NATIONAL QUALITY FORUM

Moderator: Benita Kornegay Henry
July 1, 2019
11:40 am CT

(Harrell Didwala): Good afternoon everyone. This is (Harrell) from NQF. I know people are joining the Web link in the call. Thank you so much for dialing in early. We are just going to wait for more people to join and be ready to start at 2:00 Eastern Time.

Dr. (James Rosenzweig): Hello?

(Harrell Didwala): Yes?

Dr. (James Rosenzweig): Hello, this is (Jaime Rosenzweig).

(Harrell Didwala): Okay hi. Hi, Dr. (Rosenzweig).

Dr. (James Rosenzweig): I know I'm early. I know I'm early…

(Harrell Didwala): Thank you.

Dr. (James Rosenzweig): …but I usually screw these things up, so I want to make sure it was working in time of discussion.

(Harrell Didwala): No that's perfect. We always ask the committee to join early if they can just to make sure they're able to get everything. So I would just tell the committee members if you already called in and listening if you haven't already, I did send out the voting link in an e-mail today. And it's also - should be in the meeting appointment. So if you want to go ahead and click into that, it'll be ready to go for the…

Dr. (James Rosenzweig): Yes. I've already clicked into the voting link. Yes.

(Harrell Didwala): Perfect. All right.

Dr. (James Rosenzweig): So when I'm discussing the case, will someone be actually showing the actual information on the case as I'm discussing?

(Harrell Didwala): Yes. So we'll do what we did at the in-person meeting last week. We'll do a screen share of the measure worksheet of the measure you're talking about, you know, whatever criterion you're talking about.

Dr. (James Rosenzweig): Okay.

(Harrell Didwala): And you should be able to see it on the Web platform, too, as you're watching it, so.

Dr. (James Rosenzweig): Okay.

(Harrell Didwala): Okay.

Dr. (James Rosenzweig): Thank you.

(Harrell Didwala): Thank you. All right. We'll just - I'm just going to go on mute and let others join.

(Dale): Hello it's (Dale). I'm here.

(Harrell Didwala): Hi, (Dale). It's (Asava) and I. Yes we're just letting people join. Do you have any last-minute question?

(Dale): I don't think so.

(Harrell Didwala): Okay. All right. So hopefully we can start on the dot.

All right. I'm just going to go back on mute while others join.

Okay. Good afternoon everyone. We're just going to give it about 2 more minutes to let people join into the call for the Primary Care and Chronic Illness Post-Evaluation Web Meeting for spring 2019 cycle.

All right. It looks like it's 2 o'clock. (Adam) and (Dale), I think we're ready to start from the NQF side, if you guys are ready.

Man1: I'm ready.

(Harrell Didwala): Okay.

Man2: Yes.

(Harrell Didwala): All right. And are the developers PCPI on?

Woman1: Yes we're on.

(Harrell Didwala): Perfect. All right. So we are here today for our post-evaluation Web meeting of spring cycle with the committee again.

Next slide please.

And just a short reminder, this is our NQF Project Staff team. I myself, (Harrell Didwala), the project manager on the team, I'm joined by (Asava), who is our project analyst. We actually have a senior director here, Andrew Lyzenga, who some of you may know who's an NQF senior director and has been with NQF several years, joining us today. So I just wanted to introduce him.

Next slide.

All right. So our agenda for today is just to get - go through the remaining measures that we were unable to get through at last week's in-person meeting. We had three measures left and we'll go through them in a few future slides. But I'm just going to go ahead and pass it to (Adam) and (Dale) for some - any introductory words before we move forward.

(Dale): So this is (Dale). So it is important that we do the best we can to get through these three majors today. Two of them though are going to be discussions of majors that would - we will have talked about before. So the first E major we'll start with today is the major for one that we talked about at the end of the day when we were together in Washington. And then we have two diabetes majors, one being that we'll hopefully spend some time and do a good discussion, the second one being the E major of the same performance matrix. So I'm hoping we can be fairly efficient with our process as two of

these majors we will have talked about before when we go through them and we can get through all three today.

(Harrell Didwala): Okay. Thank you, (Dale). All right. Well let's go ahead and move forward. We just want to do a quick roll call first to make sure we have participation from the committee. So I'm going to pass it to (Asava) who's going to quickly go through our roll call.

(Asava): Good afternoon everyone. Just say "present" or a note that you are on this phone call today.

I've got (Dale) and (Adam) confirmed.

(Lindsay Bedford)?

(William Carey)?

(Kim Elliott)?

(Kim Elliott): I'm here.

(Asava): Thank you, (Kim).

(Scott Friedman)?

(Scott Friedman): Present.

(Asava): Thank you.

(Donald Goldman)?

(V. Catherine Gray).

(V. Catherine Gray): Present.

(Asava): Thank you.

(Faith Green)?

(Faith Green): Present.

(Asava): Thank you.

(Daniel Greninger)?

Dr. (Daniel Greninger): Present.

(Asava): Thank you.

(Skarlin Hayden Greeson)?

(Jeffrey Lewis)?

(Catherine McLane)?

(Catherine McLane): Present.

(Asava): Thank you.

(Anna McAllister)?

(Anna McAllister): I'm here.

(Asava): Thank you.

(Sonali Noreen)?

(James Rosenzweig)?

Dr. (James Rosenzweig): Present.

(Asava): Thank you.

(Victoria Shamugan)?

(Rishi Singh)?

(Rishi Singh): Present.

(Asava): Thank you.

(William Taylor)?

Dr. (William Taylor): Present.

(Asava): Thank you.

(John Ventura)?

(John Ventura): Present.

(Asava): Thank you. So those are all our standing committee members. The next slide…

(John Goldman): Hi. (John Goldman) has joined.

(Asava): Oh. Thank you, Dr. (Goldman).

The next slides are just the names of our expert reviewers.

(Harrell Didwala): Okay. Sure. And did anyone else joined late from the committee that didn't announce themselves?

All right. So it looks like right now we have a quorum at 14. So maybe others will be joining in a minute or two late but we'll keep close check of that.

So again, just a reminder, we have to have a number of 14 present to have quorum and to vote. And then again a "Passed" recommendation would be greater than 60%. "Consensus Not Reached" would be 40% to 60%. "Do Not Pass" is less than 40%. Okay.

Next slide.

All right. Just a quick recap. So at last week's in-person meeting, we did get through some measures. Six measures were recommended by the committee and you can see them listed there, 0086, 0541, 2522, 2523, 2525 and 3059E.

Next slide.

Oh, one back one please. Okay. And one measure there was a consensus not reached on reliability by the committee which was 3060E. Okay.

And next slide.

And these are the measures that we are reviewing today. So we have three measures, as (Dale) mentioned. And we can go ahead and move forward.

Next slide.

All right. So, (Dale), I'm going to pass it back to you.

(Dale): All right. Thank you. So remember the major that we're talking about now is 0086E, primary open-angle glaucoma optic nerve evaluation. From a PCPI foundation, I'm going to see if the developer has a few introductory comments to make.

PCPI, if you're on the call - I know you're on the call. Are you on mute?

(Harrell Didwala): Yes I know that they had announced themselves. (Dale), this is (Harrell).

(Dale): Yes I heard them announced themselves also, so.

Woman2: Hi there. I don't know if you're talking about PCPI staff. We just got cut off. We just dialed back in.

(Dale): Yes we just want to know if you had any introductory comments on 0086E.

Woman2: We do not. Well, we do. It's 0086 is - E is the electronic health record version of the one that we discussed on, what was it, last Wednesday. So it's

the primary of an angle glaucoma optic nerve evaluation. It's the exact same structure of the measure but this one has different specification and that it is for, as I mentioned, for EHR.

So again, the measure looks at the percentage of patients 18 years and older. And these are patients with primary open-angle (unintelligible) committee had some questions last week about whether it was really open - POAG or whether it had additional glaucoma included. And as we mentioned, that's something that we're going to discuss with the technical experts panel.

And then these measure assessments had had an optic nerve head evaluation during one or more visits. And as Dr. (Craig), if you'll recall last week, he gave a good introduction on how optic nerve evaluation is a good indicator of glaucoma damage. So good measure assessment whether it's done regularly to keep track on that and to perhaps change treatment (unintelligible).

So happy to get the conversation started and answer any questions (unintelligible).

(Dale): All right. Thank you for that introduction. So I'm going to turn it over to (Catherine McLane) as the lead discussant. I will point out, (Catherine), that because the evidence behind the major is largely identical, we do have the option in this particular conversation to adopt the evidence vote that we had for 0086 before.

(Catherine McLane): Yes. I think we should do that. And I had to leave the meeting early, so I didn't - wasn't there for the discussion on the non-E measure. And did it pass? Was it endorsed?

(Dale): It did move forward.

(Catherine McLane): It did move forward, okay. Great. So it wouldn't make a whole lot of sense to discuss the E measure if the other one didn't pass.

All right. So we just had a discussion, a nice introduction from PCPI on the kind of overview of the measure. And I think you all just captured in more detail last time. With regards to the evidence, it's exactly the same. So I would move that we kind of skip that discussion and vote and move forward.

