is, suppose somebody tests
4 positive on a home test. Is that fact
5 reported to a local or state health department
6 or CDC?

7 CO-CHAIR JARRIS: It won't be
8 required to be. But on the other hand, if you
9 create an environment where people then go to
10 clinical testing, the right thing has
11 happened. And in theory --

12 MEMBER STOTO: So I think -

13 CO-CHAIR JARRIS: -- it could
14 drive earlier testing.

15 MEMBER STOTO: So I think that
16 actually helps the validity. So the home
17 testing is basically an incentive for people
18 to get into the official system, essentially.

19 DR. WORTLEY: I think if home
20 testing doesn't result in people who test
21 positive presenting for care, there's a
22 failure there. I mean, because we want these

1 people to then show up for care somewhere.

2 And if that person who tested
3 positive and then waited five years, and
4 presented for care once they were systematic,
5 that would be a problem.

6 I mean, they would show up as a
7 late tester, even though in fact, they had
8 tested earlier. But the testing would not
9 have accomplished what it needed to.

10 DR. HALL: That's not really a
11 diagnosis, home testing, right?

12 DR. WORTLEY: No. Not a confirmed
13 diagnosis.

14 CO-CHAIR JARRIS: Bobby.

15 MEMBER PESTRONK: How does NQF, on
16 the clinical side, deal with this sort of
17 fractaling that happens in the conversation
18 about a particular measure? I mean, now we're
19 beginning to examine other aspects of the care
20 system that could influence this population
21 measure.

22 And yet, it seems to me from the

1 discussions that we've had, NQF wouldn't call
2 for -- Or maybe I shouldn't say that. Would
3 NQF, now recognizing that it would be useful
4 to have other kinds of quality measures in its
5 basket, call for these other kinds of measures
6 in order to have a more complete understanding
7 of how the care system's actually working?

8 DR. BURSTIN: That's a great
9 question. And I like fractaling as well, of
10 a measure. I haven't thought about it that
11 way.

12 I think in some ways what we would
13 really more so look at is whether those other
14 considerations, like home testing, are threats
15 to validity of this measure.

16 So as an analogy, we've had a
17 whole series of discussions about the
18 medication adherence measures that we have
19 endorsed, in which increasingly people are
20 using the \$4 generics, and not necessarily
21 putting those prescriptions through their
22 health plan at all.

1 And so increasingly there's
2 concern that that estimated ten to 15 percent
3 of prescriptions, to look at adherence with
4 certain drugs, may not be captured in health
5 plan data anymore. Sarah knows this well.

6 Is that a threat to validity of
7 any of the other underlying adherence
8 measures? So I think for where we are right
9 now is, I'm listening to this discussion.

10 The main question for me is, is
11 the growing movement towards home HIV testing
12 an inherent threat to the validity of this
13 measure?

14 Or is it something, which I think
15 it is given the newness of that, that that is
16 something that we would encourage CDC to keep
17 an eye on, you know, as the measure comes back
18 for re-review.

19 They increasingly try to present
20 data to give us a sense of what proportion of
21 patients we might not be capturing because
22 they're going outside the traditional testing

1 pathway.

2 CO-CHAIR JARRIS: And, Pascale, or
3 others, can you, I mean, there must be
4 research into the whole notion of home
5 testing. Because there certainly was
6 objections to that by many people, that
7 demonstrated some benefit to home testing.

8 And, for example, was it
9 specifically looked at, that home testing
10 actually did drive into earlier clinical care?
11 Because there's probably literature on this.

12 I can't believe FDA approved it,
13 and CDC would have endorsed it if there wasn't
14 some evidence to say home testing is a good
15 thing.

16 DR. WORTLEY: And you know, I'm
17 unfortunately not familiar with that body of
18 literature. But I would imagine that there
19 was information presented. And also I would
20 guess, and I certainly can follow up and find
21 out for you, is that I'm sure we'll be
22 monitoring it.

1 The question is through which
2 vehicle we'll be monitoring it. And we do a
3 survey of high risk persons. And I would
4 think that would be one way that we would
5 monitor it. So at this --

6 CO-CHAIR JARRIS: So if the
7 measure is a population health measure,
8 basically saying, if you do well on this
9 measure, that people are diagnosed early on.
10 That essentially means you've created a whole
11 environment among that population, where
12 people seek testing and care early.

13 So if you were being measured on
14 this, let's say as a kind of a care
15 organization, and doing poorly, you would have
16 to go out in the community to work on this
17 issue, which is what I like about it. It
18 really does drive people toward a population
19 approach.

20 And one of those strategies you
21 might very well specifically take on is home
22 testing, as a way of feeding people in. So I

1 think it may not at all be in conflict with
2 this measure. It may actually be supportive,
3 and an intervention you'd want to take up to
4 improve on the measure.

5 MS. JACOBSON: Elisa, this is
6 Dawn. I'm on the call. Can I make a quick
7 comment on this, that I would like to put on
8 the table to discuss tomorrow as well?

9 MS. MUNTHALI: Sure.

10 MS. JACOBSON: What I liked about
11 this measure is that it is a real population
12 health measure, that uses a population health
13 data set.

14 And I think, if you think of the
15 table that we were doing as examples in the
16 white paper, what you're describing are
17 interventions that would be what we're, at
18 least for now, calling health improvement
19 activities, that would either be done by the
20 clinical care system or, you know, another
21 community based organization or a public
22 health agency.

1 And so this is where the linking
2 of the health improvement activities to the
3 ultimate population health outcome measures
4 that were selected would come into play. And
5 no one's reporting like that yet.

6 If NQF moves in that direction, it
7 would be the first organization that I know of
8 that would be really getting the complimentary
9 and synergistics. And your interventions link
10 to the health outcome.

11 Even healthy people doesn't do
12 that. They mix them up in their chapters. So
13 I would like to put that on the table for
14 tomorrow's discussion.

15 CO-CHAIR STANGE: This is Kurt. I
16 think it's -- I also like this as a
17 population health measure. And I think it's
18 really an outcome measure. And the point that
19 Bobby brought up.

20 I think there is a higher level of
21 utility of a measure that lets you start
22 thinking mechanistically about the ways that

1 it might be changed. I don't think to be a
2 good measure that you have to have those
3 mechanisms built into the measure.

4 And the simplicity of this,
5 particularly for something that we don't
6 really have a good way of getting a
7 denominator, is nice.

8 I mean, if there are some ways to
9 add some of those things on that would let you
10 know what you would do about this outcome,
11 that would be great.

12 But I don't think it needs to be a
13 criteria. Because I think that just
14 complexifies the measure. And it really
15 starts to eat away at the feasibility.

16 CO-CHAIR JARRIS: And we don't
17 want things complexified. So, Mike.

18 MEMBER STOTO: I agree with those
19 comments. I want to come back to Helen's
20 point about viewing this as a threat to
21 validity, the home testing, and broaden it a
22 little bit.

1 I think the way you have to think
2 about this is that, the concept we're talking
3 about is widespread in early screening, and
4 widespread in early testing. Although it's
5 measured in terms of proportion with late
6 diagnosis. The concept really is screening
7 and testing.

8 And then if you think about it
9 that way the home testing is not a validity
10 problem. But in fact, it's an intervention.
11 And I think that makes it -- I'm more
12 comfortable with it because of that.

13 MEMBER BIALEK: Does the validity
14 of the measure ever become part of what gets
15 approved as the measure? What I mean by that
16 is, in this instance we have it looks like 80
17 percent or so completeness.

18 And if one determines that this is
19 an important measure, and if the completeness
20 of the reporting declines, then that would
21 suggest there's a potential adverse population
22 health impact. And so does the completeness

1 of the measure possibly become a measure as
2 well?

3 MEMBER STOTO: What's the 80
4 percent completeness?

5 MEMBER BIALEK: What I was reading
6 here is completeness of HIV and AIDS case
7 reporting is estimated at more than 80
8 percent. And I didn't know if that meant --

9 MEMBER STOTO: So I think the
10 question -- If 80 percent -- If there's 80
11 percent completeness of the original HIV test,
12 and 80 percent of the AIDS result, the
13 proportion late may actually be correct.

14 Even though there's
15 incompleteness. So I think you have to sort
16 of come back to the question about what's the
17 concept that's being measured here. And it
18 may be that that completeness is not an issue.

19 I need to think it through to be
20 sure about that. But that's the question I
21 think really is, does this completeness get in
22 the way of this measure measuring the concept

1 that we want?

2 CO-CHAIR JARRIS: Is completeness
3 something that is tracked on an ongoing basis?
4 And how do you do that?

5 DR. HALL: So we have completeness
6 measures for -- We evaluate our surveillance
7 system once a year. And we have some methods
8 that we use, like capture recapture. Or we
9 calculate the expected numbers based on some
10 regression analyses.

11 And right now HIV and AIDS
12 reporting is mandatory in all areas. Of
13 course there's always possibilities that
14 completeness may lag because of personnel
15 turnover or other issues.

16 And it is also really very, very
17 high, virtually 100 percent, in areas where
18 there's 100 percent mandated laboratory
19 reporting, where all HIV diagnostic reports
20 come in, and where all CD4s are reported.

21 As you may know, most of the AIDS
22 classifications are these days based on CD4,

1 rather than on ROIs. So while there are
2 always, you know, some challenges with
3 completeness, completeness is very high for
4 the surveillance system.

5 And the other incentive for being
6 complete is that Ryan White funding is based
7 on both AIDS case reporting and HIV case
8 reporting. So it's in the interest of all
9 areas to make sure that they have complete
10 data.

11 CO-CHAIR JARRIS: What is the
12 possibility of looking at this at less than a
13 State level? Or perhaps you have directly
14 funded counties or cities. But I mean, how
15 could this be used at a health system level?
16 A health care system level?

17 DR. HALL: Well the levels that
18 can be looked at is state, city, county,
19 census tract and by diagnostic facility. So
20 it can be looked at, you know, at all of these
21 levels.

22 DR. WORTLEY: I think that when we

1 think about looking at it by diagnostic
2 facility, it's probably good to think about
3 what kind of facilities it would make sense to
4 look at for. For example, closed systems like
5 Kaiser or VA. I think it's easy to see that
6 it would make a lot of sense.

7 Other facilities it wouldn't make
8 necessarily a lot of sense. Because it might
9 just be a place where, you know, people showed
10 up, presented once they were ill. And their
11 testing could have happened anywhere. But
12 used judiciously, it could be used at the
13 health system level.

14 CO-CHAIR JARRIS: Matt, and then
15 Bobby.

16 MEMBER STIEFEL: Perhaps this is a
17 tomorrow topic as well. But there have been
18 several comments that this is an outcome
19 measure.

20 And it's important because we have
21 to make a determination here about if it's an
22 outcome measure or not in our evaluation. It

1 is certainly associated with an outcome.

2 But, you know, I might argue that
3 it's somewhere in the causal pathway short of
4 an outcome. That the outcomes have to do with
5 infection rates and complications of the
6 disease, and mortality associated with it.

7 And so I mean, there's an
8 immediate question about how do we handle
9 that. But then the broader question about
10 families of measures on this causal pathway to
11 outcomes.

12 And maybe this is a piece of a
13 family of measures that ultimately I think we
14 would want to look at infection rates and
15 mortality.

16 MEMBER STOTO: Could I just speak
17 to that one? I mean, Dawn mentioned that it
18 was a population measure. And I agree with
19 that. But I agree with Matt, that I don't
20 think this is an outcome measure.

21 And I think that if we could
22 somehow measure the proportion of people who

1 have HIV, who have been tested positive, which
2 I think this is what this gets at. We would
3 see that would be a process measure. And that
4 would be short of an outcome measure.

5 CO-CHAIR JARRIS: But it's a
6 process measure. But it's not unlike A1C,
7 which is a proximal measure. BMI is not an
8 outcome measure.

9 MEMBER STOTO: I think it's more
10 like have you been tested for A1C, rather than
11 what is your A1C level.

12 CO-CHAIR JARRIS: Well it began
13 with, have you been tested in the last year?
14 And then it went to six months. And then it
15 went to the A1C level of less than seven,
16 where all of us in clinical medicine thought
17 we were going to be killing people, until we
18 learned you could actually do that. And so,
19 you know, this measure may be the same, that
20 over time it gets refines.

21 MEMBER STOTO: But as you went
22 through that progression, you switched from a

1 process to an outcome measure. And I think
2 that even though this is measured in terms of
3 disease status, in fact what it's getting at,
4 the concept that it's getting at is screening.

5 DR. BURSTIN: I think we would
6 classify this as an intermediate outcome
7 measure. Very analogous to A1C testing versus
8 blindness, mortality, et cetera, complications
9 from diabetes.

10 Late diagnosis in general, I mean,
11 I think that there's multiple measures that
12 sort of look at an outcome of a late
13 diagnosis, which I think is essentially
14 getting at. To me it's an intermediate
15 outcome. But it's --

16 MEMBER STOTO: Yes, but I don't
17 think it's getting at late diagnosis. I think
18 late diagnosis is the specific thing that's
19 being calculated.

20 But I think the real thing that
21 they're interested in is screening. And
22 that's the challenge here is, that the late

1 diagnosis.

2 I mean, there's no doubt, if you
3 look at the words it's late diagnosis. But
4 the reason for doing it is because -- And
5 that's the distinction I think is important
6 here.

7 MEMBER QASEEM: So Michael, if
8 it's getting to the screening, why don't we
9 just make it the screening measure? I'm a
10 little bit confused. Maybe I'm getting lost
11 a little bit here.

12 MEMBER STOTO: Well there's two
13 ways of doing that. One is you could say, of
14 everybody, what proportion has been screened?
15 And I guess you could do that with the survey
16 questions.

17 MEMBER QASEEM: Well because if
18 that's the intent, maybe that's what should be
19 the measure. Because that's now how it's
20 reading right now, the way it's written.

21 MEMBER STOTO: Yes.

22 CO-CHAIR JARRIS: This is more

1 than a screening measure. Because this is
2 basically at the point of diagnosis. What
3 stage are you at screening? You could be
4 screened and then never go to care. And
5 you've been successful at being screened.

6 MEMBER QASEEM: Exactly.

7 CO-CHAIR JARRIS: Except you're
8 dead. So I mean, this is a little bit further
9 downstream I think than just screening.

10 MEMBER STOTO: Well I agree with
11 Matt, that this is a question for tomorrow.
12 I don't think it's an easy call.

13 DR. WORTLEY: Can I just interject
14 one thing? One of the complexities around the
15 have you ever been tested issue, is that we're
16 not actually recommending for the entire
17 population of the country to be tested.

18 The recommendations read for
19 routine opt out testing in health care
20 facilities with an undiagnosed prevalence of
21 HIV greater than .1 percent. And so we do use
22 the NIHS, for example, to see what percent of

1 the population has ever been tested.

2 But the need for testing in Omaha
3 isn't the same as in New York City. So we
4 don't really know, well what should it be.
5 And in Omaha it probably makes more sense to
6 have targeted testing programs.

7 So the late tester diagnosis, what
8 it's really looking at is the effectiveness of
9 your testing program, however you're
10 implementing it given where you are, which
11 would be different in New York City and in
12 Omaha, for example.

13 CO-CHAIR JARRIS: Bobby, you've
14 had your card up.

15 MEMBER PESTRONK: I was going to
16 say that it's both screening and treatment.
17 But when I look now at the actual numerator
18 statement, there's nothing about treatment.

19 Diagnosis presumes treatment, I
20 guess. But it doesn't necessarily mean that
21 treatment has followed diagnosis. So it's
22 really screening then that this is looking at,

1 rather than treatment.

2 I think it's presumptuous to
3 assume that diagnosis necessarily leads to
4 treatment. The other thing -- So that's on
5 that, my observation on the last comments.

6 Before that, I am looking at -- I
7 mean, the outcome is certainly important. But
8 the way at least the evaluation sheet is
9 constructed right now, it talks about
10 opportunity for improvement. It doesn't talk
11 about outcome necessarily.

12 And there are lots of ways to
13 think about this as an opportunity for
14 improvement. And that's what I think is
15 important about this measure, as a population
16 measure.

17 That's because I don't know
18 anything about HIV and screening, and rates,
19 and what's actually going on there right now.
20 So my question to the folks that do know is,
21 how much variability is there right now, in
22 where there are data available to understand

1 what kind of variability in this measure there
2 might be? What's the answer to that question?

3 CO-CHAIR JARRIS: There is some
4 documentation in here on that, in terms of
5 people at high risk and low risk, and things
6 like that. And there is quite a bit of --

7 MEMBER PESTRONK: Quite a bit of
8 variability, yes. So then it's -- Yes, okay.

9 CO-CHAIR JARRIS: Matt, and then
10 Elisa.

11 MEMBER STIEFEL: Well it's kind of
12 a funny type of screening. It's like a
13 Bayesian screening measure. It's screening
14 given that the disease happens. And you don't
15 know that when you're going to do your
16 screening program obviously.

17 So the screening decision I think
18 we're hoping to induce or create, is screening
19 of what you know at the time, which is high
20 risk people. And so it just seems clearly
21 that this is a --

22 We're trying to improve screening

1 for high risk. Because you can't improve
2 screening for known disease. Otherwise it's
3 a cart and the horse problem.

4 CO-CHAIR JARRIS: But doesn't this
5 also drive the link between screening and
6 definitive diagnosis? It's not purely
7 screening.

8 MEMBER STOTO: Well the reason for
9 screening is to identify people who have the
10 disease. And the sooner the better.

11 CO-CHAIR JARRIS: But it doesn't
12 necessarily happen without building a system
13 where screening leads to care.

14 MEMBER STOTO: I guess -- Well
15 maybe the question is what you mean by
16 screening. I think that it's a screening and
17 testing, and getting a diagnosis.

18 CO-CHAIR JARRIS: Well I don't
19 lump all that together in screening.

20 MEMBER STOTO: Yes, right.

21 CO-CHAIR STANGE: So this is a
22 multi -- There are many pathways to get --

1 MEMBER STOTO: But not testing.

2 CO-CHAIR STANGE: -- to this
3 beyond screening programs.

4 MEMBER STOTO: But not treatment.

5 CO-CHAIR STANGE: I mean, there's
6 public awareness. There's early detection in
7 clinical care. There's lots of ways,
8 pathways, by which this is an overall
9 synthetic outcome issue.

10 MEMBER STOTO: Yes. So Dawn is
11 right that this really is a good example of a
12 population health measure. And it's one as,
13 I guess it was Pascale that was saying is that
14 is allows different communities to approach it
15 in different ways, depending on the nature of
16 their population and their respecer, and so
17 on.

18 And it really does measure pretty
19 well how good you're doing at screening and
20 diagnosing people at high risk, who are the
21 ones who should be getting it according to the
22 CDC recommendations, in an indirect way.

1 MEMBER QASEEM: But in this one
2 they are talking about treatment. Maybe I'm -
3 - Because they are talking about going to
4 Stage III. So the treatment is part of it.

5 I don't think this is -- I'm not,
6 again maybe -- Like Bobby, you just said that
7 it's reading as screening. I still don't
8 think so.

9 Because, yes, I completely agree
10 with what you're saying that it's diagnosis.
11 But then if you read the numerator it's
12 talking about diagnosing progressing to Stage
13 III.

14 MEMBER STOTO: Well but remember,
15 the three month window is aiming at getting at
16 the concept of someone being diagnosed with
17 AIDS at the same time they're diagnosed with
18 HIV.

19 And it's not that there's an
20 intervention within that three month period
21 that will stop you from getting, prevent you
22 from transitioning to AIDS. It's that you

1 were diagnosed with HIV so late in your
2 disease process that you're already at AIDS.

3 MEMBER QASEEM: So can I ask a
4 question from CDC folks? Can you just help us
5 out? What was your intent? Is it for getting
6 to screening? Maybe I missed that part. Is
7 it for screening? Or are you looking at
8 diagnosis here? I mean treatment.

9 DR. WORTLEY: No. It's not about
10 treatment. It's about really the
11 effectiveness of the testing activities in a
12 given state or community.

13 MS. MUNTHALI: I just wanted to
14 remind the committee about the preliminary
15 voting results from the workgroup. We have
16 those up on the screen. I don't know, Paul or
17 Kurt, are there any of the results for any of
18 the criterion that you want to point out?

19 I'll also have you look at the
20 overall recommendation and the rationale for
21 that. And feel free to ask your colleagues
22 for more input on that.

1 CO-CHAIR STANGE: I guess
2 particularly focusing on is there anything new
3 that hasn't come up in the discussion to focus
4 us toward getting ready to vote on these
5 things? So with this as yet another source of
6 input in addition of our discussion.

7 MEMBER STIEFEL: This is just a
8 question. How do we address the issue about
9 the data presented over 12 months, but the
10 measure is about three months? So when we
11 evaluate the sufficiency of the evidence, what
12 do we do there?

13 MEMBER STOTO: I think there's a
14 broader question that if they could re-write
15 their proposal, having heard this discussion,
16 they would make a much stronger case for a lot
17 of things. Not only that but a number of
18 thins.

19 So I think that if we look at the
20 documentation per se. And this is a much of
21 a problem, I think of NQF as it is of CDC, it
22 doesn't -- A lot of these points are not made

1 adequately. That's only one.

2 But I think that with everything
3 that we -- So I would vote very differently
4 knowing what I know, versus knowing what I saw
5 in the documentation, is the issue.

6 DR. BURSTIN: Just one comment, as
7 somebody who has reviewed way too many NQF
8 measures over the years. I actually think
9 this is actually quite well done.

10 I think the evidence is incredibly
11 clear. They make a clear connection between
12 early testing and the outcome. I think they
13 provided very good evidence that the
14 surveillance system is reliable, with a high
15 capture rate.

16 I do think Matt's point is well
17 taken. I think it would be helpful to
18 understand what they expect the differences
19 might be in terms of the reliability and
20 validity of the measure versus 12 months,
21 versus three months.

22 And is there any reason to expect

1 that those data are somehow going to suffer?
2 But I actually see this as quite good. And
3 actually remarkably fit the boxes well.

4 MEMBER STOTO: I disagree about
5 the documentation. But I agree about the
6 final value of the measure.

7 CO-CHAIR JARRIS: So this issue of
8 three months -- And like the CDC response.
9 Is it 12 months just to allow the period of
10 time to clean up the data?

11 DR. WORTLEY: Irene, do you want
12 to take that? Or I --

13 DR. HALL: Go ahead, Pascale.

14 DR. WORTLEY: Well the 12 months
15 was what we -- As Irene mentioned a while
16 ago, is the measure that has been in our
17 surveillance report for a number of years.

18 And because of the desire to make
19 it a cleaner measure, that is, a measure
20 simply of concomitant Stage III and HIV
21 diagnosis, that is, somebody who's being
22 diagnosed at the time they have CDC defined

1 AIDS.

2 It was changed to this three
3 months, which is -- The three months I think
4 has caused some confusion. But it is meant to
5 mean a concomitant. That's their stage of
6 diagnosis.

7 And because the data are being
8 currently prepared for release, we can't share
9 them with you. But the vast majority of
10 people, in terms of, you know, giving you a
11 sense of what the data would look like. They
12 don't really look that different.

13 Because the vast majority of
14 people who were diagnosed within 12 months in
15 fact have a concomitant diagnosis. Does that
16 clear things up a little? We don't expect
17 that the reliability or the validity would be
18 any different.

19 CO-CHAIR JARRIS: Okay. Anything
20 new before we go on to the voting process.

21 MEMBER KINSINGER: This is Linda.
22 I just have a question. So that's actually

1 really helpful. But do you expect changing it
2 to three months then to improve care? Or just
3 to make the whole process a little cleaner,
4 and more accurately reflecting what it is
5 you're looking for?

6 DR. WORTLEY: It makes the measure
7 cleaner. So it really -- As Irene was saying
8 before, when we look at what's in 12 months,
9 then the whole concept of treatment and
10 progression comes into play.

11 Whereas here we're just saying, of
12 the people who got newly diagnosed with HIV in
13 2012, how many of them were diagnosed so late
14 that they in fact already had AIDS? And
15 that's really what the measure is.

16 MEMBER KINSINGER: So you don't
17 necessarily expect performance of screening to
18 necessarily improve?

19 DR. WORTLEY: No, we do. Because
20 if, you know, at the extreme example, if we
21 were to all of a sudden screen everybody in
22 the country, all of those undiagnosed people

1 out there, and we know there's 250,000 of
2 them, would then be diagnosed. And they
3 wouldn't be diagnosed in five years or in ten
4 years when they might be late diagnoses.

5 CO-CHAIR STANGE: This is Kurt.
6 It seems to me that the going from 12 months
7 to three months improves the interpretability
8 of the measure.

9 DR. WORTLEY: Exactly. That was
10 the purpose of it.

11 MEMBER STOTO: And the only reason
12 --

13 DR. WORTLEY: Irene, if I'm saying
14 anything wrong, correct me.

15 DR. HALL: I'll correct.

16 MEMBER KINSINGER: And that seems
17 a good outcome, to have it be clear. But I
18 just think it's important for all of us to
19 understand that's what we're looking for, is
20 just simply -- Not simply perhaps. But just
21 trying to make this a better measure, as
22 opposed to expecting that all overall care

1 processes will change.

2 MEMBER STOTO: And the reason that
3 the 12 month figures were presented is because
4 the three month -- It's just a timing issue.
5 The three month figures are not publicly
6 available.

7 DR. WORTLEY: Right. If we had
8 been doing this in six months, we wouldn't
9 have even had to talk about the 12 month
10 measure. We wouldn't have. All we would have
11 talked about was the new measure.

12 CO-CHAIR JARRIS: So now that
13 we've decomplexified this, let's move on to
14 voting.

15 MS. MUNTHALI: Follow my own
16 instructions. For 1A, impact, our rating
17 scale, high, moderate, low, insufficient
18 evidence. We have everyone in the room. I
19 think Linda's gone. Oh, Linda, you're still
20 there. But Sarah's gone.

21 MEMBER KINSINGER: Moderate.

22 MS. MUNTHALI: Okay. And so we

1 have eight high and three moderate. So we can
2 go on to 1B, performance gap. Same rating
3 scale. Three are missing from the -- Okay,
4 we have everyone. Linda?

5 MEMBER KINSINGER: Moderate.

6 MS. MUNTHALI: Okay. So we have
7 seven high and four moderate. And so 1C,
8 evidence. This is one yes, two no, three
9 insufficient evidence. One more. Okay, we
10 have everyone in the room. Linda?

11 MEMBER KINSINGER: Yes.

12 MS. MUNTHALI: Okay. So that's
13 ten yes's and one no. So we move on to the
14 second criterion. Oh, sorry. We have to --
15 Sorry, I was moving too fast. Okay. So this
16 is reliability and validity. The scientific
17 acceptability of the measure properties.

18 And just to remind you, this is
19 the extent to which the measure as specified
20 produces consistent and credible results about
21 the quality of care when implemented. And the
22 measure testing must demonstrate adequate

1 reliability and validity in order to be
2 recommended for endorsement.

3 And so for 2A, which is
4 reliability, high, moderate, low, insufficient
5 evidence. I think we need three more. Okay,
6 we have everyone in the room. Linda?

7 MEMBER KINSINGER: Moderate.

8 MS. MUNTHALI: Okay. So four high
9 and six moderate, and one low. Okay, so we'll
10 move on to 2B, which is validity. And again,
11 same rating scale. I think we have one
12 missing from the room. Okay, we have
13 everyone. Linda?

14 MEMBER KINSINGER: Moderate.

15 MS. MUNTHALI: Okay, so three high
16 and seven moderate, and one low. Okay. So
17 now we're moving on to usability. And this is
18 the meaningful, understandable and usefulness
19 for public reporting.

20 Rating scale, high, moderate, low,
21 insufficient evidence, insufficient
22 information. The timer has started. We're

1 missing four. We have all ten. Linda?

2 MEMBER KINSINGER: High.

3 MS. MUNTHALI: Okay. So we have
4 six high, four moderate and one low. Okay.
5 So feasibility. The extent to which the
6 required data are readily available,
7 retrievable without undo burden. And can be
8 implemented for a performance measurement.

9 (Off the record comments.)

10 CO-CHAIR JARRIS: Let me just say
11 that if the summary --

12 MS. MUNTHALI: I'm sorry, the mic
13 is off.

14 CO-CHAIR JARRIS: -- of this
15 voting feels like it would make a significant
16 difference to split the two, you can raise
17 that as an issue.

18 MS. MUNTHALI: Okay. So
19 feasibility. High, moderate, low,
20 insufficient information. One more. Linda?

21 MEMBER KINSINGER: High.

22 MS. MUNTHALI: Okay. So five

1 high, five moderate, and one low. Okay. So
2 this is the overall suitability for
3 endorsement. Does the measure meet NQF's
4 criteria for endorsement. This is yes, one,
5 and no is two. Okay, we have everyone in the
6 room. Linda?

7 MEMBER KINSINGER: Yes.

8 MS. MUNTHALI: Okay. So --

9 CO-CHAIR JARRIS: Can I just raise
10 question?

11 MS. MUNTHALI: Oh, sorry.

12 CO-CHAIR JARRIS: This may be
13 precisely how the voting is going, but we
14 always have one no. And I'm just -- Are all
15 the clickers working? Just may be different
16 people. I'm just curious.

17 MS. MUNTHALI: We think they're
18 working. We're receiving it, yes.

19 CO-CHAIR JARRIS: Can we do a test
20 vote? We're all asked to vote, press number
21 one?

22 MS. MUNTHALI: Let me just, as a

1 matter of public record, just state what the
2 vote was for this. It's ten yes's and one no.
3 And so do you want to do a test to make sure -
4 -

5 MS. CHANDLER: Everyone press yes
6 --

7 CO-CHAIR JARRIS: Everyone presses
8 a one, let's make sure we get all ones.

9 MS. CHANDLER: If everyone --
10 We're going to try it one more time. If you
11 could look to the light, you should see a
12 green light if your remote is working. If
13 anyone sees a red light, please let us know.

14 (Off microphone comments.)

