

NATIONAL QUALITY FORUM

Moderator: Reva Winkler
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10:00 am CT

Operator: Welcome to today's conference. Please note today's conference is being recorded. Please standby.

Reva Winkler: Hello everyone. This is Reva Winkler with the National Quality Forum. With me here in our offices is Katie Streeter and Jessica Weber, the project team for this Pulmonary and Critical Care Endorsement Maintenance project. Welcome to this conference call of the COPD (dysnea) Workgroup.

This morning, our goal is to address preliminary reviews of a sub group of the measures that will be discussed by the entire committee at their in person meeting in March. Just a note, we do - this is a public call and we do have folks listening in.

There will be an opportunity for public comment at the end of the call. A recording and a transcript of this call will be posted on NQF's Web site for public view.

So what we're - what we want to do today is have the workgroup members, the four of you - Dianne Jewell, Norman Edelman, Christine Stearns and Steve Grossbart have an opportunity to kind of huddle together and look at your preliminary reviews of the group of measures that address COPD and the one measure for (dysnea).

Thank you all very much for submitting your preliminary reviews. We've sent you a spreadsheet with the results of those. I think this provides a good starting place for discussion for each of the measures.

We do really want to focus in on areas where your - there may be some disagreement around the committee members that would - or the workgroup members that would benefit from further discussion or particularly issues or concerns about the measures.

Our measure developers are available with us and to respond to any of your questions or concerns or provide additional information or clarification if needed. So feel free to make use of that and ask those questions.

So before we launch into looking at the eight measures that are on our agenda today, does anybody from the workgroup have any questions about what we're trying to accomplish?

Dr. Norman Edelman: Yeah. This is Norman Edelman. I have not seen the spreadsheet. When did you send it?

Male: Yeah. Neither of I.

Katie Streeter: Oh. I sent one this morning and then also last night.

Reva Winkler: There was one sent last night with an update that was sent this morning from Katie Streeter.

Dr. Norman Edelman: Well I have not gotten it.

Reva Winkler: Okay. And if you are on the webinar Jessica will be putting the spreadsheet up. Okay?

Dr. Norman Edelman: Okay.

Reva Winkler: All right? So those are - that's how it's available. Any other questions? Okay. Then this is the last of the four workgroup calls. Your colleagues from the other workgroups have been through this.

I think there have been some good discussions and raised some issues and questions so that we'll have a very robust conversation at our in person meeting. So we might as well start at the top. The first measure for us to discuss is Measure 91, COPD's spirometry evaluation.

And Dianne I believe you were the lead discussant for this measure. And if you could just basically do a quick, you know, kind of summary of the various criteria beginning with importance and then moving onto reliability validity and then usability and feasibility and raise any of the issues that you identified in your review.

Dianne Jewell: I'd be happy to. I want to clarify for all the participants on the call what you're seeing in the spreadsheet for my comments was from my review of the initial submission from the AMA PCPI.

There were - we were waiting on data submissions and I was not able to review the data and update my comments in response to that.

So there - you will see some places where I have marked it insufficient or unknown and that was completely because I didn't have the updated materials when I conducted my review.

So with that in mind this is the use of spirometry evaluation in patients who have a diagnosis of COPD, patients aged 18 years and older. There's clearly evidence of high impact relative to the incidents and prevalence of COPD in the general population.

I had a question for the measure developers about why this measure was designed for 18 and older given that the impact seems to be in the - and is documented in the older age group. But I appreciate that that opens the measure up to wider use by doing it that way.

The issue around performance gaps clearly were the evidence that was submitted. There were gaps demonstrated. This is a measure that's publicly supported with CMS and the PQRS system. There's also plenty of published evidence to this effect.

The one piece that I still wasn't clear about based on the way the measure is defined is that the guidelines are pretty clear about use of spirometry to confirm a diagnosis of COPD. There seems to be conflicting information or support for use of spirometry for routine management and so I can't quite tell from the measure whether this is really intended to cover both of them, both new diagnoses and routine management or not. That's relevant to this issue of the gap and where the performance gap might be. So I'll be looking for some clarity about that.

The reliability and validity data came through and while they were only able to test based on one site's worth of data for validity they did compare to actual clinical records and so I believe that that is sufficient for the purposes of meeting the criterion that we have for validity.

Reliability was well established based on the statistics they provided. There is also something - I'm a little unclear about the stratification or the disparity - not stratification but issue around disparities. The measure developers do cite literature related to disparities.

But they did not submit data from their own measure illustrating this and I wasn't clear whether that's because it's not currently configured to the (exam) or whether that was simply an oversight. So that was another outstanding question that I had.

The feasibility and usability, you know, I'm not clear that patients would necessarily know how to use this information, particularly if it's not clarified as to when this evaluation was supposed to be occurring. In other words, is it a new diagnosis or routine management?

But overall I believe that the feasibility and usability, quite curious, seemed to be adequately addressed in the submission.

Reva Winkler: Great. Super. Any other comments from other workgroup members?

Dr. Norman Edelman: Yeah. This is Norm Edelman. I guess I have the same problem. It's not clear what the goal is. So if a diagnosis of COPD has already been made and then you use spirometry are you trying to find the number of inappropriate diagnoses?

Do you think this will somehow indirectly encourage physicians to do spirometry in circumstances where there's shortness of breath which is really what you'd like to achieve. And I understand why you can't do that from the administrative data.

But as written the goal - the health improvement goal is not really clear to me.

Reva Winkler: Okay. Perhaps - could someone from the developer - Kendra did you want to respond to the questions that have been raised?

Kendra Hanley: I'll defer to my colleague, (Catherine Oz). And then we also have our physician leader Dr. Santotomas on the phone. So (Catherine) will start off and then Dr. Santotomas we might ask you to add in some additional...

Dr. Linus Santotomas: Sure. Yes.

Kendra Hanley: Thank you.

(Catherine Oz): Actually I was not - this is (Catherine). I wasn't part of the original workgroup but what I understand from the measure is that we want to use the spirometry to confirm the diagnosis but at any time because we had no way to capture the data of a new diagnosis.

So this means that if a spirometry evaluation had been done that would count for the measure. And any time during the evaluation period an evaluation could be done. I hope that that clarifies but I'd also like to ask Dr. Santotomas if you have anything to add?

Dr. Linus Santotomas: Yeah. So just to give the background, you know, as far as the concern and really the rationale for this is one, to answer the question of how will this improve health? One, COPD is under diagnosed.

It is also over diagnosed if that - and just to explain what I mean by that, a lot of people who are smokers and have shortness of breath are automatically labeled as COPD but really the diagnosis entails proving that that patient actually has an obstructive physiology because there are actually other lung diseases that are associated with smoking.

Or there could be other diseases that may not be due to the smoking and yet this is labeled as COPD. So that's really one. So it actually serves a purpose in terms of management. The confirmation is important because the management is different for different lung diseases.

So potentially one may be under diagnosed and not treated with what they should be given. And some are misdiagnosed and given bronchodilators when really those bronchodilators are probably really not doing anything and it's a waste of money. So that's kind of the rationale behind this.

As far as when it is to be done yes, it's - this is more for confirmation. And like in asthma where a, you know, repeated spirometry to monitor how lung function is doing is encouraged. In COPD you only need to prove once that it's COPD or confirm it, okay, and that should be enough.

There is no agreement on how often that should be repeated. So as far as, you know, how many times it's, you know, there just has to be at least an indication that it was done. Yes?

Dr. Steven Grossbart: Steven Grossbart here. I have a question and it's something that Dr. Edelman's comments sparked this. So basically the way this measure is calculated it's on a 12 month window and it is being used in public reporting currently.

But that means that we're incentivizing physicians to do the test whether the patient needs it or not because it has to be done once in a 12 month period. And is there a reason why a confirmed diagnosis of COPD would not be an exclusion in the denominator?