So, (Dale), how do you - how do we proceed with that?

(Dale): Yes. I'll leave that to (Asava) and (Harrell) to set up the Poll Everywhere. So you should have the Poll Everywhere screen which you can vote on.

(Harrell Didwala): Yes. So I would say - this is (Harrell) from NQF. Unless anybody on the committee objects to pulling over the votes on evidence for 0086E, we do not need to vote. But if anyone objects, we will vote on evidence.

(Dale): Thank you, (Harrell).

(Harrell Didwala): And just a reminder that 0086 on evidence they were all "High" and "Medium." There are nine votes for "High" and seven for "Medium." So…

(Dale): So I'm going to ask by exception, is there anyone on the committee who believes that we should not accept the evidence vote that we have at the meeting - the in-person meeting and should revote?

So hearing none, I think we can go on to our next discussion on gap.

(Catherine McLane): Great. And actually this is going to be - I would propose that it's the exact same information for the gap as well. So I would propose that we carry forward the votes from the gap as well.

(Dale): (Harrell), is that acceptable?

(Harrell Didwala): I would just - so you did provide the similar information but as you're looking at gap, you want to look specifically at the E measure rating. So I would recommend if you don't want to discuss it, that's fine but I would say we should vote on it just so that it's focused in on the E measure performance gap rate if that's acceptable with everyone.

So do you want us to open up voting for gap or is there anything additional to discuss?

Man: Yes.

(Harrell Didwala): Okay. All right. We're going to open up voting for gap.

Man: I'm still not seeing Polling Everywhere. It's still down for me. Is there…

(Harrell Didwala): Okay. I think (Asava) just activated it. (Asava)?

(Asava): I see it. Do others see it?

Man: I did see it.

Man: Yes.

(Asava): It's the same Poll Everywhere link that we've sent in the previous e-mail. So if you click on it, it should be activated now. We're currently voting on "Importance to measure and report performance gap," Measure 0086E. The options are High, Moderate, Low and Insufficient.

At this time we have 11 committee vote for "Moderate" and two for "Low." We need one more vote to achieve quorum.

Dr. (Rishi Singh): I will vote "Moderate." I apologize I'm trying to get on. So I have - I'm getting on the link again to get on there. But for some reason, it wasn't working for me. I'll try again now.

(Asava): Thank you, Dr. (Rishi).

(Harrell Didwala): Okay. Did anyone not vote besides Dr. (Singh)?

All right. So we have 15 for "Moderate" and one for "Low." So we will go ahead and close it.

(Dale): All right very good. So, (Catherine), do you want to go ahead to reliability?

(Catherine McLane): Yes. So - and again, this idea is a little bit different than the other one. But I think it's largely the same because I think where we get to the differences on - is actually on the feasibility pieces where there'll actually be meaningful differences. So the reliability on this particular measure, it's on my notes. I'm doing this electronically from not my desk. Sorry.

All right. So on this one, the E measure actually they tested it in two different large ophthalmology groups. One was in Chicago and the other I believe was in another northern state I'm not recalling which one. And basically they

looked at the reporting and these two different sites in some total of, like, over 10,000 providers EHR reporting I suppose with PQRS additionally. And they were able to identify over 2 million events over those - that large number of providers in the PQRS but that additionally they assessed these in two separate clinical settings. And let me find the numbers.

And the other thing - the one thing that the preview called out was that there was some concerns about the reliability because it was compared with the diabetic retinopathy documentation. And I thought that some of the specialty care for glaucoma is fragmented across different docs. So maybe not necessarily the right group of docs that we're looking at this. So that was their concern with that.

And then additionally, there are some other specific codes - and I'll have to kind of call out to the measure developer to comment to us on this. There are some specific codes that were missing that were of concern, H40.1294, H40.1193. And so that's getting too specific but I think we need to get a comment from the measure developer on that.

(Dale): PCPI?

(Pam Charney): Yes hi this is (Pam Charney). I just wanted to make sure my colleague, (Jamie), has an open line. I think this is a question for her, the coding specific question.

(Catherine McLane): Okay. And do we have any ophthalmologist on the call?

Man: I am.

(John Kaufman): Yes. Yes this is (John Kaufman).

(Catherine McLane): Yes. So the question we have is, do these codes -- and you are probably familiar with them -- one for low-tension glaucoma unspecified, indeterminate stage or there's another one for primary angle glaucoma, unspecified eye, severe stage. And apparently those are missing and I'm not, you know, we need to defer to you guys to know if those are commonly coded.

(John Kaufman): They're not commonly used but they probably should be included but these codes are not used very often. You know, in general, we try to avoid the unspecified codes. So most of the time they're specific codes.

Dr. (Rishi Singh): Yes I think last week…

(Catherine McLane): Understood.

Dr. (Rishi Singh): …we had a conversation about this actually with Dr. (Friedman). And so you might want to go back and revisit that conversation we had with him because - and, (John) - I know (John) very well. (John), this is (Rishi). Basically…

(John Kaufman): Hi.

Dr. (Rishi Singh): …the last week's discussion we had was around the fact that this measure was being called initially around primary open-angle glaucoma and yet it could apply to other disease states as well. And we - I think that they were going to speak to - Dr. (Friedman) is going to speak to the measure developers about what the intention was and whether they were going to widen the scope or not. But I don't believe that low tension - I believe low tension was being omitted for a specific reason.

(Jamie): Hi this is (Jamie) with the PCPI. Yes we did discuss the coding contents last week with respect to the claims and registry version of this measure. What is included in our measure coding and value sets aligns with how the measure was developed initially. There are low-tension glaucoma codes. Recently though we did remove the unspecified eye related concepts especially after a conversation with our Technical Expert Panel as well as having representatives from Ophthalmology on the line in order to align with their recommendations for coding and the desire to kind of get better documentation, encourage better documentation for the purposes of a measure.

So within the value sets for the ECQM, we do not include unspecified eye codes. We do provide - we do include primary open-angle glaucoma as well as low-tension glaucoma. And as was just mentioned, we - after last week's conversation, we do plan to raise some questions to the - just for confirmation to whether we want to modify any of the codes in future iterations of the measure but this - what's been included has been the way that the measure is being developed and implemented in its earliest iteration. Hopefully that helps.

(Catherine McLane): So is the plan then - so I guess, you know, for the purposes of kind of voting on whether people think, you know, this is reliable or valid measure, are we voting on, you know, the measure as presented or is PCPI committing to add those additional codes and just so we're clear on what it is that we're voting on.

(Jamie): This is (Jamie) from PCPI again. At this point, we wouldn't commit to making any modification to the measure. Again I'm not quite certain what codes we would consider adding after I think the conversation was regarding, you know, making sure that we have the correct codes there. So I - perhaps

I'm a little bit confused about that but we would not be committing anything at this point because we wouldn't want to engage our Technical Expert Panel in conversations about how this measure might be modified in the future.

(Dale): And this is (Dale). I would say we have to vote as the major has been presented.

(Catherine McLane): Okay. All right. So…

(V. Catherine Gray): This is…

((Crosstalk))

(Catherine McLane): Sorry.

(V. Catherine Gray): This is (Catherine Gray). It wasn't one of the issues of removal of the low-tension glaucoma because it so specifically says that it's the opposite. I mean, wasn't that part of the question last time?

(Catherine McLane): Yes it was raised by Dr. (unintelligible) in a conversation ensued about what we might want to discuss with our Technical Expert Panel. I believe that we explained during the call last week or during the committee meeting last week that the codes have not actually changed. The content of - for the claims registry we utilize ICD-10. For our ECQM, we include ICD-9, 10 and SNOMED. And so from the earliest development of the measure, we have included the same codes from ICD-9 to ICD-10 and to SNOMED.

And so though the measure was developed with various optometrists, ophthalmologists and other providers because we do employ a multidisciplinary stakeholder group during measure development, it was

decided to include that. We are going to try to do some digging in the offseason, if you will, in preparation for our Technical Expert Panel convening later this summer in order to figure out if there is potentially a rationale as to why that - why those codes were all designated as appropriate especially given the information that was shared.

However, just a reminder that that's how the measure has been implemented and the coding had been aligned from year to year. So I think we are still - we haven't made significant changes to the coding but recognize that there is technically a misalignment with the language primary open-angle glaucoma and the inclusion of the low-tension glaucoma codes.

So we definitely are planning to take that information back and the feedback back from the committee here and discuss it with our TEPs.

(V. Catherine Gray): Well, this is (Catherine) again. Therefore I can presume that we could vote on it as appropriately for reliability. But then the - that throws the question about validity, what - it's not lined up. I mean, however we think about it, something kind of not right.

(Dale): And this is (Dale).

(Catherine McLane): And then on the validity, too, it's also no risk adjustment on this measure.

(Dale): So, (Catherine), do you have any other conversation about reliability? Let's take it one step at a time.

(Catherine McLane): That's it.

(Dale): Anyone else on the committee have any comments about the reliability testing? So again, if I - summarizing pieces, you'll be - (Jamie) correctly the specifications haven't changed over time in terms of the included diagnoses. I know (Dan) have raised questions during our last face-to-face meeting about whether some of the codes should be included because it doesn't seem consistent with the title of the metric. But other than that though, the actual codes have not changed over time.