15 CO-CHAIR JARRIS: So 2020. Well
16 anyway that is the first time we've actually
17 endorsed a measure. So this is a historic
18 moment, right? Well first time in this
19 process, second stage. So let's go on to --
20 That's right, 2020, adult current smoking
21 prevalence. And who do we have? Dawn
22 Jacobson, from Legacy. Are you on the line?

1 MEMBER PESTRONK: Excuse me. In
2 the SharePoint there are two 2020s. The one
3 we're looking at is the updated one. Is that
4 correct?

5 MS. CHANDLER: Yes. That's
6 correct.

7 MEMBER PESTRONK: Okay. Thank
8 you.

9 CO-CHAIR JARRIS: Donna, are you
10 on the line and on muted?

11 MS. MUNTHALI: Anika?

12 OPERATOR: The line has
13 disconnected.

14 MS. MUNTHALI: Oh, her line
15 disconnected. Okay. So I guess we can start
16 talking about the measure. And if Donna wants
17 to join later when we have questions, we'll
18 try and get in touch with her.

19 CO-CHAIR JARRIS: Okay. So this
20 is Amir?

21 MS. MUNTHALI: This is Amir and
22 Kurt.

1 CO-CHAIR JARRIS: Kurt.

2 MEMBER QASEEM: Okay. So I'm not
3 sure if I have the updated one. Maybe I
4 didn't download the updated one. Is that the
5 one where fix on the numerator and denominator
6 show? It probably did. Okay.

7 MS. CHANDLER: Yes. So just in
8 the last few days, since may of you inputted
9 your results, we received an updated form,
10 which is on SharePoint. And I'll circulate
11 that right now if you don't have it.

12 MEMBER QASEEM: So this measure is
13 about the percentage of adults who are
14 currently smoking. And it's a pretty simple
15 measure actually, I think.

16 And I do think it's a very useful
17 measure, in terms of to find out what's going
18 on in your community to figure out of course,
19 the resources as well as the plans you're
20 going to put into place to address this issue.

21 So in terms of the evidence that
22 was presented, you all know that smoking can

1 be beaten. There is enough there regarding
2 this.

3 My only thing, that I think I
4 raised in the group as well. Isn't this
5 information already available? And that may
6 be just me. And maybe in the area where I'm
7 in, where I've worked. I always felt like
8 this information was already there.

9 So I wasn't really sure what we
10 were adding. Or maybe, there's probably a lot
11 of communities that are out there that this
12 information is not available. So it's going
13 to be extremely beneficial in that case. But
14 that's my only thing. Otherwise it's a pretty
15 good measure.

16 CO-CHAIR STANGE: Sure. I think
17 it's a great population health measure. It's
18 feasibly collective. It's not -- You're not
19 able to get granular geographically on it.

20 And of course there's other kinds
21 of tobacco that are an issue. But it's
22 already being collected. It's useful to

1 monitor.

2 We have data going back decades.
3 So it's useful to look at trends. So I guess
4 the only issues would be harmonization with
5 other measures. But I didn't see a problem
6 with it at all.

7 CO-CHAIR JARRIS: Madeline.

8 MEMBER NAEGLE: I'm wondering if
9 the maker of the measure would speak to the
10 reasons for the exclusion of people in the
11 military and for people who are
12 institutionalized?

13 Since the rate of smoking among
14 people with mental illness is the highest.
15 People in substance abuse and psychiatric
16 facilities have the highest.

17 So to use a measure which excludes
18 two groups. Military I would also submit are
19 at risk for addiction. So would the maker
20 speak to that please?

21 CO-CHAIR JARRIS: I don't know
22 that they're on the line. We're calling them.

1 So maybe we should hold.

2 MEMBER STOTO: I think I know the
3 answer to that one.

4 MEMBER NAEGLE: Okay.

5 MEMBER STOTO: I think it's
6 because they're not in the National Health
7 Interview Survey, which is what they're
8 talking about here. So I think --

9 I mean, I agree that this is an
10 important thing to measure. There's no doubt
11 about it. But the documentation is really
12 about its implementation in the National
13 Health Interview Survey, rather than about it
14 as a measure.

15 So, yes. I mean, what about the
16 Behavioral Risk Factor Surveillance System,
17 and so on? And lots of other surveys that ask
18 about smoking?

19 I think that we should be
20 endorsing the measure based on the definition
21 of smoking to be used in surveys, rather than
22 the particular thing.

1 So there's lots of things like,
2 you know, what does it count to be a smoker?
3 And that's not addressed here. I think
4 typically you have to be -- I think there's
5 a standard definition of that, that's used in
6 the surveys. I forget what it is.

7 CO-CHAIR JARRIS: Smoked one or
8 more cigarettes --

9 MEMBER NAEGLE: More than ten
10 cigarettes a day.

11 MEMBER STOTO: Something, well I
12 don't think it's that much. But there is a
13 standard.

14 CO-CHAIR JARRIS: Jason.

15 MEMBER SPANGLER: I had a
16 question. And this is directed mainly to NQF.
17 There are several other tobacco measures. And
18 some of them seem like they should be with us.
19 And they're not. And I'm wondering why.

20 And not necessarily phase -- I
21 don't think it was brought up in Phase I.
22 Because I assumed they'd be talked about in

1 Phase II. But there aren't any in Phase II.

2 And I know that some of them
3 haven't passed through our steering committee,
4 but are in the behavioral health steering
5 committee. Just wondering why, if we know why
6 that was.

7 And because for a lot of us in
8 prevention in public health, they are
9 population health measures. And whether there
10 needs to be some harmonization of those with
11 this measure. And how that would work when
12 there's two different committees working on
13 different types of measures.

14 DR. BURSTIN: You're absolutely
15 right. So these are measures that could have
16 fit in either place. Because we knew there
17 was going to be a whole large set of measures
18 that were hospital based, we thought it might
19 be best to keep them with the behavioral
20 health measures, including mental health,
21 substance abuse, et cetera.

22 That committee -- Actually

1 Madeline happens to be serving on both
2 committees. So she is your bridge to both of
3 them. Thank you, Madeline. And those
4 measures were just reviewed. And I can tell
5 you that there was a --

6 And actually maybe one useful
7 thing for us to do before we conclude is,
8 we'll bring you the, at least the description
9 and the specifications of the measures
10 preliminarily approved. Actually going out to
11 comment.

12 I think it just began yesterday.
13 So there is a hospital based screening
14 measure, that the Joint Commission put
15 forward, that narrowly was approved. There is
16 a clinician level measure, where clinicians --

17 It's a question. Did you ask the
18 patient do they smoke and offer assistance
19 with quitting as a combination measure. And
20 then there's a third measure.

21 And actually NCQA's here. Dawn
22 may want to speak to this, which is actually

1 a series of supplements to the clinician group
2 health plan, CAHPS? Thank you. The health
3 plan CAHPS tool, in which there are a couple
4 of specific, smoking specific survey measures
5 added there.

6 So the issue is, none of those get
7 to the population level. I still think it's
8 reasonable for us to consider whether the
9 definitions are a lie. But it's a little
10 different because one of them is a provider
11 answering the question.

12 One of them is a survey though, at
13 a health plan level. And one of them is a new
14 institutionalized patient question. So I
15 think the harmonization issue is definitely
16 worth exploring.

17 CO-CHAIR JARRIS: If I could just
18 come out, just in terms of the strategy? If
19 we're looking at this process, we'd like to
20 have a smoking measure, as opposed to not
21 having a smoking measure.

22 And one of the issues we've had is

1 that people didn't come forward with measures.
2 So I would suggest we adopt what we get. And
3 then in the next process we'll be looking for
4 a best measure among a group of measures.

5 But rather than hold off and have
6 no measure, let's pick this one and hope that
7 will tweak the other people who didn't submit
8 their measure.

9 CO-CHAIR STANGE: If I could just
10 follow up on that? To the question, what does
11 harmonization mean in this context?
12 Harmonizing this with the clinical measures
13 doesn't make sense.

14 We're talking about harmonizing
15 with other population measures. And we don't
16 have those on the table. So what does -- I
17 mean, do we just say we need to -- This is
18 fine, but insufficient for sub-populations.
19 And there may be other complimentary or better
20 ones.

21 DR. BURSTIN: This is the way we
22 try to explain harmonization versus competing

1 measures. I don't think these measures are
2 competing. They are a different population,
3 different denominator, different patient
4 population. I think they are potentially
5 issues of harmonization, because it's the same
6 measure focus.

7 So in fact, if this measure at the
8 population level asks about hundred
9 cigarettes. And the other measures don't. I
10 guess to me there's an opportunity there for
11 harmonization. I agree it's not clear it has
12 to happen right now. But I do think it's
13 something worth exploring.

14 CO-CHAIR STANGE: Will the NQF be
15 accepting other population measures? Because
16 it would be -- To Paul's point it would be
17 fine to have this out there.

18 Then people that know of other
19 measures could say, wait a second. They get
20 sub-populations that are excluded for
21 logistical reasons, or whatever. Would there
22 be a process for people to submit other

1 measures?

2 DR. BURSTIN: Yes.

3 CO-CHAIR STANGE: Okay.

4 MEMBER KINSINGER: And this is
5 Linda. Just maybe again for the discussion
6 tomorrow. But in thinking about the forms.
7 I found the evidence presented by the
8 developer here about why smoking is bad for
9 you to be not very useful. Nobody's arguing
10 whether smoking is bad.

11 I think the evidence that we're
12 asking for from the developer is how well can
13 this be measured? What's the impact of using
14 this measurement? How does it lead to change?

15 So if there could be some
16 clarification about, you know, what sorts of
17 evidence we're looking for, it seems to me
18 that would help.

19 CO-CHAIR JARRIS: Bobby?

20 MEMBER PESTRONK: A couple of
21 things, just to go back to what Mike said. In
22 Sections 2A 1.3.7 and .9, it gets at the

1 exclusions. That's the description that they
2 simply aren't collecting those data. So
3 they're citing them as an exclusion for this
4 particular measure.

5 But this is then looking through
6 the other end of the tube, if you will.
7 Because those populations have the highest
8 rates of tobacco use, some link to a
9 stratification, which provides the data for
10 these other populations, is extraordinarily
11 important in understanding the prevalence of
12 smoking in a population.

13 Because without those, you lose
14 track of these populations, which actually
15 should be the target of interventions. But
16 because the measure that's being used excludes
17 them, gives you a false picture of what's
18 going on in the entire population.

19 CO-CHAIR JARRIS: Couldn't a
20 complimentary measure handle that?

21 MEMBER PESTRONK: Yes.

22 CO-CHAIR JARRIS: Because see the

1 number of people with mental illness who are
2 institutionalized is minuscule.

3 MEMBER PESTRONK: Yes.

4 CO-CHAIR JARRIS: And it's a
5 temporary population in most cases.

6 MEMBER PESTRONK: I would vote to
7 endorse this measure. But I think it's
8 important in the context of the conversation
9 that we had before to look at this through the
10 other end of the tunnel.

11 And say to ourselves, you know,
12 where are those data? Where is that measure
13 about these two populations? Because that's,
14 it is a minority population in the way that
15 you describe it. We should know what's going
16 on to reduce smoking within those smaller
17 population groups. So that's just a comment.

18 The other question I had is in
19 Section 5B, where I was looking at the
20 competing, the description of the competing
21 measures. And I just wondered why the point
22 of contact for Legacy was Tom Friedan?

1 MS. MUNTHALI: So Legacy is the
2 developer. And the CDC is the steward of the
3 measure. I don't think --

4 CO-CHAIR JARRIS: I think Matt, I
5 think and then Mike.

6 MEMBER STIEFEL: The notion of
7 looking at total population only is kind of a
8 slippery slope. Because it would exclude a
9 lot of the other measures proposed for this
10 group to review.

11 The NCQA measures that are health
12 plan performance measures. So it's a pretty
13 important topic. And, you know, using the
14 language of the white paper, there's this
15 notion of a geopolitical population with sub-
16 populations within it.

17 I don't think we're looking at
18 only geopolitical populations for all of the
19 measures here. And harmonization just becomes
20 that much more important, where there may be
21 a number of sub-population measures for
22 smoking. And in fact --

1 So the broader question is, I
2 think a lot of the measures we're looking at
3 are about the boundary or intersection between
4 public health and clinical care.

5 And how we may roll up clinical
6 care measures for a geographic area, to begin
7 to look like total population measures. So
8 maybe this is just a tomorrow question. But
9 it's an extremely important topic.

10 MEMBER STOTO: I was going to say
11 the same thing. And I would just add one more
12 thing. To the extent that, you know, we're
13 moving towards accountable care organizations,
14 and so on, I mean, that just forces us to
15 think about this intersection even more.

16 And it's an absolute essential
17 that measures we talk about for the whole
18 population, geographical populations, are
19 consistent with the ones that we use for
20 health service organizations.

21 MEMBER STIEFEL: And it's really
22 important. Because without getting this

1 information from clinical care, we rely on
2 things like these very high level, population
3 level surveys that are getting worse and worse
4 over time, from BRFSS to National Health
5 Interview Survey. And so we really need to
6 get this information from the clinical system.

7 CO-CHAIR JARRIS: I think they're
8 all complimentary. And the population's
9 relative. The population may be me as an
10 individual, my family. If you're a clinician
11 it's what is my patient panel.

12 If you're a insured it's who is my
13 enrollees. If you're a county it's who lives
14 in my jurisdiction. I think that all those
15 things are complimentary based on sort of your
16 line of vision.

17 MEMBER STOTO: I think that's
18 absolutely true. I was just reacting, maybe
19 Matt too, to Helen's point that we're talking
20 about population today. And these other
21 definitions of population are in some other
22 part of the discussion.

1 DR. BURSTIN: The question I guess
2 -- I didn't realize this was only at the
3 national level. This doesn't, there's no
4 capacity to bring this down at all to lower
5 levels of aggregation?

6 MEMBER STOTO: Well that's why I
7 think that we need to think about the
8 question, as opposed to the particular
9 implementation on NIHS. On NIHS it is only at
10 the national level. But the Behavioral Risk
11 Factors Surveillance System is at the state
12 level.

13 And New York City has its own
14 survey. And California has its California
15 Health Survey that can do it in a lot of
16 geographical areas. So there's lots of
17 different ways that this can be implemented.

18 DR. BURSTIN: But do all those
19 surveys use the same questions?

20 MEMBER STOTO: Well I think that
21 they tend to.

22 FEMALE PARTICIPANT: And the

1 definitions?

2 MEMBER STOTO: Well probably not
3 exclusively. I think that there has been a
4 lot of attention over time to try to get them
5 to formalize those things. I'm sure it's not
6 perfect.

7 CO-CHAIR JARRIS: Sarah, did you
8 want to say something on that.

9 MEMBER SAMPSEL: I would -- Just
10 to answer Helen's question. They don't use
11 the same questions specifically. So you can't
12 really compare the results from BRFSS at the
13 county or state level to the national NIHS
14 results.

15 There is some capability of
16 drilling down on NIHS results. But they're
17 rarely published. And still you can't get
18 down to the county level like you can the
19 BRFSS.

20 CO-CHAIR JARRIS: Ron, I think.
21 And then Amir after that.

22 MEMBER BIALEK: I have a comment

1 and a question. First of all, did anybody
2 from Legacy end up on the line? Okay. Okay.
3 Just the question that was raised earlier, you
4 know, why this particular measure?

5 There was some very practical
6 considerations was given the time frame. This
7 was probably the easiest measure that Legacy
8 could develop and provide the documentation
9 within the time frame that they had. They are
10 interested in other measures.

11 And I don't know if it's
12 appropriate for the committee to provide some
13 guidance, if you will. But that's something
14 that I think they would look forward to.

15 There was some discussion about
16 taxation measures, and discussion about indoor
17 air types of measures as well. So that's the
18 comment.

19 The question is really for NQF,
20 which is, when we endorse a measure, are we
21 endorsing the measure and the source? Or are
22 we endorsing the measure where there could be

1 multiple sources?

2 DR. BURSTIN: It's actually very
3 dependent on the way the measure is submitted.
4 And the reliability and the validity data they
5 submitted.

6 We've had this discussion very
7 similarly with some fo the child health
8 surveys that have been submitted to us and
9 endorsed.

10 And those are conducted in a way
11 where they have done, for some of the items,
12 a good deal of research showing that those
13 data can be used with those survey items, a
14 group of survey items we pulled out from the
15 larger child health survey to be used at lower
16 levels of aggregation.

17 So it was more so that they pulled
18 out a series of measures out of the larger
19 child health survey. And at the state level
20 those data are dependent currently on that
21 child health survey being administered.

22 And it was a major point of

1 discussion at the Board of what is the utility
2 you need to wait on the national source of
3 data to provide, you know, information. And
4 that only went to the state level.

5 I think this one may be a bit more
6 controversial. Because I think the question,
7 particularly when you get to usability is,
8 what is the usability to drive quality
9 improvement at a --

10 Or what's the accountability for
11 the nation? Short of Regina. I mean, it's
12 just this is a tough one I think in some ways,
13 if it's only at that level of analysis.

14 MEMBER STOTO: But I think that
15 Legacy probably didn't understand this
16 discussion we were having. And if they had
17 they probably would have said, here's a
18 definition --

19 Here's a smoking question. It's
20 been used on NHIS. It's been used on BRFSS.
21 It's been used here and there. I mean, lots
22 of things our questions are asked differently

1 on those different surveys.

2 But I think this one actually is
3 asked the same in all those surveys. I'm not
4 totally sure about that. But I bet that they
5 could make a case for this question as
6 implemented in population surveys. If they
7 had been asked to make that case.

8 CO-CHAIR JARRIS: Amir, did you
9 still have a comment or question?

10 MEMBER QASEEM: Sure. I was just
11 going to ask about the age. It says 18 and
12 over. And I understand it's because of the
13 data sources and all of that.

14 But shouldn't we think about
15 younger age? Like when we were talking about
16 HIV it was 13 on. Smoking starts pretty
17 early. And also most of the intervention's
18 varies.

19 And I think that data is not
20 available and would be very helpful. The
21 earlier you have interventions it seems to
22 work better.

1 MEMBER KINSINGER: Can I just
2 respond to him? I think that's part of the
3 same thing that we were just talking about.
4 It's that because NHIS -- Actually NHIS is
5 the whole population. But BRFSS is 18 and
6 over, if I understand it.

7 MEMBER QASEEM: NHIS is 18 and
8 over too. But they ask questions in there
9 about the children in the household. But
10 they're not being a force.

11 MEMBER STOTO: Okay. So it really
12 has to do with the specifics of the
13 implementation, as opposed to the concept
14 that's being measured here.

15 CO-CHAIR JARRIS: So this is
16 Donald Rumsfeld's comfort. You go the CSAC
17 with the measures you have and not the
18 measures you wish you had. Is that it? So
19 Bobby did you?

20 MEMBER PESTRONK: The 2A13 says
21 it's conducted among the adult 18 and older.
22 So that may be why the specify it that way.

1 Helen, I wanted to ask you to just say again
2 what you just said, when it gets to the Board
3 level.

4 I mean, this then -- This is a
5 measure that has applicability at the national
6 level. But doesn't necessarily have
7 applicable at the state or the municipality or
8 county level. And so is that seen as a
9 weakness of the measure?

10 DR. BURSTIN: I think initially it
11 was. And I think we've sort of gone past
12 that. We've had a lot of discussion as part
13 of this committee, shared with the CSAC as
14 well, in terms of that there are accountable
15 entities in public health. Accountable
16 entities at various levels, state, county, et
17 cetera, community.

18 And I guess the question would be,
19 at a national level, does that hold? And I
20 just think it's a question for us we need to
21 really think about. But I think will get up,
22 I know will get brought up as this measure

1 moves forward.

2 CO-CHAIR JARRIS: It's also
3 interesting timing. And I would agree, at the
4 national level I mean, it would be nice if
5 Congress cared about this. But they know this
6 data close enough at the national.

7 And it hasn't led to any
8 improvement at that level. But the BRFSS is
9 about to go through, or has gone through a
10 revision to incorporate different ways of
11 weighting the populations, and to incorporate
12 cell phone surveys.

13 So we're just about to have
14 announced new BRFSS data, which will actually
15 show higher rates of tobacco than we've ever
16 seen before. Because you're now sampling
17 population that are lower income, and things
18 like that with cell phones, not land lines.

19 So it's going to be a very
20 confusing time to have a smoking measure. And
21 that probably is being released imminently,
22 isn't it? So boy this sure wouldn't be the

1 one I'd pick to endorse first. But if it's
2 all we got, what do we do?

3 MEMBER PESTRONK: Does somebody
4 have to claim accountability from the Board's
5 perspective? I mean, one might argue that the
6 expenditures that CDC is making right now for
7 the web and television commercials on smoking
8 are an implicit claim of accountability. I
9 mean, is that what --

10 DR. BURSTIN: I don't know. I
11 just think this will be -- We've never had a
12 measure that came in only at a national level.

13 MEMBER PESTRONK: Yes.

14 DR. BURSTIN: So I think it's
15 going to raise questions, particularly as you
16 get to the usability criterion here of what is
17 the usability for accountability and quality
18 improvement? Just a question.

19 MEMBER PESTRONK: You know, this
20 is a little bit of a tease. But it's kind of
21 good that this is suggesting that there ought
22 to be accountability at the national level.

1 Because there's certainly a push to require
2 accountability at the state and local level.

3 CO-CHAIR JARRIS: This one of the
4 --

5 MEMBER PESTRONK: It's part of the
6 answer for our question.

7 CO-CHAIR JARRIS: This issue of
8 accountability is one of the refrains that
9 comes up constantly about there is no
10 accountability --

11 MS. JACOBSON: Helen, this is
12 Dawn. Can I make a comment on my previous
13 practice on that in L.A. County?

14 DR. BURSTIN: Why don't we let you
15 guys call it when --

16 CO-CHAIR JARRIS: Go ahead,
17 please.

18 MS. JACOBSON: Or Kurt or Paul.
19 If this is to be meaningful at the local
20 level, where I think change happens, then this
21 is not a helpful data source. We never even
22 referred to it in L.A. For adolescents we

1 used the Youth Risk Behavioral Surveillance
2 System.

3 And I think the reason the county
4 health rankings is at least marginally
5 successful is because it uses BRFSS data,
6 which gives meaningful data for state and
7 local practitioners to make influence change.
8 So I'm really concerned about using NHIS. I
9 don't think it's relevant in practice.

10 CO-CHAIR STANGE: I think one of
11 the important things that we did the last time
12 we were together is try to expand the view of
13 what accountability means. And to expand the
14 idea to include multi stakeholder groups.

15 I think because this is at a
16 national level it actually, as Bobby said,
17 raises the gaze to that level. But I agree
18 with you that it doesn't have -- That's
19 actually a good thing.

20 But I think we want to keep that
21 idea going forward that we don't want to limit
22 ourselves to a single organization or entity

1 that would be accountable.

2 The transformative thing that
3 population health measures could do would be
4 to stimulate multi stakeholder groups at
5 various levels that are actionable. And
6 there's limit to that to the national level.

7 MEMBER PESTRONK: Again, how do we
8 go back to ask for measures that would use the
9 ones that Dawn has just suggested as sources
10 of data. We have to, I mean, I think we
11 should ask for them. But that's not part of
12 the typical process.

13 DR. BURSTIN: We frequently go
14 back to developers for additional questions.
15 And I guess if the committee feels like it
16 would be more appropriate to bring a measure
17 down to lower levels of aggregation to be more
18 usable, we could --

19 I mean, I'm not sure if the folks
20 from Legacy have joined us yet. But they've
21 been working with CDC. CDC is the source of
22 both of those surveys. I was just looking up

1 the items on BRFSS. They're not the same, but
2 they're not dissimilar. It's just the
3 question is --

4 MEMBER PESTRONK: It's not more.
5 It's a both and, rather than either or, is my
6 point. That this is good on its own. But to
7 address the concerns that Dawn has raised,
8 using the other data sources make it useful
9 for other folks.

10 MEMBER STOTO: I think that the
11 fact that this is at the national level is a
12 bit of a red herring. I think that if Legacy
13 Foundation understood the rules better, they
14 would have said, oh let's put forward a survey
15 question that can be used in BRFSS and other
16 things that can show up at the county level
17 and so on.

18 And I think so the bigger question
19 is that we don't, we haven't yet communicated.
20 Maybe because we haven't yet decided what we
21 really want.

22 And this question about

1 accountability I agree is central. And I
2 don't think that really is very well reflected
3 in any of the documentation that we have yet.

4 CO-CHAIR JARRIS: So this notion
5 of a measure, does it apply to -- And it will
6 be extremely helpful to have somebody, and I
7 think this has been said, put forward a way of
8 measuring smoking that was then endorsed. And
9 then could be used in all these various
10 different surveys.

11 Because right now then it's just
12 noise. Because everyone defines it slightly
13 different. I mean, does NQF do that? Do they
14 say, okay here's your question, no matter what
15 survey you're using? That would be helpful to
16 start harmonizing all this disparate
17 information.

18 DR. BURSTIN: Right. When it's
19 been validated that there is a, you know, a
20 gold standard of this is the way to do it.
21 You know, again, we had a similar issue of
22 medication adherence.

1 There are multiple ways to measure
2 adherence. We had a whole exercise several
3 years ago to say, based on the available
4 evidence this is the preferred method.

5 I just, the question is, given the
6 way it's asked so differently in a clinical
7 setting versus a public health setting, you
8 know, is it still logical to ask in exactly
9 the same way? Maybe we can grab the actual
10 survey items used in the CAHPS tool that NCQA
11 --

12 CO-CHAIR JARRIS: I think to
13 harmonize it in the population health measures
14 would be helpful. And the way you ask it is
15 a doctor to your patient sitting in front of
16 you could be very different.

17 DR. BURSTIN: I agree, yes.

18 CO-CHAIR JARRIS: I guess we had
19 Matt.

20 MEMBER STIEFEL: It's basically
21 what you said. But I think it raised a
22 question about the role of this group, or the

1 role of groups like this.

2 And is the approval process always
3 a measure and specifications, and an
4 instrument? Or can we decouple those and talk
5 about a measure and its specifications that
6 could apply to --

7 And that would be I think an
8 extremely important contribution. And
9 potentially even to be able to bridge the gap
10 between clinical measures and population
11 health measures.

12 CO-CHAIR JARRIS: Probably as you
13 think about it, the definition I've seen is,
14 have you smoked one or more cigarette in the
15 past year? Because that's not how I ask my
16 patients if they smoke.

17 I'd say, are you a smoker? And
18 who the heck knows what that means? So it
19 would be interesting to standardize it in both
20 cases. Bobby is your, is that a laggard flag?

21 MEMBER PESTRONK: The information
22 that's provided in this form that we're

1 looking at, the question is, have you smoked
2 at least 100 cigarettes in your entire life,
3 from NHIS at least.

4 CO-CHAIR JARRIS: I've smoked 99.
5 So I guess I'm off the hook. Okay. We don't
6 -- Any questions on the phone? And I assume
7 we don't have Legacy or someone from CDC here.

8 OPERATOR: At this time in order
9 to ask a question, press star then the number
10 one on your telephone keypad. At this time --
11 Excuse me, you do have a question from Mary
12 Pittman.

13 MS. PITTMAN: It's not so much a
14 question as I've been listening to the
15 conversation. I agree. And I can't always
16 pick out who's voice it is.

17 That having a measure at the
18 national level, even though we may not be able
19 to harmonize immediately all of the sources of
20 data from the local level. It's really
21 important to lift up that there needs to be a
22 national accountability.

1 And I think, Helen, you're saying
2 that that's a little different from the usual
3 process. But if you could start with that and
4 then push down to get the harmonization of the
5 way the questions are asked, is that feasible?

6 DR. BURSTIN: I think there are
7 just a lot of unknowns here. I don't think we
8 know. I think this is why we're doing this
9 project. We'll put it out for public comment.
10 We'll figure out what the various forces our
11 there say.

12 I will say having pulled up BRFSS
13 that I think BRFSS is a lot closer to the way
14 we ask these questions in practice, which is,
15 you know, are you a current smoker? Do you
16 smoke every day, some days, former smoker,
17 never smoked?

18 So you know, it may just be a
19 question of whether, in fact, the BRFSS survey
20 may be a better fit as something that could be
21 harmonized moving forward, rather than NHIS.

22 CO-CHAIR JARRIS: Mary, we'll move

1 you over to the open line.

2 MS. PITTMAN: Thanks.

3 OPERATOR: At this time there are
4 no further questions.

5 MEMBER STOTO: I would like to
6 propose that we actually postpone voting on
7 this one, and ask for clarification. I mean,
8 it strikes me that what we should be asking
9 for is a survey question that can be
10 implemented in surveys at a lot of different,
11 for a lot of different populations, including
12 healthcare service population.

13 CO-CHAIR JARRIS: Then I would add
14 to harmonize at the different, at least
15 geographic levels, if not down to the health
16 system levels.

17 MEMBER STOTO: I just don't think
18 that the people who put together the
19 documentation understood this. And we
20 probably didn't even understand it ourselves.
21 I don't want to be critical of them.

22 CO-CHAIR STANGE: I wonder if, I

1 don't know if we're ever going to have a more
2 informed vote than we have right now, while
3 this is in our heads, and we're face to face.

4 And if we're trying to get a toe
5 hold to move thing forward -- I would wonder,
6 Mike, if it would better to go ahead and
7 approve this, with the idea that we don't even
8 have it on the table in front of us, the types
9 of measures that it needs to be harmonized --

10 MEMBER STOTO: I wouldn't be able
11 to vote yes for it.

12 CO-CHAIR JARRIS: What's the
13 process? So if we go back for clarification,
14 and they come back with something, will we
15 even be here? I mean who will respond to
16 that?

17 DR. BURSTIN: We'll just do it off
18 line. We'll bring it to you. You'll have a
19 conference call. We'll have you do Survey
20 Monkey to vote. It's fine.

21 We routinely go back to
22 developers, have them tweak, bring back,

1 respond, have the committee weigh in again.