Kendra Hanley: Actually this is Kendra Hanley from the PCPI. You know, the measure might be required to be reported on an annual basis as it is implemented in the CMS PQRS program.

However, in the specifications it does indicate that you should use the most recent, you know, if a COP - if a spirometry had been done in the past you would use the most recent value from that test and it's not limited to the reporting here.

So you can actually report on a value from a prior test. So it's not encouraging...

Dr. Steven Grossbart: So what...

Kendra Hanley: ...if it needs to be performed again.

Dr. Steven Grossbart: So it will not encourage overutilization...

Kendra Hanley: It will not.

Dr. Steven Grossbart: ...for unnecessary testing.

Female: Yeah.

Dr. Steven Grossbart: Okay. That clarification is helpful.

Reva Winkler: I'd like to just build on that because when you look at the specifications on page nine and talk about the numerator time window. It says at least once during the measurement period. And that really does tend to indicate you're looking for that spirometry every year.

So perhaps the way it's worded isn't the way you intend?

Female: Yeah Reva, I think we could probably make some clarification on whether or not we're talking about reporting versus actual action on behalf of the physician and we'd be happy to make that clearer.

Dianne Jewell: Yeah, this is Dianne Jewell. I think that would be helpful simply because the guidelines, and just my experience in practice, we're not routinely monitoring these folks.

There's not value added once the diagnosis has been confirmed and therapy has been initiated unless there are some, you know, specific events that warrants reinvestigation. And the wording at least as I read this, seems to imply that any old time would be okay and I know that's not your intention.

But I wouldn't want to encourage, particularly if you think about a non specialist practice. I wouldn't want to be encouraging inadvertently overutilization by those who were less familiar with the guidelines.

Christine Stearns: This is Christine Stearns. I have just a quick question I think. On page 6 it mentions that the guideline recommendation for spirometry is not consistently recommended for all COPD populations. I didn't see but perhaps you can point me toward it, any exclusions that would seem to reflect that.

That this is not recommended for all populations. Could you help me with that? This seems to apply to all populations that have a COPD diagnosis.

Dr. Linus Santotomas: So one, if it's been diagnosed before, meaning by spirometry again there is no clear benefit that repeating it would have a, you know, would have any benefit to the patient or change in care.

The other thing is those who are actually really severely debilitated then those patients may not be candidates for this either just because the way the procedure is done there's so much effort and sometimes it becomes a useless step because they do not meet the technical criteria on how the test is done just because they're so debilitated.

Christine Stearns: Okay. Okay. And - but that is not necessary to reflect - to exclude those patients from your calculation?

Female: So the medical reason that is part of the measure would allow the physicians to make those judgments on a case by case basis.

Christine Stearns: Oh. And that is in the denominator exclusion?

Female: Yes.

Christine Stearns: Which seems to be sort of (broad). Could you explain those exclusions to me in documentation of medical reasons but also patient reasons? Is that what would be encompassed in those kinds of exclusions?

Female: Yeah. And so this goes back to sort of our PCPI methodology on how we represent exclusions and exceptions in our measures. The medical - and so we allow for three categories of exclusions, medical patient or system.

And so, you know, in a measure that's looking at a certain medication a medical reason might be an allergy, a contraindication. In this case it might be the things that Dr. Santotomas described.

A patient reason could be that the patient actually does not want to have the test performed so they would decline, you know, having the test. Does that help provide a little bit of guidance?

Christine Stearns: It does. Thank you very much.

Reva Winkler: All right. Any other discussion from the workgroup members? What we will be doing is summarizing the points you've raised. We'll follow up with PCPI to maybe clarify those specifications as discussed.

And we'll be packaging your preliminary ratings as sort of the starting point for the discussion for the steering committee going forward at their meeting in March. So is there anything else about this particular measure? I will mention that this is a clinician level measure.

We will be looking at a very similar measure from NCQA at the end of the call. The developers weren't asked to go at the end of the agenda and so we will be kind of regrouping back to look at a more health plan level measure addressing a similar - the same topic.

Dianne Jewell: Reva, can I ask the developers just one more question?

Reva Winkler: Please do.

Dianne Jewell: Am I correct - this is Dianne Jewell again. Am I correct in believing that the measure in the PQRS system as implemented, does not allow you to assess disparities or is not configured to assess disparities? I know you've presented evidence that's published.

But in terms of the actual measure itself, there were no data specific to that that were submitted in the updates so I just wanted to clarify that.

Female: So it's not required to be reported but that's across the PQS program. It's not necessarily specific to this measure.

Dianne Jewell: Okay.

Female: So CMS as the receiver of these data has that information from the claims and other characteristics for whom they're providing pain for the care. So the ability to actually stratify by those data elements is there.

Dianne Jewell: But they weren't able to make that data available to you for the submission? You have the other data from the system. That's why I was just curious.

Female: Yeah, no, we did not receive that additional patient characteristic data.

Dianne Jewell: Okay, thank you.

Female: Great.

Reva Winkler: Okay. If that's all for that measure then we probably should move on. the next measure is Measure 102. This again is another measure for COPD.

Inhaled bronchodilator therapy again from PCPI, percentage of patients aged 18 years and older with a diagnosis of COPD who have had an FEV1 over FVC less than 70% and have symptoms who are prescribed an inhaled bronchodilator. Dr. Edelman, this is your...

Dr. Norman Edelman: Okay. I guess I'm going to need a little help in understanding these forms.

Reva Winkler: Okay.

Dr. Norman Edelman: So the brief description of the measure is clear. And then what I'd like to do is go to page 8 and look at the specific guideline recommendation and there is a recommendation three for stable COPD patients with respiratory symptoms and an FEV1 less than 60% predicted.

Recommended treatment with inhaled bronchodilator is great. A strong recommendation, moderate quality evidence. Now I agree with that. And if that's the guideline, you know, I think it's strong. But then another guideline - recommendation four is presented.

And that focuses on monotherapy and it's not at all clear to me why monotherapy has to be insisted upon. And then there are other descriptions concerning the better efficacy of long acting bronchodilators relative to short acting bronchodilators and that's all under quote verbatim.

So I mean I need to understand what the actual metric is intended to be. Now going beyond that the evidence of high impact is clear and it'll be clear for all of these in the COPD category. The benefits - and they're discussed accurately.

There is no question that the benefits in terms of relieving symptoms had been documented. The benefits in terms of reducing exacerbations with long acting bronchodilators have been shown with I believe a moderate degree of confidence and I agree with that.

And they point out quite correctly that other benefits in terms of mortality and disease progression have not been shown. I agree with their discussion of the performance staff.

I think their discussion of disparities is excellent and we ought to bear it in mind when we look at some of the other applications that claim that there are no disparities in COPD because it raises issues for me. Going through the rest of the application, the quality of the body of evidence I think we've discussed.

And I think they point out that the evidence for improving symptoms and reducing exacerbation is pretty good although not perfect across the entire spectrum of COPD.

And there's a long list of potential conflicts of interest and we come back to the specific guidelines and in the reliability I think that the reliability is addressed satisfactorily. So I think this is a good measure if the measure is the single statement under recommendation 3 under - in page 8.

Reva Winkler: Okay. Page 8. Okay.

Dr. Norman Edelman: Do you see my problem? I don't know what the measure is.

Reva Winkler: Okay. If you go to page 10 under precise measure specifications 2A1.

Dr. Norman Edelman: Two A1 point what?

Reva Winkler: Yes. Numerator statement, numerator time window, denominator details - numerator details. The second section is the denominator.

Dr. Norman Edelman: Okay. All right, it says patient who were prescribed an inhaled bronchodilator.

Reva Winkler: Right.

Dr. Norman Edelman: So am I to take that as the specific measure?

Reva Winkler: Yes. That's the numerator description. Any details in terms of definitions and coding are in the details section.

The denominator is all patients aged 18 years and older with a diagnosis of COPD who have an FEV1 to FVC ratio less than 70% and have symptoms such as (Dysnea), (cossputum) or wheezing.