(Jamie): That's correct.

(Dale): Are there any other discussion or comments about reliability that we need to (unintelligible)?

Then hearing none, let's go ahead and take a vote on reliability.

(Asava): Okay. We are activating the voting. The polls are now activated for reliability. The options are for High, Moderate, Low and Insufficient. And this is Measure 0086E, the E measure version of 0086.

All right. We now have 12 votes in for "Moderate" from the standing committee and four for "Low." So the measure passes on this criteria.

(Dale): Okay. (Catherine), do you want to go ahead and discuss validity?

(Catherine McLane): So the validity of this measure again kind of raising the issue again that was raised for the reliability is that the measure was tested, most compared with the diabetic retinopathy documentation and this issue is to whether it was kind of the right docs that they were testing it on and maybe our ophthalmology colleagues can comment on this whether a good practice, you know, or, you know, testing it on doctors taking care of diabetic retinopathy

would, you know, somehow be different than docs that would be taking care of patients who have glaucoma. So let me stop there if our ophthalmology colleagues can comment on that.

Man: Well I think there's some overlap in the general ophthalmology certainly followed with diabetic retinopathy. They also follow glaucoma. But on the other hand, as a retina specialist, I follow a lot of patients with diabetic retinopathy and not as many patients with glaucoma. So, you know, it's not the exact same group of doctors that are reporting of these measures. Remember that the doctors can choose which measure is the most relevant for their specialty. And so people think when I choose based on whether they have a lot of patients. So I wouldn't expect them to be exactly the same groups of doctors.

Man: And I…

Man: I agree with that. I think the general ophthalmologists that take care of eye disease can report on both measure. Again it's voluntary but as the three retina specialists on the call to - hi, (John), we…

(John): Hi.

Man: …probably don't take care of hardly any people with glaucoma other than the stuff that we create. So if you're looking, it depends on what kind of docs are - what kind of docs you're actually querying. If it's again general ophthalmologist's answers, it's probably okay because you're looking at retina doctors that do primarily diabetic retinopathy, the answer is probably not.

Woman: I guess the question to help you guys is -- and you just kind of alluded to it -- is the glaucoma that you guys are seeing going to be different in the glaucoma that a glaucoma specialist or a general ophthalmologist are seeing?

(John): Up to some extent yes but, I mean, for example, I've used the glaucoma measure in the past even though I don't primarily, you know, manage glaucoma but, you know, the goal is to choose something that you see a lot of. And if, you know, you see a lot of one, you report on it. If you don't see a lot of one, you don't report on it.

Man: So - and I agree with (John). Probably (John) does not follow patients with just glaucoma. He follows patients with comorbidities. They have diabetes and glaucoma or they have (unintelligible) and glaucoma. It's unlikely that (John) follows patients for glaucoma, for example. So that'd be mostly again general ophthalmologists.

(John): Or glaucoma.

(Catherine McLane): Right. So I guess from the standpoint of the measure though, the question would be, are the - just trying to understand if the information that we've been given on this measure again is a valid representation of the measure and things that could be kind of threats to that ability could be if the sampling with the measure was tested if the patients were, in some meaningful way, different if the docs are - or your practice setting are different in some way that the measure - you would report on the measure differently, the process would be done differently that some of this is different in your practice versus the other, you know, stripes of ophthalmologists who would also be measured on this.

Man: I don't think there's a huge difference. So I would suggest that, you know, the measure, as it stands, is pretty good and, you know, the ophthalmologists who

report on it read the measure and may decide, you know, if they're going to report on it. But I don't think the measure needs to be altered because of that.

Dr. (Daniel Greninger): I agree. This is Dr. (Greninger). But my question about the validity had more to do with the fact that they have to pick something to compare it to for empirical validity and the diabetes item is probably the best one to compare it to. So the validity probably is higher except for the fact that some people might be taking care of different type of patients,

And so from a statistical perspective, you know, perhaps correlation coefficient would be even better if you had a larger group of people within that population who are taking care of both and maybe using both measures regularly.

(Catherine McLane): Okay great. And the last comment then on validity is pertaining to the risk adjustment. And they're - this measure is not risk adjusted. So comments from our ophthalmology colleagues on that?

Man: I don't think that risk adjustment really makes sense for this. I mean, it's well known that certain racial classes have more glaucoma but I think it's important in some of the various measures that are used for the quality indices but I think in this situation I'm - I don't think that applying the risk adjust one population against another makes a lot of sense. I mean, I'd be interested what (unintelligible). I don't think so.

(Dale): I agree. This is (Dale)…

Man: I agree. When measure was up, I think they looked at that and didn't take a need to be risk adjusted.

Man: I agree. The process may be right. It doesn't make a lot of sense, I don't think.

(Dale): Any other…

Woman: Yes, I mean, where that could come in is if it is easier or difficult to perform this process in certain groups of people. And so we know social determinants of health, you know, kind of drive a lot of not just adherence to process measures but, you know, whether these processes get done and there's a lot of factors that play into that. I mean, you could argue on the one hand. Well, of course, you know, patients should have this done. So therefore we shouldn't risk adjust it.

On the flipside, I can see, you know, a certain hospital or clinic setting saying, you know, patients or disadvantaged patients, you know, are less likely to agree to do this measure, and therefore, should be risk adjusted. So that - those are kind of the two sides to that coin.

Man: I don't think it's relevant just because doing an evaluation of the optic nerve is just part of a good ophthalmologic exam and like admitting a blood pressure or a weight on patient in an internist's office. So I think it needs to be done regardless of how unmanaged or disadvantaged people are. And it's really not particularly more difficult to do in a poor patient intercity population as opposed to a wealthy (unintelligible).

(Catherine McLane): All right. All right, (Dale), I think that's it for validity.

(Dale): Okay. Any other comments from the committee on validity?

Dr. (William Taylor): Yes this is - yes this is (William Taylor). In addition to social determinants as well as risk adjustment (unintelligible) age. Do we have a faulty comparison if the age distribution for the comparative group is different?

Man: Again, I don't think so. You do this whether the patient is 90 or whether they're 40.

(Dale): Any other comments from the committee?

(V. Catherine Gray): This is (Catherine Gray), yes. I just want to raise the question. I think there's sort of a face validity to this that all makes sense. But I think if there's a question of technical validity, if you have - if the measure or the metric is supposed to be, you know, one thing that it actually includes other glaucoma in there. So I believe that because we don't know if you remove those codes, especially on E measure, what it would all look like, you just don't know because we don't have any data. I'm just saying that there's a real validity question. It could be resolved by analysis to determine if it is or not. But it's a big issue in my book.

Dr. (William Taylor): Yes it's (William Taylor). I agree. We're not supposed to be necessarily fine-tuning the question of whether the reliability measure policy as it is might have given a reasonable result. We're supposed to, I believe, say whether this meets the NQF criteria for liability and it sounds like it's pretty problematic.

(Dale): Okay. So we've moved on from reliability. We're discussing validity at the moment. So it's the major capture the information about the condition of concerns. So key comment to validity at this point.

Woman: But I think that the comments from the last week are relevant to validity because those codes and, you know, validity is the measure of measuring what it supposed - what it's intended to measure. And I think there's some question about that given this coding issue.

(Dale): And I actually - so here I want to hear from the ophthalmologists because if I heard the conversation correctly, whether we have extra codes or not, if you have a glaucoma patient, you're going to do the optic nerve evaluation either way.

Man: Yes I would agree. You're going to evaluate the optic nerve regardless because even in low-tension glaucoma, they get large cups and lose visual field because they have low-tension glaucoma, so glaucoma at normal eye pressures.

Man: And can we get the - what's being shown visually to us to correspond to what we're talking about please?

Man: We just need to scroll up to validity.

Woman: Scroll up?

(Dale): Yes there's empiric and (unintelligible) validity on there.

Are there other questions or comments about validity?

So hearing none, (Asava), I think you can open that poll.

(Harrell Didwala): Okay. We are activating it.

(Asava): So the poll is now open and you vote in for validity on Measure 0086E which is an E measure version of 0086. Primary open-angle glaucoma optic nerve evaluation. The options are High, Moderate, Low and Insufficient.

(Harrell Didwala): Okay. I think we're waiting for one more person.

(Asava): All right. So we are at 16 votes, 7 votes for "Moderate," 8 votes for "Low" and 1 for "Insufficient." I will quickly check on the percentages.

(Harrell Didwala): Okay. So this is showing 44% "Moderate." So that would be a consensus not reached. So we would go ahead and move forward. We just won't vote on overall endorsement. (Dale)?

(Dale): Okay. So we'll go on to feasibility. (Catherine)?

(Catherine McLane): So the preliminary rating for feasibility was "Moderate" that some of the kind of note or comments people will put in was they thought that it's like a pretty common thing to do which is to document the optic nerve head…

((Crosstalk))

(Catherine McLane): Hello?

(Dale): Yes go ahead, (Catherine).

Man: I'm sorry I apologize. I forgot to mute.