2 I think the other question is, do
3 we actually need to actually touch base with
4 CDC is my question, since this is based on the
5 NHIS.

6 MEMBER STOTO: And also, CDC is
7 not just CDC --

8 DR. BURSTIN: I understand. It's
9 --

10 MEMBER STOTO: BRFSS --

11 DR. BURSTIN: Right.

12 MEMBER STOTO: -- and NHIS are
13 two very different parts of CDC.

14 DR. BURSTIN: I get it.

15 CO-CHAIR JARRIS: What about other
16 -- I mean, what happens in terms of
17 additional measures coming in? Is this call
18 closed, and then we periodically there will be
19 another open call for measures? Or can things
20 just come in at any time and --

21 DR. BURSTIN: Again, some of that
22 is evolving. I'm not sure exactly what our

1 time line is here. I don't know how quickly
2 CDC could get something into us that's sort of
3 more, you know -- Or even Legacy working with
4 CDC to potentially even modify this one. Or
5 modify the certs. We'd be happy to look into
6 that.

7 The other thing is, I mean, that
8 we will expect to be having, you know, many
9 projects over time looking at these areas. So
10 we can easily bring them in. Our thinking is
11 usually once we kind of go past -- And I
12 think a lot more question to be answered
13 tomorrow.

14 A new area like population health,
15 like we've done resource use, the expectation
16 would be in any projects going forward we
17 would welcome population level measures as
18 well as clinical.

19 CO-CHAIR JARRIS: I think that's
20 something that we really need to talk about
21 tomorrow.

22 DR. BURSTIN: Yes. I agree.

1 CO-CHAIR JARRIS: Because there
2 will be a time at which we can birth this
3 thing and give it to every committee. But I
4 think it's probably premature.

5 And one thing to consider would
6 be, knowing what we just learned from this, do
7 we actually then want to put out subsequently
8 another call that is a more informed call?

9 MEMBER NAEGLE: I just had a
10 question for Helen. So thinking about how
11 we'd want to harmonize this with populations,
12 specifically sub-populations.

13 Is that going to be forthcoming
14 anytime soon as we move that agenda? So that
15 at some point we could look at this in a more
16 comprehensive way.

17 DR. BURSTIN: Yes. I mean the
18 Behavioral Health Committee looked at the
19 various smoking measures. This was not part
20 of it because it had not been evaluated yet.

21 So we could certainly provide to
22 you that comparative table of the different

1 measures we already have, and the way that's
2 asked, and share that with you.

3 And I think the timing is good. I
4 just don't -- Yes, I think the question is,
5 I'm not sure they have to be exactly identical
6 for now, given where we are as a country.

7 There's just a lot to do here.
8 And I think there are going to be clinical
9 measures as Paul pointed out. They're going
10 to be asked differently.

11 But I guess the question is, if
12 the health plan measures get aggregated up,
13 are we going to wind up with just very
14 different numbers if they aggregate up to
15 states, for example. I'm just not sure.

16 CO-CHAIR JARRIS: Ron, then Bobby.

17 MEMBER BIALEK: I'm not real clear
18 on what we would be asking Legacy to do. is
19 it two things? Would we be asking them to
20 suggest a particular question? And would we
21 also be asking them to suggest a particular
22 data source for prevalence?

1 Because I think we want to have a
2 measure of prevalence that will be adopted, or
3 endorsed. So is that the two things that we
4 want to do? or do we want to do one, or not?

5 CO-CHAIR JARRIS: Yes. I sort of
6 see that one is, what is the question? And
7 can that be standardized? And then the second
8 is the means to do that at sort of a national
9 enterprise level. Federal, state, local, and
10 then perhaps even health system. Bobby, did
11 you have a --

12 MEMBER STOTO: So it's not a
13 single survey, but it's something that a way
14 of implementing it is --

15 MEMBER PESTRONK: I'm more
16 troubled by the actual question that's being
17 asked in the National Health Interview Survey.
18 And whether that's actually generating what
19 the measure says it's generating.

20 Because the description of the
21 measure that's proposed is the U.S. population
22 that currently smokes. The questions that are

1 asked to supply the data are whether you've
2 smoked 100 cigarettes in your life.

3 That's not producing whether you
4 currently smoke. And actually, if that -- you
5 could never become a non-smoker if that's the
6 question being asked.

7 MEMBER STOTO: That's the
8 definition of ever smoker, rather than current
9 smoker.

10 MEMBER PESTRONK: Yes.

11 MEMBER STOTO: So they didn't even
12 pull the right question.

13 MEMBER PESTRONK: Right.

14 MEMBER STOTO: I mean, the right
15 question is on NHIS, but they seemed to have
16 pulled the wrong one.

17 MEMBER SAMPSEL: Actually I need
18 to find it again. But somewhere in this
19 documentation it says that the actual
20 numerator is do you currently smoke now, out
21 of those that say they've ever smoked 100.
22 And it's somewhere. I just have to find it

1 again.

2 MEMBER STOTO: But that's not
3 right either. That's the proportion of ever
4 smokers who are current smokers. What we
5 really want is the one --

6 MEMBER SAMPSEL: No. It's saying
7 now. So if you go to --

8 MEMBER STOTO: That's the right
9 numerator, but that's wrong denominator is
10 what I'm saying.

11 MEMBER SAMPSEL: So if you go to
12 2A 1.2, the time period for current tobacco
13 use is defined by survey respondents who
14 endorse that they now smoke cigarettes every
15 day, or some days.

16 MEMBER STOTO: That's right. But
17 the denominator should not be the ever
18 smokers. The denominator should be the total
19 population.

20 DR. WORTLEY: That's in 2A 1.4.
21 It says the denominator is the adult age 18 or
22 older population of the U.S.

1 MEMBER SAMPSEL: Right.

2 DR. BURSTIN: According to the
3 NHIS website the first question is a screener.
4 Have you ever smoked at least 100 cigarettes
5 in you entire life?

6 There is a follow up question
7 about current smoking practices, which then
8 asks do you smoke now? And then, I'm sorry,
9 they have then transitioned later -- I'm
10 sorry, it used to be that. Now it says, do
11 you smoke every day, some days, or not at all.

12 So there may be more consistency
13 to BRFSS than we know. This just doesn't
14 describe it very well. So I think we really
15 need to get a handle on how NHIS and BRFSS
16 relate here. And are the questions similar or
17 dissimilar?

18 And I'd also like to pull the
19 questions that are being used as part of the
20 health plan CAHPS supplement. Oh, do you?
21 Yes, that would be great. Thanks, Dawn. That
22 would be helpful.

1 MEMBER PESTRONK: You know, in the
2 documentation here they may just have
3 inadvertently pulled the wrong question.
4 Because what they're showing as the questions
5 asked in NHIS is two identical questions.
6 Right. Cut and paste problem.

7 MS. ALAYON: Would it be helpful
8 for us to just -- I'm Dawn Alayon. I'm from
9 NCQA. I am the measure champion for medical
10 assistance for smoking and tobacco use
11 cessation

12 Would it be helpful if I describe
13 the measure first, before I get into the
14 questions, so you understand what the
15 measure's about? Excuse me? Just briefly.

16 This is definitely part of the
17 CAHPS survey and the CAHPS survey is part of
18 AHRQ. And we have three different indicators
19 advising smokers and tobacco users to quit.
20 Discussing cessation medications and
21 discussing cessation strategies.

22 So for each indicator we have a

1 set of questions for each. And the questions
2 are part of the -- So we have a set for
3 commercial and Medicaid. And a separate
4 question set for Medicare. So when we get to
5 the numerator we can get to the questions.

6 So for example, for advising
7 smokers and tobacco users to quit we have a
8 question of, in the last 12 months how often
9 were you advised to quit smoking or using
10 tobacco by a doctor or other health provider
11 in your plan.

12 For discussion smoking cessation
13 medications we have a question of, in the last
14 12 months how often was medication recommended
15 or discussed by a doctor or health provider to
16 assist you with quitting smoking or using
17 tobacco. Examples of medication are nicotine
18 gum, patch, nasal spray, inhaler, or
19 prescription medications.

20 And for discussing cessation
21 strategies, in the last 12 months how often
22 did your doctor or health provider discuss or

1 provide methods and strategies, other than
2 medication, to assist you with quitting
3 smoking or using tobacco. Example and methods
4 that apply are telephone helping, individual
5 group counseling or cessation program.

6 DR. BURSTIN: Is there a screener
7 question?

8 CO-CHAIR JARRIS: Yes. Those are
9 all clinical questions.

10 MS. ALAYON: A screener question?

11 CO-CHAIR JARRIS: They aren't
12 population questions --

13 MS. ALAYON: No, not at all.

14 CO-CHAIR JARRIS: -- nor are they
15 assessing the prevalence of smoking --

16 MS. ALAYON: Yes.

17 CO-CHAIR JARRIS: -- along
18 whatever the relevant population --

19 MS. ALAYON: Right. This is a
20 self report. This is not at the population -
21 Well it's not population in the sense of the
22 CDC measure. So it's just very specific to

1 the patients.

2 MEMBER STOTO: But those questions
3 only make sense to ask a smoker --

4 MS. ALAYON: Smokers, right.

5 MEMBER STOTO: So the previous
6 smoker, do you smoke?

7 MS. ALAYON: Do you smoke? Well
8 that's --

9 CO-CHAIR JARRIS: For example --
10 Yes, you're right. The population question
11 was, do you smoke?

12 MS. ALAYON: Right.

13 MEMBER PESTRONK: But then in the
14 context of the plan, it's did you ask the
15 patient if they smoke?

16 CO-CHAIR JARRIS: Among
17 representative sample of the plans members.

18 MEMBER STOTO: No. This is the
19 survey of the patients. So not of the
20 physicians, this CAHPS survey.

21 MS. ALAYON: Yes. This is
22 patient's self report.

1 CO-CHAIR JARRIS: Okay. So let's
2 take stock of where we are and decide what our
3 next step is. I believe what we've talked
4 about is going back to Legacy/CDC to ask them
5 if there is a measure that they can propose
6 that could be consistently applied no matter
7 what the measurement tool was, or the means of
8 doing the questioning.

9 And then secondly a measure that
10 could be harmonized at various populations.
11 National levels, federal, state, local levels.
12 And then perhaps the third question is, and
13 could that in fact be utilized? The same
14 question at a clinical level, as at a
15 population level. Does that capture?

16 MEMBER PESTRONK: Except that I
17 would be comfortable if they came back and
18 said here's our proposal for each as well,
19 federal, state, or local. For the reasons
20 that we discussed here, which is it makes
21 sense to have a national measure.

22 And until the questions can be

1 harmonized there's no reason not to have a
2 national measure which draws from a source
3 which gives valid, which has valid and
4 reliable data to support. And the same would
5 be true at the state level and at the local
6 level.

7 DR. BURSTIN: I mean, it certainly
8 seems logical that any survey items should be
9 harmonized. I did find it. I'm sorry, just
10 to interrupt briefly.

11 The first question sounds a lot
12 like BRFSS's, which is do you now smoke
13 cigarettes or use tobacco every day, some days
14 or not at all. That's BRFSS. So I think
15 that's, my guess is that's exactly how that
16 got into the CAHPS tool. So we can confirm
17 that.

18 CO-CHAIR JARRIS: Bobby, it may be
19 that intermediate steps come back with
20 separate levels of the questions. But at some
21 point it would be real nice to know that if
22 you aggregated all your counties that was your

1 state. And if you aggregated all your state,
2 that was your national number. And that they
3 weren't all variations.

4 MEMBER PESTRONK: There's no
5 question in my mind that that would be better.
6 But until we're there, there's no reason not
7 to have the other, right?

8 CO-CHAIR JARRIS: Okay. Mike.

9 MEMBER STOTO: I'm going back a
10 long time ago when I worked in this. And my
11 recollection back then was the office of
12 smoking and health, which I think is still
13 part of CDC, had made a big effort to try to
14 harmonize the asking of these questions. I
15 don't know whether they're still active and
16 doing these kind of things or not. But they
17 would be a good contact.

18 CO-CHAIR JARRIS: Yes. When we
19 say CDC we better ask the right part of CDC.

20 CO-CHAIR STANGE: I agree with
21 Bobby that asking to do multiple measures
22 would be ideal. We don't really have a place

1 on the form, I think, for putting the measure
2 into context.

3 And so if there's some way of
4 informally communicating to say that they get
5 bonus points if they at least put whatever
6 measure or measures they propose into the
7 context of other population health measures
8 that are usable at different levels, that
9 would be really helpful to the, whoever is
10 looking at this in the future.

11 CO-CHAIR JARRIS: Okay. Have we
12 done what we need to on this measure? And
13 then in that case, we have an opportunity to
14 go for public comment for a few minutes. And
15 any members of the public --

16 CO-CHAIR STANGE: Even before
17 that, I just want to let people, both in the
18 room and outside the room, what I've put up
19 here. We have, for the discussion tomorrow we
20 have some good general questions.

21 There's a lot of -- People have
22 used the phrase, oh that's maybe a discussion

1 topic for tomorrow. That's come up a lot.
2 And so to compliment the more general
3 questions tomorrow, if we have some of these
4 specific questions that come up in the course
5 of doing this kind of work I think that would
6 be very helpful.

7 So I've put up what I've heard as
8 a list here. And I'm going to stick it on the
9 wall because I've filled up this sheet. But
10 I think, what I'd like to suggest as a process
11 is, any time in the course of the discussion,
12 or just a thought that pops into your head, if
13 you have things you'd like to get on the table
14 for the discussion tomorrow, let's capture
15 those in real time to inform our discussion.

16 And I think maybe at the end of
17 the day, both for those from the committee on
18 the phone, and for public comment, we could
19 have a moment just for people to suggest
20 things for the larger discussion tomorrow. I
21 don't know if there's any comment on that.

22 CO-CHAIR JARRIS: Mike.

1 MEMBER STOTO: I think it's a good
2 idea to do. And I'd like to add something to
3 it if I could?

4 CO-CHAIR JARRIS: Sure.

5 CO-CHAIR STANGE: Anybody can add
6 anything at any time, yes.

7 MEMBER STOTO: Okay.

8 MEMBER NAEGLE: I was just going
9 to comment that I think this is a great
10 example of how we as a committee can make
11 recommendations or not act on things with a
12 goal of improving the quality of reporting.
13 This is such an important issue for us.

14 And just thinking of the
15 perspective of my work in addictions, how we
16 have functioned really without sufficient and
17 accurate information about this particular
18 problem and many other problems that we're
19 going to be looking at in relation to
20 prevention and changing lifestyle behaviors.

21 So I really would like us maybe to
22 consider there are times to maybe go for more

1 quality. To say, yes, maybe we need to do the
2 optimal. And maybe it isn't just sufficient
3 to say let's use what we have until we get
4 there.

5 Because if we have the power as a
6 committee to say, come back with something
7 better before we go forward, maybe we should
8 use that.

9 CO-CHAIR JARRIS: Which raises for
10 me the issue of -- And some of these issues
11 in smoking is a clear one. Do we also want to
12 ask them for, when there's area of clear
13 disparities for a measure that's specific to
14 that?

15 So for example, in the population
16 of mental illness and addictions we want a
17 specific smoking measure there if they can
18 come up with one. So 40 some percent of the
19 cigarettes smoked, right? Matt.

20 MEMBER STIEFEL: It would seem
21 like a useful question to ask developers, if
22 you're proposing that this measure could be

1 used in multiple venues or for multiple sub-
2 populations, it's likely that the proposer is
3 going to have to talk about the performance
4 statistics and psychometrics for the
5 population that they know.

6 And then make some assumptions
7 about, we think it would also work for other
8 populations. But we don't know, we don't have
9 the performance statistics for application in
10 a clinical setting. But it's at least worth
11 considering.

12 MEMBER SAMPSEL: I think the only
13 other thing I was going to add was, Helen,
14 when you read back that question, it was not
15 only about smoking, but tobacco use.

16 And so, you know, that's something
17 we've been struggling with as we've been
18 trying to do population health estimates of
19 health of any state that WellPoint is in, that
20 you may be seeing smoking rates go down, but
21 you're seeing tobacco use and other mechanisms
22 going up.

1 And so kind of the question to me
2 is, are they also harmonizing on that line as
3 well, that it's a dual question of both
4 smoking and tobacco use.

5 CO-CHAIR JARRIS: I visited one --

6 MEMBER KINSINGER: I think that's
7 a really important question not only for
8 adults, but when you get to the under 18
9 population that's where you're seeing some of
10 the major growth is in other forms of tobacco
11 being used.

12 CO-CHAIR JARRIS: I visited one
13 jurisdiction of each of the new health
14 commissioners when they got put in place,
15 where their tobacco smoking rate was extremely
16 low. And it's because there's very high rates
17 of marijuana smoking.

18 MEMBER KINSINGER: So you want to
19 just ask if they're smoking. You don't want
20 to know what they're smoking.

21 CO-CHAIR JARRIS: Okay, so --

22 MEMBER PESTRONK: Where the Youth

1 Risk Behavior Survey is a better one. Because
2 it's asking about multiple --

3 MEMBER SAMPSEL: Cigars,
4 cigarettes --

5 MEMBER PESTRONK: Cigars,
6 cigarettes, legal, illegal drugs.

7 CO-CHAIR JARRIS: So should we
8 open up now to public comment? Anyone in the
9 room would like to make a comment?

10 MS. SHAH: Can I make a comment
11 for Peggy, who's not here?

12 MS. MUNTHALI: Sure. Could you
13 come up to a mic please?

14 MS. SHAH: She should be here.

15 CO-CHAIR JARRIS: Could you come
16 to the mic so people on the phone can hear?
17 And then we should try to rescue Peggy.

18 MS. SHAH: My name is Amishi. I
19 work with Peggy. We spoke with Elisa
20 yesterday on the phone. And one of our
21 questions was that some of the measures that
22 are already there, they do seem to be fitting

1 with public health quality aims. But they
2 were not mentioned.

3 And one of our thoughts was, if
4 people are really aware of what the aims are,
5 and if there was a way that -- I'm going to
6 lose my voice. If there is a way to make them
7 aware of what the aims are, or at least let
8 them know that these are there in there?

9 In the guidance document that is
10 there if we could put a list of the nine aims
11 or have the URL or something. This was one of
12 the things that we had in mind.

13 MEMBER PESTRONK: Can I ask a
14 question about that? Would you argue that, or
15 suggest that all nine of the aims need to be
16 met? Or that some threshold number of the
17 aims need to be met in order to use the public
18 health quality framework as an evaluative
19 framework?

20 MS. SHAH: I would let Peggy have
21 her final say on this. But I think that if we
22 are looking at individual measures, I don't

1 think it may probably be possible to have all
2 nine of them.

3 But if there is like, as you're
4 saying, like a certain threshold, then that
5 would be good. Because I think if we saw the
6 adult HIV one and the one before that, which
7 was -- Just the one before that? No.

8 The third one that we discussed.
9 That was also something that we thought that
10 it met the criteria for the aims. So even if
11 certain are met I would be fine. But again,
12 I think Peggy would have the final say on
13 that.

14 CO-CHAIR JARRIS: That might be
15 difficult in looking at them now, for a single
16 measure to meet all of them. But --

17 MS. SHAH: Yes.

18 MEMBER BIALEK: I think
19 demonstrating how they're considered, just
20 discussing them could be sufficient to inform
21 the committee's work.

22 CO-CHAIR JARRIS: Are people

1 familiar with them? You want me to just tell
2 you what they are? Or are you familiar with
3 them? That's not a yes or a no. I'm just
4 getting blind stares back.

5 Okay. So it's population
6 centered. I won't go into definitions.
7 Equitable, proactive, health promoting, risk
8 reducing, vigilant, transparency, effective
9 and efficient. And you just google public
10 health aims and you'll come up with them.

11 Thank you. Are there other? I
12 guess Peggy's -- I asked and they didn't know
13 where Peggy was outside the room. So I guess
14 we'll give her a chance later to speak.
15 Anyone on the phone like to make some comment?

16 OPERATOR: At this time to ask a
17 question press star then the number one on
18 your telephone keypad. At this time there are
19 no further questions.

20 CO-CHAIR JARRIS: Okay. We have a
21 45 minute break for lunch scheduled. We are
22 half an hour early, which I don't think anyone

1 will object to.

2 So why don't we shoot for 12, 1:15
3 p.m. to reconvene, if that works for folks?
4 And people on the phone, just to let you know,
5 that's when we all start to get back together.

6 DR. BURSTIN: The developers are
7 welcome to eat lunch with us, please.

8 CO-CHAIR JARRIS: Thank you.

9 (Whereupon, the above-entitled
10 matter went off the record at 12:27 p.m. and
11 resumed at 1:16 p.m.)

12 CO-CHAIR JARRIS: Could we get
13 ready to open the phone lines, please?

14 OPERATOR: All lines are open.

15 CO-CHAIR JARRIS: Okay. Why don't
16 we open the lines, Operator.

17 OPERATOR: Did you want all lines
18 open?

19 DR. BURSTIN: They're all open.

20 CO-CHAIR JARRIS: They're all
21 open. Okay. Well very good. Well welcome
22 back from lunch everyone. We had an

1 excellent, healthy lunch here, right?

2 Following the NQF policy for healthy foods.

3 So the next step for us will be to
4 review the committee recommendations for
5 additional candidate measures clustered around
6 BMI. And do we have representatives from the
7 organizations available?

8 MS. MUNTHALI: Yes, we do. The
9 first measure is measure 0029, counseling on
10 physical activity in older adults. It's two
11 parts. A is discussion physical activity and
12 B is advising physical activity.

13 This is an endorsed measure by
14 NCQA. Dawn, I think your colleagues are going
15 to introduce the measure. And so, I'm sorry,
16 I don't have your names.

17 CO-CHAIR JARRIS: If you could
18 introduce yourself, please?

19 MS. GIOVANNETTI: No problem. I'm
20 Erin Giovanetti. I'm a research scientist at
21 NCQA. And I'm going to be presenting the
22 measure 0029 on counseling on physical

1 activity in older adults.

2 So this is a survey measure that
3 is administered through our health outcome
4 survey. It's strictly for older adults, age
5 65 plus. There are two rates in this measure
6 that are assessed through two questions.

7 The first question asks, in the
8 past 12 months did you talk with a doctor or
9 other health provider about your level of
10 exercise or physical activity? And then gives
11 some examples.

12 And then the second question asks,
13 in the past 12 months did a doctor or other
14 health provider advise you to start, increase
15 or maintain your level of excessive or
16 physical activity? And then gives some
17 examples.

18 This measure is based off of the
19 4As model of ask, assess, advise and assist.
20 Similar to the way that we designed our
21 smoking survey measures.

22 The measure has good reliability,

1 which I think is all documented in the
2 submission form, based on guidelines on U.S.
3 Preventive Services Task Force recommendations
4 about physical activity in older adults, and
5 the importance of that.

6 I am happy to answer any
7 questions. One thing that has come up before
8 when we've presented survey measures to
9 steering committees, just because we don't
10 exactly know where to put it in the form.

11 Health outcome survey is a survey
12 that is broadly fielded to Medicare
13 beneficiaries. It does allow for a proxy
14 response. So if someone is unable to answer
15 this question for themselves, there is an
16 option for a proxy response on this.

17 And there's a whole method for
18 determining if someone is cognitively impaired
19 enough to require a proxy response. Or the
20 person can choose to have a proxy assisted
21 response.

22 That may not be in the submission

1 form just because we weren't entirely clear
2 where that would go in the form. But also
3 happy to answer any questions.

4 CO-CHAIR JARRIS: Kurt.

5 CO-CHAIR STANGE: It would help me
6 to have you make the case for why this is a
7 population measure. I mean, the link between
8 counseling by health care professional and
9 actual behavior change is there. But I mean,
10 it's probably maybe good enough to be a
11 clinical measure.

12 But multiple determinants of
13 health behavior change for this seems like the
14 influence of counseling. Clinician counseling
15 is just a really small factor compared to the
16 others. So why is this not a clinical
17 measure? Why is this a population measure?

18 MS. GIOVANNETTI: I guess I'm not
19 entirely clear. This is a clinical
20 performance measure.

21 DR. BURSTIN: Let me just speak to
22 that. We included these remaining BMI and

1 weight measures in this part of the project.
2 Because we were expecting to get population
3 level measures that reflected that. These are
4 clinical measures up for endorsement
5 maintenance.

6 The question would be, what are --
7 As we go through this exercise, what are
8 potential other population level measures that
9 would be complimentary. But there is no
10 expectation --

11 These measures are already
12 submitted. We just moved them here because we
13 thought we'd have population level obesity
14 measures.

15 CO-CHAIR STANGE: Were they
16 submitted in response to this call for
17 population --

18 DR. BURSTIN: No. The prior work.

19 CO-CHAIR STANGE: So this is the
20 old phase when we're still keeping --

21 DR. BURSTIN: This is the
22 remainder of the measures from Phase I, where

1 we though we would actually have some very
2 nice complimentary measures. We fully
3 expected in this are that we thought we'd need
4 to do some harmonization on. So we kept them
5 in the project.

6 MEMBER PESTRONK: So you're asking
7 us to endorse them, or adopt, or review them
8 in the same way that we've reviewed the other
9 ones?

10 CO-CHAIR JARRIS: Well we, in our
11 criteria -- This is a population health
12 measures work group. Do we have a criteria
13 which would be such that we would only adopt
14 a measure if it were a population health
15 measure?

16 Because if it's not a population
17 health measure, should we refer it to some
18 other committee, whose jurisdiction it falls
19 within? Or are we saying this is a Phase I,
20 and therefore --

21 Because I could see that it is --
22 If you are looking at the 5,000 patients that

1 belong to health plan X and are surveying
2 them, you're getting a sense of how health
3 plan X's immediate population.

4 So really it goes back to Phase I.
5 But this is not a Phase II issue. Prior to
6 this committee, where would a question like
7 this have been reviewed in NQF?

8 DR. BURSTIN: Probably just a
9 prevention committee, or something along those
10 lines. Or potentially behavioral health. We
11 just really did expect we could get multiple -
12 -

13 You know, we specifically
14 highlighted obesity in our call for measures
15 for this phase. We thought there would be
16 some logic of having the together. We're very
17 surprised. And after lots of begging and
18 pleading, got no population level measures
19 around obesity.

20 Although interestingly, one of the
21 developers for one of these measures is the
22 City of New York Department of Mental Health

1 Hygiene.

2 CO-CHAIR JARRIS: Okay. So let's
3 look at it within that light, that it is a
4 patient population measure, which is Phase I
5 of preventative service, clinical preventive
6 service type measure. So, Sarah, you I
7 believe from the committee reviewed this. Do
8 you want to make any comments?

9 DR. BURSTIN: She's not here. But
10 there were other --

11 MS. MUNTHALI: I'm not following
12 my own rules. It was Rhonda Medows. She
13 couldn't joint us today. But I think there
14 were others in the workgroup that reviewed
15 this measure as well. So if you'd like to
16 share anything with your colleagues, please do
17 so.

18 CO-CHAIR JARRIS: Okay. Anyone
19 else have a comment or question? And again,
20 let's hone in down and look at it from that
21 point of view.

22 MEMBER KINSINGER: Paul, this is

1 Linda on the phone.

2 CO-CHAIR JARRIS: Go ahead.

3 MEMBER KINSINGER: And I wanted to
4 make a comment again about the evidence that's
5 quoted, which is all about the benefits of
6 physical activity for older folks, which is
7 completely non-controversial, totally agree,
8 no problem.

9 But it would seem to me that the
10 evidence that should have been presented for
11 this measure was something -- Or at least
12 commented on somewhere. Something about the
13 effectiveness of counseling older patients
14 about physical activity in the healthcare
15 setting.

16 So again, and this has come up on
17 several of them. I don't think the evidence
18 that's presented is really the useful evidence
19 that we need to judge the measure on. Just a
20 comment.

21 CO-CHAIR JARRIS: Madeline.

22 MEMBER NAEGLE: I would agree with

1 that. And I just would suggest that since
2 this measure was first approved there has been
3 considerably more evidence about counseling
4 about physical activity, in terms of levels
5 and specific advice to particular issues. So
6 I feel that the evidence which we have before
7 us doesn't really speak to provider activities
8 and their effectiveness.

9 CO-CHAIR JARRIS: And the evidence
10 that you're aware of, would it support this
11 measure or not? Are you prepared to talk
12 about that?

13 MEMBER NAEGLE: The evidence that
14 I'm aware of, and I guess I have to put on my
15 other hat. That I direct our WHO
16 Collaborating Center on Geriatric Education.

17 And a lot of the work that we've
18 looked at really suggests that the advice
19 about physical activity has to be targeted
20 toward people's particular conditions, toward
21 their capacity, toward their rankings in
22 groups.

1 So that first of all, discussing
2 doesn't really do anything. It's not
3 paralleled to the 5As. I know that that might
4 have been the original thinking about it now.
5 But the evidence would suggest that that would
6 not be appropriate as a parallel.

7 So that I think that it could be
8 far more specific, and therefore more useful
9 to both providers and consumers, in terms of
10 what the consumer would expect to hear. And
11 to the provider in terms of what the provider
12 should be offering.

13 CO-CHAIR JARRIS: All right. At
14 some point I guess then, if you want to follow
15 up to that. And I guess the question is,
16 would the instrument you're using allow you to
17 get more specific in this fashion.

18 So that you could document that a
19 useful intervention actually occurred.
20 Because you're asking a patient. And would it
21 work to ask a patient about that specific type
22 of counseling?

1 MS. GIOVANNETTI: So that is, I
2 agree with you. And I apologize that the
3 evidence didn't speak to exactly about the
4 counseling. We were really focused more
5 around the guidelines around the activity.

6 We did look at more specific
7 questions that really got at targeting whether
8 or not they were targeted to the condition, to
9 the exact circumstances of the patient.

10 We are constrained however, in
11 that this is a large survey in which we had
12 the option of two questions. Only two
13 questions was the space with which we were
14 able to do this. Because of the length of the
15 overall survey, the health outcome survey,
16 which gets multiple things.