Dr. Norman Edelman: Okay, so that's fine. And I think those were appropriate.

Reva Winkler: Any other thoughts from other workgroup members? In general those of you who submitted your ratings have generally felt it rated at moderate to high on most of the sub criterion across without any - I don't see any significant issues raised. Okay? Any other discussion?

Any comments from measure developers?

Female: Nothing from us. Dr. Santotomas did you want to make any comments?

Dr. Linus Santotomas: No. Not really. I think yeah.

Reva Winkler: It's pretty straightforward? Okay. Then the next measure is measure 1825. This is a new measure submission. The first two measures were measures that have been previously endorsed by NQF and were undergoing maintenance review. This measure is a new measure from active health management.

And it is management of poorly controlled COPD. And this is the percentage of patients aged 18 years or older with poorly controlled COPD who are taking a long acting bronchodilator. And again so very similar to the measure we had previously.

Dr. Edelman I think this is also your measure because the two are quite similar.

Dr. Norman Edelman: They are quite similar. They're - the age group is similar. The difference here is the specify a long acting bronchodilator not simply a bronchodilator. In their description of the recommendation they use the word monotherapy but they don't use that in the numerator statement.

So I need clarification of what's intended. Is - do they mean monotherapy literally? So do they mean if the patient is also taking an ICS they would not meet the measure? Or is the measure as stated in the numerator simply taking a long acting bronchodilator?

Reva Winkler: Do we have someone from active health on the phone? (Bonnie) are you with us?

Operator, is - do you see if any of our measure developers from active health are on the public line perhaps?

Female: Are they expecting you?

Operator: We do have a line from Jay Rajda that is from Active Health.

Reva Winkler: Okay. Why don't you open that up?

Operator: And Lindee Chin from Active Health.

Reva Winkler: Great.

Operator: And both of those lines are open at this time.

Reva Winkler: Great. Hi guys.

Lindee Chin: Hi.

Reva Winkler: You've heard Dr. Edelman's comments. Perhaps you can clarify?

Lindee Chin: Yeah. So our measure actually - our denominator is looking for those with a COPD who are on already short acting bronchodilators and have exacerbations. And the numerator is looking for those who are then prescribed long acting bronchodilators.

Dr. Norman Edelman: But you would not exclude anybody prescribed long acting bronchodilators as well as an ICS. Am I correct?

Lindee Chin: Right. We are not - we're just looking specifically for those on short acting and they've had exacerbation.

Dr. Norman Edelman: I'm talking about the numerator. If somebody were given a combination medication which included a lab and an ICS they would meet the criterion. Is that correct?

Lindee Chin: Yes. Yes.

Dr. Norman Edelman: Okay. So I understand that now. I didn't quite understand it because the word monotherapy was used some expansively.

Lindee Chin: Yeah. I think if you...

Dr. Norman Edelman: So going through this the impact is high. I agree with that. The ratio disparities is probably correct. The body of evidence focuses on comparing long acting bronchodilators rather than on the efficacy of long acting bronchodilators in this definition.

So it's not clear that they've actually shown that long acting bronchodilators are useful in this setting. Although people have shown that and the evidence of that is reviewed in the gold publications. So with this clarification let me look at the reliability.

The reliability is tested. So with this clarification this is an acceptable submission to me.

Reva Winkler: Okay. Thoughts or comments from the other workgroup members?

Dr. Steven Grossbart: Steve Grossbart here. I had a couple of questions about that - the performance gap. I didn't see strong evidence of a performance gap in the submission and I'd like to know if the developer can speak to that.

Lindee Chin: Hello? Can you hear me?

Reva Winkler: Yes.

Lindee Chin: Okay, sorry. I think we're trying to get our other subject matter expert Jay, Dr. Jay Rajda on the phone but for some reason his line doesn't seem to be working. But in regards to your question again it was around the performance gap you said?

Dr. Steven Grossbart: Yeah.

Lindee Chin: I guess in particular we found that we looked at our population of people in our database and found that about 76% of those with COPD and exacerbations and on short acting bronchodilators were given long acting bronchodilators. However, which means that 24% were not doing that.

And our population - I mean our, you know, the extent of COPD patients is a large amount so 24% is not a small amount of people.

Dr. Steven Grossbart: Right.

Reva Winkler: Do you have a rough number on that population that...

Lindee Chin: Yeah. In terms of what our population was, the 24?

Reva Winkler: Yeah. Seventy-six percent of what?

Lindee Chin: Of our denominator. Let me get that number. Sorry.

Dr. Steven Grossbart: It's on page 14. I'm seeing 8657, just shy of 9000. So - and you know that that 24% were eligible for the therapy?

Lindee Chin: Yes. We exclude people who don't have - have allergies - have a lung transplant and if they're allergic to any medications and we also include those types of people as well.

Dr. Steven Grossbart: And I have a second question about eSpecifications, use of electronic health records.

Lindee Chin: Okay.

Dr. Steven Grossbart: I mean this looks like it's electronic data that's collected through chart abstraction rather than during the delivery of care itself as would be the case in an EHR. Is that correct?

Lindee Chin: It's a combination. We actually get data from various sources so we get payer claims data from pharmacies as well as health plans. We also get data from patients themselves in our disease management program.

So if they talk to one of our disease management nurses and tell them that they are on medications we collect that data. And then we also, with some of the health information

exchanges, we'll get that data as well from - extracted from EHRs or records. It is not at the point of care though.

Dianne Jewell: Hi. This is Dianne Jewell. I could use some help understanding the reliability and validity information you submitted. It appears that you've submitted relative to the entire plan subscriber base as opposed to the population and question for the measure and so I wasn't sure what actually had been tested.

And you describe a method but it seems as if you're testing using the entire database. And when I saw the mean ages of 37 and 35. I thought that's definitely not the COPD population...

Lindee Chin: Right that was - we - the data was on - that's our sort of - the reliability data on our members from the test health plan that we use. So we described that process. And in the testing results we talk about how many patients had actually these types of data sources.

Dianne Jewell: Okay. But you haven't actually tested the measure then?

Lindee Chin: No. We have tested the measures. The 76% - any time we do any sort of measure and it gets released into our sort of - what we call our production environment and clients use it we go through the process of testing and I think that we described it in one of the other sections.

We manually actually look at patient data that we get to make sure that people who fulfilled the numerator were appropriate and those who filled the denominator were appropriate as well. So we do a sample of that and manually look at it.

Dianne Jewell: Okay. So you haven't done - but you haven't done any kind of statistical assessment of reliability or validity in the measurement? That's what I'm asking.

Lindee Chin: I - of the measure itself? No. We talked about sort of how - what we do with our test data sample.

Dianne Jewell: Okay.

Reva Winkler: Any other questions from workgroup members?

Dr. Jay Rajda: Hi. This is Jay Rajda. I guess I just got back on. I was not on the call for some reason. I'm back in the conference now. But I just wanted to make a comment about the literature.

The reason why we quoted the literature we did is because we are looking for the specific instance where a patient is on short acting bronchodilator and still having, you know, poorly controlled COPD, evidence of exacerbations, you know, in which instance a better maintenance therapy is necessary.

So, you know, in comparing short acting bronchodilators and long acting bronchodilators for, you know, evidence of further exacerbations, preventing further exacerbations and preventing hospitalizations it seems that there's a benefit of using long acting bronchodilators.

You know, those are, you know, we try to quote those studies to back up this measure.

Dr. Norman Edelman: Yeah, thank you. That was clear.

Reva Winkler: Right. Any other thoughts on this measure before we move onto the next? Okay. Well then moving right along, the next measure we have is another new measure. This is an outcome measure. This is measure 1891. This is from CMS.

This is hospital 30 day all cause risk standardized readmission rates following COPD hospitalization. This type of measure is not new to NQF. We certainly have seen this measure for AMI, heart failure and pneumonia but this is a new topic area for this type of measure. So Dr. Grossbart?