(Catherine McLane): Got it. Anyways, as I said, "Moderate," it was rated "Moderate" feasibility. Folks thought that the stuff that was being - the processes detailed on this measure are generally and easily documented and that there are tools

available. There was a comment that folks don't necessarily use CPT II codes to document but, you know, I guess if they want to use the MIPS measure, they're going to use the code. So I have no other comments if others on the committee had other comments on the feasibility.

(Dale): Are there any other comments?

So hearing none…

(Jamie): This is (Jamie) from the PCPI. Sorry I just wanted to quickly mention there may be some confusion upon the reviewers. The CPT II codes are not actually applicable to the ECQM. Those would have been pertinent to the claims and registry version of the measure because CPT II are not used in ECQM space on the terminologies recommended by the (ONCHIC) Standard Committee and also based on the value sets that we've provided.

(Dale): Thank you, (Jamie).

(Scott Friedman): This is (Scott Friedman) again. So when I - I didn't even mention that when I reviewed the 0086. Some of these comments are somewhat ridiculous. So I only mentioned the comments that were - I thought were pertinent.

(Dale): Any other comments? So again, the CPT codes are not relevant to this since it's an electronically captured major.

Any other comments about feasibility?

Okay, (Asava), go ahead and open that poll.

(Asava): So the poll is now open for this feasibility on 0086E. The options for feasibility are High, Moderate, Low or Insufficient.

Woman: (Heather), please call 519.

(Asava): We're waiting on two more votes.

(Harrell Didwala): And just a reminder, if you are not speaking, please put your phone on mute. I'm hearing some feedback.

(Asava): All right. At this point, we have one committee member voted "High" on feasibility and 15 committee members selected "Moderate" for 0086E. So the measure passes on this criteria.

(Dale): All right. Thank you. So, (Catherine), use and usability…

Woman: (Please 522).

(Catherine McLane): So use and usability? Preliminary rating on this was a pass. If used in several programs, MIPS, US registry and the more registry, the more registry is a QCDR. So I guess kind of my kind of take on this is it's, you know, it's usable. It's - the codes are laid out and it's being used in a couple of registries. So it appears to be a useful measure. But we'd look for feedback from our ophthalmologists who may actually be using the measure.

((Crosstalk))

(John): This is (John). I think it's certainly usable from - it's very usable. So it's - we use it in the office registry a lot and the - it's used in the (Optum) Registry as well as public reporting.

(Dale): Any other comments on use?

And then, (Asava), go ahead and open the poll for use.

(Asava): The polls are open for use Measure 0086E. The options for committee members are Pass or No Pass.

Waiting on one more vote. And we have 15 committee members who - 16 committee members who have voted for "Pass" on Measure 0086E, the criteria of "Use." The measure passes on this criteria.

(Dale): All right. And the last is usability.

(Catherine McLane): I'm sorry then we just to usability.

(Dale): We did use. Is it used in the public program which it is.

(Catherine McLane): Yes all right. So usability, also preliminary passed. They got a Moderate rating on that. And I think that did a discussion as largely what we just have, you know, is it usable, are people using it, is it - can people use it in the office and I don't know if folks have anything additional to add.

(Dale): Any other comments from other committee members?

So hearing none, we'll go ahead and open the poll on usability.

(Asava): So the poll is open for usability. The options that we have for Measure 0086E are High, Moderate, Low and Insufficient.

And this is the last criteria that we'll be voting for this measure on this call. So far we have one committee member vote "High" and 15 committee members voted "Moderate."

(Dale): All right. Thank you guys very much. As (Asava) said, we won't be voting on the overall measure that may come back to us at a future call.

So we'll move forward now with our next measure which is 0089, diabetic retinopathy, communication with the physician managing ongoing diabetes. And our lead discussant is (James Rosenzweig).

Dr. (James Rosenzweig): Yes hi. Okay. So this measure basically seeks to - it identifies the percentage of patients - oh wait, am I suppose to wait for the measure developer first to present…

(Dale): Sure. Yes good point. I'm sorry. That's my fault. (Jamie) or others, do you have any comments about just an introduction to this measure?

(Elvia): Yes, hi. This is (Elvia) from the PCPI. And we have several staff members, (Jamie) included, but we also have other staff members who can answer questions. But to present our measure, we actually have Dr. (John Thompson), an ophthalmologist, and he is our content expert whom we invited today. So, Dr. (Thompson)?

Dr. (John Thompson): Hey thank you. I mean, basically I'll give a brief summary in the communication between ophthalmologists. I think this is a very good measure because a communication between ophthalmologists and primary care doctors is still not optimal and this measure remains important and relevant since this communication is associated with an increased likelihood to return for follow-up ophthalmic examination of recommended intervals and this was actually

found in a publication just in 2016 in one of the top journals, (unintelligible). So, you know, this is important and that communication remains critical.

And the intent of this measure is to try to improve communications better between ophthalmologists and primary care physicians and it sets an important example for the patient and I think this is something that maybe isn't captured as well in a discussion like this but when I see every diabetic patient I see, I ask them their A1c and they get used to this, you know, year after year that I'm going to ask them this and it emphasizes the importance of good glucose control.

And as I mentioned, there is a gap in care and this is a patient-centered measure which has been identified as priority by CMS to have patient-centered measures and there's very strong evidence scientifically that improved glucose control helps to slow the progression of diabetic retinopathy both in the DCCT and UKPDS which were large randomized studies.

Also American Academy of Ophthalmology preferred practice patterns which is sort of like the bible of what we should do as ophthalmologist sets the standards of care for this and, you know, it's critical that we continue to communicate with our primary care colleagues. And there is still a gap in care that surveyable were 4000 physicians found that about 80% of the specialists, 81% of the specialists claim they were sending this material to the primary care but only 62% of the primary care doctors and I've certainly had the situation personally where I've seen a patient with diabetic retinopathy and they're sort of dropped off the face of the earth in terms of my situation and their doctor notices that they haven't received a note from me, electronic or paper, and they say, "Well, you know, have you seen Dr. (Thompson) recently," and the patient kind of missed, "Well, I, you know, I missed an appointment," whatever. And so this improves - this helps to improve

adherence and it happens the other way as well where I say, "Well, who's your internist now," because the primary care doctor often changes, you know, over a course of years and years and the patient as well, you know, Dr. (Smith) retired and I haven't picked a new primary care doctor yet and I can say, "Well you really need to do this," you know, "How are you managing your insulin or your oral hypoglycemics?"

So I think this two-way communication has proven itself to be very valuable in terms of improving compliance and improving glucose control. So I would support this measure.

(Dale): All right, thank you for the introduction.

So, (James), do you want to go ahead?

Dr. (James Rosenzweig): Yes. I'm also a (Jamie) actually but I don't want to get - I don't think I have the similar voice.

I want to thank Dr. (Thompson) because basically this is - I agree that this is an extremely important measure. And while I know there were issues raised by the expert viewers, I hope I can convince the committee to allow this measure to be continued with endorsement by NQF.

As a measure - I'm an endocrinologist and it's very common for us not to receive reports back from the ophthalmologist. We often joke that sometimes sending them to the ophthalmologist just like with respect to their eyes is like sending them down the event horizon of a black hole.

So it's - obviously it depends upon the specific circumstance but to a larger extent, it's very important for the primary care doctor or the endocrinologist to

be able to know the level of retinopathy in order to be able to make decisions about how to treat the patient. It's an extreme - you know, most of what we do in diabetes is to try to prevent the long-term complications with diabetes. So I think it's - I would strongly urge that the committee continue to endorse this.

In addition, they mentioned some of the recommendations of guidelines from the American Academy of Ophthalmologist but from our point of view as well, I - there's some tabs come out - guidelines from the American Diabetes Association that I could summarize that strongly indicate that this is a - an important component.

If you look at the ADA 2019 recommendations, they say, "Diabetes care should be managed by a multidisciplinary team that may brought them primary care physicians, subspecialty physicians, nurse practitioners," et cetera, et cetera. And then ongoing management should be guided by assessment of diabetes complications and shared decision-making to set therapeutic goals.

And diet - and the other big issue is that at one time, there was - the recommendations had to do with basically everyone setting it - achieving glycemic controls with an A1c of, I would say, less than 7% or less than 6.5%. But now the recommendation is that the glycemic targets are individualized and established complication levels are important determining factor in setting A1c goals.

The other aspect to this is that they recommend shared decision-making with the - between the patient and the physician in order to be able to set these individualized goals and to be - in able to do that you really need to - the physician needs to know what the A1c - excuse me, what the level of

retinopathy is. And also it can make impact - it has an impact on the various modes of treatment. So for instance, the patient has macular edema, new macular edema, you have to be a little careful about the rate in which you improve glycemic control because an extreme drop in average glucose control may be associated with some worsening of findings at least temporarily.

And in addition, we're not just dealing with A1c or the blood glucose control as a way of treating this but we have to consider treating hypertension and also getting the patient to stop smoking and also even, you know, management of cholesterol is a factor. I mean, if you - if the report said that their cholesterol lacks, for instance, in the retina, that has an impact as well.