17 So having a multi question tool
18 would have been, could get at much more
19 specific information. And I think is still
20 something that is useful.

21 However, we were really looking
22 for a measure that said across the entire

1 population of older adults, just was this even
2 discussed in the physician's office?

3 And they did look at several
4 questions that talked about more specific
5 interventions. Patients found those
6 confusing.

7 So in the cognitive testing, what
8 they found was that it was better if you had
9 the question be as broad as possible to
10 include physical activity and exercise.
11 Because people qualified those differently.

12 To not specify what the condition
13 was, because for different people with
14 different conditions, there might be different
15 recommendations from their physicians. So
16 this is really trying to get at the fact of --

17 It is a low level measure. I
18 agree. It's not getting at what you want.
19 It's not a guideline or any sort of advice to
20 physicians about what they should be doing.

21 However, I will point out that
22 even at this low level, we're still seeing a

1 pretty significant quality gap, with only 50
2 percent of patients reporting that their
3 doctor even asked them about their level of
4 physical activity. So I think it's still
5 pointing to something that is a quality of
6 care gap.

7 MEMBER STIEFEL: Two things, I
8 guess. The first is, I'm drawing increasingly
9 unclear about the distinction between a
10 population measure and a clinical measure.
11 And it sounds like you've got a bright line in
12 your mind. But they're getting mushed
13 together for me.

14 And perhaps that's a good thing.
15 Maybe that's a direction we need to be going.
16 This is a, you know, you could argue that this
17 is a sub-population measure, if you're looking
18 at populations of health plans.

19 And I'm not sure of this in or out
20 notion of only geographic population applies.
21 I agree this is a low level. This is a major
22 strategic initiative in our organization, to

1 be doing this measurement. And including
2 measuring exercise is a vital sign.

3 Perhaps the efficacy of the advice
4 at the clinic visit is not as great as other
5 interventions. But promoting awareness of
6 this is I think powerfully important. And
7 this is a step in the right direction, like a
8 lot of the other measures we're looking at
9 where the measure itself --

10 (Off the record telephone
11 interruption.) CO-CHAIR JARRIS: Okay.

12 MEMBER STIEFEL: What was I
13 saying? That this is an important component
14 of a broader -- Like, you know, smoking
15 itself isn't a population improvement measure.
16 Assessment of physical activity is a first
17 step in a very important population health set
18 of measures.

19 CO-CHAIR STANGE: This isn't an
20 assessment of physical activity, right? It's
21 clinician counseling for people 65 and older.
22 And to Madeline's point about the evidence for

1 the efficacy of counseling, which I think is
2 relevant to this.

3 I mean, I -- There really has
4 been a lot of research done that's come out
5 since the task force looked at this. Have
6 they looked at this again since 2002, which is
7 what I just googled?

8 MEMBER SPANGLER: Yes.

9 CO-CHAIR STANGE: So what's the
10 latest recommendation?

11 MEMBER KINSINGER: It will be
12 coming out in about a month or so.

13 MEMBER SPANGLER: Yes.

14 CO-CHAIR STANGE: Okay. So --

15 MEMBER SPANGLER: And did you have
16 a systematic review that came out in December
17 of 2010, hereabout? Behavior counseling to
18 promote physical activity, and a healthful
19 diet to prevent cardiovascular disease in
20 adults. But not beside that, and in that
21 specific population, elderly population.

22 CO-CHAIR STANGE: So even, I mean

1 --

2 MEMBER SPANGLER: It's adult.

3 CO-CHAIR STANGE: Even if we're
4 able to extrapolate to the older populations,
5 we so often have to do, does the evidence
6 produced support Madeline's contention, and my
7 impression that there is evidence, a greater
8 body of evidence of the efficacy of
9 counseling?

10 MEMBER SPANGLER: The conclusion
11 from the systematic review is counseling to
12 improve diet or increase physical activity,
13 change health behaviors, and was associated
14 with small improvements in adiposity, blood
15 pressure and lipid levels.

16 CO-CHAIR STANGE: So for this
17 measure that seems very important. It's not
18 really about just changing the behavior,
19 rather does counseling make a difference.
20 Okay.

21 MEMBER STIEFEL: Paul, could you
22 respond to the question that I raised about

1 where is the line --

2 CO-CHAIR JARRIS: I would put, you
3 know, if we look at the NPP. And I think you
4 may have been the one that actually came up
5 with the three tiers originally. I would put
6 this --

7 This is a clinical behavior, a
8 clinical behavior service. One on one type
9 issue. In that case I would put it in that
10 Tier I, looking at clinical preventative
11 services at a population level.

12 In this case the population is the
13 health plan, or whoever is using this. I
14 think it doesn't get -- And I would agree
15 with you, that's necessary, but wholly
16 insufficient intervention in the whole system
17 of interventions.

18 To go beyond that, it would be
19 great to have a measure among, of the actual
20 physical activity level. For example, in a
21 jurisdiction or a population. Because then
22 it's not a matter of I counseled you, it's

1 actually a step beyond that.

2 Not only did I talk to you about
3 it. But I have to make sure that there's a
4 safe place to walk in your community, that you
5 can go out after dark if that's when you
6 exercise, without being assaulted, that you
7 can go to playgrounds. So it gets beyond the
8 four walls. This is still a within the four
9 walls question.

10 MEMBER STIEFEL: We just talked
11 about smoking though. And it was just an
12 assessment of do you smoke?

13 CO-CHAIR JARRIS: Which is
14 probably the same category here.

15 MEMBER STOTO: No. I think it's
16 not. If it was --

17 CO-CHAIR STANGE: That was a
18 different measure, you're right. That was
19 prevalence of smoking in the population.

20 CO-CHAIR JARRIS: It's about do
21 you smoke, which is different than did someone
22 counsel you about smoking.

1 MEMBER STOTO: I think these are
2 really fundamental issues that the fact that
3 we're struggling with these strikes mean that
4 the people developing the measures probably
5 are struggling even more.

6 And maybe we should put this off
7 until tomorrow. But I want to raise a flag
8 here that I think would be useful to provide
9 some guidance with examples, perhaps. That
10 sort of say, look at these different kind of
11 measures.

12 How do they fit into the
13 population health logic model? What kind of
14 evidence do you have to propose for each one?
15 And things like that. I think that could be
16 useful.

17 MEMBER PESTRONK: This is a
18 proposed measure that's coming back after
19 having been approved, for maintenance. So is
20 there anything that has happened in the last
21 three years, roughly, that would suggest that
22 it shouldn't be endorsed again?

1 Has anybody raised issues to
2 suggest that, you know, this one didn't work?
3 Or we've got problems with it? Because
4 somebody did a thorough review of this the
5 last time in another place. So what do we
6 know about that?

7 CO-CHAIR JARRIS: Well from what
8 Jason said, the review was in December. And
9 it supported that there's some level of
10 evidence that this probably does some good.

11 I mean, we could also -- If this
12 kind of assessment and counseling isn't going
13 on, that's bad. If it is going on, it may be
14 good.

15 So from that point of view, if 50
16 percent of the folks are responding that they
17 never even were assessed and counseled, that's
18 bad. So I do think there's a gap here that
19 could be improved.

20 It's just with this, again I think
21 we have to be clear that this is like the
22 Phase I of the three phases. And not get lost

1 and think we've done our job by approving
2 these very narrow, in the four walls type,
3 measures.

4 MEMBER PESTRONK: That I get.
5 I've got a brighter line in my head between,
6 you know, measures like this and measures that
7 we have tried to conceive as population based
8 measures.

9 And the smoking is an example of
10 one of those that seemed to fall way over on
11 the other side of the bright line, on the
12 brighter side of the line.

13 The question for me, setting aside
14 all that, in trying to answer the question
15 that we're getting asked, is should this be
16 re-recommended? Has anything happened in the
17 last couple of years that suggests that it
18 shouldn't be?

19 And if nothing has come up that it
20 shouldn't be, and people are using it, and
21 they're getting good value out of it, and
22 there's variation in what's being done, and

1 therefore being able to have this measure
2 illuminates that variation, and moves people
3 towards reducing the variation, then --

4 DR. BURSTIN: And just to reflect
5 on that. I mean, when a measure comes back in
6 for maintenance, it's not just that nothing
7 bad has happened as a result of having the
8 measure out there. But has anything positive
9 happened as a result of having the measure out
10 there.

11 So perhaps NCQA could speak to --
12 I mean, it looks like at least the section 2B5
13 indicates that across Medicare plans there's
14 been little changed. Now again, it's not
15 clear how much of that, you know, rates across
16 the years have not changed much.

17 But maybe that, you know, in terms
18 of future tense, that may point to Paul's
19 earlier point. That if it's only a discussion
20 between you and your provider -- And I'm
21 curious about Sarah's perspective on this as
22 well. As opposed to your health plan.

1 Potentially doing activities
2 outside of those four walls, which may get you
3 closer to more of a population level measure.
4 Just an interesting discussion I think for us
5 to have. But I think we're really seeing not
6 much difference. Erin, do you want to respond
7 to changes?

8 MS. GIOVANNETTI: Yes. So there
9 was little attention paid to this measure. I
10 agree. Which is why you see in the data that
11 we have up until 2009 reported here. You
12 don't see much change.

13 However, it has been adopted into
14 the Medicare Stars program, Stars rating
15 program, which has put a lot more attention on
16 these measures. And so we are --

17 And unfortunately, you know, just
18 because of the data delay we don't have those
19 numbers directly available right now. But we
20 do expect that with that, this measure will
21 start to move. Because if anything, people
22 want to increase their stars.

1 CO-CHAIR JARRIS: Elisa, did you
2 want to address this issue of --

3 MS. MUNTHALI: Yes. There was a
4 question about whether or not we received any
5 information on its use. And what we do as
6 part of the endorsement maintenance process --

7 When we put out the call we ask
8 people in the field if they have any comments
9 about the measure. And just as a matter of
10 public record, we just wanted to note one
11 comment that we received. And we shared it
12 with NCQA. I don't have your response. So if
13 you want to respond verbally you can do that.

14 This comment is from Carmella
15 Bocchino. And she's one of our member
16 counsels. So she recommends that NQF
17 harmonize this measure with language used in
18 the HOS survey, particularly -- This is in
19 quotes "physician recommending an increase or
20 maintaining exercise."

21 Additionally we recommend NQF
22 explore additional means of reporting, beyond

1 self reporting. Since exercise can be
2 categorized as a vital sign.

3 And so we just wanted to pose it
4 to you to respond to that. I think, Dawn, you
5 sent us your response. And we're trying to
6 find it on the P drive.

7 DR. REHM: Yes, hi. I'm Bob Rehm.
8 I'm the Assistant Vice President for
9 Performance Measurement at NCQA, and formerly
10 worked with Carmella at AHIP.

11 And actually had a conversation
12 with Aparna Higgins, who's a member liaison to
13 our committee on performance measurement,
14 about the perfectly harmonized measure within
15 a measure.

16 And she said, yes, that was an
17 error on our part. So it is the measure that
18 it is, which is the one that's self reflecting
19 I guess. I don't know.

20 (Off microphone comments.)

21 MEMBER STOTO: So I've got just a
22 technical issue. the denominator statement

1 actually is a statement of the numerator, if
2 you read it. It's 2A1.4.

3 And you can infer what the
4 denominator is. It's just contained in there,
5 Medicare members of 65 and older. But it then
6 restates to numerator. So just to be clear.

7 MS. GIOVANNETTI: That was
8 something that got messed up in the
9 transmission of the form. I apologize. I
10 don't know what happened. But that's not the
11 --

12 MEMBER STOTO: Oh, yes. Well not
13 quite, but -- Anyway, that's a technical
14 thing that --

15 MS. GIOVANNETTI: Oh, no. I
16 apologize, no. The reason that that is there
17 is because the answer to the question is yes,
18 no, or I've had not physician visit in the
19 past 12 months.

20 Anybody who reports yes or no is
21 in the denominator. If they report not having
22 had a visit in the last 12 months, they're not

1 in the denominator.

2 MEMBER STOTO: Oh.

3 MS. GIOVANNETTI: So we only
4 include people who had a visit in the last 12
5 months.

6 MEMBER STOTO: I see. I didn't
7 get that. But okay.

8 CO-CHAIR JARRIS: This is a four
9 walls question then. Because you're not
10 asking the entire plan's enrollment. You're
11 just asking those who had a visit.

12 MEMBER STOTO: And who answered
13 the question.

14 CO-CHAIR JARRIS: Madeline, did
15 you --

16 MEMBER NAEGLE: I would just ask
17 that we might clarify if we're going to say
18 this has worked so far. But you're still not
19 getting great response. I think it was about
20 50 percent are actually doing this.

21 Rather than using vague terms like
22 discussing physical activity -- You used the

1 language, Paul, when you were just talking
2 about it. Saying did you assess and counsel?
3 So maybe it should be assessing physical
4 activity and then advising. And that would
5 maybe be a little bit more specific.

6 CO-CHAIR JARRIS: Yes. Someone has
7 to translate that into patient language.

8 MS. GIOVANNETTI: And we did. We
9 tested that language with the patient, with
10 did the physician assess your -- Although we
11 were not asking specifically about whether --

12 In the cognitive testing I don't
13 think we were getting at did they assess your
14 level of physical activity. That, we were
15 more asking about did the doctor ask you about
16 it.

17 And they did test a variety of
18 different languages, which is why they ended
19 up on -- Discussing was the term that made
20 the most sense in this older population.

21 MEMBER STIEFEL: This just right
22 to that point. It sounds as if what Paul and

1 Bobby were saying earlier is that this would
2 be very different if this were a measure of
3 assessing physical activity. Then it would
4 look a lot like the smoking measure.

5 And this is just a little bit
6 removed from that. It's discussing physical
7 activity, which isn't quite at assessment.
8 But it was, in part, because it was put in
9 consumer friendly language. So it's close to
10 an assessment measure.

11 We've added exercise as a vital
12 sign. So we're measuring it as well at every
13 visit. But it sounds like that's a very
14 important distinction. Kind of a subtle
15 distinction.

16 MEMBER PESTRONK: It's a sub --
17 To that point it's a sub-population, which is
18 non geographic in nature. So if, in fact, we
19 want to think about sub-populations that are
20 non geographic in nature, then it has the
21 potential to be a measure that has to do with
22 the population, which is the clinical

1 population in a particular organization, or in
2 a particular plan. That's the distinction
3 that I was making in my own head on this one.

4 CO-CHAIR JARRIS: Does anyone else
5 want to talk before we allow Ron to say
6 something?

7 MEMBER BIALEK: I feel like I'm
8 home. Well actually it's okay. Because I'm
9 very confused at this point. You know, I
10 think of some of the earlier comments were
11 about impact.

12 And so we have counseling here.
13 And we have physical activity here. And at
14 least, again what I'm reading, that link
15 between counseling leading to the physical
16 activity is not made. And I know Jason added
17 some information that was important. But I
18 don't see that being made.

19 And so my question is, if we are
20 to apply the same criteria that we did this
21 morning, where we look at, let's say 1B,
22 performance gap, demonstration of opportunity

1 for improvement in health.

2 It doesn't suggest to me that the
3 counseling measure has demonstrated an
4 opportunity to improve health, because the
5 counseling measure doesn't make that tie to
6 increased physical activity.

7 CO-CHAIR STANGE: So I think we've
8 done two re-frames. At least since I was
9 initially voting on this and thinking about
10 it. One, is that we're thinking back to the
11 clinical preventive service delivery measures,
12 and not holding this to a population health
13 standard.

14 And then second, I think is
15 Bobby's very helpful comment that this has
16 been previously endorsed. So what's new? The
17 new thing is that now it's actually got some
18 teeth, some incentivization for people to want
19 to use it. That's important. That increased
20 the impact.

21 And then Madeline and Jason talked
22 about if anything, the evidence for what Ron

1 just brought up is certainly, probably very
2 greatly enhanced since the last time it was
3 looked at.

4 So to get back to Bobby's frame.
5 What's new? The two things that are new are
6 in a positive direction. It was already
7 endorsed before.

8 So I'm not hearing any discussion
9 about why we shouldn't re-endorse this with
10 that initial kind of re-frame, that this is a
11 clinical preventive service delivery measure.

12 CO-CHAIR JARRIS: Okay.

13 MEMBER PESTRONK: Does every
14 measure that NQF has endorsed get used by
15 someone? Or do the measures that NQF endorsed
16 sit out there as a collection of measures to
17 be chosen by someone to be used? And then, so
18 that's one question.

19 The second is, progress in the
20 direction that we would hope isn't the right
21 question, isn't the right framing. Because
22 failure on a measure is an indicator of what

1 shouldn't be done, if people have been trying
2 to have progress occur in the right direction.

3 It suggests what people shouldn't
4 try again. Or shouldn't try again in exactly
5 the same context. So, Helen, that get's back
6 to, you know, the question is, has this been
7 chosen? And now it looks like it might be
8 chosen.

9 And I don't care whether there's
10 progress or not. What I care about is
11 somebody pays attention to the analysis about
12 why there was progress or not.

13 And that things don't get repeated
14 over time. People don't do the same things
15 over and over again, failing to learn from the
16 experiment that they conducted.

17 CO-CHAIR STANGE: So just to be
18 clear, Bobby, I wasn't talking about progress
19 in actually the health behavior that's being
20 measured, or the counseling. Progress in
21 meeting the criteria is what I was speaking to
22 --

1 MEMBER PESTRONK: Okay.

2 CO-CHAIR STANGE: -- with your
3 initial re-frame.

4 DR. BURSTIN: But does it answer
5 your question? We actually have been trying
6 to track uptake of NQF endorsed measures. And
7 in fact this past year did a very detailed
8 analysis of all 700 measures in the portfolio.

9 And the overwhelming majority --
10 I think it was almost 90 percent, are in use
11 in some program. In fact, a good number of
12 them are used in federal programs, not
13 surprisingly.

14 A good number of them are used by
15 states. Some of the state based measures from
16 AHRQ, for example, the RQIs and others, PQIs.
17 And then there's a set of measures that are
18 used in benchmarking, quality improvement, a
19 series of things.

20 Not all of them have moved into
21 sort of high stakes accountability
22 applications. But the vast majority of them

1 are in use.

2 We've also learned, as part of our
3 usability task force this past year, it
4 usually takes at least one cycle of a measure
5 being out, a new measure, to get really picked
6 up for use.

7 MEMBER STIEFEL: Perhaps this is
8 just a tomorrow question. But the point that
9 Bobby raised is an important one where I might
10 disagree.

11 The notion that if we're looking
12 at a non-geographic sub-population, does that
13 mean we can't have population health measures?
14 Because a lot of what I do is population
15 health measurement for a non-geographic sub-
16 population.

17 And would argue that if we could
18 find harmonization between Kaiser and
19 WellPoint and United, and the public health
20 department in a geographic area, the union of
21 those sub-populations comes close to being the
22 population. And I think that's a very

1 important direction.

2 MEMBER STOTO: Can I just add to
3 that? I mean, I agree with what Matt said.
4 But I also think it's important to have these
5 population health measures for the population
6 you said to begin with.

7 Because so for instance, take
8 something like the immunization measures we
9 were looking at last time. If you measure
10 immunization status among the people who
11 happen to have come in during a given time
12 period, versus immunization among everybody
13 who's enrolled in the program, they are
14 fundamentally different. And they tell you
15 different things.

16 And I think that the second one is
17 the population health measure. And I think
18 that's the one that we should be doing, even
19 for service oriented populations.

20 CO-CHAIR JARRIS: Okay. Any of
21 our committee people on the phone have
22 something to say? Otherwise I think we're

1 probably ready to move on.

2 OPERATOR: To ask a question press
3 star then the number one on your telephone
4 keypad.

5 CO-CHAIR JARRIS: Actually, I
6 wasn't opening up to the general population.
7 I just thought if there were some committee
8 work members. Maryann and Linda?

9 MEMBER KINSINGER: No further
10 questions from me, thanks.

11 MS. JACOBSON: This is Dawn. Can
12 I make one comment as a public person?

13 CO-CHAIR JARRIS: Go ahead.

14 MS. JACOBSON: I just want to
15 reiterate, based on what we found in the
16 environmental scans, that the measure is
17 currently submitted as a health improvement
18 activity of the clinical care system. It's
19 not a population health measure.

20 The solution would be using
21 something like BRFSS to measure physical
22 activity rates at the population level. In

1 the future, ideally a health information
2 exchange that could pool all of that
3 information, and be used geographically to
4 assess counseling at the population level
5 would be another solution. But we don't have
6 that in most areas of the country yet.

7 CO-CHAIR JARRIS: That raises
8 another possibility. Maybe this is another
9 one of those areas where it would be useful to
10 have, what is the question. And have it used
11 by CMS and have it used by Kaiser, and have it
12 used by BRFSS, so it was harmonized. Now what
13 that has to do with what we're doing today
14 confuses me.

15 MS. JACOBSON: I would just
16 recommend that we use a measure like
17 prevalence of physical activity, using an
18 existing survey. Because our limitation right
19 now is we rely on these self reported
20 population health surveys to make decisions
21 for change.

22 So I don't see this measure being

1 a population health measure. And, you know,
2 Healthy People has all sorts of population
3 health measures that have been vetted for
4 similar things, like validity, accuracy, what
5 data set do we use, what's meaningful at the
6 local level.

7 And I'd like to see measures that
8 are truly population health measures be
9 selected, not clinical care measures. I guess
10 is -- I don't if that means we have to redo
11 it.

12 CO-CHAIR JARRIS: Yes. This would
13 be more of a population health measure if the
14 question was, are you, whatever it happens to
15 be, are you physically active 30 minutes,
16 three times a week, or whatever the question
17 is.

18 And then it would reflect upon
19 that population served by that insurer.
20 That's more of a population measure, as
21 opposed to were you counseled, which is a
22 clinical intervention measure.

1 MS. JACOBSON: Yes.

2 MEMBER STOTO: Can I disagree with
3 that? I mean, I think that -- Was that Dawn
4 speaking? I think that that reflects the
5 distinction they make, and she makes in the
6 paper about population health outcome
7 measures, as opposed to population measures.

8 Because I think that you can talk
9 about doing an activity like counseling among
10 everybody in a population, geographically or
11 defined as Matt says. And that's not -- And
12 that's of use.

13 That's distinct from an outcome
14 measure. And this one's about the counseling
15 and the discussion, rather than the physical
16 activity as an outcome.

17 MS. JACOBSON: Right. And maybe
18 we can talk about this tomorrow again as well.
19 But if we had a valid, reliable population
20 health data set that gave us that information,
21 we could then logically use it as a proxy for
22 downstream outcomes if the evidence clearly

1 links it, which I don't know if it does.

2 But we're limited with our data
3 sources right now, I think. And I wouldn't
4 use a health plan data set to assess
5 population health the way it's collected no.

6 CO-CHAIR JARRIS: All right. So
7 there's a lot to discuss tomorrow. I throw
8 into that what's also the question, if you
9 have actually population health outcome
10 measure, would you necessarily use that rather
11 than a process measure like counseling. For
12 tomorrow maybe.

13 DR. BURSTIN: In some ways those
14 may be complimentary. I have a question for
15 NCQA, since you guys are here, in terms of
16 question wording. And this came up earlier
17 before you came in. Dawn was helping us out
18 with looking at the smoking measures.

19 Do you look towards the national
20 surveys for the wording? For example, BRFSS
21 or NIHS to determine what questions you'll
22 ask?

1 Because one of the questions
2 that's been asked is, if you want to get a
3 family of measures, you'd certainly like to
4 have the same word choices used for your
5 surveys at the health plan level as we're
6 seeing at the population level.

7 MS. GIOVANNETTI: So I can answer
8 to the, you know -- Definitely as we develop
9 new measures we look to already established
10 measures questions. We definitely want to go
11 with --

12 If there's something out there
13 that's validated, that gets at what we want,
14 we go with that. When this measure was
15 developed, back in 2003, we did the cognitive
16 testing in 2004, I wasn't part of the team
17 that developed this.

18 But that's part of the
19 environmental scan that they do. They look
20 across measures that are existing to determine
21 if there's one that they could use and put
22 into that survey.

1 I suspect for this one, there was
2 not one existing at the time that they felt
3 was appropriate for the 65 plus to be
4 administered. It's a self administered
5 survey.

6 DR. REHM: And just to the smoking
7 cessation question. Originally when NCQA
8 promulgated that measure, it was using the
9 very early public health service ask and
10 advise to quit. There was the two questions.

11 And then as the public health
12 service guidelines expanded, I think Dr. Fiori
13 led that, then we added to it essentially. So
14 this is a measure that essentially grew over
15 time versus a essentially as a place holder
16 for a significant public health threat.

17 And we had, you know, a lot of
18 resistance among different communities who
19 didn't want us to go there. And so, I mean,
20 some of these measures have a life story. And
21 smoking is one case.

22 This is, of course, an area where

1 as we get new recommendations from the USPSTF,
2 coming soon, we would imagine we would look
3 forward to the opportunity to make sure that
4 we are capturing all those elements that we
5 could.

6 At least in this area within the
7 constraints of the health outcome survey
8 itself, which is a fairly burdensome survey as
9 it stands. But again it is an instrument of
10 accountability, which we think is quite
11 important.

12 CO-CHAIR JARRIS: Okay. We should
13 move on and I think probably to the voting
14 process. Yes, why don't we first -- Sue, I
15 apologize that we haven't given you an
16 opportunity to introduce yourself to
17 everybody, let the folks on the phone know
18 you're here. And we also updated any
19 conflicts. So if you could do that.

20 MEMBER PICKENS: Sue Pickens,
21 Director of population medicine, Parkland
22 Health and Hospital System, Dallas, Texas. I

1 don't believe I have any conflicts at this
2 time.

3 CO-CHAIR JARRIS: Thank you.
4 Elisa.

5 MS. MUNTHALI: Okay. So we'll
6 start with importance to measure and report.
7 1A, impact. The rating scale, just to remind
8 you is one for high, two for moderate, three
9 for low and four for insufficient evidence.

10 And remember, Sue you wouldn't
11 remember this, but make sure you point, yes,
12 your clicker to this monitor here. And we
13 have 20 seconds to record the vote. So the
14 timer is on. We need three more votes. And
15 one more.

16 (Off microphone comments.)

17 MS. MUNTHALI: Okay. So Mary and
18 Linda on the phone.

19 MEMBER KINSINGER: This is Linda.
20 And I would say moderate.

21 MS. MUNTHALI: Mary Pittman, are
22 you still on the line?

1 MS. MUNTHALI: Okay. So there's
2 seven highs, three moderates and one low. So
3 the next category is 1B, performance gap.
4 Same rating scale. You have 20 seconds. I
5 think we have five more in the room. I can't
6 see what number that is. Two more. One more.
7 Okay. We're fine. Linda?

8 MEMBER KINSINGER: High.

9 MS. MUNTHALI: Okay. So ten highs
10 and one insufficient. So we'll move on to 1C,
11 which is evidence. And the rating scale is
12 one for yes, two for no, and three for
13 insufficient evidence. Okay. We have
14 everyone in the room. Linda?

15 MEMBER KINSINGER: Well based on
16 what was submitted, I guess I'd have to say
17 insufficient.

18 MS. MUNTHALI: Okay. So we have
19 six yes's, three no's and two insufficient.
20 So we move on to scientific acceptability of
21 the measure properties.

22 This is the evaluation of

1 reliability. Rating scale from high to
2 insufficient evidence. This is 2A. I think
3 we're missing one. Okay, we have everyone in
4 the room. Linda?

5 MEMBER KINSINGER: High.

6 MS. MUNTHALI: Okay. So seven
7 highs, three moderate, one low. Next is
8 validity, 2B. Same rating scale. We have
9 everyone in the room. Linda?

10 MEMBER KINSINGER: Moderate.

11 MS. MUNTHALI: Okay. So six high,
12 four moderate, and one low. So we'll move on
13 to usability. Same rating scale. We're
14 missing one person in the room. Okay, we have
15 everyone. Linda?

16 MEMBER KINSINGER: High.

17 MS. MUNTHALI: Okay. Seven high,
18 three moderate and one low. And the last
19 criterion is feasibility. Same rating scale.
20 We're missing one. Okay. Linda?

21 MEMBER KINSINGER: Moderate.

22 MS. MUNTHALI: Okay. So three

1 high and eight moderate. And so now we're
2 going to vote on the overall suitability for
3 endorsement. This is a yes or no vote. One is
4 yes, two is no. Okay. Linda?

5 MEMBER KINSINGER: Yes.

6 MS. MUNTHALI: Okay. So ten yes's
7 and one no. So the measure passes.

8 CO-CHAIR JARRIS: Thank you. As
9 you can tell we're having some adjustment
10 issues here with the new work area. So that
11 reflects us and not you. And thanks for your
12 work.

13 Please consider what we talked
14 about though in terms of how to make a
15 population more broader population measure, as
16 opposed to an encounter measure as you go
17 forward with these things. Thanks.

18 Next we are back up to New York
19 City. Do we have folks on the phone from New
20 York who'd like to speak to Measure 0023, BMI
21 in adults older than 18 years of age? And I
22 just ate at Carnegie's Deli this weekend. So

1 that's where you have to start. One sandwich
2 took four days to finish.

3 MS. MUNTHALI: Operator? Anika?

4 OPERATOR: Yes.

5 MS. MUNTHALI: Hi. Is Sam Amifar
6 on the phone?

7 OPERATOR: Hold a moment.

8 MS. MUNTHALI: Okay.

9 OPERATOR: If you're on line can
10 you please press star one? And their line is
11 open

12 MR. AMIFAR: Hello?

13 MS. MUNTHALI: Sam?

14 MR. AMIFAR: Hi.

15 MS. MUNTHALI: Hi. This is Elisa.

16 If you could go ahead and introduce the
17 measure for the committee, that would be
18 great.

19 MR. AMIFAR: Okay.

20 MS. MUNTHALI: Thank you.

21 MR. AMIFAR: Sure. I'm Sam Amifar
22 from the New York City Department of Health

1 and Mental Hygiene. And the measure that we
2 put in front of you, I think the number was
3 0023, Body Mass Index, BMI in adults greater
4 than 18 years of age.