Dr. Steven Grossbart: Thank you. So measure number 1891, hospital 30 day all costs risk standardized readmission rate. Walking through the tool I think the importance is - I felt the importance was well documented. This disease group, COPD represents 4% of all patients who are readmitted.

And the current readmission rate is 23% of all COPD patients returned to the hospital within 30 days. The - so I thought the importance was very high and that the evidence was compelling.

The - this is an outcome and the measure specification - I'm going to go right to the measure specification so I'm in page 6 of the form. This is based on - this is a measure that is based on Medicare claims so the data submission process clearly has a relatively low burden on the providers.

And it also identifies any patient with a - the denominator is any patient with a discharge of COPD, any Medicare enrollee who's with the discharge of COPD and the denominators are readmission to any facility. So it measures readmissions across multiple facilities.

So if you are discharged from a tertiary care center and end up in a critical access hospital the tertiary care center is flagged with the readmission. The - I felt the, you know, the exclusions and so on were appropriate.

The questions around electronic health record are not applicable since this is coming from the Medicare claims data and that an HER alternative would not be operationalizable if that's a real word. The - I think the usability was high.

These measures - similar measures are already in place and are being used in public reporting and are now being used in payments embedded in the inpatient prospective payment system rule. So usability is - I felt was very high.

And I also thought that given the endorsement by the NQF of very similar measures that this made it all the more robust a measure. The hierarchical adjustment methodology has been reviewed under other clinical areas and it's fairly well vetted.

And I believe that risk adjustment methodology is relatively robust as well. And that's about it.

Reva Winkler: Okay. All right. Anything from any other workgroup member?

Dr. Norman Edelman: Yeah. Norm Edelman - I have two questions and they really pertain to this and the subsequent one because they're very, very similar from the same source. One is a relatively small issue so in - I mean we all know now that a separate phenotype in COPD is propensity for repeated exacerbations.

And that has to be risk adjusted. It just can't use severity by spirometry. But in this document the only risk adjustment is for patients who had exacerbations and were ventilated. There's no risk adjustment for patients with previous admissions with exacerbations.

So I think that's probably not a major issue but it might have an impact. The other issue is kind of brand new and I am glad I'm not sitting among you. You'd probably throw things at me. And that is a pretty good job is being done to risk adjust for the patients.

But since this measure is going to be used to compare institutions you really have to risk adjust for the institutions.

Now there's a pretty good discussion of why they feel it's unnecessary to risk adjust for SES and race and I worry about SES because I think there could be two conflicting issues going on and I may discuss it when I do mine. But the one thing that's not included is particulate air pollution.

I mean we know pretty well now that exacerbations of COPD deaths from cardiopulmonary disease have a pretty strong correlation with ambient air pollution particularly particulate pollutions.

And, you know, it might, if this is going to be used to compare hospitals and maybe even to determine reimbursement to hospitals you might be prejudicial against hospitals that are in high pollution areas versus low pollution areas.

And this notion would be actually relatively easy to test both in this application and the next one. If - because almost all of the hospitals I think they will be regional county level particulate measures. And one could enter that in the model and see if there was a significant reduction of variants.

So, you know, I think it's important to do our best to risk adjust the hospitals as well as the patients.

Reva Winkler: Great. Okay. I think Elizabeth Drye from Yale is on the line. Liz, did you want to comment?

Elizabeth Drye: Yeah, hi. Thanks for the excellent summary. Per Dr. Edelman's question, I think I first just wanted to clarify his comment about prior - his concern is that we do adjust for risk factors accumulated from - that we accumulate from the patient's inpatient or outpatient stay.

So if the patient's been admitted prior to the admission we're looking at, the index admission for the one we're evaluating for readmission, we will gather those risk factors for those patients.

You don't adjust - I think you were mentioning this - I mean I think this is what you were getting at for how many times they have been admitted, in other words, that they've been in the past year. Is that what your particular concern was?

Dr. Norman Edelman: Yeah. Yeah, you want to know - I think you want to know whether this is a patient who is prone to frequent exacerbations because most people recognize that now as a separate phenotype in COPD.

Elizabeth Drye: Yeah. And I'm going to ask my colleague Peter Lindenauer to speak to the phenotype issue.

But I'll just say one of the reasons we don't adjust for the sort of conundrum it presents to try to adjust or something like that is that if there are hospitals that frequently - that don't do a good job discharging and doing follow up care - arranging follow up care during transition to the outpatient setting or if there are house systems more broadly that really rely on hospitals for a lot of care.

And don't handle patients well in the outsetting, those are the systems that will have high both admission and readmission rates. And we don't want to adjust that away.

I hear what you're saying that maybe a patient factor but it also can be - frequent admissions can also be the exact system problem we're trying to bring out in this measure and so...

Dr. Norman Edelman: I agree with you.

Elizabeth Drye: ...that's our dilemma there. I don't know Peter, if you wanted to comment on this.

Dr. Norman Edelman: In order to make that valid you'd somehow have to know that institutions that you're comparing to each other had the same level of the frequent fliers because it is a patient factor as well as a hospital factor.

I think that's what the new information is and it requires some sort of caution and I'm not sure I can tell you what sort of caution it would be right now.

Peter Lindenauer: So I mean I - this is Peter Lindenauer. I think it's an interesting point and this is relatively new information within the world of COPD that there do appear to be frequent exacerbators and there may even be genetic markers associated with the frequent exacerbator phenotype.

But I think Elizabeth's point is a critical one which is that, you know, obviously in a measure intended to evaluate hospital performance on the basis of readmission rates adjusting for the - that very outcome that is of interest is problematic.

And if there were other data available about the patients that we could use to identify that frequent exacerbator phenotype other than their - the number of times they've been admitted that would be helpful. But I'm not aware of any other...

Dr. Norman Edelman: As you know, there are none at the moment.

Peter Lindenauer: Yes then, you know, then the factors that are in the model. And I think to your point which is that you also would have to presuppose that there were differences across hospitals in the proportion of patients with this frequent exacerbator phenotype makes me less concerned that that would be a cause for, you know, significant bias in the measure.

Dr. Norman Edelman: Yeah. I take your point.

Elizabeth Drye: I just would add to your other point about particulate air pollution. I think that's a great point. I don't - we haven't tried to bring in environmental factors at the hospital level into these measures. It's not easy to do but probably not impossible to do and I think substantively it's a great point.

At this point I don't think we can, as a practical matter, modify the measure in that direction but I think it's something we should be thinking about.

Dr. Norman Edelman: Well if it's too hard to do I mean to me it's not hard to do. The data are readily available.

But if it's too hard to do then my suggestion is you consult the rather extensive literature on this and come up with some estimate of the level of uncertainty or bias that could be introduced by this in going forward in using this metric.

Elizabeth Drye: All right, thanks for that point.

Reva Winkler: Any other comments or thoughts from committee members on this measure, the readmission measure?

Male: I would just like to echo that it's certainly worth testing that the air quality is as Dr. Edelman suggested. And even if you can't modify the measure in a timely fashion you could test it and roll it - and potentially roll it out as a factor. And that would be very helpful for - in our deliberations.

Christine Stearns: This is Christine Stearns. Could I just ask are you looking to ((inaudible)) the air quality at the hospital or the patient, I mean in New Jersey we travel a lot to get to hospitals ((inaudible)) might be a little difficult.

Male: You'd be able to do...

Dr. Norman Edelman: Well the best you'll get is county level. So...

Male: And Medicare has zip code data.

Christine Stearns: Okay.

Dr. Norman Edelman: Well but there's no monitoring at a zip code level.

Male: But they should be able to map that to a county.

Dr. Norman Edelman: Yeah. So the best you'll get is - Medicare, you're right. So Medicare has zip code data. You could easily allocate that to a county and not all counties in the United States have monitoring but the majority do. And those data are collected by ETA. It's not hard to get.