(Dale): This is (Dale). I say - so I have no question with the better glycemic control proof of outcomes for diabetics. The evidence question for me is, does the communication from the ophthalmologist to the primary care physician change glycemic control? I mean, I think it's important. I want ophthalmologist to communicate with the primary care physician, for sure. We're held accountable. The primary care physicians are all held accountable for reporting they've done the eye exam. And without the documentation you can't claim that you have. But the evidence question for me was not about any question about better control, better outcomes. It's will the communication from the ophthalmologist to the primary care physician change management or - and I suspect that's why the staff rated it, you know, lower on the evidence.

Man: Well - no go ahead.

Man: So I don't believe that study has ever been done. And I don't think there's any scientific proof that that's the case. As ophthalmologist, we did the next best thing. We took patients and we randomized them and we gave a

(unintelligible) for lack of better terms, to the patients and we gave - we did standard care and then we gave - we were more specific to another group of patients. And then we measured the hemoglobin A1c. I think it was a six-month follow-up and the results were we found no (particularly) significant decrease in hemoglobin A1c.

So the answer is that study has not been done but the next best thing has been done and it showed no decrease, better control in diabetes based on hemoglobin A1c as the primary outcome.

Man: But I think that it's…

Man: Yes.

((Crosstalk))

Man: You're saying that the actual - was this communication with the physician or was it communication with the patient?

Man: It was with the patient. So we didn't - so we could've done a couple of things. We could've had the patients go back to their primary care provider and have - and - but the easiest way to just - that wasn't feasible. The best way to do the study was to have a talk, a discussion with the patients that was vetted by endocrinologist and diabetologist. And they received more explanation about their eyes, the fact that they're having changes from their eyes from diabetes. And if they control their blood sugars better, in theory on average, their retinopathy will not progress or progress more slowly.

And we did that and we spent more time with the patients. We counseled them more aggressively and we still cannot move the - we couldn't lower the

hemoglobin A1c any better than the patients that said just control your blood sugars.

Dr. (William Taylor): And this is (Bill Taylor). Could I add onto that? This seems to me that this measure, this should be the poster child, so the measure that violates all of the measure must-pass criteria for NQF. And in order to pass it, we have to acknowledge that. Not only is the question did communication from ophthalmologist about the importance of diabetes control change A1c; the question here is this required communication from the ophthalmologist to either the primary care clinician or the endocrinologist because it's not specified, it says the physician managing diabetes care, does that result in improved management that results in diminished vision loss? Right.

So we know it wouldn't produce diminished vision loss if A1c isn't better controlled. But there's nothing in here that suggests and there's no evidence anywhere to suggest that requiring ophthalmologist to send out a report to the person they think is the physician managing diabetes is going to ultimately result in better vision. There's a hope that it might. I hope that it might and I hope that someday the study is done. And I hope that when that happens, we pass the measure that requires it. But in the meantime we have to admit that there is no evidence. The only evidence being cited is a cohort study, the retrospective cohort study that's unadjusted for potential confounders and a recommendation from the American Academy of Ophthalmology that there should be good communication. Nobody would question the importance of good communication. As somebody who's practiced primary care for more than 40 years, everybody should be communicating fully and the primary care doctor should have full access to everything that happens to the patients whose care is involved.

But we're talking specifically as an NQF organization with a bunch of carefully developed criteria. Does this measure meet the criteria? And the only way we could say it would be would be to violate all the rules. And it seems to me that…

Man: Yes.

Dr. (William Taylor): …that's not what we're here for.

Man: Well, I would maintain that with respect to identifying or slowing the rate of progression of retinopathy that that would be impossible to really be able to identify with any kind of controlled studies. Because the progression of retinopathy takes - you know, go - it takes place over a considerable period of time. The study to identify…

((Crosstalk))

Man: …the importance of glycemic control took, like, six to nine years before you could actually see any result. This measure has only been in place for four years I think.

Dr. (William Taylor): Yes, I think all of us would be happy (unintelligible) communication from, you know, ophthalmologist to the treating physician resulted in better diabetes controls. They have better A1cs, right? And we could extrapolate from that and say it should ultimately lead to better vision. But we don't have that.

(Dale): Right. So…

Man: Well…

((Crosstalk))

(Dale): …for retinopathy. And as far as (eye doc) and doing clinical research, I do a lot of this. It's almost impossible when we look at the primary care providers to get the appropriate feedback. So I think that's why we did the next, again next best study where we actually counseled the patients and again, the results were we couldn't move the needle.

Man: Well from the point of view…

(Donald Goldman): This is (Don Goldman). Hello. Hello?

Man: Go ahead, (Don).

(Donald Goldman): This is (Don Goldman). I think that the closing the loop in communication for this kind of thing is a ubiquitous problem in primary care, ranging from results of colonoscopy to eye exam as to urological examinations, you name it. And if we had a measure for every one of those conditions, it would be incredibly burdensome. So if any measure ever gets developed over closing the loop, it ought to be an all-or-nothing closing the loop on all referrals and such things. I mean, there must be 100 potential measures for this kind of communication that could have.

Dr. (William Taylor): Yes. This is (Bill Taylor) again. Thank you, (Don). I agree entirely. But we haven't closed the loop with this measure. It only has a one-way communication from the ophthalmologist to the person managing the diabetes. And it's interesting the American Academy of Ophthalmology Preferred Practice Pattern Committee which recommended doing this said if the ophthalmologist knows whether the diabetes is well-controlled or not, the

ophthalmologist can help put in a vote for, you know, "Gee, you're really better; see your doc and get your A1c controlled."

So what the rationale I used was not for ophthalmologist communicating with the treating doctor. It was for the treating doctor to communicate with the ophthalmologist. All of which is great that we would all believe in. But it sure doesn't come close to justifying this measure.

Man: Well, I would just say…

(John): This is (John)…

((Crosstalk))

(John): I just wanted to ask a logistical question. If you follow the algorithm in our work manual, it looks like it may allow us to vote insufficient evidence with exception. But I would just lie to ask the NQF staff what - how did we vote for insufficient evidence with exception since (unintelligible) the options are High, Moderate, Lower, Insufficient?

Man: Right. So that's a good question. And, yes, just sort of to answer some questions, this is sort of - not to direct the committee in any particular sort of, you know, end but this is the kind of situation I think that we've carved out this sort of insufficient-with-exception option where there is an absence of evidence or a difficulty in gathering evidence specific to the process in question and we do allow for an insufficient with exception to get there. A majority of the committee does have to vote insufficient first. So they'll be first to vote with your four options, High, Moderate, Low, Insufficient. If the majority of the committee gives it an "Insufficient," then we can move onto a second vote where we say, yes or no for an exception. But if we have any

other results besides a majority with insufficient, then we go with whatever that vote is.

Does that make sense?

(John): Yes thank you.

Man. Yes, right.

((Crosstalk))

Man: Is it appropriate for us to now talk about this question of insufficient, you know, with exception?

(Dale): Sure we can.

Man: Sure.

(Dale): I haven't quite understood - I'm not sure I quite understand what we mean by exception if the evidence is insufficient.

Man: So…

Man: In the NQF comments on the evidence…

((Crosstalk))

(Dale): So we try to sort of keep this exception for situations where there's not poor evidence. You know, maybe there - in some situations there's evidence and it's just - you know, there is no association, you know, between the process

and the outcome in question or is low-quality evidence or that sort of thing. This isn't - you know, this is really for situations where there's kind of an absence of evidence. And it could be for situations where it's really difficult to gather the data. I know that we've had this situation in some other projects where we're looking at, for example, pediatric populations. And it's in a - has very small numbers. And it's just really hard to get a robust, you know, study of these and gather evidence. So - but the, you know, committee members generally agree that despite that absence of evidence they feel that it is important and that it's - there's ground for an exception to the evidence criterion in that particular instance.

Man: Yes. I would suggest that yes, the evidence hasn't been yet collected properly and that we need to know more about the actual, you know, the actual result. This is a process measure. I don't think we'll be able to necessarily identify progression of retinopathy as an outcome but we could look at things related to whether or not the patients get properly referred back to the ophthalmologist and whether or not certain decision points are reached with the patient to achieve certain goals.

Dr. (William Taylor): It's (Bill Taylor) again. The NQF staff, when they got to the point of saying the committee could consider insufficient evidence with exception said, "Well you might base it on the rationale that it might help even though there's no evidence and it certainly doesn't do any harm." And I would like to point out to everybody as a primary care physician trying to recruit people into the field of primary care, the primary care doctors, as you know, are drowning in a sea of paper and clicks and so on. And, you know, putting more papers into that fax machine if we don't think there's evidence that they're actually helping when, you know, buried in the fax machine could be a, you know, potassium of 6 or whatever or there could be more of an opportunity to talk to our patient or deal with the problem rather than go

through another pile of results coming in or reports that might have already been conveyed in other manners is actually a downside of doing this. And we should limit ourselves to things that meet the criteria that we're charged to meet.

Man: Well, that - from the perspective of someone who benefits from this measure, it can identify - for instance, it can enable the primary care physician to know what the level of retinopathy is but also whether or not the patient has actually been seen by the ophthalmologist. Otherwise, we ask the patient. You can get - you don't necessarily get reliable information about that.

Dr. (John Thompson): Yes this is (John).