5 CO-CHAIR JARRIS: Yes. That's
6 correct. Would you like to give us any
7 background on it?

8 MR. AMIFAR: Sure. So this
9 measure was developed in about 2006. And the
10 purpose of it was to measure a number of BMI
11 measurements that providers were taking.

12 The suspicion was that actual
13 numbers were pretty low, in terms of height
14 and weight being taken in a lot of our
15 clinics. We wanted a measure that would give
16 an administrative associate or manager of the
17 clinic an idea of the rate of BMI being
18 recorded.

19 At the same time have a measure
20 that on the alerting side would alert the
21 provider that a particular patient in front of
22 them being seen, would need to have height and

1 weight measured so that BMI can be reported
2 for that particular patient.

3 The idea was we would have
4 probably a multi-stage process with the
5 measure. Ideally down the road we would like
6 a measure where if a BMI is high or out of
7 range, either, you know, obese or extremely
8 low, that a measure would prompt the provider
9 to do something about it. Counseling and
10 discussing options for an obese patient for
11 example.

12 The first step of it in 2006 was
13 however, to get a baseline recording of how
14 much BMI is being recorded. Then the measure
15 was incorporated into a lot of the practices.
16 Bu 2007 we got our numbers back. And I think
17 we had about 20 percent compliance rate with
18 the BMI.

19 And over the course of the 2008-
20 2009 the numbers steadily improved. I think
21 the last numbers we have about 65 or 70
22 percent. They might even be higher now. We

1 don't have current years, 2011 numbers yet.

2 And the idea was once it gets into
3 a certain threshold, we're thinking maybe 80,
4 85 compliance with it, then we would modify
5 the measure and make it not only measuring
6 BMI, but also working on the intervention part
7 of it.

8 CO-CHAIR JARRIS: How was it --
9 Is this a -- How was it submitted to you?
10 And what sense do you have of how much of the
11 issue is that it's not done versus how much of
12 issue is that it's done but not reported to
13 you?

14 MR. AMIFAR: It's submitted -- We
15 have about 600, 700 practices, about 2500
16 providers now. The practices have their own
17 servers. And the electronic health record
18 submits it to us electronically and
19 automatically on a monthly basis. And is sent
20 to our servers at Department of Health for
21 analysis.

22 And so we get these automatically.

1 And the provider doesn't have to do much in
2 terms of -- Actually it doesn't have to do
3 anything in terms of having these numbers sent
4 to us.

5 There are occasional transmission
6 issues. And some practices do not transmit,
7 and haven't been transmitting because of
8 technical issues with the transmission.

9 But for the most part we get a
10 good representation of our different
11 practices. And could you repeat the second
12 part of the question again?

13 CO-CHAIR JARRIS: No. You
14 answered it. Thanks.

15 MR. AMIFAR: I did. Okay.

16 CO-CHAIR JARRIS: Thank you. Who
17 among the committee reviewed the measure?
18 Jason?

19 MEMBER SPANGLER: Yes. That was
20 me. My response is, I don't know if you saw
21 the memo. Most of them were in there. Just
22 some questions about, some of the responses

1 didn't seem adequate enough. And I felt like
2 some of the citations were just a little weak.

3 There also, one thing to note is
4 that, this is also a topic in progress for the
5 task force. And they are in the final stages
6 now too of updating their screening and
7 management of obesity in adults. So that's
8 something to keep in mind. It should be
9 coming out in the next few months.

10 One of the other questions that I
11 had was the time frame, the 24 months. And
12 the developer I guess responded to that, that
13 there wasn't evidence for that. But I guess
14 it was convenient for the providers there.

15 And then gave more details about
16 the exclusions. So my main issue with this
17 measure is that it's -- And I really
18 appreciate this side by side comparison. Is
19 that there are competing measures for this.

20 So two that are endorsed,
21 including this one and 421. And then a new
22 one that NCQA submitted, 1690. So I think we

1 need to address the competition and
2 harmonization of those.

3 And they have slight differences,
4 each one of these. And I think each of the
5 elements have, I would say good components
6 that we could probably --

7 I don't know if we would combine
8 them or add to one of the measures that have
9 the most. But I think we should probably, I
10 mean, we should only have one measure I think
11 that covers BMI.

12 CO-CHAIR STANGE: So based on
13 Jason's comment that the U.S. Preventive
14 Services Task Force is going to come out with
15 new recommendations soon. And based on the
16 measure developer's plan that this becomes a
17 measure that includes counseling beyond
18 measurement.

19 And based on the harmonization
20 issue that Jason brought up. I mean, is this
21 something where we ask the NQF to look at
22 harmonization issues? And then updating based

1 on --

2 DR. BURSTIN: No. We ask the
3 developers to harmonize.

4 CO-CHAIR STANGE: Okay. So we ask
5 -- I guess the question is, if the task force
6 comes out with something that's, and maybe
7 people have some inside information on this,
8 that's beyond just the screening, that's
9 screening and counseling. Is that, if that's
10 where you want to go, would you want to update
11 this to reflect that?

12 DR. BURSTIN: It's the New York
13 City's guys on the phone.

14 CO-CHAIR STANGE: Right. Right.
15 Thank you. I'm sorry, so that was a question
16 for the developer, the New York City Health
17 Department. I'm sorry, I don't have your
18 name.

19 MEMBER SPANGLER: Sorry. Kurt,
20 can I address that real quick?

21 CO-CHAIR STANGE: Yes, thanks.

22 MEMBER SPANGLER: The old

1 guideline they use, the SPS evaluation does
2 also include counseling. So one of the
3 questions I had, which I don't -- Actually I
4 don't think it's reflected in the memo.

5 But one of the questions I have
6 written down on my -- And I think we brought
7 up during the call was, why is this not a
8 measure for both components? Just for
9 screening and not for counseling?

10 DR. BURSTIN: Although I was
11 actually at the task force at the time. And
12 it was specifically, if you were in settings
13 that had specialized obesity programs. So it
14 was nuanced at the time. You could pull it
15 up. I'm curious to see if there's better
16 evidence now.

17 MEMBER SPANGLER: So that's a
18 great question. I had that question as well.

19 CO-CHAIR STANGE: For the measure
20 developer. Do you want to think about
21 updating this based on what the new task force
22 recommendation?

1 Particularly since that's your
2 intent, is to move in the direction of a
3 measure that's about screening and counseling?
4 Recognizing that there still are many
5 practices for whom the screening is a current
6 unmet step.

7 CO-CHAIR JARRIS: Sam, are you
8 maybe muted? Or we could repeat the question.

9 MR. AMIFAR: Hello? Can you hear
10 me now?

11 CO-CHAIR JARRIS: Yes.

12 MR. AMIFAR: Okay, great. Sorry
13 about that. So back in 2006 when we first
14 introduced the BMI measure we didn't
15 incorporate counseling. Primarily because the
16 electronic health record vendors we were
17 dealing with didn't have a mechanism of
18 incorporating counseling sessions into
19 electronic health records.

20 And so since we always knew that
21 this was going to be a preliminary BMI, that
22 we would want to do an intervention down the

1 road at sometime.

2 This was meant to be a stop gap
3 type of measure, where we would try to
4 increase the BMI recording rates to a certain
5 respectable amount.

6 And then once that happened then
7 we would want to update the measure. And in
8 terms about updating the measure. We
9 obviously are very interested in updating the
10 measure.

11 We haven't updated this particular
12 measure because, like you said, there are a
13 couple of measures that are in this class and
14 are competing.

15 And I think specifically 0421, if
16 I have the number right, is a measure that we
17 do like in terms of an annual BMI screening
18 that incorporates counseling. And with BMI
19 parameters of greater than 30, or less than 20
20 or 18.5 were numbers we were comfortable with.

21 We were thinking of incorporating
22 that. And we didn't want to update this

1 measure and have one that's very similar to
2 the one that's already being considered. And
3 it's already endorsed.

4 CO-CHAIR JARRIS: So do you -- In
5 looking at this then, would you be supportive
6 of measure 0421?

7 MR. AMIFAR: We would, you know,
8 in terms of I think having too many measures
9 in the same field that are competing or are
10 not very different from each other, I think is
11 confusing for the public in general, the
12 developers and practitioners.

13 So we would be supportive of 0421,
14 or another one the group determines to be a
15 good representative measure that's supported
16 by evidence currently.

17 CO-CHAIR JARRIS: Mike and Sarah?

18 MEMBER STOTO: I think it's
19 important to be careful about exactly what's
20 being measured by these three things on the
21 chart.

22 And that this, the one that we're

1 currently discussing, 0023, is similar in
2 concept to 1690, which is about documenting
3 BMI. But 0421 is about actually doing
4 something when you find somebody is out of the
5 normal range.

6 I mean, that's fundamentally very
7 different. And I think that what Sam was
8 saying earlier is that they're thinking about
9 this 0023 as something they can do now, so
10 that at some point in the future they could do
11 something like 0421.

12 But it's not like one is a
13 substitute for the other. No. I don't think
14 it's a substitute at all. I think that they
15 address very different things.

16 I mean, right now, I mean, I can
17 imagine that if the physician measures the
18 patient's height and weight. And then the
19 system calculates the BMI. It may not ever
20 tell the physician even what the BMI is, and
21 whether the patient's out of range. And
22 that's --

1 MEMBER SPANGLER: I think what
2 you're -- Mike, what you're pointing out is,
3 if you look at 0421, that and is capitalized.
4 So you need both components. That's what
5 you're talking about.

6 MEMBER STOTO: Right.

7 MEMBER SPANGLER: Not just the
8 first one.

9 MEMBER STOTO: Right.

10 MEMBER SPANGLER: It's not an
11 and/or.

12 CO-CHAIR JARRIS: Right. But
13 isn't that what Sam is saying? They're ready
14 to move on.

15 DR. BURSTIN: They're ready to
16 move on.

17 CO-CHAIR JARRIS: As long as their
18 electronic health system's ready to move on.
19 So wouldn't we, you know, drive -- This
20 reminds me of the diabetes one. The first
21 question was, do you get an A1C once a year?
22 And the question after a while is, duh?

1 MEMBER STOTO: Yes.

2 CO-CHAIR JARRIS: And then, what's
3 the level?

4 MEMBER STOTO: I guess maybe we
5 should ask Sam. Because I heard him say maybe
6 that they were not ready to do something like
7 0421 yet.

8 DR. BURSTIN: I thought he said he
9 was.

10 CO-CHAIR JARRIS: I thought he
11 said he was too.

12 MR. AMIFAR: Hello?

13 CO-CHAIR JARRIS: Yes, Sam.

14 MEMBER STOTO: Okay, you're the
15 one.

16 MR. AMIFAR: Okay. Great. We
17 actually are ready to do something like 0421.
18 We brought the preliminary measure up to about
19 75, 80 percent.

20 So I think once it gets that high
21 we're ready for actually some kind of
22 intervention. And we'd be supportive of

1 counseling involved in patients who have a
2 higher BMI.

3 MEMBER STOTO: Okay. Thanks. I
4 misunderstood that.

5 MR. AMIFAR: Okay. No problem.

6 CO-CHAIR JARRIS: Sarah, then
7 Kurt.

8 MEMBER SAMPSEL: And I think this
9 was touched upon a little bit in that part of
10 the conversation. In that one of the things
11 the workgroup was talking about is how do you
12 deal with these multi-component measures.

13 And we'll deal with them again in
14 a few minutes. But, you know, so if we're
15 looking at 0421, while there's an and, there's
16 also an if in there. And so, you know, it's
17 a translation issue.

18 And so if New York's moving to
19 that as well, that's something also to kind of
20 consider. Because BMI, in and of itself is,
21 you know, as Matt probably knows as well, is
22 one of those things we're trying to get

1 doctors to document.

2 And so even alone it's a useful
3 piece of information. In moving patients, you
4 know, whether up in BMI, which doesn't seem to
5 be a huge problem in our country, or down in
6 BMI. You know, that's kind of another
7 clinical process that we would have to get to.

8 But the other thing that I would
9 wonder from New York would be, if you get to
10 that point where you're going to that, you
11 know, the 04210 where the doctor obviously has
12 the BMI in front of them.

13 Will you be capturing that data
14 too, so that you then be able to have
15 population based metrics for New York on
16 really where the population is falling on the
17 BMI scale.

18 MR. AMIFAR: In terms of actually
19 getting numbers out of the EHRs, we don't get
20 actual values out of it. We do get
21 categorical groupings. So we probably would
22 get a count, for example. A monthly count of

1 people who have a BMI over 30.

2 But actual BMIs being sent to us
3 on a per patient basis, we would not be
4 getting. We generally just get counts of a
5 certain categorical variable that we're
6 interested in.

7 CO-CHAIR JARRIS: Sam, the clinics
8 you talked about that are reporting this. Are
9 those the New York Department of Health
10 clinics? As opposed to all the providers and
11 all the medical practices. Because you'd only
12 be rolling up a subset of the population.

13 MR. AMIFAR: Right. These are
14 actually not Department of Health clinics per
15 se. They are practices that are associated
16 with our regional intervention center. A
17 primary care information project.

18 We, for the past five years have
19 been helping practices, private practices,
20 community health centers to adopt EHRs, and to
21 start using them effectively. And so they're
22 primarily small practices out in the

1 community, with a couple of community health
2 centers.

3 CO-CHAIR JARRIS: But they're not
4 necessarily representative of the whole New
5 York population?

6 MR. AMIFAR: They are pretty
7 representative of the New York City
8 population. We have about 2.5 million
9 patients represented in New York City. It's
10 slightly predisposed to the underserved
11 community.

12 Because under our initial grant
13 that's who we were, those are the providers we
14 were targeting, people who've had at least
15 maybe 30 percent Medicaid patients.

16 So we are biased towards the
17 underserved community. But we think overall
18 it's a pretty good representative sample of
19 the New York City population.

20 CO-CHAIR JARRIS: Kurt?

21 CO-CHAIR STANGE: So for Sam's
22 population practices and his REC, the CMS

1 endorsed measure is the next step. The
2 question I think for us is whether it's useful
3 to have a measure that's more of a
4 developmental measure for the practices that
5 aren't there yet.

6 And I don't know what the national
7 data are. And it's a rapidly evolving area.
8 But I doubt that 79 percent of the practices
9 nationally are reporting BMI. There's still
10 a big lag for, first of all measuring height.

11 Second of all, for people with
12 paper records BMIs tend to not be calculated.
13 And there are still a number of electronic
14 health records that surprisingly don't
15 calculate BMI.

16 So the question is do we want, as
17 a developmental stage for the next few years,
18 while everybody's catching up with doing this,
19 do we want a measure that just does the
20 assessment, and doesn't include doing
21 something with it?

22 I mean, is that a useful thing?

1 And does that fly in the face of NQF's desire
2 to harmonize? Or is that really saying, the
3 field is at a variable stage?

4 There's some for which this is too
5 low a bar. And there's some where if you set
6 the bar higher you don't give them the
7 stepping stone to get there.

8 DR. BURSTIN: These are all good
9 questions. But usually our process is, we go
10 through each measure. We indicate whether
11 it's suitable for endorsement. And then we
12 have this exercise with the developers.

13 Because we have not actually heard
14 yet from Quality Insides or NCQA about the
15 measures they put forward, where they may
16 actually have some suggestions about why
17 their's is a better mouse trap.

18 But I guess my major question for
19 New York is, do they feel they want to
20 continue to be the -- To maintain this
21 measure as an endorsed NQF measure?

22 And if not, would they be willing

1 to work with the other developers to kind of
2 potentially works for their needs, the Board
3 of Public Health needs, and the needs of the
4 other developers here.

5 I mean, I will point out 0421, as
6 I understand it, has been retooled for EHRs
7 already, as part of meaningful use. So it
8 might be not too much of a heavy lift for New
9 York City to adopt it into their measure,
10 which I believe is based on E-clinical works,
11 one the EHR they adopted.

12 MR. AMIFAR: Yes. In terms of the
13 New York City viewpoint. I mean we'd be happy
14 to work on a new measure. I think, you know,
15 New York City might be a little bit ahead of
16 the curve in terms of nationally where we are.
17 And we're ready for a new measure.

18 We understand that other practices
19 throughout the country might need a crutch.
20 And we consider this measure really a
21 preliminary step, a crutch measure.

22 We'd be happy to continue

1 supporting it if the feeling is that this is
2 necessary. But for us, you know, it's getting
3 close to retiring it in terms of usefulness to
4 New York City. And we'd be happy to work on
5 a new measure such as 0421, or whatever else
6 that we're going to be developing.

7 MEMBER STOTO: I'd just like to
8 suggest that the one that we should be talking
9 about harmonizing with is 1690, which is the
10 NCQA one, which is really fundamentally the
11 same thing, except for minor differences.

12 CO-CHAIR JARRIS: So the question
13 here is, would the measures be, would the
14 language of the measures be the same? It
15 would be collected differently, since one's a
16 health plan and one's a clinic. But that gets
17 to what we were trying to say before that we
18 would like to have, the same measure applied
19 differently.

20 MEMBER STOTO: Yes. But they both
21 have to do with whether or not BMI is
22 documented.

1 CO-CHAIR JARRIS: Right.

2 MEMBER STOTO: And that's -- But
3 the NCQA guy may disagree here.

4 DR. REHM: I'm mindful of Helen's
5 recommendation to kind of -- I've been
6 through a lot of these panels. I kind of live
7 here. Dawn lives here more than I do.

8 Because it's, you're beginning to
9 conflate the individual measure with the
10 potentiality of where we could go downstream.
11 And quite often those are, you know,
12 sequential conversations.

13 But, you know, because it's been
14 raised, one difference is that -- You know,
15 this is an interesting -- Because, you know
16 the paradigm is different. New York City is
17 a terrific leader in community health.

18 And they have, you know, kind of
19 worked that field, and have an EHR specified
20 measure in use with a fairly large population
21 being assessed. Their success at this is
22 quite phenomenal. They're approaching 80

1 percent.

2 You look at health plans across
3 the country with a measure that's been in play
4 for three years, I think. And performance is
5 not, you know, it's around 50 percent if
6 you're lucky, depending on Medicaid,
7 commercial and Medicare.

8 I think that number is probably
9 more reflective of what's actually taking
10 place in the marketplace. So the question is,
11 well my sense of the question. Helen can
12 probably articulate this much better.

13 Is there a need for endorsement of
14 novel approaches to measurement, that can be
15 adopted by other people who are, in New York
16 City's case, interested in using EHRs in their
17 community to support a measure that appears to
18 be moving quickly? And to be very successful,
19 who knows what's driving the car there?

20 Is it the decision support system
21 from the EHR? Who knows? But there is a
22 slight difference in our measures. New York

1 City, because of the EHRness of it all, is
2 just really looking at a height and weight,
3 that then can be calculated by a system.

4 Again, not with a physician or a
5 clinician interface. And then therefore, in
6 some ways, kind of like the old days of
7 looking at measures, some of the low bar
8 measure of simply documentation. Really, did
9 you document height and weight?

10 In our measure, you'd have to have
11 actually entered the BMI. You'd have to have
12 calculated it in the medical record. And
13 calculated in the medical record and then put
14 a date next to it. So that you know that
15 someone's performed that function.

16 DR. BURSTIN: I mean, it's just
17 not that clear cut. I mean, most EHRs just
18 take your height and weight and create a BMI.
19 The last thing I want to do is actually have
20 to pull up the NHLBI calculator, which is how
21 most providers do it, to figure out and then
22 enter it.

1 DR. REHM: It may be New York City
2 can describe exactly how that takes place.
3 When I read the spec, I interpreted it
4 differently. That there was something else
5 that might be going on.

6 Because they talked about
7 difficulties getting the BMI calculated
8 depending on the fields. And so it's an
9 interesting lesson on how complicated getting
10 what appear to be simple things done.

11 CO-CHAIR JARRIS: But if the
12 system -- I mean if you enter a height and
13 weight and the system calculates the BMI, with
14 no clinician, nurse or doctor interface, that
15 is an extremely low bar.

16 Because then there's no cognitive
17 process going on here. Therefore, the doc may
18 not even know what the BMI is when the
19 patient's in there.

20 MEMBER KINSINGER: This is Linda.
21 If I could ask a question? Because I'm pretty
22 familiar with how EHRs work in our VHA

1 healthcare system.

2 And that is that, while there is a
3 specific field for vital signs, where heights
4 and weights can be entered, they are often
5 entered in the free text note box. And so are
6 not captured.

7 And we continually reinforce with
8 our providers, put it in the right place,
9 where it's in the calculable and computable,
10 and searchable field. Don't just put it in
11 the note section. And I wonder whether there
12 are, to what extent does that happen? Or is
13 that allowed in the New York City system.

14 MR. AMIFAR: In the New York City
15 system, we have a section on the vital screen
16 where height and weight need to be entered.
17 They can make it mandatory, so that someone
18 can't leave the screen until they actually do
19 it. That's an option for the particular
20 practice. They can do that or not do that,
21 depending on how they wish.

22 And within the height and weight

1 field you cannot put free text in there. It
2 has to be numeric. And there are some out of
3 range boundaries. So if you put a height, for
4 example, eight feet, it will not take it.

5 You have to put something that's
6 reasonable. Once they've put the height and
7 weight, then the system automatically
8 generates a BMI for the patient.

9 MEMBER KINSINGER: And so how many
10 practices have made that mandatory as opposed
11 to optional?

12 MR. AMIFAR: That we don't have
13 data for. It's a setting within the EHR
14 system that they can make it mandatory or not.
15 And I think that's why we have some
16 variability in our numbers.

17 But there has to be structured
18 data within that field. They can't just type
19 in whatever they want. And we've modified
20 that since, I think 2007, 2008. So that the
21 data in there is valid and interpretable by
22 the system.

1 CO-CHAIR JARRIS: So I think the
2 question is, is 0023, BMI in adults greater
3 than 18 years of age, 1690, Adult BMI
4 assessment. I mean, the question is,
5 shouldn't there be one measure of this that
6 could get implemented in different ways?

7 It could be that in New York City,
8 because you put it in the vital stats, it
9 calculates the BMI and comes up that way. It
10 could be that in another setting it's actually
11 a calculation that the provider has to do and
12 date. But it has to be in there.

13 I mean, it doesn't make sense to
14 me to have two separate measures for these
15 things based on how their implemented. The
16 implementation's secondary to what the measure
17 is we're trying to achieve.

18 MEMBER STOTO: You're talking
19 about 0023 and 1690, right?

20 CO-CHAIR JARRIS: Yes.

21 DR. REHM: Just a comment. So,
22 you know, we've run across this quite a lot.

1 We have a lot of competing measures out there
2 that we try to harmonize or align. So when
3 steering committees review these, they're
4 reviewing these on the right of criteria you
5 see.

6 And one of them is where this
7 measure's been tested. And so our locus of
8 interest in this particular measure is health
9 insurance plans across the continuum,
10 commercial, Medicare and Medicaid.

11 New York City's is on clinicians.
12 A measure specified for clinicians needs to be
13 tested for clinicians, needs to have
14 performance data for clinicians. A measure
15 for health plans needs to be tested for health
16 plans and et cetera, et cetera. Just the
17 corollary.

18 So, you know, so even if we were
19 to have a harmonized measure, let's say two,
20 three years from now. Wait for the task force
21 guidelines to come out. And we believe that
22 there are maybe two dimensions that are of

1 interest to clinicians that are exactly the
2 same interest to health plans.

3 But then because of the nature of
4 health plan accountability, you could very
5 well have a third dimension, or third element.
6 Because of the nature of the beast.

7 Just like when you're thinking
8 about population health at large, the health
9 of the nation. You may be measuring things
10 quite differently than you would at the level
11 of interest of a clinician.

12 So in that spirit, you would
13 likely not get what I would call a picture
14 perfect mirror image for clinicians that you
15 might have for a health plan, that you might
16 have for a State Medicaid department, or any
17 other level of accountability that you choose.
18 Accountable care organization perhaps.

19 So I think that's where this, the
20 idea that you can simply have one without
21 doing the testing, without having the
22 performance data being generated by the system

1 of interest, where it gets a little naughty.

2 Ten, 15 years from now, we may be
3 in a place where the nature of the data and
4 the flow of data moving makes this a moot
5 point. But we're not there. And I think
6 that's the challenge we're facing.

7 We have one foot in kind of in
8 our, you know -- Maybe it's archaic, but, you
9 know, we believe health plans need to be held
10 accountable in the U.S. And we believe that
11 measures that do that are valuable.

12 And we also believe that measurers
13 need to hold, you know, providers accountable,
14 as well as communities, you know. But that
15 again needs to be developed over time.

16 CO-CHAIR JARRIS: Matt.

17 MEMBER STIEFEL: I mean, that's --

18 DR. REHM: I'm just looking at --
19 I'm sorry.

20 MEMBER STIEFEL: -- an important
21 general philosophical argument. I don't think
22 it applies in this case. BMI assessment is

1 BMI assessment.

2 And I don't think that those
3 issues about the difference in specifications
4 of the measure are germane to the -- It may
5 be differences in sample size, and those kinds
6 of other attributes. But not the definition
7 of the measure.

8 MEMBER STOTO: Just to -- I agree
9 with that. And to continue, I'm looking at
10 1690. And even though it applies to health
11 plans, it's only of patients who have had an
12 outpatient visit. So that makes it a lot
13 closer to the New York measure.

14 CO-CHAIR JARRIS: So what the
15 question comes down to is, does NCQA endorse
16 a measure? Or does it endorse measures in the
17 context of the specific means in which they
18 are collected?

19 Because if that's what's being
20 endorsed, we will have potentially an infinite
21 number of BMI. One for nurse practitioners,
22 one for PAs, one for MDs, one for specialists,

1 one for you name it. And that's I think
2 exactly what we're trying to get away from.

3 DR. BURSTIN: Couldn't agree more.
4 Ideally you would love to have a measure that
5 works at multiple levels. Keep in mind they
6 are often very different data sources. That
7 measures need to be specified differently, for
8 an EHR versus claims, for example.

9 So we recognize that. And at
10 least for where we are right now, they can be
11 different measures, but they should be fully
12 harmonized. The age group should be the same.
13 The definition of BMI should be the same. The
14 time period should be the same. Is it 12
15 months or 24 months? Should you have
16 counseling in or out?

17 I mean, those are all the
18 discussion items we need to go through. So
19 what I would actually recommend we do, just
20 because I think this happens -- It's very
21 easy to get excited about the --

22 We think harmonization is sexy and

1 interesting, leap to that. But we actually
2 need to do first I think, is to actually walk
3 through the evaluation of all three measures.

4 And then walk back and have this
5 discussion of, is there potentially an
6 opportunity to bring some of these closer
7 together, or merge a couple of them? Or
8 figure out what makes the most sense.

9 But it's hard to do that, because
10 you haven't even talked about the other two
11 measures yet. So let's actually, I would
12 recommend just finish this evaluation and just
13 move on. And then we'll get to the good
14 stuff.

15 CO-CHAIR JARRIS: Okay. All those
16 in favor say, aye. We then are probably at a
17 point of voting on 0023.

18 DR. BURSTIN: Yes. I agree.

19 MS. MUNTHALI: Okay. For
20 importance to measure and report, one --

21 MEMBER QASEEM: What are we voting
22 then, though? Because --

1 CO-CHAIR JARRIS: So we're
2 evaluating measure 0023. And we'll go through
3 each of the measures. And then we'll put them
4 in a pile and look at harmonization.

5 MEMBER QASEEM: But don't you
6 think we need to look at all of them before we
7 vote on them?

8 DR. BURSTIN: Essentially what
9 you're going to do. I'm sorry. Let me
10 qualify that slightly. When there are
11 competing measures, essentially all you're
12 going to do at the end of this process for
13 each of these three, is indicate whether they
14 have met the criteria for endorsement.

15 You will then -- You're not going
16 to approve one of them. You will then go
17 through the harmonization exercise. And then
18 you will vote to say which ones you actually
19 approve.

20 Does that make sense? First, our
21 first stopping point is, we don't really care
22 about harmonization if the measures don't meet

1 our criteria. Let's get them first, see if
2 they're actually --

3 CO-CHAIR JARRIS: It's like in a
4 vacuum.

5 DR. BURSTIN: Exactly.

6 MEMBER STIEFEL: A slight
7 modification. I wonder if we could have the
8 discussion for all three, and then vote for
9 all three right in a row? I mean, I don't
10 know.

11 I reviewed the other one, 1690. I
12 don't know if I should be saving my comments,
13 which are obviously equally applicable to this
14 one. Maybe we should just get all of the
15 comments out, and then just vote on them all.

16 CO-CHAIR JARRIS: Okay. So 1690
17 we move to then? We'll keep you in suspense,
18 Sam.

19 MR. AMIFAR: Okay.

20 DR. REHM: Actually I think the
21 order was to go to CMS. Sepheen Byron is
22 going to join us. She helped with these

1 measures originally, and has the history.

2 CO-CHAIR JARRIS: 0023 and 1690,
3 on their face look very similar.

4 DR. REHM: I just don't --

5 CO-CHAIR JARRIS: So CMS as a
6 whole --

7 DR. REHM: Yes. I didn't know if
8 CMS had it's moment in the sun. Had CMS had
9 an opportunity to present it's measure. Yes.
10 That would be helpful since I'm waiting for
11 Sepheen. That's right. That's what we told
12 them.

13 DR. WILSON: Hi. This is Don
14 Wilson. I'm medical director for Quality
15 Insights. And with me I have Sharon Hibay,
16 who directs our measure and development
17 initiatives.

18 And we developed this measure
19 under contract with CMS. So we're the actual
20 measure developer, but CMS is the actual
21 measure steward. And we actually have some
22 CMS folks on the line I believe, that may

1 chime in if need be.

2 This measure I think was
3 originally developed in 2008, and received
4 endorsement at that time. I think as you
5 folks, and it's been alluded to by Helen and
6 others, it's been --

7 Since it was developed it's been
8 used now for probably at least three years in
9 the PQRS program for our physicians to
10 voluntarily report on. And most recently now,
11 it's one of the three core measures in HITECH.