Elizabeth Drye: Okay, well I'm not sure as a practical matter what we'll be able to do in the very short term but we'll follow up with you on that. I actually started my career working on air pollution before I went into medicine and I'm very sympathetic...

Dr. Norman Edelman: That's wonderful.

Reva Winkler: Yeah. This is Reva. Just one other comment - Steve when you were presenting - first discussing it you talked about this being a measure for Medicare patients.

But I would like to point out that this measure is designed for two cohorts - one for the Medicare population which indeed is what we're used to seeing reported on Hospital Compare for other conditions.

But they have also tested this measure in an all pair data set to determine whether the risk model is applicable for all ages. And indeed the rather lengthy supplemental technical document around the testing and used in this - in an all pair data set has been shared with you.

And so the specifications do allow for the broadest population as well as just the Medicare population.

This expanding beyond the Medicare population has been something that stakeholders have really pushed for with the earlier, you know, heart failure AMI type measures and within the last year that testing has been done.

And so pretty much all of these measures that were originally just for Medicare have been tested and found that they can be used in an all ages all pair data set. So I just want to make - to point that out.

Dr. Steven Grossbart: Thank you. And that doesn't change...

Reva Winkler: Okay.

Dr. Steven Grossbart: ...my assessment.

Reva Winkler: Okay. So anything else on measure 1891, that's the readmission rate? Okay. You guys are also an efficient crowd. So the next one is another new measure, really the companion measure, Measure 1893 which is the 30 day mortality rate for COPD.

And Dr. Edelman, you kind of started alluding to the similarities of the two measures and perhaps you'd like to just talk about any particular differences?

Dr. Norman Edelman: Well so they are similar. I think for this measure the - for me the issue of air pollution is more important because this is all cause mortality. And in fact air pollution is as important in predicting cardiovascular mortality as it is in predicting respiratory mortality.

I think the air pollution issue is stronger in this. Otherwise I think the issues are the same. There are a couple of things I've highlighted. I think the, you know, the measures are clear and simple to measure. The reliability is assessed as fair and that seems - it's probably correct.

And somewhere in here it points out that there are currently no accepted approaches to distinguishing between hospitals. Am I right about that? So one wonders - yes, page 20, analytic method - method for discriminating hospital performance has not been determined.

So that - I don't quite understand that so if there is no method for discriminating amongst hospitals a why are we doing that, are we going to report data that seems to show differences between hospitals but in fact the differences have not been determined to be statistically valid?

So that's my major question.

Elizabeth Drye: Reva, would you like me to answer it?

Reva Winkler: Yes. Go ahead please.

Elizabeth Drye: Okay. And CMS I think is on the line too. So I think our language could have been more clear there. But the models as you know produce a distribution of risk standardized mortality rates.

And the similar measures that are in public reporting for AMI, heart failure and pneumonia, we build a confidence interval around that - the rate for every hospital.

And truly CMS has made a policy call to identify hospitals that are better than average statistically, at a 95% confidence level or worse than a typical hospital. And so that's how we distinguish among performance with these rates in public reporting.

We use - it's really - there's an interval estimate but it's ((inaudible)) a confidence interval. And CMS is using, you know, what is a pretty strict test. If you're 95% sure that your whole entire confidence interval is above average, higher than average than your mortality rate would be worse.

And if it were below then your mortality rate would be better. And so we identify hundreds of outliers that way better or worse hospitals.

This measure we would - we haven't run those numbers for this measure and then the exact approach you take, how many years of data you use, whether you stick with the 95% confidence interval or not. That will determine how many outliers there are if that's the way CMS wants to go.

So that's what we meant when we a bit cryptically, I see now, said, you know, the measure of determining or distinguishing performance has not been decided. It just means CMS hasn't decided how they'll apply an uncertainty estimate and display the result yet.

Dr. Norman Edelman: Okay. So now I understand what you meant and thank you for the explanation. But I don't understand why you decide on your criteria post talk. I mean do you have a preset idea of how many hospitals you want to define as good and bad?

Elizabeth Drye: Again are you going to see if CMS is on the line and they can speak to that? We don't have a preset idea and there, you know, there are choices. The more certainty you demand in your confidence interval but your outliers you have. And I mean I have an opinion but I'm the measure developer.

The measure is flexible in how it can be used. So that...

Dr. Norman Edelman: Clearly. And in other words...

Elizabeth Drye: We're not sure that there are going to be outliers but I couldn't tell you how many unless we ran all those numbers and put the choices out there.

And it's not - once the measure is approved again I wouldn't want to lock CMS into any particular - or if someone uses on alternatives that' snot into any particular approach of saying which, you know, how they want to draw the line when hospitals are better, worse or no different.

Dr. Norman Edelman: Yeah. Another word for flexible is arbitrary. I've made my point.

Elizabeth Drye: Right. I think I...

Dr. Norman Edelman: Thank you.

Elizabeth Drye: And I would just say I mean you have to make a choice and the goal in all of this is always to be really transparent. So when the similar measures like a pneumonia measure is

displayed on Hospital Compare currently the confidence interval is displayed and the, and, you know, it's described.

So if you're - you do - it's challenging for outcomes measured so they'll have uncertainty as you know. But our goal is to just be completely transparent. So whatever decision is made for reporting that arbitrary, you know, that decision is very clear to people so they can interpret the results.

Male: You know, that said CMS has, in the other measures, pretty much said that half the hospitals in the nation aren't going to get value based purchasing dollars for - because they're below the targets.

So if you don't hit the 50th percentile you're not in the - you're not going to have potential for earning any payback. So in effect there are penalties for half the hospitals.

Dr. Norman Edelman: Yeah. That's like no child left behind. Everybody has to be above average.

Lein Han: This is silly. I'll say - Lein are you on the line? Do you want to answer this?

Dianne Jewell: Yes. Hi, I tried to - hi, this is Lein Han, CMS. I tried to wait until I hear more about other people, what other people thing. And I - Elizabeth is right. And when we submit this measure to NQF we were thinking that we're submitting the measure to NQF to endorse our methodology.

And for - so for the IQR, the public reporting, if Elizabeth explained that we used that methodology, competency interval and for COPD I don't think that CMS has decided whether and how we're going to use the COPD measures for value based purchasing or for payment purpose here.

So - and then the payment methodology I - CMS will publish the rule this year. We haven't made the rule yet, how we're going to calculate the payment method. And I believe what you are referring to is what the law says in the Affordable Care Act.

But what I'm trying to say is that we come to NQF and ask for endorsement of the methodology. And we have not decided how we're going to use these measures or whether we're going to use this measure. But the intention is to use it for public reporting so far.

Dr. Steven Grossbart: Steve Grossbart here. And this is really a point of clarification for the NQF staff.

Whether or not CMS has determined how to use the methodology the active endorsement by the NQF is basically where as a committee and ultimately the NQF membership are saying that this measure is appropriate for accountability and public reporting and value based purchasing. Is that correct?

Reva Winkler: Well certainly for accountability. And public reporting have been - are sort of the watch words. And those encompass any number of things including payment incentives and the like. So that's exactly right.

We don't - I mean NQF's endorsement really includes assessment of the measure, how well it performed, how well it can, you know, provide valid and reliable information about performance.

How any particular entity such as CMS or anyone else might use that in any kind of particular programs whether it's public reporting or payment or whatever, is a little beyond the actual endorsement of the measure so that line is a bit fuzzy because there are implications for how the methodology can produce information and the kinds of information that could potentially be used in any number of ways.

Male: But if it's not endorsed I thought, my understanding was it would be more difficult for CMS to use it for accountability in public reporting or value based.

Reva Winkler: Yeah, I mean CMS is - okay Lein did you want to comment?