Man: In regards to (Don's) point - yes I'm sorry, go ahead.

Dr. (John Thompson): The biggest reason to do this - and nobody is going to do the randomized control clinical trial, you know, to prove that it actually, you know, improves outcomes for diabetic retinopathy. That'd be incredibly expensive and, you know, multiyear study, probably eight - five- to ten-year study. But even if it improves compliance, we have good treatments now for macular edema. And by the time the patient loses vision, we're behind the eight-ball. So I think even if it only improves adherence to returning to the ophthalmologist. The internist, you know, says, you know, "Have you seen Dr. (Thompson) in the last year? I didn't get any reports. Normally I get a report every, you know, six months from him." And if it improves that, you have something valuable.

So I would argue that even that improves compliance, you have a valid measure even if you don't have the randomized clinical control showing that you've improved diabetic retinopathy.

Dr. (William Taylor): Yes. But we don't need a measure for everything that's good practice. I mean, we're swamped…

Dr. (John Thompson): Right.

Dr. (William Taylor): …with measures. This is a prime example of the will and desire to measure everything that matters just because it matters. I mean, I just think it's a question burden already.

((Crosstalk))

(Dale): This is (Dale).

Dr. (William Taylor): Thank you.

(Dale): So this is (Dale). I mean, it's - this is an excellent conversation and I think it's absolutely a critical conversation because it impacts this metric and the measure that follows.

Are there - do people have other comments that haven't been made up to this point about evidence? That's really all we're talking about right now. Is there evidence to support this measure? Are there any other comments from other committee members or anyone that hasn't had a chance to speak that might make a difference here?

I really didn't mean to cut it off completely. I just - you know, I think we're hearing a lot of the same discussion repeatedly.

Other comments or anything else that any of the committee members want to highlight about this particular measure?

Hearing no other comments…

((Crosstalk))

Dr. (Daniel Greninger): I have - actually I have one quick question. It's Dr. (Greninger). Would not having this measure in place make it more difficult for primary care physicians to complete a separate measuring, having to do with the percent of their patients who have a diabetic eye exam completed? In other words, would unintended consequences of not passing this measure lead to worse outcomes? I don't - I know that's not the exact question at hand but I'd be curious what the primary care physicians think about that.

Dr. (John Thompson): I'm sure - this is (John Thompson) again. I'm sure it would because this is one of our quality measures, so we adhere to it. And if Medicare or NQF no longer cares about a measure, we're going to pay attention to other things. And we're not going to pay as much attention communicating with the primary care provider.

(Catherine McLane): Yes. So I think…

Man: Yes.

(Catherine McLane): … - this is (Cathy McLane). A couple of comments on this one. So I think that it's a little bit problematic when you got one group of doctors, in this case the ophthalmologist, who are seeing the patient and identifying a problem for which there is a treatment that another set of doctors, i.e. the primary care doctors or endocrinologists, you know, ought to kind of get on the ball on and kind of treat more aggressively, i.e. the A1c level or the blood sugar.

And while the ophthalmologists are going to do some specific treatment to the retina, the kind of overall disease picture is managed by the primary care docs. And so insofar as the primary care docs really do need that information to most effectively manage the patient, I think that it's a, you know, it's a valid measure.

I think that the kind of issues that I have with this are more along the lines of, like, how do you measure that? And it wasn't clear to me in the materials that I looked at. Is it that simply, the ophthalmologists have to document that he or she sent a note or is it that you're looking to see if the note actually ended up in the primary care doctor's record, which is I think really more meaningful one? And I think that to me is the - it's more of a methods issue for this measure.

Dr. (John Thompson): Well, this is (John Thompson). It's the former that the electronic record says (unintelligible) we're not talking to the ECQM right now but that the electronic record says and says that a fax was generated or a letter was generated. So we have to basically check a box saying send this to the primary care doctor.

(Catherine McLane): So the whole measurement is done at the ophthalmologist side of it. It's not whether…

((Crosstalk))

Dr. (John Thompson): Right. We can't really, you know, know what the internist is actually looking at or seeing. But it's that we have sent it by some - most of the time now it's faxed.

Man: And while we're clarifying what evidence we're talking about, it's not well specified what actually goes into that report nor to whom it is sent.

(Scott Friedman): Yes, again this is (Scott Friedman). So I'm sure (John) knows, at least with my experience that I also send measures electronically or fax and I get feedback occasionally where the docs didn't receive it. We know that some of the time, even though we do our best effort to send it, they're not - at least they're saying they're not getting it.

(Dale): Other specific comments about evidence? You know, some of this is leading over into some of the feasibility issues and other things.

So I think, (Asava), we can open up the poll unless somebody objects at this point.

(Asava): Okay. We're going to open it up. But just as a reminder, again if you are hoping that we're going to vote for insufficient for evidence exception option, we must have greater than 60% of the committee vote right now on insufficient to vote on that option. If it's less than, if it's 60% or less, then we wouldn't have that option, so…

Woman: All right.

(Dale): So the wrong question's opened in the poll right now.

Woman: No, this is the right one. We are first voting for evidence, Moderate, Low or Insufficient. If greater than 60% of the committee select "Insufficient," then we will have the option to vote on evidence with (unintelligible).

(Dale): Okay. On my screen it's showing Usability and Use.

Woman: Oh okay. Can you active - is that activated? All right. I'm seeing it. How about the rest of the committee members?

(Dale): Here it is.

Man: Now we do.

((Crosstalk))

Man: It shows up.

Man: It came up.

Woman: Okay great. All right. So I will pass it to (Asava).

(Asava): All right. So the polls are now open for evidence on Measure 0089, Diabetic Retinopathy, Communication with the Physician Managing Ongoing Diabetes Care. The options here are Moderate, Low or Insufficient. And we're just waiting for few more votes. One more.

Okay. If any - oh, here we go. All right. So we have one committee member who voted "Moderate." Two members voted "Low" for evidence. And 13 committee members selected "Insufficient for Evidence."

Man: So now as I understand it, we go to a (unintelligible).

Man: I'm sorry, I didn't hear you.

Woman: All right. We're just going to convert it to percentage. All right. (Asava), can you read out the percentages for insufficient? I'm not seeing it.

(Asava): So we have 6% vote for Moderate; 13% vote for Low; and…

Woman: Okay. So that would be 81%. Okay. All right, just making sure. Thank you.

So we'll move forward to the next slide to vote for insufficient with evidence.

Man: With exception.

Man: With exception.

Woman: Yes. I'm sorry, yes. Thank you.

Man: Okay. I would just recommend that we include the exception because the discontinuation of this measure would send a very bad message to primary care doctors.

Woman: Okay. So this slide…

Man: The primary care doctor, I think it might send a great message. One more - one last thing in the fax, it doesn't have any evidence base to support it.

(Asava): So we have…

Man: Can I ask a question on the primary care doctor? I just want to understand this better because I guess I'm at a loss. My wife being a primary care physician, I work a lot with primary care. That interpretation of there not being any evidence to do any of this, so if you have patient who presents with a severe

retinopathy, for example, a proliferative disease, it's likely they have kidney disease, they have neuropathy. Is that not a red flag for you all? I guess I'm - I've just heard the opposite. And I would just understand better from you.

Man: No, no. Of course it is.

Man: Okay.

Man: Anything that's relevant to the care of the patient that a specialist finds out should be communicated to the primary care doc and the people involved in the patient's care. Nobody can argue with that. But as (Don Goldman) already pointed out, if we make standards for every single one of those communications back and forth that has to happen, there were thousands of them. People will spend all their time in documentation worrying about billing and no time taking care of their patients. We're already crushing people with the burden. And NQF has done really nice job, I think, with setting up criteria so that the measures that we support meet those criteria. We can hold our heads high and says, "This is something that there's evidence to believe it's actually likely to improve care and if it's going to add to the burden it's worth it."

And here, we don't have anything that lets us say that. Yes we need to know that. Hopefully the ophthalmologists pick up the phone and call - or have another system in place. Certainly reports of relevant information should always happen. The question is if we require this, do we have reason to believe that somehow, people's vision is going to be better? And we don't have it yet. So we ought to put our emphasis on the ones where we do have some evidence…

Man: Yes. Well, again…

Man: …because those are the criteria we're going to follow.

Man: … - yes. Well that's the concept I'm - again I don't think this improves vision as much as it does improve the fact that it allows you as a clinician who's managing the entire care of this patient to understand this patient is at high risk for other morbidities and causes of mortality. And what I hear from my primary care doctors is thank you for saying that information because I am now screening them for their neuropathy with the neurologist or, you know, a podiatrist where I didn't do that before because I didn't realize it was so severe. So…

((Crosstalk))

Man: Yes, I agree with that. I agree with that.

Man: I don't think it would help…

((Crosstalk))

Man: We ought to have that information. We don't have a reason to have one more criterion though to measure it that is supported by evidence. We don't have it.

Man: Okay.

(Dale): I'm going to ask that we - since we have ongoing - are there other comments about the exception? And maybe we clear this poll and reopen this poll once we're convinced we're done with that conversation.