12 So it's one of the measures that
13 all physicians have to report on, in order to
14 be able to achieve their meaningful use
15 incentives. So it's getting a widespread use
16 in that venue.

17 And I would just like to -- One
18 of the things we were talking about -- It was
19 the New York group for instance. And he was
20 talking about he's with the REC. We're also
21 in REC. So I'm very familiar with what that's
22 doing.

1 So I would assume in the New York
2 situation, because all these docs are getting
3 the meaningful use, they're having to use this
4 measure anyway. So all the docs that he's
5 talking about are using this in their system,
6 E-Clinical Works.

7 Being certified for meaningful use
8 is already programmed and set up, and should
9 be doing this automatically. I mean, it
10 should just be happening. So if you're a doc
11 that's going for meaningful use, you are using
12 this measure today, and will continue to do
13 so.

14 So basically I think everybody's
15 probably familiar with the measure at this
16 point. It is a two part measure. And to
17 answer someone else's question about it being
18 a two part.

19 Because of the way this measure is
20 reported, it is reported in a granular way.
21 So you can actually get statistics on just
22 whether the BMI was done or not and

1 documented. There's an entry reported that
2 way.

3 But they actually get performance
4 for the whole measure, you have to do both
5 pieces. But we do actually collect data on
6 just, for people who just did the BMI, but
7 didn't do the follow up. Or for people who
8 did the BMI, but did the follow up. Or people
9 who did the BMI but didn't do the followup.

10 So there's several different ways
11 that it's all reported. So we can really sift
12 that granularity out if we're interested in
13 looking at data subdivided or, you know, cut
14 and sliced in that manner.

15 So basically it's looking at, as
16 you see here, one of the things that our
17 technical advisory panel was very concerned
18 about when we developed this measure early on,
19 was that we not only focus on obese patients.

20 But really zeroing in on the fact
21 that in the elderly patients, your
22 malnourishment and low BMI is actually perhaps

1 even more of a problem than the overweight, as
2 far as increasing mortality. So for that
3 reason we really had --

4 And also there was lots of
5 discussion about whether there really is a
6 different BMI level range for elderly folks.
7 And really looking at the literature. And
8 most of the folks on our panel really felt
9 strongly that there really was a different set
10 of BMI norms for elderly patients.

11 So that's reflected in our
12 measures. You can see it's broken out by
13 different age categories. So basically our
14 measure is that of looking at the BMI, whether
15 it's documented in the previous six months,
16 either by the provider themselves.

17 Or they can actually call our
18 measure if they have it, if they're able to
19 show that it was done somewhere else, but they
20 have it documented in their record. And if
21 the BMI was outside of parameters, whether
22 some followup was done.

1 Again we really wanted to go that
2 extra step to say that they didn't want to
3 just have the BMI documented. They wanted to
4 see if some action was taken based on it. So
5 it has to --

6 If the BMI is outside of the
7 parameters, a followup plan has to be in the
8 record in order to get full credit for the
9 measure. And if you look at our measure, you
10 can see the components of what constitutes a
11 followup plan. There's things --

12 A future appointment for followup
13 of the BMI, for education. There's referrals
14 to different kinds of providers, whether a
15 medication was prescribed specifically related
16 to weight, whether dietary supplements were
17 prescribed, excercise counseling, nutrition
18 counseling, et cetera.

19 So you have to have at least one
20 of those things in your record to show that
21 you did some followip if your BMI is outside
22 of parameters in order to get credit for the

1 measure. So that's pretty much, I think, a
2 symopsis.

3 CO-CHAIR STANGE: Why six months?

4 DR. WILSON: I think that was --
5 I don't know that we really have a definite
6 strong guideline on that. I think that was
7 just a strong consensus on the part of the
8 panel, that it should be done at least within
9 every six months basis.

10 CO-CHAIR STANGE: Going down to 18
11 though, I mean, most 18 and 20 year olds don't
12 come in even annually, let alone six months.

13 DR. WILSON: Well it's basically
14 if they've -- It's for patients that have
15 been seen during the reporting period. And
16 for the measure, it was originally written for
17 the PQRS program.

18 So the reporting period is
19 typically a year. So if you're seen in the
20 office within the -- The denominator, you
21 have to have been seen in the office within
22 the past year.

1 And if you are, then you should
2 have had a BMI within the past six months
3 documented. If you've been seen at any time
4 during a year, during the past, within the six
5 months of that visit you would have had a BMI
6 documented.

7 CO-CHAIR STANGE: So why not make
8 it a year then?

9 DR. WILSON: I think that folks
10 felt that being a year would be a bit too
11 long. That you can have a significatn change
12 in your BMI, you know, if you allow it to go
13 longer than six months. That it should be at
14 least assessed --

15 CO-CHAIR STANGE: So your focus --

16 DR. WILSON: -- within a six month
17 period of having been seen in the office.

18 CO-CHAIR STANGE: So you're
19 focusing on the frequent flyers then, right?
20 You're excluding people from the denominator
21 who haven't been in in the last six months?

22 DR. WILSON: No. It's basically

1 again, it's a matter of they're seen -- If
2 the patient is seen in the office any time
3 within the year, you want to see whether
4 they've had a BMI within the previous six
5 months. So it wouldn't be a frequent flyer.

6 CO-CHAIR STANGE: So I came in
7 nine months ago. I had a BMI, but it wasn't
8 in the last six months. So I'm excluded from
9 the denominator? Or I'm --

10 DR. WILSON: You're in the
11 denominator because you were seen during the
12 year.

13 CO-CHAIR STANGE: But so then in
14 the numerator then, I actually -- I didn't
15 get a BMI done, because it was done nine
16 months ago?

17 DR. WILSON: That's correct. You
18 wouldn't be --

19 CO-CHAIR STANGE: Well that seems
20 wrong, right? Your intent is to look in the
21 last year. And so you're penalizing me if I
22 didn't happen to be in the last six months.

1 It doesn't --

2 MEMBER STOTO: It makes sense for
3 part A, but not for Part B.

4 DR. WILSON: I'm not sure I --
5 Again, you have to be seen anytime within the
6 year. At the time of that visit, you have to
7 have had a BMI within the previous six months
8 to get credit.

9 And you only have to have that
10 happen once during the year. So it's to be
11 reported once during the year. So as long as
12 any visit --

13 If I was seen in the office for
14 any time that year, if at that index visit if
15 I had a BMI within the previous six months,
16 then I comply for the measure.

17 CO-CHAIR JARRIS: So you came in
18 nine months ago and had a BMI at that visit.
19 Therefore, that BMI nine months ago was within
20 six months of that visit.

21 CO-CHAIR STANGE: So you're more
22 likely to be compliant if you're a frequent

1 flyer I guess.

2 DR. WILSON: Yes.

3 CO-CHAIR JARRIS: Is there any
4 evidence to support this? That BMI should be
5 done within six months? I've never seen it.
6 But I'm wondering where that came from.

7 DR. WILSON: Again, as I recall
8 that was a, sort of a consensus of the TEP
9 panel. That was the reason why -- I'm trying
10 to think back at the guidelines. I'm not sure
11 that we have a guideline that ever
12 specifically states how often a BMI should be
13 done.

14 CO-CHAIR STANGE: You know, maybe
15 --

16 DR. WILSON: One's 12 months, I
17 think one of the other measures is two years.

18 MEMBER STOTO: So maybe this
19 should be a harmonization question later.
20 Because one of these measures is six months,
21 one is 12 and one is 24. So that might just
22 be something to think about later on.

1 CO-CHAIR JARRIS: So when you
2 develop measures, what burden of evidence do
3 you require? You mentioned dietary
4 supplements.

5 And I'm wondering what evidence
6 was looked at to recommend dietary supplements
7 as a disposition for someone with an elevated
8 or low BMI?

9 DR. WILSON: I think that there's
10 probably pretty good evidence that dietary
11 supplements help people who are malnourished.
12 I mean, I'm not sure that we have an article
13 that says that, but --

14 MEMBER KINSINGER: It depends a
15 lot it would seem to me on what the dietary
16 supplements are. I mean, there's a whole huge
17 range of different things thta are all kind of
18 bundled under the broad name of dietary
19 supplements. If you're talking about
20 nutritional drinks like Ensure or something,
21 that's one thing. But if you're talking about
22 --

1 CO-CHAIR JARRIS: Ephedrine.

2 MEMBER KINSINGER: Ephedrine.

3 That's another dietary supplement that would
4 not help. Exactly.

5 CO-CHAIR JARRIS: Don't you have
6 to assume at some point that the physician did
7 the right thing? That the --

8 DR. WILSON: Right. I mean, I
9 would think that you wouldn't have someone,
10 you know, giving ephedrine to somebody who was
11 under -- You know, again I think the -- And
12 these were really just listed as examples.

13 In other words, the goal of the
14 measure is to show that some followup is done.
15 It's really not necessarily saying whether it
16 was the right followup.

17 In all honesty, you just want to
18 have documentation that the physician looked
19 at the BMI and did something about it. He
20 decided to, you know, came up with a treatment
21 plan or care plan.

22 It's not really assessing whether

1 there was an appropriate medication
2 prescribed, et cetera. It's just whether a
3 care plan, or a followup plan was done, as a
4 followup to the fact that the BMI was
5 abnormal.

6 MEMBER KINSINGER: I'm sorry. Can
7 you tell me where the followup requirements
8 are? I'm having a hard time finding it.

9 DR. WILSON: It's listed under --
10 If you look under definition, it should be, if
11 you have the measure specs, under numerator.
12 It's in definitions. It says BMI, elderly
13 BMI, calculated BMI, followup plan.

14 And again, if you look at the
15 language in the measure, it says, followup can
16 include. And it's documentation of a future
17 appointment, you know. Again these are
18 examples of what a followup plan can be.

19 MS. HIBAY: Just to make sure
20 everyone understands the source document. I
21 think you have two documents, which is the
22 NQF, the submission form of the information we

1 had to provide. And then there's a
2 supplementary document.

3 And the first attachment of that
4 supplementary document is, are the measure
5 specifications themselves. And the
6 definitions are there, including what
7 constitutes a followup plan.

8 In the EHR specification of this
9 measure, when you're doing claims in registry,
10 the way that you report the measure, you're
11 not necessarily saying --

12 And this is followup specific to
13 upper parameters or parameters above the
14 normals. And this is followup based upon the
15 low normal parameters.

16 So the definition in the
17 specification is provided as a lump of, this
18 what could constitute, may constitute. But
19 it's not limited to followup.

20 But in our EHR specification of
21 this measure we have specifically looked at
22 what are those appropriate followup

1 interventions that would be okay for lower
2 parameters, okay for higher parameters.

3 Perfect example would be, so if
4 you're in the upper parameters, way upper
5 parameters, you would not, you would
6 potentially refer someone to a bariatric
7 surgeon.

8 So we have a codification for that
9 measure, which obviously if someone is below
10 parameters, that's not an appropriate followup
11 for them. So there's, you know, there's a
12 teasing out of that information as, you know,
13 as we go forward.

14 But the information on the
15 specification that you have, it's a lumping of
16 the parameters for upper and lower. Excuse me
17 the followup for upper and lower.

18 DR. WILSON: But again I want to
19 stress that fact that the measure itself is
20 really just documenting that a BMI was done
21 and that there is some sort of followup.

22 It's not really assessing whether

1 it's appropriate followup. Because we got
2 into lots of discussions with that with our
3 TEP. And really decided we weren't --

4 This was not what this measure was
5 about. Because that creates a whole new set
6 of issues, you know, whether it's appropriate
7 followup.

8 CO-CHAIR JARRIS: Thanks. Ron and
9 Bobby.

10 MEMBER BIALEK: I think I recall
11 seeing a reference to the Clinical Preventive
12 Services Task Force in this. And I guess what
13 I'm wondering, and I don't know this off hand.
14 Does the task force itself suggest the
15 followup activities?

16 I know there's evidence that the
17 followup is effective. And I'm just wondering
18 why the followup piece to this is not just
19 tied to the Preventive Services Task Force
20 recommendations.

21 MEMBER SPANGLER: Can I comment on
22 that, follow up on that? That was the exact

1 same question I have. Because the systematic
2 review for the new update, which was
3 published. They have --

4 One of their questions was, is
5 there direct evidence that primary care
6 setting screening programs for adults, adult
7 obesity or overweight, improve health
8 outcomes. Or result in short term or
9 sustained weight loss or improved
10 physiological measures.

11 And they didn't identify any
12 trials on screening programs. So the same
13 question that I had for 0023 is why didn't you
14 include screening and counseling in your
15 measure? And they said they willing to do it.

16 It's the same question I have for
17 1690. Because there's no evidence that just
18 screening does anything. You do need that
19 component.

20 DR. WILSON: If I can answer that
21 though. I think what we're saying here is
22 that it's screening. But the fact that it's -

1 - The physician is now aware of it and
2 actually comes up with a treatment plan,
3 right? So it's actually --

4 I guess the question you have to
5 assume that treatment for obesity is
6 effective. I mean, so you're wanting to see
7 that the physician recognized it and developed
8 a treatment plan or followup plan for dealing
9 with the obesity. If it's not documented on
10 the chart, you assume that the physician
11 didn't recognized it even.

12 So the fact that he documents it
13 and then documents that he has a followup
14 plan, that shows that the did something about
15 it and actually created some sort of a
16 treatment plan. And he's going to followup
17 and manage that problem for that patient. It
18 was diagnosed.

19 CO-CHAIR JARRIS: Bobby.

20 MEMBER PESTRONK: Set aside the
21 fact that the exclusions are different for
22 each of the BMI measures that we are

1 considering. And as to whether one set of
2 exclusions is better than another set of
3 exclusions to give us, have the measure give
4 better data.

5 If 0421, which is looking at both
6 screening and followup were the recommended
7 measure, after we discuss all the measures.
8 And the data were -- And providers or
9 organizations weren't as far along as New York
10 City, or plans that were interested in both
11 screening and followup.

12 Would the failure to capture the
13 followup information in those places that
14 aren't far along, be problematic? Or would
15 they simply be able to report that first step,
16 which was the first step that New York City
17 took? And be able to decide how well they
18 were doing it, that first step?

19 DR. BURSTIN: So I think the
20 question actually for QIP is, is it reported
21 out at two separate rates? Such that you
22 would still have the BMI measured rate

1 separate?

2 MEMBER PESTRONK: And the reason
3 for asking the question is, if it can be
4 reported out that way, then there's no reason
5 to consider or recommend the other two
6 measures. Because you get more from the third
7 measure, which allows the followup to be
8 counted as well.

9 DR. WILSON: The way the measure's
10 currently specified, yes. You can approximate
11 out, as I said. If you notice the HCPCS codes
12 that are in the measure.

13 They actually specify out why you
14 failed. Did you fail just because you didn't
15 document the BMI, but you failed because you
16 didn't do the followup plan. So you can sort
17 out those numbers in the measure.

18 But again, let me point out, just
19 so we're aware of the context of how this is
20 being implemented in the EMR. Again, for most
21 physicians that are going for meaningful use,
22 they're having to do both things now.

1 And in order to get your
2 meaningful use, you have to report on this
3 measure, you know, and show that you have
4 performance. So doctors, at least if they're
5 going for meaningful use, they have to report
6 that they're doing both things, you know.

7 And again, most certified
8 products, again all certified products for
9 meaningful use, which most physicians are
10 implementing, do calculate the BMI.

11 As long as, I think the one person
12 brought up, the only problem where I could see
13 where it would be not happening is if the
14 physician is not recording it in structured
15 data fields, where the BMI literally could
16 calculate it if they're dictating in and out.

17 That wouldn't be the case. But as
18 long as they're documenting height and weight
19 they're EMR should calculate a BMI. That
20 should be a given.

21 MEMBER PESTRONK: Second question.
22 Just to deal with the exclusions then. Why

1 are there so many more exclusions proposed in
2 0421 than were proposed in 0023 or 1690?

3 And does that alter the nature of
4 the validity or reliability, I guess would be
5 the -- Does that alter characteristics of the
6 measure in some way that would be undesirable?

7 DR. WILSON: In all honesty, when
8 you look at the data as far as how many
9 patients are actually excluded for these
10 exclusions, it's very minimal. It's very
11 rare.

12 These were brought up again
13 because people on, folks on our TEP, you know,
14 that really had this bias, that they felt it
15 not appropriate for instance to --

16 You know, if someone has a
17 terminal illness, you know, are you really
18 going to try to talk to that patient about,
19 you know -- And is fair to ding a doc if
20 you've got somebody who's going to --

21 You know, with the expected life
22 expectancy of two months. Are you really

1 going to ding him for not talking about their
2 weight, you know, that kind of thing. So they
3 really felt that it was appropriate to have
4 that be an exclusion.

5 MEMBER PESTRONK: Okay. I was
6 thinking about it in the context of
7 immunizations, where we're finding more and
8 more people say, I just don't want to be
9 immunized.

10 And everybody says -- Not
11 everybody, but then, you know, the provider
12 says, well okay. So one of the exclusions
13 here is if the patient refuses the
14 measurement.

15 Is it still okay? Or something to
16 be examined there to see whether the rates of
17 refusal have to do in which the way the
18 process was proposed to the patient?

19 DR. WILSON: And I think how you
20 deal with that generally is, you know, you can
21 certainly look again to see if the refusals
22 are reported, as far as what they were.

1 And if you have a doc that's an
2 outlier who has a much higher refusal rate
3 than other folks, that would be a reason you
4 would zero in on that particular provider to
5 say, why does he have such a high refusal
6 rate?

7 You know, I think my sense of this
8 is, eventually I want -- If we could convince
9 providers that it was okay to be dinged
10 occasionally, I think we could probably be
11 better off. And I'm kind of getting off on my
12 own soapbox here.

13 But if we could do away with some
14 of these exclusions and just realize that
15 you're going to have an occasional patient
16 that you may get dinged on. But it happens to
17 everybody. Because it really does create such
18 a level of documentation issues in trying to
19 figure out how to define some of these things.

20 But the problem is that, at least
21 in my experience in working in the quality
22 improvement organization is, it's hard to sell

1 it to physicians.

2 You know, when they look at this
3 and they say, wait a minute. And they come up
4 with all these scenarios like that, you know,
5 you're going to ding me if I have somebody
6 who's got cancer.

7 You're going to tell me I have to
8 tell them they've got to, you know, lose
9 weight. That kind of thing they get -- You
10 can't get their buy in. But if you can tell
11 them, you're excluded, doctor. You don't get
12 dinged for that patient. Then they accept it.

13 CO-CHAIR JARRIS: Actually I
14 think, Bobby, that's an important point to
15 raise. And I feel really strongly about this,
16 having worked in physician incentive programs.

17 I thought we were past that issue
18 of docs saying, I can't control the patient.
19 He won't get on the scale. With vaccinations
20 you're exactly right. Or with asthma
21 treatment plans.

22 We all would say, yes,

1 occasionally you're going to get somebody, no
2 matter what you do, who's going to refuse to
3 get on the scale, refuse the vaccine. But
4 that's a small number.

5 And the better doctor will have
6 fewer of those refusers than the poor doctor.
7 So you're going to get measured on it and
8 understanding that once in a while you're
9 going to get dinged. I thought that we were
10 beyond that discussion ten years ago. And I'm
11 sorry to hear we aren't.

12 Now you're a public agency, so
13 you're, you know, the bait is built into the
14 process. Isn't NCQA beyond that, that whole
15 issue about -- I mean, there's no exclusion
16 for the patient refusing your vaccine rates.

17 And the second point is, I could
18 care less whether a doctor documents the
19 reason why the person didn't get on a scale.
20 Because that should be such a small number
21 when it's legitimate, that it should just be
22 dismissed and removed as a complication. So

1 Bob, can you comment?

2 DR. REHM: Well, you know, we're
3 on record as having very, very few exclusions
4 for the denominator, or exceptions in the
5 numerator for that matter.

6 But there's clearly attention.
7 Some are more -- The current immunization
8 situation is very problematic, because the
9 number of refusals out there is getting higher
10 and higher, unfortunately.

11 On the other hand, our rates are
12 fairly stable. So I don't know what's, there's
13 kind of -- The people who do want them,
14 really want them. And the people who choose
15 not to -- So in a funny way it's not
16 affecting the national or regional rates. But
17 underneath that we perceive an issue.

18 CO-CHAIR JARRIS: So would it help
19 CMS, and if we can do this in the context of
20 this in endorsing a measure, to say, we don't
21 want those two exclusions. Take them out.
22 And then we'll endorse you. Because frankly,

1 I feel strongly --

2 MS. HIBAY: Is Dr. Dan Green on
3 the phone still?

4 CO-CHAIR JARRIS: -- I really
5 dislike those.

6 MS. HIBAY: Because I understand
7 he called in.

8 MS. HIBAY: Dr. Dan Green is, I
9 think might be on the extension.

10 CO-CHAIR JARRIS: Is there a Dr.
11 Dan Green there, operator?

12 MS. MUNTHALI: Anika?

13 CO-CHAIR JARRIS: Yes. Dr. Green
14 if you're muted, it would be a help to unmute.

15 MS. HIBAY: I can't speak for CMS,
16 but I can say that we will present the
17 information. I know that we have been
18 presenting other measures.

19 And there were requests made by
20 workgroups and by committees to make
21 modifications to the measures. And CMS made
22 every effort to, you know, move those

1 modifications forward.

2 So I can say that we can bring
3 that back to CMS if they're not on the line
4 still. I would say that it would most likely
5 be very favorable.

6 DR. WILSON: So again, if you can
7 just tell me which two was it? Was it the
8 refusal and --

9 CO-CHAIR JARRIS: Any other reason
10 documented in the medical record by the
11 provider, explaining why BMI measurement was
12 not appropriate. It was Thursday and I didn't
13 feel like asking that day. I documented it in
14 the medical record.

15 CO-CHAIR STANGE: So I have two
16 process things. But, Bobby, do you have
17 something specifically on this issue before I
18 do that?

19 MEMBER PESTRONK: I have a
20 question about this, but not the question
21 we've been discussing.

22 CO-CHAIR STANGE: Let me do the

1 two quick process ones. One, I've seen a
2 couple of people get up, presumably to go to
3 the bathroom. So wonder if we need a break.

4 And the other process question is,
5 we're in the process of discussing three
6 separate measures.

7 And are we getting into enough
8 detail that we're going to have a hard time
9 holding the three in our head to vote on them
10 separately at the end?

11 And so the question is, should we
12 -- When should we take a break? So raise
13 your hand if you need a quick break. Okay.
14 So a small, but perhaps urgent minority.

15 And then the other thing, are we
16 getting to a level of detail on these
17 discussions on the three separate measures,
18 that we maybe need to back off to Helen's
19 suggestion and vote on them separately?

20 DR. BURSTIN: We still haven't
21 talked about he NCQA measure.

22 CO-CHAIR STANGE: Well that's

1 exactly the point.

2 MS. JACOBSON: Kurt, this is Dawn.
3 Could I just have a conversation with you and
4 Paul briefly, during the break?

5 CO-CHAIR STANGE: Okay.

6 MS. JACOBSON: As co-chairs.

7 CO-CHAIR JARRIS: Sure. We'll
8 keep you on speaker phone. No problem.

9 CO-CHAIR STANGE: My cell, Dawn,
10 is 216-2345-9504.

11 MS. JACOBSON: Or can we just use
12 the --

13 MEMBER PESTRONK: So my personal
14 conclusion is, actually the discussion of all
15 three simultaneously has helped me decide
16 which one I think is the best one. And to
17 recommend.

18 CO-CHAIR STANGE: Are you going to
19 be able to vote separately on all the items
20 for all three? Are people holding that in
21 their heads okay?

22 CO-CHAIR JARRIS: The other --

1 Right.

2 MEMBER SPANGLER: We're not voting
3 on the best one though. We're voting for each
4 of these individually as if the other ones
5 didn't exist first, right?

6 CO-CHAIR JARRIS: We're not voting
7 to endorse this. First we're voting just it's
8 appropriate. Because one of the things I
9 would think about considering.

10 And the Legislature used to do
11 this all the time. The legislative
12 committees, they'd say, you know what, the
13 three of you go in that room and talk and come
14 back with one measure.

15 And I don't know if we can do that
16 also. But I think if they're close enough to
17 say to the three parties, sit down and come
18 back with something that meets the following
19 criteria --

20 DR. BURSTIN: That's not possible.
21 We haven't even talked about the -- That's
22 the big question. We haven't talked about the

1 third one yet. So I think we need to talk
2 about the third one. And then we can have
3 that discussion.

4 CO-CHAIR STANGE: All right. I
5 withdraw my question then.

6 MEMBER PESTRONK: May I ask then
7 another question? Why, given that this one,
8 0421, addresses screening and followup. Why
9 wasn't it proposed just to measure BMI and
10 have that be the measure of interest?

11 So that in the population,
12 whatever that population under consideration
13 is, one sees whether there is a reduction in
14 BMI, where it would be appropriate to have a
15 reduction in BMI?

16 Why are we focused at the
17 screening and some followup level, rather than
18 at the outcome level, which would be hey, you
19 know, okay, yeas they're screened. Okay,
20 there's followup.

21 But the real issue is, did BMI
22 drop for those for whom it was appropriate to

1 drop. Why aren't we measuring that one? Why
2 hasn't anybody proposed that as a measure?

3 CO-CHAIR JARRIS: That's your next
4 job. Matt.

5 DR. WILSON: I think that
6 certainly is a very reasonable measure. I
7 mean, this measure was actually though, again
8 developed previously as a measure to really
9 evaluate, as a process measure to evaluate
10 clinicians.

11 And really trying, the goal was to
12 get clinicians more focused on making sure
13 they are checking BMI and doing something
14 about it.

15 But I think you're exactly right.
16 I mean, there should be an additional measure
17 to have as an outcome population based
18 measure. It makes perfect sense.

19 But I think, again I don't think
20 one necessarily negates the other. You know
21 what I mean. I think they each have their own
22 purpose.

1 Because it's probably very
2 difficult, if you're trying to evaluate an
3 individual practitioner with very small number
4 of BMI patients that have elevated BMI, it may
5 be very difficult to evaluate him
6 statistically if he only has five patients
7 that are like that.

8 You know, on a physician level
9 it's really very difficult to really
10 distinguish good performers from bad
11 performers versus looking at the whole
12 population. But if you're looking at an ACO
13 or a health plan, then it makes sense to do
14 that.

15 MEMBER STIEFEL: I reviewed 1690
16 and was going to save my comment about that
17 until then. But it's exactly that point. I
18 think if this group is going to make a
19 difference, and sort of chart a different path
20 from the standard kinds of NQF endorsed
21 measures, that's the sort of thing that we're
22 going to need to do.

1 Now we're obviously hamstrung in
2 that we don't have a BMI measure in front of
3 us. But they're sure out there. And it's so
4 close. All of these are about doing the
5 assessment that of course could yield a BMI
6 measure.

7 It raises lots of different
8 measurement issues about, you know, risk
9 adjustment and that sort of thing. But these
10 are so close.

11 And, you know, I think Dawn's been
12 making this point all day, is that what we
13 have is a set of health improvement
14 activities, where I'm hoping that our work
15 will, at some point, yield health outcome
16 measures.

17 And BMI is a nice one. And if
18 they're doing this assessment, they're getting
19 BMI. It's just too bad that we can't just
20 take the next step to reveal it.

21 MEMBER STOTO: I think I agree in
22 principle with that. But the thing is they're

1 not getting the BMI on anywhere near a
2 representative sample of the population. So
3 to report the BMIs that come out of the
4 databases that we're talking about here, we're
5 not -- I think could be misleading.

6 MEMBER STIEFEL: I mean, we do it
7 for everybody. And if the other health plans
8 do it for everybody. And if the public health
9 systems do it for everybody. As I said, the
10 sum of those, or the union of those would be
11 the BMI of the population. So it seems like
12 a good place to start.

13 MEMBER STOTO: Right. But if
14 you're only doing it on 70 percent or 30
15 percent of the patients to begin with, which
16 is the situation for people that are not as
17 advanced as Kaiser Permanente, then the BMIs
18 that come out of it is not really meaningful.

19 MEMBER STIEFEL: That's why I can
20 see for -- If you're looking at clinicians,
21 then the preventative care and screening BMI
22 is a process measure, which they have a small

1 population, large population, you can look at
2 whether they did those activities.

3 When you actually get to the
4 health plan level, like an NCQA measure,
5 that's when I'd really want to see there's a
6 statistically significant difference in the
7 BMI of a population being cared for. Because
8 you all of a sudden are aggregating to a large
9 enough level.

10 And when we used to go to NCQA and
11 have to report on our HEDIS measures, we did
12 have to report statistically significant
13 improvements in certain HEDIS measures.
14 That's where I would look at the leadership of
15 NCQA to come in at that level. Not at the
16 clinician level.

17 MS. JACOBSON: This is Dawn. And
18 thank you, Matt, for bringing it back around.
19 What I really talk to the co-chairs about is
20 a concern of mine that we're going to be
21 endorsing clinical care system measures, not
22 total population health measures.

1 And I wanted to clarify what the
2 goal of this committee is. My understanding
3 is we are looking for total population health
4 measures. That those clinical care measures
5 would influence. Along with policy
6 interventions that health departments do, and
7 other things.

8 So I'm really concerned that none
9 of these use the right data sets that's going
10 to give us a truly, true measure of population
11 health. And why are we endorsing them?

12 CO-CHAIR STANGE: So, Dawn, I
13 think there's a lot of people that share your
14 frustration. You probably missed the part of
15 this discussion where we said we're actually
16 going back.

17 These are Phase I clinical
18 measures that we're looking at. And that's
19 the lens with which we're looking at them now.
20 So we shared that. And we'll be discussing
21 that tomorrow as well. I think that's a
22 portion of the discussion tomorrow as well.

1 So we're just processing.

2 We're behind schedule. But I
3 think getting all these on the table is what
4 we've decided to do. And I think that we'll
5 save time at the end when we look to
6 harmonizing. So that's the path we're on.