Lein Han: I saw the question is about, you know, the threshold, the benchmark and the confidence interval, you know, to exactly how CMS is going to determine. I don't think we have any decision made about that yet. And also I don't think we come here to propose that method and ask for endorsement.

So I need NQF to clarify that too.

Reva Winkler: No, and that's what I just said.

Lein Han: Yeah.

Reva Winkler: That's what I just said. I mean we don't know that. And but Steve to your question is, you know, CMS does look to NQF for a - our process to evaluate the measures and grant the endorsement and so it's been a good relationship going forward.

And so if there are issues and concerns about the measure that make people uncomfortable about potential endorsement I think we want to raise them, I think we want to discuss them, give CMS an opportunity to respond to them, things like that.

Any other questions Dr. Edelman, Dr. Grossbart, any of the other committee members? Christine or Dianne, did you have any questions about this? I think the acceptability of outcome measures out in the field is - has grown tremendously in the last several years.

I think a lot of the initial anxieties around them have - are lessened though outcome measures are more challenging. They're methodologically more complex.

Dr. Norman Edelman: I'd just like to say one thing. And I take CMS's point of view and I understand our job is really a technical job.

But I - for this measure, for mortality, I really think ambient levels of particulate pollution are potentially important. And I think the methodology exists and the data exist for that to be tested.

Reva Winkler: Okay. And I think that message has been, you know, relayed to the developers for their consideration. Anyone else on the workgroup? Any other comments for this measure before we move on?

Dianne Jewell: I don't have any comments. This is Dianne.

Reva Winkler: Okay. All right, then let's move onto the next measure on our agenda. This is measure 179. And this is a measure that has - is primarily used in home healthcare around improvement in (dysnea).

And this is the percentage of home health episodes of care during which the patient became less short of breath or (dysnic). This is an outcome measure and Christine did you want to kind of share your thoughts? Christine did I lose you?

Christine Stearns: I apologize. I had you on mute so that you all missed...

Reva Winkler: Okay.

Christine Stearns: ...my brilliant thoughts. So but I - let me start with a disclaimer since I don't have a clinical background. Is it (dysnea)? Okay, so thank you. So I looked through this one and so the information that we have indicates that there have been improvements in the measure over time.

It looks like we first - it was first approved by NQF back in 2009. However, the information that we have doesn't tell us what those improvements are. So perhaps after I finish we might be able to get that information at a later date. It suggests - there is a suggestion that the agencies are improving here.

I guess perhaps as were needed to there's now being a publicly reported measure.

So we don't have the specific details nor how many patients are in the affected population although there is information in the submission that does suggest that a large percentage of certified home health agencies are in fact reporting this information.

There does seem to be a significant performance gap. I guess they're at 62% of patients that are showing improvement upon discharge. They do ((inaudible)) for improvement.

In terms of evidence there is some evidence but none of it being specific studies, they don't support home healthcare interventions for patients with COPD. And so I think that was sort of the highlights. If anyone has any questions or anything else to add ((inaudible)) through the submissions.

Dianne Jewell: This is Dianne Jewell. I guess this is probably for the measure developers if they're on the phone. Which patients are we talking about? Any home healthcare patient with any diagnosis?

Reva Winkler: Do we have any...

Deborah Deitz: Hi. This is Deborah Deitz from (APT) and working on the CMS team at that. Can you hear me okay?

Reva Winkler: Yes, thank you.

Deborah Deitz: Sure. This is for all Medicare and Medicaid patients who we have not restricted them by condition. It's based on the information that's collected versus - via the Oasis assessment. And it's all adult, non maternity Medicare and Medicaid patients who are receiving skilled services.

Dianne Jewell: And then until they are discharged?

Deborah Deitz: Yes. It measures their level of (dysnea) at the time of admission and their level of (dysnea) at the time of discharge in comparison.

Dr. Norman Edelman: (Dysnea) is kind of like the opposite end of the extreme from death. It's a very subjective, difficult to measure symptom and I guess this shows my ignorance in knowing how to use this tool.

I could not find the specific tool that was to be used to measure (dysnea) and the assessment of how reliable it is. There's a recent review of (dysnea) in one of the lung journals pointing out that it's an exceedingly difficult thing to measure.

Deborah Deitz: The - I'll tell you that the Oasis assessment asks the clinicians who measure and report, whether or not the patient is having (dysnea) with minimal exertion and describes what that is, with moderate exertion which is walking distance is less than 20 feet and a few other things and also when walking more than 20 feet. So...

Dr. Norman Edelman: So is that a questionnaire? Or is the patient actually exercised?

Deborah Deitz: This is the guidance for clinicians is that this is to be that, you know, evaluated by observing the patient.

Dr. Norman Edelman: By exercising the patient. Is that correct?

Deborah Deitz: Yes.

Dr. Norman Edelman: Or is it just guessing what that might be?

Deborah Deitz: It is supposed to be administered by actually seeing what the patient does in their home.

Dr. Norman Edelman: Oh. And I - obviously I missed the testing of the reliability and the validity. But is this a reliable test?

Eugene Nuccio: Hi, this is Eugene Nuccio from the University of Colorado. When we developed the original instrument for Oasis we did field testing of the reliability of that instrument. And I believe that information was sent to NQF, the data that we had for that.

Let me go back to your previous question regarding the scale that is used. It is a - it's a behaviorally benchmarked scale, a five point scale where the patient is in fact observed walking around or moving around in their home environment - in his/her home environment.

So it is based on observational data that's taken at either the start of care or the resumption of care.

The behaviorally benchmarked options are fairly precise in terms of for example, moderate exertion is described and checked with, you know, while dressing, while using a commode or bed

pan or walking a distance less than 20 feet so that there are benchmarks that are in the - on the item itself that the nurse is using.

And there's also a guidance manual that goes into additional detail. Regarding the validity and reliability of that instrument the - using the standard scale for reliability it was judged to be either very good or excellent in terms of its reliability in the field testing.

We have not changed the item since the field testing that went on back in about 1999, 2000.

Christine Stearns: And I am correct that all of this information is captured electronically and therefore that has all captured that there - I think on page 14 you discussed that you have - you go out and audit the information to ensure that it is (accurate)?

Eugene Nuccio: Currently what happens is Medicare or state surveyors will go out and check the patient records for documentation within the assessment notes. And to make sure that those corroborate the scoring on the assessment, Oasis assessment instrument itself.

So that's sort of an ongoing thing. What I was referring to was based - was back at the very beginning of when the item was developed. And again I emphasize that the item has not been changed since the time of that analysis.

That our records - the data show from three different assessments that we were in - we had highly reliable results.

Christine Stearns: Great. Thank you.

Dr. Steven Grossbart: Steve Grossbart here. I have a question. This is not truly, although the data is available electronically that's because the home care agency enters it into the Oasis database

manually. I mean so this is really not data that's collected directly during the delivery of care. It's the billing process isn't it?

Eugene Nuccio: It is the - the data are collected at a visit that typically lasts about two hours or so at the start of the care or the resumption of the care. So it is the initial clinical assessment of the patient.

And then the information - the other end of our care episode is based on the discharge survey again using the same item and again the same home visit to the patient.

Dr. Steven Grossbart: But there's no formal electronic health or eSpecification around this measure?

Eugene Nuccio: I'm afraid I don't understand what your question is.

Dr. Steven Grossbart: That the data is not flowing from an electronic health record into Oasis. It's flowing from data collected from the medical record. Am I missing something? I mean is that...

Eugene Nuccio: The Oasis instrument or assessment instrument is either a paper and pencil or an electronic based assessment tool that the nurse or the physical therapist would go out to start...

Dr. Steven Grossbart: They complete it in the presence - they complete the Oasis form in the presence of the...

Eugene Nuccio: Yes.

Dr. Steven Grossbart: ...patient? Okay.

Eugene Nuccio: It's not a data extraction if that's what you're asking.

Dr. Steven Grossbart: Yes. That's helpful.