(Don Goldman): It's (Don). Just, I guess, some editorial comment a little bit. But just because there isn't a measure doesn't mean that good care isn't necessary or even standard. I can see somebody successfully going to court for the lack of communication, something that the primary care doctor felt impeded care. But whether or not we had a NQF measure won't affect that one way or the other. Not all good care needs to be measured.

(Dale): Other comments? Any other comments at this point?

Man: I would just…

Woman: Just following up on that comment. I think that, you know, that, like another way to say that is, is this like a good guideline if it doesn't meet the standard of a quality measure? So I'm not suggesting one thing or the other but I think that that…

Man: No, that's about - that's right.

Woman: …is something we need to consider.

Man: I think that's right.

Woman: Yes.

Man: Not everything every clinical practice guideline needs an NQF measure.

(Dale): Any other comment?

Dr. (John Thompson): It hasn't - has - this is (John Thompson). Has it not tended to occur in the past that when NQF removed endorsement for measure that CMS also

removed it as a measure? And I believe there is history of that in the past that the NQF has sort of a good housekeeping, you know, seal of approval on these measures and if NQF doesn't endorse it, then…

(Dale): Yes.

(John Thompson): …there's a reasonably good chance that Medicare is going to remove the measure and…

(Dale): (It is limited). It's a great example of that, so.

((Crosstalk))

(Dale): I think we need to be cautious here though. That's not for this committee to decide whether CMS decides to continue using it as a measure or not. We're strictly at this point, we're still in the evidence conversation.

Man: Well, I just think that there hasn't been enough testing to really determine whether or not this is - this measure has insufficient evidence. And I think that discontinuing of the measure would actually adversely affect the care of the patient from the - at least from the point of view of the primary care doctor or endocrinologist who's coordinating the diabetes care.

(V. Catherine Gray): Good. This is (Cathy Gray). I just want to say not everything out there (unintelligible) just evidence. But it doesn't mean that it shouldn't be done or whatever. But the other compelling thing that argues to me about the exception is the comment from, you know, the staff that the evidence communication could not be harmful and it could be potentially beneficial; therefore we may consider that an exception as should be in this case.

And that seems right to me. But I think it is a point well-taken that as the committee reviewing this, we should go sort of point back to about the developer and, you know, its connections to the expert or expert panel that they really should consider trying to get, you know, someone to, you know, gather more evidence so we're not in this kind of limbo land.

I think some people - you could find some ways to gather evidence that may not be the, you know, randomized control study kind of approach. But you could gather some better evidence (unintelligible). That's…

((Crosstalk))

Dr. (William Taylor): It's (Bill Taylor) again. I want to register the strongest objection of the idea that it probably doesn't or may not do any good but it can't do any harm, so we should go ahead and keep it. By that criterion we will flood an already flooded group of people who are trying to practice medicine and are impeded by some measures which have no validity. And to throw them out there and say it might not have the evidence to support it when it comes from NQF, which is all about rich set of criteria because that will limit us to things that are evidence-based flies in the face of what we're here.

((Crosstalk))

Woman: Right. To be clear, for this - this measure is the ophthalmologist, right? This one is on the ophthalmologist, not the primary care doctors.

Man: Yes.

Man: Yes. It's just one more piece of paper in the fax machine or a few more clicks to do. That's not harmless.

Man: Well, but the other aspect is that primary care doctors are faced with a lot of documentation issues as well. Should they not - maybe perhaps we should eliminate the measure of the reporting - referring a patient to an ophthalmologist and not have that necessarily be required as a measure.

((Crosstalk))

Man: I don't think that's before us right now.

Man: Right. Right.

Man: And the thing is…

((Crosstalk))

(Dale): So let's keep this conversation to this metric.

(Kim Elliott): And this is (Kim). I just think we really need to stick with what we're actually looking at, what we're being asked to do for the specific measure and whether the evidence or whatever supports what we're voting on.

(Dale): Agree. Are there other comments that haven't been made at this point? I know there's a lot of passion about this particular topic. And I understand that.

(Pam Charney): This is (Pam Charney) with the PCPI. It is a different comment. So I was wondering if I could have just a second to make a different comment.

(Dale): Okay.

(Pam Charney): And it relates primarily to I think an acknowledgement in the (unintelligible) community and a strong push for measures around care coordination. But I think all care coordination measures suffer from the same challenge that this measure suffers from and that there's not a lot of evidence that, you know, can support it from the NQF evidence quantity/quality consistency of the evidence perspective. But there's been a significant call for measures around care coordination, if you see it in CMS as meaningful measures initiatives and very few measures that address that.

And for this particular measure, given I think the significant morbidity, mortality for this patient population, it could have a - and it probably likely does and if used and it's continued use have a significant impact on the patient population. So it seems like, you know, an important valuable measure and addressing a very well-known and unaddressed gap in the measurement field. So I just wanted to have that separate - slightly different comment than those that have been made.

(Dale): Any other new comment…

((Crosstalk))

Woman: Yes, I just wanted to kind of comment. And I think this does - this kind of gets again to this problem of our very fragmented health system. And it seems to me - and this isn't something that we're going to solve here today. And I know that the MAP tries to work on this. But it seems to me that when we're considering such measures, we should be considering kind of groups of measures. And in this instance, you know, it would seem like, you know, the kind of daisy chain here is that yes, as an ophthalmologist, you know, that diabetic, you know, retinal exam, that information should get, you know,

communicated to the primary care doctor and endocrinologist. And - but that isn't good enough just to see that document - that ophthalmologist who kind of did a consult know there - you know, on his or her ends of it, is that good enough? Or does it need to be that the primary care doctor actually receive it? Right now we're getting more complicated here, right, and kind of getting into systems issues which matter in terms of delivering high-quality care.

And then, you know, we should take that measure separate or, you know, the primary care doctor - does the primary care doctor do something about, you know, A1c levels when the patient has some, you know, (unintelligible), you know, or some small vessel disease, et cetera.

So, anyways, I just kind of - I'm just trying to (carve) that out. I think that it's a problem of our fragmented healthcare system and, you know, perhaps also in the ways that we think about quality measures and that we ought be thinking about things kind of in a more kind of holistic way and thinking about all the pieces at the same time rather than in a piecemeal fashion that we currently do.

And that's my last comment. I got no more to say on this.

(Dale): All right. Anything else new? If not, I'm going to call the question.

All right, hearing nothing, (Asava), do you want to open the poll again?

Woman: All right go ahead.

(Asava): So the poll is now open for exception to empirical evidence for Measure 0089. The options are Insufficient Evidence with Exception. And the other option is No Exception.

Woman: Okay. And just to be very clear, if you want to have the measure move forward, you would select Option A, "Insufficient Evidence with Exception.'

Okay, I think we're waiting maybe on one more person.

(Asava): All right. So far we have seven votes in for "Insufficient Evidence with Exception" and eight votes for "No Exception."

Woman: All right. And she's just going to convert it over and then we'll explain the next step in a second.

(Asava): So we have (47%) (unintelligible) Insufficient Evidence with Exception and 53% with No Exception.

Man: So that'll fall in our so-called gray zone. This is - well, we may have a consensus not reached on this criterion. So we will continue to review the remaining criteria and revisit this question after the comment period.

(Dale): All right, (James), do you want to go ahead with conversation about gap?

Dr. (James Rosenzweig): Sure. Well, the data was collected between 2014 and - to 2017. And the first year the data was collected, this was for the - from the CMS QPP and QRS programs. And at the - for the first year it was 81%. It then declined to 75%. And it's stayed about that at 75%. So that would indicate that there is a performance gap.

(Dale): Any other comments related to gap?

Dr. (James Rosenzweig): I would just also not take it to mean that just because it went from 81% down to 75% that that's - would indicate that there has been a significant improvement of - or worsening of the gap since the measure was instituted. I think that…

(Dale): It's probably more reporting.

Dr. (James Rosenzweig): It might be a reporting issue. Yes, the first year maybe early adopters or (unintelligible).

(Dale): All right. We'll move ahead. Any other comments about gap?

If there are none, we'll go ahead with the vote on gap.

(Asava): So the poll is now open for gap on 0089. The options are High, Moderate, Low or Insufficient.

We're at 12 votes. We're waiting for four more.

So far we have 15 committee members that have voted "Moderate" for gaps on Measure 0089. So the measure passes on this criteria.

(Dale): All right. (James), reliability.

Dr. (James Rosenzweig): Okay. Hold on a second. Yes. So with respect to reliability, you have it up there. There was a certain amount of disagreement. It was (unintelligible) insufficient by the staff with respect to reliability. However, I don't know whether it was - reliability was adequately tested.

Does the measure developer have anything to say about this?

(Dale): So I - just real quickly, I think this is the same issue we've dealt with on multiple measures where PCPI gets an unidentified data-sub to actually be able to evaluate this. Now the same issue we've talked about with several other measures. So the staff had to rate it "Insufficient." But we're able to move past that if we believe that the metrics that were provided by PCPI are insufficient.

Dr. (William Taylor): This is (Bill Taylor) again. I think it's worse than the previous ones. It's like the previous ones that there is no separate level of analysis by individual or group. Instead there's a combined level of analysis. And that if I understand correctly, that violates the NQF criteria.