7 We do need to take a break I think
8 for our transcriptionist's purpose. And I'm
9 using you as a foil for the fact that I could
10 use five minutes myself. So I wonder if at a
11 point we could take five, come back, finish
12 this measure.

13 And then I think go through the
14 third BMI measure before we get to the child
15 measure. And then do the third measure and
16 discuss our options among these three. Is
17 that, my co-chair, is that reasonable?

18 CO-CHAIR JARRIS: Yes. Yes,
19 sounds good. How much time are we taking?

20 CO-CHAIR STANGE: So we'll take a
21 five minute break. Really just a quick break.

22 MEMBER KINSINGER: Kurt?

1 CO-CHAIR STANGE: Yes, Dawn?

2 MEMBER KINSINGER: Hi. This is
3 Linda. I just wanted to let you know that I'm
4 going to have to drop off at 3:30 p.m. And
5 won't be able to rejoin the call.

6 CO-CHAIR STANGE: Okay.

7 MEMBER KINSINGER: So I'll be here
8 until then, but then we'll be signing off.

9 CO-CHAIR STANGE: Okay. Thanks,
10 Linda.

11 (Whereupon, the above-entitled
12 matter went off the record at 3:10 p.m. and
13 resumed at 3:22 p.m.)

14 CO-CHAIR STANGE: The five minute
15 break for 13 minutes, we're going to reconvene
16 here, please.

17 CO-CHAIR JARRIS: Kurt, you're
18 getting us started, right.

19 CO-CHAIR STANGE: So we're
20 discussing three measures and we have
21 completed our discussion of 0023. I guess the
22 question is are we done with our discussion of

1 0421 or does anyone have anything they want to
2 ask or say about that before we move on to
3 1690?

4 DR. BURSTIN: Since it was raised
5 earlier I just wonder whether anybody wants to
6 further discuss the issues of the evidence for
7 the underlying recommendations for follow-up
8 because that's going to come up as an evidence
9 vote.

10 CO-CHAIR JARRIS: I think that's a
11 topic that, it sounds like it's worth
12 discussing. It sounds like the CMS process is
13 more of a consensus expert testimony type
14 process, which is evidence but typically a
15 very low level of evidence in terms of the
16 USPA preventive task service.

17 And that the harder evidence,
18 which lags in time, should come out in the
19 next couple, few months from a new
20 recommendation from the U.S. Preventive
21 Services Task Force.

22 So we're in this odd period of

1 time where we don't have the definitive
2 recommendations. And so the question is where
3 do we go here. Do we go with, go ahead.

4 MEMBER SPANGLER: We don't have
5 the recommendation yet but we do have the
6 systematic evidence review that is guiding
7 that recommendation, which they do cite in
8 their studies of body of evidence.

9 CO-CHAIR JARRIS: How consistent
10 is the CMS?

11 MEMBER SPANGLER: They say that
12 behavioral based treatments are safe and
13 effective for weight loss, although they
14 haven't been studied in persons with Class 3
15 obesity.

16 Medication may increase. So I
17 think they encompass that as their follow-up
18 plan. But it's screening and some sort of
19 intervention.

20 The new recommendation is not
21 going to be screening and counseling. It's
22 going to be screening for a management of. So

1 I think they're trying to be consistent with
2 that with their follow-up plan as a
3 management.

4 DR. WILSON: And again, if I can
5 just say that this measure is really just to
6 show that there is a follow-up plan. We
7 didn't really want to get down into what is
8 the appropriate follow-up. Because we see
9 that maybe being under a subsequent measure on
10 down the road.

11 So it's really just these things
12 that are in this measure are really just
13 examples to help a physician understand what
14 they need to have documented in their record
15 to show that they've done something about
16 their elevated BMI.

17 And we're not really assessing
18 whether it's necessarily the appropriate
19 follow-up, just that they've recognized the,
20 like I think someone else said before, you
21 could have an EMR that's calculating your BMI
22 automatically and you may not have even

1 looked at it.

2 But to get credit for this measure
3 you have to show that I've acknowledged it,
4 it's out of parameters, and this is what I
5 intend to do about it.

6 But we're not really assessing
7 whether it's appropriate or whether it's an
8 evidence based intervention, just the fact
9 that you have an intervention in place.

10 CO-CHAIR JARRIS: So then
11 developmentally, could that be justified
12 developmentally as the same way we, at one
13 point, were looking at. Was a hemoglobin A1C
14 done in the last year?

15 Now it may have been 12, but it
16 was done and you got the points. So is that
17 a consistent argument here? Because it would
18 be much better if we said the following
19 evidence based follow-up actions were taken.
20 But that doesn't yet exist.

21 DR. WILSON: I think the analogy
22 would be, in that case, once the hemoglobin

1 A1C was done and it was elevated, did you do
2 something about it. Did the physician
3 acknowledge that and say I'm going to do X-Y.

4 But we're not really necessarily
5 saying that he said he was going to give
6 insulin. Well insulin wasn't appropriate.
7 Maybe he should have done this or that. We're
8 not really evaluating that.

9 We're just saying that we want to
10 see that at least he did something about it.
11 He acknowledged it and then came up with a
12 plan.

13 MEMBER STOTO: I would say that
14 just doing the hemoglobin A1C is parallel to
15 the first part of this measure and to 23 and
16 1690.

17 So the evidence question then
18 becomes, for Part B of this question, is doing
19 any old thing, is there any evidence that's
20 effective? And, of course, the answer can't
21 be true.

22 DR. WILSON: So is it premature to

1 have a Part B?

2 MEMBER SPANGLER: There are things
3 that are effective and this demonstrates that.
4 And I think what you're asking is, instead of
5 having a follow-up plan, should it be
6 something like evidence based intervention is
7 done. Because the follow-up plan could be I
8 didn't do anything.

9 MEMBER STOTO: So if the follow-up
10 plan is, I invited them to play checkers
11 everyday, that would not be the kind of thing,
12 I presume, that the Preventive Services Task
13 Force says is appropriate for --

14 (Off microphone comment)

15 MEMBER STATO: Right, yes. And so
16 if you have any follow-up plan at all there's
17 no evidence that having any follow-up plan is
18 effective in helping people.

19 CO-CHAIR JARRIS: I guess where
20 are we in the evolution of this? Because it
21 sounds like maybe 50 or 60 percent of people
22 don't even document the BMI. So the first

1 step would be just get them to document the
2 thing.

3 But those who have, could we take
4 a similar process to say, well, if you haven't
5 even recommended follow-up that can't be good.

6 But if you have recommended
7 follow-up it might be good. So then later, it
8 gets modified to what those follow-ups are.
9 I'm stuck. That's why I'm asking.

10 MEMBER SPANGLER: I think that, at
11 least in my experience whenever we've dealt
12 with TEPS, when it comes down to having to
13 define a very constrained finite list of what
14 is acceptable follow-up or what is evidence
15 based interventions, that's when you get
16 yourself in a go around circle that you never
17 come out of.

18 And people are always sometimes
19 very uncomfortable that we've gotten
20 everything on the list that really isn't
21 evidence based intervention, that you've
22 necessarily named everything.

1 MEMBER STOTO: But I think that
2 what it will come down to is that when we
3 have to vote on the evidence, that just
4 following up in however the physician sees as
5 appropriate, I think we'll probably say is
6 weak evidence.

7 CO-CHAIR JARRIS: Is it different
8 than counseling?

9 MEMBER STOTO: That would be
10 follow-up, right?

11 DR. WILSON: Counseling is follow-
12 up, yes.

13 MEMBER STOTO: Counseling about
14 what? If they document the high BMI and they
15 say you should lose weight that would count
16 as counseling.

17 CO-CHAIR JARRIS: Ron.

18 MEMBER BIALEK: So the U.S.
19 Preventive Services Task Force says screen
20 all adults for obesity and offer intensive
21 counseling and behavioral interventions. And
22 I'm just, again, wondering why that

1 terminology might not be in the measure?

2 MEMBER SPANGLER: I think because
3 that is from 2003 and the new one is from
4 what we have. We are in this interim period
5 where we have an up-dated on the evidence.
6 But we don't have the recommendation that
7 follows that evidence yet.

8 MEMBER BIALEK: Understood. So
9 then the next question would be when it comes
10 to that measure and it speaks to counseling,
11 it speaks to follow-up, why not simply
12 reference, consistent with the U.S.
13 Preventive Services Task Force
14 recommendation?

15 DR. BURSTIN: I think partly
16 because the measure has to be specified as to
17 what that means, particularly for the HR,
18 which is, I think, an issue.

19 But one recommendation would be we
20 recognize evidence changes. It changes all
21 the time. So I think, based on the current
22 evidence, and I'd appreciate Jason's read on

1 this since you've obviously looked at this
2 more carefully, if what is cited there under
3 follow-up management is reasonably
4 appropriate for where we are right now then
5 that's probably okay.

6 But it would certainly be a
7 requirement that QYP return to NQF with an
8 update to this measure when those USPSTF
9 recommendations come forward if, in fact,
10 there's anything in here that's no longer
11 appropriate follow-up.

12 The idea of just saying any
13 follow-up management, you may be recommending
14 some things that are inappropriate. And
15 that's not okay.

16 And that's why, I think, really
17 reconciling with the updated recommendations
18 when they come out in the next few months is
19 really critical.

20 CO-CHAIR JARRIS: Matt?

21 MEMBER STIEFEL: Short of that, it
22 creates an interesting circumstance. And the

1 question is, if we don't have evidence about
2 follow-up, is screening and follow-up better
3 than just screening?

4 Well, it's at least as good as
5 just screening and is likely to be better.
6 Because some of that follow-up will be
7 useful.

8 MEMBER SPANGLER: And according to
9 this most recent review, screening doesn't
10 change outcomes by itself. So it is not just
11 as good. It is better.

12 CO-CHAIR JARRIS: Amir?

13 MEMBER QASEEM: So looking at this
14 evidence review, I looked at it as well. And
15 I don't think we will ever be able to get
16 into some specific follow-ups. The evidence
17 is just not there.

18 I was just thinking about some
19 other guidelines. Even if, let's say, if A1C
20 comes higher for Type 2 diabetes you're
21 supposed to start behavioral counseling and
22 weight loss and all that before you go into

1 the medication management and all that.

2 But I don't think you can start
3 having a specific measure that says, well,
4 did you do this first. And then did you
5 start out with metformin first before going
6 on with the expensive medications out there.

7 I think we can keep it just broad,
8 the way it is. And that probably is more
9 logical. Even if that task force does come
10 out with some specific thing that you start
11 off doing this, I think there is going to be
12 so much variation based on the patient,
13 especially when it comes to obesity.

14 I just don't see that you can have
15 a measure that says that you just do this,
16 this and this.

17 CO-CHAIR JARRIS: So what Helen
18 was saying, keep it more general now and ask
19 to have it reviewed when the task force
20 guidelines come back. And we'll bring it
21 back if something more specific --

22 (Off microphone comments)

1 CO-CHAIR STANGE: So just before
2 we take on the other discussion, we're going
3 to finish this. We're going to then blaze
4 through 1690 because we've surfaced all the
5 issues about this general topic.

6 Then we're going to vote on the
7 three and then we have two more that we'd
8 like to get done before we end today. So
9 just as we're making our comments, thinking
10 about new topics.

11 CO-CHAIR JARRIS: Bobby?

12 MEMBER PESTRONK: So that last
13 series of comments brings me back to the
14 question, is all we should be interested in
15 is whether BMI was measured?

16 Because what we want to know is
17 from one point of measurement to the next
18 point of measurement was there a change.
19 What happened in between, that might be
20 useful to know and is always subject to what
21 the best evidence is. But the question is
22 whether anything happened or not.

1 CO-CHAIR JARRIS: If there were a
2 measure that looked at improvement or change
3 in BMI, I would agree with you. You don't
4 care what happens in between the two. But we
5 don't have such a measure.

6 We don't have a measure of
7 improvement. We have static points in time
8 only. We don't have a change, single point
9 in time. So if it isn't measured then that's
10 a problem.

11 MEMBER SAMPSEL: So just real
12 quick, Helen, how often in your experience
13 did the USPSTF come out with a public
14 comment, then change their recommendation
15 after the public comment?

16 So the reason I ask is this. So
17 the current draft recommendation calls for
18 physicians to screen adults for obesity and
19 offer or refer patients with a BMI greater
20 than 30 to intensive multi-component
21 behavioral interventions.

22 Behavioral interventions include

1 setting weight loss goals, improving
2 nutrition and increasing physical activity,
3 addressing barriers to change and self-
4 monitoring. So that's what we have as at
5 least what went out for public comment.

6 MEMBER SPANGLER: Basically it's
7 just more specific than the previous one.
8 It's intensive behavioral therapy.

9 MEMBER SAMPSEL: Exactly, and
10 basically all of that is also coming out of,
11 if anybody looks at the research coming out
12 of the National Weight Control Registry, that
13 you monitor your food intake by tracking.
14 You quit eating fast food. You get physical
15 activity.

16 And those are all about
17 maintaining weight. So the evidence is out
18 there. I think this still just goes back to
19 is the CDC measure, CMS measure, sorry, clear
20 enough in that follow-up component.

21 MEMBER SPANGLER: The thing about
22 that is, as you're aware at CMS, there's a

1 new coverage benefit around intensive
2 behavioral therapy for obesity that is
3 explicit. It's counseling, the five As, so
4 you could make the measure in tune with that
5 benefit as well.

6 CO-CHAIR JARRIS: All right, Matt,
7 what's next?

8 DR. BURSTIN: Based on what you
9 just said is, based on your read of this, is
10 that consistent with this measure?

11 MEMBER SPANGLER: I think the
12 measure is not as specific as that
13 recommendation. It's just much broader.
14 That recommendation could be included in this
15 measure but --

16 MEMBER SAMPSEL: I think some of
17 it's there and some of it's there and some of
18 it --

19 MEMBER SPANGLER: I think NCQA
20 hasn't come out with an updated
21 recommendation. So keeping it a little more
22 general, and saying when that recommendation

1 comes out we want to look at this again, I
2 think would be appropriate. Because we are
3 jumping the gun. NC, not NC, I keep saying
4 that, I'm sorry.

5 MEMBER SPANGLER: I think to note
6 about your question to Helen, and Helen
7 probably would agree, there has been much
8 more public comment on recommendations in the
9 past two years than there probably has been
10 in the ten years prior to that.

11 DR. WILSON: If I can just
12 interject one other thing too. I guess think
13 about, in some of these things that we're
14 talking about, how do we actually measure
15 this.

16 Like we were saying, does the
17 physician have to use, if you want to go back
18 and audit to say that he did the appropriates
19 report, does he have to use that exact same
20 buzz words that you just said or if he says?

21 That's where it starts to get very
22 dicey. And now that we're actually getting

1 into trying to put these things into an EHR,
2 where you have to have a very black and white
3 thing, you have to try to think about how are
4 you going to specify this so that you can
5 really say did the physician, or whoever's
6 being measured, meet the intent of this
7 evidence based intervention, if he calls it.

8 Do you know what I'm saying? So
9 there's always some judgement and it's really
10 hard to make if you have a very precise thing
11 that's going to fit very neatly into a nice
12 little pigeon hole anyway, if that makes
13 sense.

14 CO-CHAIR JARRIS: Amir?

15 MEMBER QASEEM: And again, I think
16 some of it is going to be a judgement call as
17 well. If you're going to look at the task
18 force word to word they're just talking about
19 obesity. They're not talking about
20 overweight, so that's a big difference.

21 That's why I think we just need to
22 keep some of these things in mind that we're

1 already little bit deviating away from what
2 the task force is recommending, and
3 underweight as well.

4 CO-CHAIR JARRIS: Okay, let's move
5 on to 1690.

6 DR. REHM: I'm going to introduce
7 Sepheen Byron, our Director of Performance
8 Measurement at NCQA, who'll be giving you
9 just a few more details on the measure.

10 But before that, and I know that
11 we're time constrained, I did want to have a
12 couple of comments based on the conversation.

13 These measures, both our trials
14 and our adult BMI measure, and our child
15 measure, as you know, has the counseling for
16 physical activity and nutrition as well. But
17 both of these measures were pretty much
18 developed concurrently.

19 We started work on those in 2004
20 so we had a long road and I've just been
21 plowing through the literature and all the
22 field tests that were done for the measures,

1 which is an incredibly large file.

2 I was trying to answer one
3 question that you had asked, which I'll try
4 to answer later on. But I did want to try to
5 convey to you that about the health plans in
6 the country, commercial Medicaid and
7 Medicare, we have about 118 million members
8 in those health plans who report huge
9 results.

10 So when we talk about national
11 measures, these measures are implemented and
12 used nationally. I think, as a consequence
13 to that scale, we are inherently
14 conservative.

15 And the discussion about the
16 report that Jason is referencing, we try to,
17 very much, not do evidence review on our own.
18 We don't think we're terribly gifted at it.
19 We think they're better people at it than us.

20 And so we do look to guidance from
21 the task force for preventive services, to
22 ACIP for immunization recommendations, to

1 other entities that we believe are really
2 good at capturing the Gestalt of sometimes
3 discordant information. And because of that,
4 even just talking about what the measure
5 could look like before that guidance has been
6 issued is, in our world, premature. We don't
7 speculate, we just wait.

8 We can think a lot about the NIH
9 cardiovascular guidelines that everyone is
10 just gasping for. But in truth, we'll just
11 wait. And when they come out we will know
12 what they say.

13 And we will do our process, which
14 includes measurement advisory panels,
15 technical expert panels that look at only
16 feasibility, and then bring it to our
17 committee on performance measurement with
18 recommendations and sometimes go through that
19 cycle a couple of times before we actually
20 have a measure that's vetted for national use
21 and then, consequent to that, seeking
22 endorsement through NQF.

1 So I just wanted to have that
2 underpinning understood. Developing measures
3 is not cheap. It's not easy. It's very
4 challenging. We don't do it on dime and we
5 don't do it in a day.

6 Measures have about got an 18
7 month from start to finish if everything is
8 good. That's the amount of things, in terms
9 of field testing and then looking at first
10 year evaluations, which we do for all of our
11 measures.

12 Once they pass that, all of our
13 measures are publicly reported. And many of
14 our measures are used in accountability
15 programs, whether those are public payers or
16 private payers.

17 So again, conservatism in this
18 case is an advantage because you don't want
19 to hold people accountable for things that
20 are on the flimsy side.

21 Now, in truth, making a measure
22 from clinical guidelines and making it

1 adaptable for measurement requires a little
2 bit of finesse. It requires balancing
3 feasibility with scientific evidence,
4 sometimes making some leaps of faith. And so
5 I just wanted to preface our comments with
6 that.

7 (Off microphone discussion)

8 MEMBER QASEEM: So you were just
9 mentioning that it's an 18 month process and
10 of course the new evidence comes out. But
11 things don't really change when it comes to a
12 measure. It takes a little while.

13 I want to, for example, point out
14 to the NCQA performance measures VT
15 prophylaxis, routine prophylaxis, there are
16 enough guidelines that are out there --

17 DR. REHM: I'm sorry what --

18 MEMBER QASEEM: Venous
19 thromboembolism prophylaxis. It's sort of
20 side issue. I'm just trying to figure out
21 the process a little bit. They want to know
22 the answer to this.

1 DR. REHM: That's not our measure.

2

3 MEMBER QASEEM: NCQA does have
4 them.

5 DR. REHM: No.

6 MEMBER QASEEM: I'm almost
7 positive, Bob, and I'll pull it up.

8 DR. REHM: It's not a HEDIS
9 measure. Can you tell me where?

10 MEMBER QASEEM: It's not.

11 DR. REHM: AMA is the steward of
12 the VT measure.

13 MEMBER QASEEM: I'll hold the
14 question back, sorry.

15 DR. REHM: Okay, thank you.

16 CO-CHAIR JARRIS: Could I ask the
17 folks on the phone if you're not speaking to
18 mute your line? We're hearing a lovely
19 conversation in the background.

20 DR. REHM: And then just to finish
21 the comment, because of the timing of the
22 2003 adult measure, pardon me, the adult

1 guidance, we locked into that paradigm.

2 And then the USPSTF did a re-
3 review of its child obesity measures. In
4 2009 they were published. I think it often
5 references 2010.

6 But again, that gave us an
7 advantage and an ability to adapt our child
8 measure to capture nutritional and physical
9 activity counseling.

10 So anytime new guidance is issued,
11 we are all over it. And we try to bring
12 those into the measurement and basically
13 evolve the measure.

14 And we've been doing it for 21
15 years. Many of our measures started very
16 pedestrian and have become a little bit more
17 sophisticated and more targeted over time.

18 So you can never guarantee these
19 things but that's essentially the way we do
20 things. So I just wanted to have you
21 understand that before we go into the measure
22 itself.

1 MS. BYRON: All right. I believe
2 you are doing the adult measure now. So this
3 is the adult BMI assessment measure. It looks
4 like the percentage of adults 18 to 74 years
5 of age with a visit who had their body mass
6 index documented in the year or the year
7 prior.

8 It's in our HEDIS measurement set.
9 It's also a measure that has been added to
10 the Medicaid adult core set for State
11 reporting.

12 (Pause)

13 CO-CHAIR JARRIS: Oh, here we are.
14 Yes, go ahead.

15 MEMBER STIEFEL: I reviewed this
16 measure, obviously. The comments are very
17 related to the other ones. But just a few
18 points about evidence, we've been talking
19 about that a lot.

20 And it's not an easy question to
21 answer. You need to think about evidence of
22 what. There's evidence that BMI is associated

1 with health outcomes of interest, like disease
2 incidents and functional status and life
3 expectancy.

4 Backing up from that, what's the
5 evidence of these follow-ups on change in BMI?
6 Backing up from that, what's the evidence of
7 assessment of BMI to follow-up to improve BMI
8 to improved outcomes.

9 And so it gets so we need to follow
10 that causal pathway. So when we're assessing
11 evidence of screening, there's the proximate
12 evidence that something is done about it once
13 there's screening.

14 But ultimately you need to follow
15 the evidence path all the way to health
16 outcomes. It raises the question about, so
17 you have a measure like this you're evaluating
18 the evidence.

19 Well, screening doesn't improve
20 life expectancy. But is it important enough
21 to put this building block in place for this
22 epidemic in the country so that you can build

1 on that building block and follow that causal
2 pathway?

3 And so it answers a different
4 question about evidence. And it was hard for
5 me to understand what I was evaluating when I
6 was evaluating the evidence. Not providing an
7 answer, I guess just a question.

8 Then the other comments, I think,
9 are things that already have been discussed.
10 This is a non-geographic visit-based
11 subpopulation measure. But is that a rule
12 out? Not necessarily if you can aggregate
13 these subpopulation metrics.

14 And then I think we've already had
15 the discussion about assessment versus level.
16 And I believe that the contribution of this
17 committee could be moving more to population
18 health measures as opposed to the clinical
19 measures. And then that would take us to
20 measuring things like BMI.

21 And disparities, we haven't talked
22 about much today. It was an important

1 criterion that this group established at the
2 beginning of our discussions, way back in the
3 first meeting that we would evaluate these
4 measures against.

5 This one performs poorly on that
6 because of the data collection issues
7 associated with this measure. So it hasn't
8 come out much in our discussions about this.
9 But we don't have good information about
10 disparities with this measure.

11 Last point is, it's noted in the
12 submission, it's due for a 2012 update. We're
13 in the middle of 2012 and there's just this
14 question of sequencing and timing if NQF is
15 endorsing an NCQA measure that's under
16 revision.

17 DR. REHM: I can answer that
18 question, yes. For instance, we have a suite
19 of four cardiovascular measures waiting for
20 NIH guidelines.

21 It would be premature, an
22 incredible waste of resources, to pull

1 together a CV measurement advisory panel to
2 evaluate our cardiovascular measures six
3 weeks, two months, seven months. It's hard to
4 tell when they'll be released, to have them do
5 that work prior.

6 You wait for those guidelines to be
7 released and then you re-visit the measure.
8 So we would wait until that USPSTF final
9 recommendation is out and work from there.

10 It's the same for vaccines that are
11 released. It's the same for a variety of
12 things. You wouldn't want to have that panel
13 be operating off of what everyone would admit
14 around the table is old evidence. So I think
15 that's the point.

16 So my thoughts, Matt, would be that
17 this measure would be re-evaluated in calendar
18 year 2013, which in our terms is next week
19 because of the way we have to plan this stuff
20 out.

21 But again, we just don't know when
22 that will be released. And again, recall that

1 we don't like being ahead of the evidence and
2 our CPM votes down measures when we're ahead
3 of the evidence, just flat out. And Helen
4 knows. She's a liaison and she's seen it
5 happen before.

6 MEMBER STOTO: Three questions, I
7 think the first one's to Helen. Is there a
8 history of NQF endorsing measures,
9 developmental measures? The thought being
10 that we want to start getting people to
11 document BMI so we can build these other
12 measures.

13 DR. BURSTIN: Those are measures
14 that are typically endorsed for a while and at
15 some point you move beyond them. One example
16 would be VTE prophylaxis.

17 There was a SCIP measure that said
18 did you order a chemoprophylaxis and then did
19 you administer it. Well, the last couple of
20 years we've said okay, enough. If you're
21 administering who cares if you ordered it. So
22 those are examples.

1 MEMBER STOTO: Okay, so the answer
2 is yes.

3 DR. BURSTIN: But over time they
4 get experience, they get high degrees, they
5 move off, yes.

6 MEMBER STOTO: Second question is
7 for the NCQA people. What do we know about
8 the relationship between BMI being documented
9 and whether the physician actually had it, the
10 result of the calculation, when he or she was
11 seeing the patient? That's the issue that
12 came up with the New York meeting.

13 DR. REHM: Our measures specify,
14 and I'll let Sepheen weigh in, she's better at
15 this than I. But this measure is specified
16 for both administrative data and then also
17 medical record review, where we actually look
18 at the chart.

19 And different from some of the
20 other measures, the BMI 28.3 would need to be
21 documented in the chart. So it's not
22 height/weight. It's great if they have

1 height/weight. It shows how they drove that.

2 But somewhere a clinician who's
3 entering in the chart is entering the 28.3 in
4 the medical record. There's corollary code
5 sets that can be used as well for that. It
6 means that they were calculated.

7 Do we know if it happened in
8 absentia of the clinician? No. But in an old
9 paper medical record not a lot of people get
10 their hands on those. It's the attending
11 nurse or the nurse practitioner or the
12 clinical practitioner.

13 MEMBER STOTO: So we really can't
14 say that just because there's a number in the
15 record that the physician had it at a time
16 when he or she could actually have counseled
17 or taken action.

18 DR. REHM: I think, then, that
19 would bring into all sorts of things that get
20 documented in a chart. You'd start
21 speculating about is the A1C from the lab,
22 that they read and is entered in by hand. But

1 I guess I really don't know the answer to your
2 question. We do take it on the merits that a
3 clinician saw that number and acted
4 accordingly. Remember, we're having 35, 40
5 percent rates of just documenting it.

6 So those are fairly low. Now,
7 they're improving and you'll see in the data
8 we've presented they're improving quite
9 dramatically, especially Medicaid plans where
10 there's a lot of emphasis. So that's the good
11 news. But it is a glass half full.

12 CO-CHAIR JARRIS: Kurt and then
13 Matt.

14 CO-CHAIR STANGE: I say this with a
15 lot of humility. I'm less than awed by the
16 logic of consistency of some of our arguments
17 here, my own thinking on this particularly.
18 The first two measures that we discussed this
19 morning, the population measures on being
20 foreign born and the year you came to the
21 U.S., we rejected the building block argument.

22 And yet here we have a building

1 block argument, actually bolstered by the fact
2 that Jason just says that the recent evidence
3 review says there actually is no evidence of
4 effective outcomes from measuring BMI.

5 MEMBER STOTO: I don't think that's
6 quite an appropriate analogy. Because for
7 that foreign born one, the issue at best would
8 be a strata. The documenting the BMI is the
9 first step towards actually taking action. So
10 I don't think it's analogous. But my question
11 really is how close does having it be in the
12 record correspond to actually the physician
13 being able to take action with it. And I
14 guess it varies, is the answer.

15 CO-CHAIR STANGE: That was actually
16 not my statement. That was my provocative
17 opening statement. But if you want to follow-
18 up on --

19 MEMBER STIEFEL: What you just made
20 is an argument in support of 421 because 421
21 requires the clinician to be aware of the BMI.

22 MEMBER STOTO: And then my third

1 question was going to be, again to NCQA, is
2 what you guys think about 421 and the
3 discussion that we had about it?

4 DR. REHM: Look, measure
5 development is hard. I've already talked to
6 that. I think anyone who's in this field
7 should be congratulated and supported and
8 nurtured.

9 We don't sit around and debate the
10 other measures. I think it is important that
11 we did mention that there was "competing
12 measure" in our submission. Because we did
13 take a turn around the block.

14 And you just may want to see how
15 that's handled in other cases. But we're
16 highly aware of this. We begin, in many ways,
17 harmonizing before the fact because Helen has
18 us so well maze-trained that to not do so is
19 to make life difficult after the fact.

20 So we've done this in many
21 settings, in many different clinical areas,
22 and we will continue to do that. It's a big

1 sandbox. We all want to play in it. And
2 we've worked collegially with all sorts of
3 folks and measure developers. And we look
4 forward to the opportunity to do so.

5 MEMBER STOTO: I wasn't asking you
6 to criticize or to praise that measure, but
7 just about the idea that you need the second
8 step for it to have evidence that it produces
9 good outcomes.

10 MS. BYRON: I would say that you
11 should remember that this is a health plan
12 level measure and theirs is a clinician level
13 measure. So it's about what is the
14 accountability of the health plan versus the
15 accountability of the physician and what are
16 you measuring.

17 So for this one we wanted to create
18 a measure that could be pulled from
19 administrative claims or from medical records.
20 It's a hybrid measure.