Eugene Nuccio: Yes. The survey that occurs of the agency is a comparison between the medical record of the patient and the data presented using Oasis.

Dr. Steven Grossbart: But this is an additional step to the care delivery process as opposed to an electronic health record where data is collected during the process of delivering care and then used for reporting.

And what I'm really trying to get through is, is the measure - is there going to be a time when the measure is no longer a regulatory burden but rather is collected during the process of care and then used for regulatory reporting. This is an add on step.

I mean the home health agencies would not have an Oasis tool if it was not mandated for conditions of participation.

Female: The Oasis is actually integrated into that part of the requirement. But it's actually integrated into their assessment process so that they don't ask their - they don't do their own assessment of (dysnea). It's part of...

Dr. Steven Grossbart: Okay.

Female: ...the care planning process.

Dr. Steven Grossbart: That's helpful.

Dianne Jewell: This is Dianne Jewell and I was - I'm looking on page 11 which I realize the measure developers can't see. But are there really 83 risk factors in your risk adjustment model?

Eugene Nuccio: Yes, there are.

Dianne Jewell: Holy cow.

Eugene Nuccio: We have - we do our data model - our risk adjustment model makes use of items from the Oasis instrument, other items from the Oasis instrument. It does not use demographic information such as race or SES. It does make use of age.

It - the number of variables was slightly inflated in that to ensure that we account for the fact that our scales are ordinal, not interval. We dichotomized each level of each scale...

Dianne Jewell: Right. Okay.

Eugene Nuccio: ...so that a scale that has five options okay, ends up with five - an item that has five options, behavioral options to evaluate ends up with five variables and that's why we end up with such a large number of variables.

Dianne Jewell: Okay. Forcing that number thinking. Okay, but that makes more sense.

Dr. Steven Grossbart: Can I follow up to that?

Dianne Jewell: Absolutely.

Dr. Steven Grossbart: So you've got 83 variables, how many classifications or categories does that truly represent? So that said...

Eugene Nuccio: They would probably represent about four or five...

Dr. Steven Grossbart: Okay.

Eugene Nuccio: ...classifications. There'd be functional. There'd be -we have a set of diagnostic groups that are used and then we have physiological and psychological characteristics also.

Female: And I apologize. I didn't have a chance to - I realize a lot of this is online as for the detail and I didn't have a chance to go and investigate all of this. But given the very low (R Squared) that you're reporting is there any thought to or maybe you've done this and it didn't pan out to be anything.

But really looking at stratification or sub analyses of some of these sub groups, either diagnostically or otherwise?

Eugene Nuccio: I think we have looked at various stratifications. The intent has always been to report the value for - in a collective kind of model because many of our agencies are - have a small number of patients.

If you then end up with a stratification situation then you end up having many agencies for whom you can't provide a - some information.

Female: Okay.

Eugene Nuccio: And the model - the (R Squared) while it is pretty low, is still really better than many of the other publicly reported measures and other settings. So...

Female: Okay, thanks.

Eugene Nuccio: Good.

Reva Winkler: Any other thoughts or questions from the workgroup members for this measure? All right.

Then I guess we can move onto the next one. The next two measures are from NCQA. The first one - 549 is pharmacotherapy management of COPD exacerbations.

And Dr. Grossbart, I think this is yours.

Dr. Steven Grossbart: Thank you. So this measure looks at patients 40 years and older during a calendar year who the numerator being an acute exacerbation of COPD and who had - were discharged and dispensed medication. So the patient needs to fill the prescription.

And the denominator is any COPD patient in that age group who's been discharged from an acute care or inpatient setting. The impact is - of the measure is relatively high. The developer makes a compelling case for the importance of - or the significant impact in the population costs and so on.

I didn't see as quite as robust assessment of the performance gap. The evidence cited is very similar to measure 102. I believe that I've got my numbers right.

But the question I have is the developer rated the evidence quality high and I didn't see that the evidence was significantly different from the evidence that was rated moderate by a different developer for a similar measure. So I thought that was - the evidence was not as robust as the developer has stated.

Reliability and validity - I do have - well I - it was not the most robust discussion and I'd like some clarification about - from the developer. I'm just looking through the testing results and the reliability and validity of the data. I had trouble interpreting. I'm flipping through my list.

You know, in terms of usability this measure has been used by the NCQA for some time. And so there's - but it - I think some of the usability issues that I found, it's calendar year data and it's health plan specific rather than patient specific.

I didn't see a strong sense of how this data is being used for quality improvement or if through all the years of collection, quality has improved. And then finally moving onto feasibility, it's a mix of data types. The - so let me get - give you a page number. I'm sorry I haven't cited page numbers.

So page 17 - a mix of data generated by healthcare personnel but coded secondarily through claims. There's no eSpecifications. This is not being driven off the electronic health record where appropriate.

There are some advantages to having the claims data such as filled prescriptions as opposed to, you know, the provider provided the prescription. But there is, you know, per the claims process it's - the reliability of the data is not as robust as if it was coming from an electronic health record.

And that's my summary.

Reva Winkler: Great. Comments from the other workgroup members? All right. Let's see if we've got the measure developer on the line. Is anybody from NCQA on the line? Operator, would you check and see if anybody from NCQA is on the public line perhaps? I think we're looking for Ben Hamlin.

Ben Hamlin: Yeah, hi Reva. It's Ben. Can you hear me?

Reva Winkler: Yep. Got you now.

Ben Hamlin: Okay. Yeah, I'm here.

Reva Winkler: Okay, great. Did you hear Steve's comments?

Ben Hamlin: I did. And so yes, I mean so basically the performance improvement component or the gap issue, you know, we have seen - we stratify this by different product lines and by the two medications in particular. We have seen an increase in performance.

We have seen a slight variation decrease over the multiple years of data collection although there still is, if you look at the (Quintel) information that's on pages 14 and 15 for the different product lines from 2010, you know, 2008 through 2010 it goes back a little further but that's because of the - we usually give them the last three years worth of data.

You will see a slight narrowing for most of these where there is some leveling. But again it's, you know, there is a considerable variation in both the means and the percentiles. So we feel that it is still a measure that has some way to go.

We're looking for again follow up, you know, following exacerbations, the discharge base measures so it's a member discharge base measure and not a, you know, a patient specific. This is a measure that we have also seen a decrease in the population, the elderly population size over the years.

So even though the rates are increasing, you know, it's a proxy for how well the plans are managing people with COPD to prevent exacerbations. And we have seen a decrease in the population number of discharges overall.

So we also feel that that's an improvement in the measure of performance even though it's not reflected directly to the rates. As far as the eMeasure specification all of our eMeasure work right now is being driven through our meaningful use project.

So we're not codeveloping eMeasure specifications for any of our measures at this time. I believe the other measure is currently being developed in our meaningful use. This one is not as specific at the moment.

Reva Winkler: Steve, did he cover all your questions?

Dr. Steven Grossbart: Yes. The only other question I have and this may not be the appropriate time, is are we going to be doing the side by side of the similar measures?

Reva Winkler: Yeah. Yes. We've got several in this project; we've got several in the asthma group as well. We've prepared the side by side that I think you've seen in your SharePoint files.

What we like to do is do the first initial evaluation of all the measures because it - perhaps there is a significant problem with the measure that you don't want to recommend it. Then we don't need to even, you know, put that into the mix of comparisons.

So that's why we want to do the first go through of all the measures on their own. And then absolutely it will be a very important part of our meeting and discussion, will be to put these very similar measures side by side and ask the question, you know, do they all add value? Do they work together?

Do we need them all?

Dr. Steven Grossbart: Thank you.

Reva Winkler: A very important conversation on related and competing measures.

Ben Hamlin: Right. But I think...

Reva Winkler: Any other comments?

Ben Hamlin: I think some of the - in this ((inaudible)) are the age ranges where, you know, we're at 40 and I believe the other measures are at 18. Again since we're getting this out of, you know, purely administrative claims we've been testing the things like concomitant diagnosis of asthma and COPD.