(Dale): That's right.

Dr. (William Taylor): There's an additional problem here which is that the reliability was only specified for outpatient post-acute and domiciliary care. And that's not reported separately or acknowledged in the submission. And the combination of those two I think made the NQF staff result in this "Insufficient" rating, if I understood it correctly.

(Dale): So post-acute care, how will be distinguished from outpatient care? I mean, after the patient leaves the hospital, does this mean, like, step-down type care? I mean, what does exactly post-acute care mean and what was domiciliary setting? Does that mean house call to individual locations or is it patients in nursing homes that are then being referred to see ophthalmologist? I just didn't quite understand the terminology here. And then I thought…

Man: Those are the questions in the report. I think the developer can probably tell us what, you know, what those categories right when they did the analysis.

(Greg): Hi, this is (Greg) from PCPI. Can you hear me?

Man: Yes.

(Greg): Hi yes. So the data that we used for this analysis came from CMS's PQRS report. And it was de-identified and didn't contain information at the levels analysis or care setting. But it - this is a nationally reported measure and it comes from providers of all different sizes and types. So I think it's fair to say that within the large dataset there are representatives for each of the different care settings. And so as for the group versus individual clinician, I believe that since they're at the aggregated level, it's just appropriate to move it forward as a group levels analysis.

Man: Okay. From my perspective, the most important aspect would be the outpatient care. I'm not sure exactly how the other two, you know, the - if someone is within, let's say, a domiciliary setting, I assume that means nursing home. Usually there's shared information between different people there. But the big issue is mostly related to when the patient is an outpatient and is seen by an ophthalmologist in one location and primary care doctor in another location.

(Scott Friedman): Yes, this is Scott.

((Crosstalk))

(Jamie): Hi, this is (Jamie) with the PCPI. Sorry, (Greg). Really quickly, just to mention within the specifications and sort of the classification of the types of visits, we do include within the denominator of the measure office visits, outpatient consultations, ophthalmological service encounters, care services in

long-term residential facility as well as nursing facility visits. And so we selected the care settings within the form based on how we interpret NQF classifications are as well as based on some of the guidance that they've provided us in the past.

(Scott Friedman): Yes, this is (Scott Friedman) again. I report on this measure and I can tell you probably 99% of mine are done in my office. I have probably a minuscule number of patients that I saw as an inpatient as a consult that are possibly reported on. And I can't imagine there's many ophthalmologists that go to nursing homes and do examinations that report on that. But presumably there are maybe a few out there.

Dr. (John Thompson): This is (John Thompson). And the same thing. I mean, even if it's somewhere like the Cleveland Clinic or, you know, New York University, you know, it may get somehow misclassified but these are outpatient ophthalmology clinics or outpatient offices, I mean, the vast majority, probably 98% or more.

Man: Yes. It would have made more sense to me to specify for outpatient care and not have the other two listed. But since I guess they are listed, they would represent a very small percentage of the total.

(Dale): Any other comments about reliability?

All right. (Asava), do you want to open the poll?

(Asava): Polls are now open for reliability on Measure 0089, Diabetic Retinopathy, Communication with the Physician Managing Ongoing Diabetes Care. Their options are Moderate, Low, Insufficient and the highest - you can go towards High.

(Catherine McLane): (Dale), this is a question. This is (Catherine). The developer said that they - basically since all the data is together, it should be viewed as a group even though - so it's not individual separate from group, right? Or should we ignore that comment or what?

(Dale): No, I think that's correct. And that is the issue that came up with the other performance measures that we discussed at the face-to-face meeting.

(Pam Charney): Yes. This is (Pam Charney). Just to clarify something at least from our understanding I think of the face-to-face meeting and other committees that have reviewed measures this time around with this newer guidance from NQF, the - our understanding is that the vote that you all are taking is related to the group level. Because since we can't differentiate between group and individual and you would assume or suspect that the individual reliability would be less and the results would be likely less of reliability results at the individual level that the group is the level at which you're making your vote.

(Asava): Just double checking, do we have any other committee members who still need to vote? We're now at 14 but we have 16 people on the line.

Man: I think, (Asava), the last two votes we've had had been 15.

(Asava): So we have 15 votes right now. One for High, seven for Moderate, six for Low and one for Insufficient.

Woman: Okay. And we're just going to convert it to percentage so everyone can see.

(Asava): So we have 7% High, 7% Insufficient, 40% Low, and 47% Moderate. So the measure is going to pass on this criteria. Oh, consensus not reached.

Woman: Yes. This is a - sorry, let's - correction. That is a consensus not reached. So we can move forward with validity. But this is consensus not reached again and just a reminder that we wouldn't be voting for overall endorsement at the (event), anyway.

(Dale): Right. So go ahead, (John) - (James) or (Jamie) with the validity.

Dr. (James Rosenzweig): Yes. The validity - preliminary evidence rating for validity by the group was "Low." I think it's not - I assume that the issue is mostly related to - so validity was related to a lack of potential data being collected.

Dr. (William Taylor): It's (Bill Taylor). I think the validity testing was the poor correlation - the validity test was its correlation with the diabetic eye exam.

Dr. (James Rosenzweig): Oh yes. Okay.

((Crosstalk))

Dr. (William Taylor): …correlation was very low. Yes.

Dr. (James Rosenzweig): Yes. The correlation was quite low. And - but you have to realize that these two are only very marginally related in the sense that the diabetic eye exam measure that that is the responsibility of the primary care doctor is really mostly related to screening of the patient. In other words, it's for all patients with diabetes to make sure that they've been checked to see if they have retinopathy; and whereas the other measures relates to people who are being seen by the ophthalmologist for established retinopathy.

So there's - there may not be very much correlation related to this because the measures are not really directly the same - evaluating the same population of individuals and the responsibility for care is by two separate groups.

There is another measure that was actually discussed in the eMeasure which we'll be talking later. There's a measure of properly documenting the level of retinopathy and whether or not the patient had or doesn't have macular edema. And that measure correlated well with the other measure of communicating it to the primary care physicians. I don't know exactly why it was just included in the eMeasure and not in this measure. But it may have to do with the fact it was only really looked at in the eMeasure.

(Greg): Hi, this is (Greg)…

((Crosstalk))

Man: I think it was in all three of them. This was claims, registry and measure. And the other one was on the eMeasure I believe. (Unintelligible) can tell us.

Man: Yes. So I don't know why it was just included in the other report. That was my question.

(Greg): Hi, this is (Greg) from PCPI. I can speak to that a little bit. So the measure was only included in the e-version, the ones with the good correlation because that only had - because we had to compare eMeasures to eMeasures and registry measures to registry measures, claims measures to claims measures. And there just wasn't a registry or claims version for that particular measure.

Dr. (William Taylor): It's (Bill Taylor). For the other threats to validity here if I read it correctly, it says there was no (test) to missing data and there's no risk adjustment.

Man: Yes. I would argue that this is like the previous measure we discussed that this - that risk adjustment is not particularly necessary. You're trying to overcome a specific deficit and the patients at highest risk shouldn't have to necessarily be adjusted or compensated for any evaluation.

(Dale): Any other comments about validity testing?

All right, (Asava), do you want to open the poll?

Woman: Okay. We're opening it up.

(Asava): The polls are now open for validity testing on Measure 0089. The options are High, Moderate, Low or Insufficient.

We're waiting on two more vote. All right. So right now we have four standing committee members - we have five standing committee members that have voted "Moderate" and 11 committee members that have voted "Low."

And I'll convert this to percentages. So that's a total of 31% for that for Moderate and 69% for that Low.

Woman: Okay.

(Asava): So the measure is going to fail on this criteria.

Woman: Okay. So we would actually stop here.

(Dale): All right. So we've not gone to the same measure but the e-version. Do we want to try to open that up? We only have seven minutes left on our allotted time.

Dr. (William Taylor): I'm (Bill Taylor). I'm the lead discussant. And I have to leave right at 4 o'clock.

Woman: Yes. I think, (Dale), this is NQF. Especially with Dr. (Taylor) leaving, we probably won't get sufficient discussion in play at this point.

(Dale): Yes, I agree. I suspect what we're going to have to do is find a one hour time spot that we can do the last measure.

(Sheryl): Yes. So this is (Sheryl) at NQF. So what our team will do on the background here is we will, you know, make sure we can have an additional Web meeting because that was not scheduled. But we will get back to the committee and the developer very quickly and then figure out if we're allowed another Web meeting that we can set that up, making sure that we get good committee availability and developer availability of course, too, relatively very soon of course.

So we will touch base with everyone.

(Dale): All right. Thank you, (Sheryl).

I know it was challenging conversation today but very, very good, very thoughtful conversation. And I certainly appreciate all the comments and the work that you've all done on these metrics. We have one to go. So we got to cross that finish line.

Woman: Yes. Thank you to everyone from the NQF side. It was a great discussion and we really appreciate all the hard work everyone has been putting into this and to everyone for the flexibility.

(Dale): All right. Thank you very much.

Man: Thank you.

Man: Thanks all.

Man: Thank you.

Man: Thanks everyone.

Man: Thank you.

END