21 And we saw it as a building block
22 of at least look to see that your members' MBI

1 is documented. And looking at the rates being
2 in 25 to 30 percent, especially for Medicaid
3 plans, it's clear that first step still needs
4 some improvement.

5 And I think measures across
6 different levels can be aligned without being
7 identical. And the considerations that come
8 into play are who's the accountable entity and
9 whether the data sources that are available,
10 what are the processes, the work flows. I'm
11 sure I don't need to remind this panel of all
12 those issues.

13 DR. REHM: Yes, if I maybe just
14 cite an example, not to compare this event.
15 We talked before about the measurement the
16 period.

17 And it's two years for the NCQA
18 measure and why that would be caught by a
19 health plan. Because whether we want to admit
20 it or not we have an overuse problem in
21 America.

22 And we don't want to have a measure

1 that essentially is trying to drive people
2 into non-evidence based frequency of visits
3 for periodic health maintenance or health
4 exams when, in fact, there's no evidence that
5 would support that.

6 So for the adult measure, we have a
7 fairly broad period, which is two years. Do
8 it any longer you begin to drop out the
9 people.

10 Do it any shorter you're basically
11 saying, boy, if I want to move my measure up,
12 pretend I'm being paid for performance, then
13 really what I need to do is I need to bring in
14 adults all the time and just crank out that
15 BMI documentation.

16 Well, the measure intent wasn't
17 intended to do that. So this is where we have
18 to balance these things. And that viewpoint
19 may not be caught at the physician level, at a
20 clinician level.

21 As a clinician, you may want to say
22 I really do want to see everybody on my panel

1 once a year. But from a health plan payer and
2 an evidence based perspective, you may say
3 that's probably not appropriate.

4 So that's an example maybe where we
5 could see, depending on the level of
6 accountability, your measure specifications
7 may shift. Or there'll at least be different
8 tensions out there.

9 CO-CHAIR JARRIS: Amir and then
10 Jason.

11 MEMBER QASEEM: I'm just trying to
12 simplify it in my mind. You guys are very
13 bright and smart and maybe you can help me
14 out.

15 So you screen for disease, only
16 those disease or whatever you're screening for
17 when the treatment is available, right?
18 That's the basic rule. And whenever you're
19 screening you want to make sure the treatment
20 is provided.

21 So when we were talking about even
22 HIV this morning, you're screening so a timely

1 treatment can be provided. In obesity case, I
2 was looking at the task force recommendation.
3 They're recommending to screen so you can
4 provide certain intervention.

5 There is no benefit of just
6 screening for something if you're not going to
7 provide that intervention. You're not going
8 to have a measure for any of the preventive
9 services if you're not going to be also
10 talking about the intervention.

11 So I feel that both of them need to
12 be together. I don't think we can have a, and
13 again, in my mind I'm really simplifying. I
14 understand the health plan level and provider
15 level and all that.

16 But the point is to calculate BMI
17 because through just one index I really am
18 having a hard time grasping all these various
19 levels. It's a BMI and it is a measure of
20 obesity. And the point is to get the
21 population level obesity down.

22 It's as simple as that. And I

1 think we probably do need to have both
2 together rather than separating them out. And
3 am I really over-simplifying this or is this
4 how you're --

5 MEMBER SPANGLER: I was going to
6 say the same thing. I agree with you that
7 rates are low at 30 percent. But there's no
8 evidence that if we get them up to 100 percent
9 that changes anything. And there's no
10 evidence that shows that it does it. So
11 there's no trials or anything.

12 MS. BYRON: And I would agree with
13 what you're saying. I think if you think
14 about measurement, you have a disease or you
15 have a condition.

16 You have obesity. You have a logic
17 model, which was well laid out about how you
18 document your BMI, you look at the BMI, you
19 assess it. You discuss a follow-up plan.

20 All along the logic model I would
21 say where do you want to measure. And so
22 we've chosen one point along the logic model

1 to measure. I don't think it means that we
2 are devaluing any other point along the logic
3 model.

4 I think what we're saying is here's
5 where we want to put our measurement efforts.
6 And, when it gets to the point where all of
7 those rates are high, they look good, then we
8 might want to turn our measurement efforts
9 towards measuring a follow-up plan or
10 measuring treatment or measuring, really
11 ideally, the outcome. Did your memberships'
12 BMI rates fall, period?

13 MEMBER QASEEM: So if you're
14 looking at one point in time, you do agree,
15 that's exactly the point I'm making. It's
16 just one point in time you're measuring, which
17 is giving you incomplete answer. You're not
18 really getting to what you're supposed to be
19 doing. You're saying that this is Part A of
20 this, whatever measure, and we need a Part B
21 as well to make it a complete measure. So you
22 see my point?

1 MS. BYRON: I do see your point. I
2 think that in an era of scarce resources and
3 deciding where you want to put your
4 measurement efforts, we've chosen to put it
5 into the documentation at this time.

6 But I definitely agree that all
7 along the point of addressing obesity,
8 treating obesity, all of those are important.
9 But this measure looks to see that there was
10 documentation.

11 It's a health plan level measure.
12 It's looking at a health plan population. And
13 this is where we believe that the point of
14 care can be improved.

15 CO-CHAIR JARRIS: Sue?

16 MEMBER PICKENS: So I just want to
17 talk at this point about the importance of
18 harmonization. Because we're a large system
19 of multiple clinics that have many health plan
20 members, yet we're also very involved in
21 meaningful use.

22 And to have to go about trying to

1 meet both measures is difficult. So the
2 harmonization is really, really key here. And
3 we're also a medical home, which is an NCQA
4 thing, so the follow-up piece is really also
5 important.

6 CO-CHAIR JARRIS: If I can jump in,
7 I'm trying to de-complexify this. Is that the
8 word? And I appreciate your comments to do
9 that.

10 To me I see two approaches we could
11 take. We could say, well, since only 40 or 50
12 percent of the time is the BMI documented,
13 let's take an incremental approach and say,
14 okay, we'll go with that measure,
15 understanding fully that when that improves
16 and there are other recommendations we can add
17 on Part B.

18 So that's one approach. The second
19 approach is to say what you said, Amir, why
20 would you do a test if you don't do anything
21 with it. That's a principle in medicine. You
22 don't do it if you're not going to take action

1 on it.

2 And therefore, why don't we take
3 that two-part measurement, similar to what CMS
4 did to say Part A, it's been documented. Part
5 B, there's some awareness and action taken.
6 So we could look at that other one. We're
7 saying, okay, the PMI's done.

8 The second thing, of if you're
9 looking for there to be some action taken upon
10 it, a referral or whatever, is it simply an
11 indicator of was the clinician aware of it?
12 Did it go into a thought process?

13 And then do something, And we
14 could take that approach understanding that
15 needs to come back as soon as the task force
16 comes back with some more specific
17 recommendations for a more specific look at
18 what action was taken.

19 So I can see either of those things
20 being justified at this point. But I think
21 we've got to start narrowing this conversation
22 down. Because it's after 4:00 already.

1 MEMBER STATO: Can I speak on that
2 point? And I think that's the right way to
3 frame it. And I think that the justification
4 for 23 and 1690 and the first part of 421 is
5 the developmental idea, that we have to start
6 doing it now so we can eventually add on
7 later.

8 Adding on the second part of 421,
9 really only says that the physician was aware
10 of it. Because just follow-up in any old way,
11 to put it bluntly, is not consistent with what
12 the task force is recommending.

13 So there's really no evidence that
14 follow-up that is as general as this will lead
15 to outcomes. So the real benefit of that
16 second part of 421 is that you're sure the
17 physician is aware.

18 DR. BURSTIN: It's also just not
19 physician. I just want to point that out.
20 This measure is specifically all clinicians,
21 nurses, PTs, everyone.

22 CO-CHAIR JARRIS: I think, Matt,

1 you were next and then Kurt and then back to
2 Sue.

3 MEMBER STIEFEL: I think that the
4 burden of evidence for this ought to be more
5 modest than what we're laying out in terms of
6 the relationship between screening and
7 obesity.

8 I think that the burden of evidence
9 for this is does increased screening lead to
10 increased follow-up. And we don't have a lot
11 of evidence about that but there's some face
12 validity.

13 And there are so many measures that
14 we're subjected to that are exactly the same,
15 measuring hemoglobin A1C or lipid levels or
16 blood pressure. All of those don't do
17 anything to outcomes in and of themselves.
18 But the causal pathway is articulated well
19 enough to recognize that first step is a
20 fundamental building block. And I think
21 that's the case with this one.

22 CO-CHAIR JARRIS: We should start

1 narrowing down here.

2 CO-CHAIR STANGE: A question for
3 Sepheen. Is there anything about the child
4 measure that can help us to understand this
5 measure?

6 So you made a different decision on
7 that measure to include counseling. Is there
8 anything in the evidence for children that can
9 help us understand your decision in this
10 measure?

11 MS. BYRON: For children there are
12 a couple of differences. We're actually
13 requiring a BMI percentile and we are
14 requiring the counseling for physical activity
15 and counseling for nutrition.

16 I believe we felt that, at the
17 child level, that was really important. The
18 task force does recommend screening children
19 and offering, or referring for comprehensive,
20 intensive behavioral interventions to promote
21 improvement in weight status.

22 And we felt that it was more

1 appropriate for children at the time that we
2 were developing the measure.

3 MEMBER STATO: It does or does not
4 say that for adults?

5 MEMBER SPANGLER: It does.

6 MEMBER STATO: It does, so it's the
7 same burden of evidence.

8 MEMBER STATO: It's the same but
9 they felt it was more --

10 MS. BYRON: And the opportunity of
11 a --

12 MEMBER STATO: -- the same evidence
13 base is there for adults that could be
14 included here already.

15 MS. BYRON: Opportunity for
16 improvement for children was seen as higher.

17 MEMBER BIALEK: I have another
18 question related to 1690. You said that this
19 is a health plan related measure.

20 And while I am understanding the
21 arguments about not measuring the screening
22 part here, that you're putting your emphasis

1 on the data for the BMI, my question is at the
2 plan level why does your measure not
3 necessarily address how the plan uses the BMI
4 data that the plan receives?

5 Because, presumably, you're
6 collecting the data for a purpose. And then
7 if you're not having the clinician do the
8 follow-up, what's the follow-up for the plan?

9 MS. BYRON: Well, I think we would
10 go back to the issue of what do you want to
11 measure versus what do you expect to be done.
12 We have heard from health plans and we have an
13 annual meeting where health plans come
14 together and share best practices.

15 And there have been several
16 examples of how health plans have looked at
17 BMI and used this measure to understand where
18 they needed to do quality improvement efforts
19 and where they needed to do some drill down
20 analyses to understand where they could
21 improve.

22 And so we have seen where plans

1 have used this measure to do quality
2 improvement. We're not necessarily measuring
3 it but we are hoping that this measure
4 provides information to kick off some quality
5 improvement.

6 And I think that's the case with a
7 lot of HEDIS measures. For cervical cancer
8 screening we measure just the screening.
9 We're hoping that when people have really low
10 screening rates that they go back and that
11 they see that their population needs
12 improvement and they organize their quality
13 improvement efforts around that.

14 Some measures get pulled into
15 health plan accreditation as well and another
16 way that we try to link the measures to
17 action.

18 CO-CHAIR JARRIS: Sarah, then
19 Bobby.

20 MS. SAMPSEL: So this is just a
21 general statement that has nothing to do with
22 the NCQA measures. But when you look at

1 guidelines and obesity recommendations with
2 adults the overall general guidelines, whether
3 they're from AAP or Internal Med or others,
4 typically follow USPSTF.

5 However, for kids there's AAP
6 guidelines and Bright Futures. And in Bright
7 Futures they clearly recommend, as a standard
8 of care, nutrition counseling and physical
9 activity counseling. So that may be why NCQA
10 chose to include those in their measure.

11 CO-CHAIR JARRIS: Bobby?

12 MEMBER PESTRONK: How would the
13 measure be written? What would it say? I'll
14 approach this in a different way. It's either
15 a point in time measure or it's a measure of
16 what happens from one point to another.

17 And it seems to me that these
18 measures are focused at a point in time to see
19 whether something was done. And what we're
20 really looking for is something that will let
21 us know whether things changed over time.

22 When I asked earlier why don't we

1 just have as the measure the BMI, because if
2 we have the measure of the BMI then we will
3 know whether things change from one point to
4 the other with respect to the BMI, which is
5 ultimately what we're interested in. So if
6 that's what we're ultimately interested in,
7 how would the measure be written? What the
8 language be so that it would be the BMI and
9 not whether the BMI was measured? Is that
10 making any sense?

11 MS. SAMPSEL: There would be a
12 number of ways to do that. One would be
13 almost the method used by PQRS where you could
14 report a G-code. So you could actually do it
15 administratively where a G-code would equal a
16 certain level of BMI.

17 So the measure would be out of,
18 well, just go with adults, out of adults 18
19 years and older. Report by segment, which
20 would be the numerators where someone falls in
21 the BMI category. And so you could do it
22 categorically.

1 Or you could do it as an actual
2 statement. The problem is, then, that's a
3 specific patient-level measure. And you still
4 have to get to the aggregate level, which is
5 why you might want to do categories. So the
6 measure would either be percentage of members
7 that fall within X BMI category, overweight,
8 obese, whatever, and do it categorically.

9 Or you would definitely have to get
10 down to patient-level data, which most people
11 don't do unless you're doing a survey.

12 CO-CHAIR JARRIS: So, Elisa, the
13 UNS operator let someone else on. After this
14 comment can we ask someone to call the
15 question, formulate a question and call the
16 question here.

17 MS. MUNTHALI: Anika, Anika?

18 OPERATOR: Yes, hi.

19 MS. MUNTHALI: Is Mary Barton on
20 the line? And if she is could you please open
21 up her line? She's been trying to reach us.

22 OPERATOR: And her line is open.

1 MS. MUNTHALI: Okay, thank you,
2 Mary?

3 MS. BARTON: Thank you, this is
4 Mary Barton, Vice President for NCQA's
5 Performance Measurement Department. And I
6 think that this conversation has been
7 highlighting the fact that clinical care of
8 obesity is currently, notwithstanding the
9 upcoming U.S. Preventative Services Task Force
10 recommendations, still in maybe a pre-
11 penicillin phase, we'll call it.

12 We have to get a lot better at
13 figuring out how to help people make desired
14 behavior changes so that they can change their
15 health trajectory with regard to their weight.

16 And the fact that we would like for
17 these things to happen, we would like to have
18 better tools than we have, but I don't think
19 that necessarily means that we're in the right
20 place to tell people precisely what they
21 should be offering to every patient, given the
22 sparseness of the research on what works for

1 what people and in what setting. I think
2 that's all. I'll stop with that.

3 CO-CHAIR JARRIS: Okay, so who
4 speaks next with our recommendation?

5 CO-CHAIR STANGE: I'd like to
6 support Helen's point of voting on the
7 measures. The two outstanding questions I
8 still hear on the table are whether it's
9 sufficient to do the BMI measurement or
10 whether that needs to be linked with
11 counseling.

12 And then the other one that Sue
13 brought up is harmonization across the
14 measures. And what I think I hear Helen
15 saying is the way to create a forum for the
16 measure developers to be able to work on those
17 two issues is for us to vote on the measures.

18 DR. BURSTIN: And only those that
19 are appropriate for endorsement, that meet the
20 criteria, will then go on to the next
21 discussion about harmonization.

22 MS. MUNTHALI: So the first measure

1 will be the New York City measure. This is
2 0023. So for importance to measure and
3 report, impact IA, the rating scale high to
4 insufficient evidence, one to four.

5 And we have 20 seconds. And
6 remember to point your clicker to Kristin's
7 monitor. Are we nine now? Okay. And, Linda,
8 oh, she signed off. So high five, moderate
9 three, and one low.

10 CO-CHAIR JARRIS: I didn't get in.
11 Put me into moderate.

12 MS. MUNTHALI: So there's a
13 correction, high five, moderate four, and one
14 low.

15 CO-CHAIR JARRIS: I don't know why
16 we had to high five, but we did it.

17 (Laughter)

18 MS. MUNTHALI: So 1B, performance
19 gap, same rating scale, 20 seconds. We have
20 all ten. So eight have voted for high and two
21 moderate.

22 1C, evidence, this is yes one, two

1 no, three insufficient evidence. Four yes,
2 two no, four insufficient evidence.

3 MEMBER STATO: What's the
4 difference between no and insufficient in this
5 case? So the question is whether yes is, more
6 than half of them are yeses.

7 MS. NISHIMI: For purposes of
8 tallying it doesn't. But obviously some
9 people feel it's a flat out no. And others
10 just think there's not enough. I think voting
11 there would be a distinction but when we
12 collapse them into the roll up category of
13 pass, no pass then it fails.

14 MEMBER QASEEM: Because this is
15 something that's been debated enough in the
16 guideline business and performance measurement
17 world I think it's important to look at it.

18 Because if you're categorizing it
19 together just like what you just said. That
20 no and insufficient is collapsed together and
21 maybe they should be collapsed together.

22 MEMBER STATO: So this distinction

1 between I and C in the task force
2 recommendations, I understand what that means.

3

4 MEMBER QASEEM: Yes, side issue.

5 CO-CHAIR STANGE: Before we go on I

6 just want to point out that we're voting not
7 to recommend a previously endorsed measure.

8 And so what's the logic for that. It's

9 logical if we actually take into account what

10 Jason said, that this evidence report now says

11 that there's no evidence of benefit from just

12 measuring this. So that would be a logic for

13 this.

14 And if that's the logic we're

15 voting with then that's fine. If not, then we

16 might want to talk about this.

17 DR. BURSTIN: And also our criteria

18 changed and became significantly more

19 stringent than they were the last time the

20 measure was endorsed.

21 MEMBER QASEEM: Do we need to vote

22 on it, that we agree with Jason's, whatever we

1 call it?

2 CO-CHAIR STANGE: Just saying that
3 would be a rationale for why we would not
4 endorse a previously endorsed measure.

5 MS. MUNTHALI: So the next measure
6 is 0421. This is also a BMI measure from CMS,
7 also endorsed. Importance to measure and
8 report, IA, impact, leaning scale, one high,
9 two moderate, three low, four insufficient
10 evidence. I think one person, good, we have
11 everyone. Six highs, four moderates.

12 1B, performance gap, same rating
13 scale, 20 seconds. We have everyone. Eight
14 high, two low. And 1C, evidence, rating scale
15 yes, no or insufficient evidence. Eight yes,
16 one no, one insufficient evidence. So we'll
17 move on.

18 This is scientific acceptability,
19 reliability, 2A, high to insufficient
20 evidence. We didn't get all the votes unless
21 somebody abstained. I don't think so.

22 We actually do need everyone. If

1 you abstained then you abstained. But
2 because we have ten as our quorum, if we can
3 do that again. One more, okay, we got it.
4 Three high, six moderate, and one low.

5 Validity, 2B, same rating scale,
6 three more, two more. Three high, six
7 moderate and one low. Feasibility, same
8 rating scale. Three high and seven moderate.
9 And feasibility, same rating scale. Five
10 high, four moderate, and one low.

11 And so now we're voting on the
12 suitability for endorsement. And this is a
13 yes and no, yes or no, sorry. Ten yeses.

14 So the next measure is 1690, an
15 adult BMI assessment measure from NCQA. It's
16 a newly submitted measure.

17 (Off microphone discussion)

18 MS. MUNTHALI: For 1690, importance
19 to measure and report, 1A, impact, rating
20 scale high to insufficient evidence. I think
21 the timer has started. Okay, we got it. Five
22 high, two moderate, and two low, and one

1 abstention from all of the voting for 1690.

2 Okay, 1B, performance gap, same
3 rating scale. Six high, two moderate, one
4 insufficient evidence. 1C, evidence, yes one,
5 two no, three insufficient evidence. Two yes,
6 two no, and five insufficient evidence. So we
7 stop here.

8 CO-CHAIR JARRIS: Matt?

9 MEMBER STIEFEL: Just a comment
10 about the voting about evidence. It's related
11 to a comment I made earlier about if it's
12 evidence from all the way from the assessment
13 to the outcome, and that's how the evidence is
14 generally written, I think that's reflected in
15 this voting.

16 If it's evidence between assessment
17 in doing something, that's a more modest basis
18 for acceptance. But it's not in our frame.
19 So it's tricky to do this evaluation.

20 Evidence of what is the question.
21 And I think that we don't have a lot of
22 clarity. If the evidence is about all the way

1 to the outcome, boy, I can think of all kinds
2 of measures that don't meet that rigid test.

3 MEMBER STATO: I would agree with
4 that and point out that, even though this is
5 still in our Phase 1 work, when we deal with
6 these population health measures that's going
7 to be an even bigger issue, sorting out what's
8 the appropriate level of evidence.

9 CO-CHAIR JARRIS: Move on to
10 children. And this is NCQA again, if you'd
11 like to speak to it. And then who in the
12 committee reviewed this one? Jason, okay.

13 MS. BYRON: All right, this is
14 weight assessment and counseling for nutrition
15 and physical activity for children and
16 adolescents. It looks at a BMI percentile and
17 at counseling nutrition and physical activity
18 ages 3 to 17 years old. There's a look back
19 period that means you're capturing 2 year olds
20 in the measure. It is included in the
21 Medicaid childrens' initial core set of
22 measures and also part of meaningful use.

1 MEMBER SPANGLER: So, yes, I looked
2 at this measure. I think all my comments are
3 in the memo. There are a couple issues that I
4 have. One is just the explanation for why the
5 age of 3 when the different guidelines had
6 differing ages.

7 The task force has 6, AAP and
8 Bright Futures has 2. So just wanted to know
9 the explanation for that. And the developer
10 did provide that. They went with the AAP and
11 then added a year. But there's no real
12 evidence for what the lower age limit should
13 be.

14 One question, which I think was
15 addressed already with the previous
16 discussion, was should there be two separate
17 measures of this or should all three, I see
18 this as three components.

19 One is a screening, then there's
20 counseling for nutrition and counseling for
21 physical activity. And should it be that all
22 three of those are into one measure or should

1 we have separate measures.

2 And they could be two separate
3 measures, one with screening and counseling
4 and nutrition, one is screening, counseling
5 and physical activity.

6 I just brought that up as a
7 question. I'm not advocating for that but I
8 don't know if there should be discussion about
9 that.

10 And then the last issue I had, this
11 is just measuring a BMI or a percentile. And
12 then my understanding of the evidence, and
13 someone correct me if I'm wrong, is the
14 evidence isn't that great for counseling if
15 you have a normal BMI.

16 So for a lot of kids, my wife's a
17 pediatrician, they still talk to them about
18 what they should eat and whether they should
19 do physical activity.

20 But my understanding is there's no
21 evidence that changes anything, that it
22 maintains current BMI or not, that the

1 counseling actually, even in children and
2 adolescents, is similar to adults, that for
3 those with an abnormal BMI, whether it's high
4 or low, is where that works.

5 So I didn't know if there needs to
6 be a stipulation there or the measure just has
7 to be adjusted for abnormal BMI or not.

8 CO-CHAIR JARRIS: On the other
9 hand, it's hard to imagine any downside to
10 giving anticipatory guidance to somebody with
11 a normal BMI about eating and being physically
12 active. So since there's no downside I
13 wouldn't worry about it being done.

14 Any other questions or comments or
15 anything unique or different about this
16 measure that we haven't beaten to death in
17 prior measures? Robert?

18 MEMBER QASEEM: Can we get a
19 response from NCQA regarding the age please?

20 CO-CHAIR JARRIS: Yes.

21 MS. BYRON: So Bright Futures does
22 recommend it for age 2 and our measure

1 captures age 2. It's written as age 3 by
2 December 31st of the measurement year. So you
3 actually do capture the 2 year olds.

4 So if you turn 3 in December you
5 were 2 for most of the measurement year. So
6 that's our way of capturing the appropriate
7 age range. And most HEDIS measures are
8 structured that way.

9 MEMBER SPANGLER: So when you have
10 an age range for any of your measures it means
11 turning that lower limit age by the last day
12 of the year?

13 MS. BYRON: Yes. So for breast
14 cancer screening you've turned 42 by the end
15 of the measurement year. But it's a two year
16 measure with a two year look back so you're
17 capturing the 40 year olds.

18 CO-CHAIR JARRIS: Okay, Bobby?

19 MEMBER PESTRONK: This one says
20 that the data source are paper medical
21 records. But I assume that something happens
22 to those records to make them electronic so

1 that things can be counted.

2 MS. BYRON: No.

3 MEMBER PESTRONK: No?

4 MS. BYRON: Plans to do a medical
5 record review. It's a hybrid measure and they
6 do pull a sample and look at medical records.

7 CO-CHAIR JARRIS: I guess it's the
8 word paper Bobby's commenting on. Because you
9 would also look at an electronic health record
10 also, right?

11 MS. BYRON: Yes.

12 MEMBER PESTRONK: And then the
13 denominator statement says the primary care
14 physician or ob/gyn, there's a specific
15 listing. This is controversial, I guess, in
16 the medical field. Who is a primary care
17 physician and who isn't. So is there some
18 good understanding of who that is?

19 MS. BYRON: Well, the measure
20 provides codes that basically defines, all
21 HEDIS measures that are relevant for primary
22 care apply to primary care physicians. And we

1 include ob/gyns in that as well. Because in
2 some states your ob/gyn can be a primary care
3 physician.

4 MEMBER PESTRONK: Is there any
5 specialty group that's excluded because
6 they're not considered a primary care
7 physician? And would someone who saw a nurse
8 practitioner, for example, be considered a
9 primary care physician?

10 DR. REHM: I think in our
11 guidelines we characterize primary care
12 practitioners. The PCP stands for many
13 things.

14 In this case it's primary care
15 practitioner. My recollection is, and I'm
16 pretty sure of it, that this includes
17 physician assistants and nurse practitioners.

18 MS. BYRON: Yes, so my apologies
19 for using that word, physician.

20 DR. REHM: But you're right. We're
21 not measuring the happenstance of a
22 cardiologist who happens to have a young

1 patient roll through, that they did the BMI.
2 We're trying to capture the primary care
3 physician, that's the intent.

4 DR. BURSTIN: And I'm not sure if
5 Sepheen mentioned it but this measure has also
6 been retooled for EHRs already, as part of the
7 meaningful use program.

8 So we say medical record but,
9 hopefully, since there are specs there, that
10 EHR is where it will, hopefully, be going.

11 CO-CHAIR JARRIS: Okay, any other
12 questions or comments? Anyone on the phone
13 from the committee? No, there's not anymore.
14 Okay, got your clickers ready?

15 MS. MUNTHALI: Okay, importance to
16 measure and report, IA, impact, high to
17 insufficient evidence, one to four. Oh, Sue.

18 CO-CHAIR JARRIS: Oh, we need Sue.

19 MS. MUNTHALI: We need Sue.

20 (Off microphone discussion)

21 MS. MUNTHALI: Okay, again, 1A,
22 impact. Eight high, one moderate, and one

1 abstention for this and for all the other
2 voting on this measure.

3 1B, performance gap, same rating
4 scale. Seven high, two moderate. 1C,
5 evidence, yes one, two no, three insufficient
6 evidence. Eight yes and one no.

7 Scientific acceptability of the
8 measure properties, 2A, reliability, high to
9 insufficient evidence. Six high and three
10 moderate. 2B, validity, same rating scale.
11 Four high, three moderate, and two low.
12 Usability, same rating scale. Five high and
13 four moderate. Feasibility, same rating
14 scale. Three high and six moderate.
15 Suitability for endorsement, yes or no. Eight
16 yes and one no. The measure passes.

17 CO-CHAIR JARRIS: Well, very good.
18 So we have gotten through this part of the day
19 and the process with these measures. I think
20 it will be interesting for us to think about
21 the outcomes here and why we thought they came
22 out the way they came out, which has

1 implications for future looking when we look
2 at different measures.

3 We, at this point, should go to the
4 public comment period. And then we can put
5 the background information for Day 2 off to
6 the morning, delay that a little bit, except
7 for the one thing Kurt wants to, excuse me --

8 (Off microphone discussion)

9 CO-CHAIR JARRIS: Operator, are
10 there any public comments or anyone in the
11 room? Okay, we'll take that as a no. Kurt?

12 CO-CHAIR STANGE: I just want to
13 offer people the opportunity for any
14 additional questions for us to sleep on to
15 frame the discussion for tomorrow.

16 We have two pages up on the wall
17 here and we have a set in the agenda. And I
18 guess that includes, after you've slept on it,
19 when you come in for breakfast if you want to
20 add anything to the list feel free to do so.

21 CO-CHAIR JARRIS: Okay, any other
22 comments today?

1 MEMBER PESTRONK: The third bullet
2 on the easel, isn't the question about it's
3 actually a question about what are they
4 smoking rather than is somebody smoking
5 something here which is making this difficult
6 to do, right?

7 (Laughter)

8 CO-CHAIR JARRIS: Who's the they?
9 Definitely been ambiguous. Okay, so logistics
10 please.

11 MS. MUNTHALI: Logistics, since
12 we've run a little late today, we will do the
13 background information for tomorrow's
14 discussion first thing in the morning.

15 We are having, after that, a
16 facilitated discussion. Kurt, Helen, Robyn,
17 Paul and I are going to talk to the
18 facilitator right after this. And that's why
19 we needed to cut our day a little short.

20 And then we also offered an
21 opportunity for folks to have dinner together.
22 If you're interested in that just let us know.

1 We have our colleague who can help to arrange
2 a place or we can offer suggestions for you.

3 We just wanted to thank you for
4 joining us today and see you tomorrow. Oh
5 yes, same time, 8:00 a.m., breakfast. And
6 we'll start at 8:30.

7 CO-CHAIR STANGE: And tomorrow we
8 really will start at 8:30 because there were
9 no plane and other delays.

10 MS. CHANDLER: One other thing, if
11 you could just leave your remotes. Thank you.

12 (Whereupon, the above-entitled
13 matter went off the record at 4:46 p.m.)
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This is to certify that the foregoing transcript

In the matter of: Population Health
Steering Committee

Before: NQF

Date: 05-30-12

Place: Washington, DC

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