And we found, you know, there's more noise below the age of 40. You know, it's kind of where we decided to start that threshold.

You know, other - I'm trying to think of some of the other differences I can't form off the top of my head but that's sort of why I think there may be some variation because of the setting for the accountability that we use these measures for.

Reva Winkler: Okay. Anything else, Steve? Any of the other workgroup members?

Female: Nope.

Reva Winkler: No? Okay. All right. Then we can move to our last measure which is also from NCQA. And we're going to go back to where we started which is spirometry testing again. And this is Measure 577, use of spirometry testing and the assessment diagnosis of COPD.

The percentage of members age 40 years and older with a new diagnosis of COPD or a newly active COPD who received appropriate spirometry testing to confirm the diagnosis and Dianne I think we're back to you.

Dianne Jewell: Yes. I'm the bookend today. So as Reva just described this measure is specified differently from the first measure I reviewed in two important ways. One is of the lower end of the age range which is at 40 as compared to 18 on the prior measure.

And the other is that this measure is more clearly specified to address confirmation of new diagnosis or newly active COPD which is much more consistent from - at least from an interpretation standpoint with the guidelines as compared to the previous discussion that we had.

There's clearly plenty of evidence, I think we can all agree and I don't know that anybody is going to debate this but the impact again is high.

And to a point that was made earlier, both the impact in terms of confirmation of appropriate diagnosis, not under diagnosing and not over diagnosing but appropriate diagnosis. The issue related to performance gap, the results are actually later on in the document for those of you that were reading it.

It's not contained in the first section of the document. But it's clear that at the health plan level there's quite a variety of performance of this measure. So I think the case has been made there.

The issue related to disparities - the NCQA has made the case that the measure is not currently configured to detect that and that it's burdensome to be able to do that at this point in time.

And so one of my questions to the measure developers is this issue of how you're looking to deal with this going forward given that published evidence is pretty clear about the presence of disparities in this area. Reliability and validity data are presented. The reliability is high.

This has been used for some time now in the (HEDIS) system so there's a good data set there to evaluate reliability.

The validity presentation - I was a little confused by the - I'm trying to find the page number here, by the title above - by the labels ahead of the actual data because it talked about numerator results. But I was under the impression that these were raised so I was confused by that.

But they're broken out by plan level and again there's a reasonable range between the 10th percentile and the 90th percentile. If I'm understanding these data appropriately it looks like there's a lot of room for improvement given that it's the 90th percentile where it's 52% in the commercial area.

But I'll take clarification on that if I need it. The usability and feasibility issues I think are pretty similar to what was just identified in the prior measure. You know, this is a plan level measure. At least it seems that - it looks like it could be used at other levels.

But in this particular system it's the plan level with the (HEDIS) system. I'm not clear what kind of improvement has been generated over time given that it's been in play for a little while so that same question there. And other than that I didn't really have any other thoughts.

Ben Hamlin: Okay. So this is Ben again. I can take the lab question first. We have noticed a modest improvement over time, not nearly what we would have expected. You know, as you noticed, the rates even across the highest quintiles are fairly low and so we would like to see, you know, better improvement there.

To address the disparity issues this is actually true across all of our measures in the (HEDIS) health plan populations. We continually test the availability of appropriate race, ethnicity, SES data in these large data sets.

And the variability is so high such that some plans have 98% complete data, other plans have 0% because they actively do not collect this information for either legal or ethical or just, you know, business model ideas.

NCQA is working very hard right now to specify what disparities data should be collected and we're going to recommend that.

We've also worked with CMS on the eMeasures side for the recent blueprint update on, you know, what information should be collected in EMRs as far as race, ethnicity and SES and so on and so forth. And there's a move now toward standardization.

But until it's mandated we don't expect to be able to reliably collect and report out that data and stratify our measures in that regard.

We're hoping that it will come soon but since it's all voluntary right now and there are still some issues around the reliability of the data collection depending on who's collecting the data and how it's being presented in the administrative plans or even in the EMR environment.

We're not ready to release a measure that is stratified, you know, holding people accountable for those disparities.

Dianne Jewell: That addresses my questions. I don't know if other folks have questions or thoughts about the measure.

Male: Minor question - under net benefit the proposal indicates that it promotes smoking cessation, administration of influenza and pneumococcal vaccine. I wasn't aware of that. Do you have data that show that?

Ben Hamlin: Not directly. No. We have - part of our work...

Male: I'm pretty sure smoking cessation is wrong. I'm not sure about the others.

Ben Hamlin: Okay, yeah. I think the idea here was that during a - during the assessment process, you know, ensuring that the vaccinations that are recommended are the guidelines that help lead to improved outcomes in COPD management, might include conversations around smoking cessation and ensuring that, you know, pneumococcal and influenza vaccines have been given in the appropriate timeframes.

Obviously for flu, you know, annually. As part of...

Male: No. I understand the idea but I think the literature don't show that that takes place.

Ben Hamlin: Yes, well we - and we actually have several measures that are trying to address those specific issues and we're trying to fold them into a composite for COPD. Unfortunately most of those, you know, even the flu vaccines and the pneumococcal vaccines are not really well represented in claims data.

So we're looking at alternative methods for incorporating those into more comprehensive COPD composites.

Reva Winkler: Any other comments? This is Reva. Oh, I'm sorry.

Dianne Jewell: No, go - I was just going to say - this is Dianne. So I realize we'll, you know, talk more in the steering committee about the side by side comparisons.

But I have to say that even - this measure strikes me as considerably cleaner than the prior measure from the standpoint that it really is specific to the place where we know the guidelines are clear about the usefulness of spirometry number one, which is the confirmation of the diagnosis and not the more abstract sort of notion of when you might use it.

And number two, I really don't see the value add of having the age range to 18 when the average age is in the 50s. And even if you drop it below that you're talking in the mid 40s. I'm worried that that encourages over utilization.

So I'm open minded to be convinced otherwise but there's a certain, you know, that's - when I put them side by side those are the things that stick out in my mind.

Christine Stearns: This is Christine. Can I, before we move on, just ask one question about the denominator? The member is required to be continuously enrolled for 2-1/2 or two years.

In that I just question whether there is a concern that that will be a hurdle particularly I guess for the Medicaid population since many members in Medicaid plans do not necessarily have continuous enrollment.

You know, that it needs - do you sort of test it to see if that is going to be a challenge, that two year continuous enrollment?

Ben Hamlin: So yes, it is a challenge. It's not a barrier however. Our Medicaid continuous enrollment criteria has a lot more of the guidance around inclusion of gaps in those coverages and understanding how the Medicaid population generally works.

Christine Stearns: Okay.

Ben Hamlin: You know, we want to ensure that the plan has data on this person for the appropriate amount of time.

And given we need to have sort of the negative diagnosis history and, you know, for the ensuring of the new diagnosis we want to, you know, we don't want to hold them accountable for something where they just - when someone switched they don't have the data but it's not really a new diagnosis.

And we want to avoid the over utilization component. You know, so again we always look at that but yeah, it is - it probably is - it does limit the denominator population a little bit given the fact that, you know, there are not a lot of people - or there are - there's probably a fair proportion of people who may get eliminated because they may not have - meet that longer term enrollment criteria.

The Medicaid population is also smaller because of the 40 and older. And in our duals we generally default to Medicare I think in our - for our dual eligibles. So it's a pretty small population to begin with I think.

Christine Stearns: Okay.

Female: Anything else from other workgroup members?

Reva Winkler: This is Reva. I have one question for you Ben. You listed that the level of analysis for this measure is potentially at the clinician group practice or individual level as well as planned level.

Are you aware of this measure being used at a clinician group level and have you tested the measure at a clinician or group level?

Ben Hamlin: We're aware of it being used at the clinician level. We haven't - we don't have any testing data for that right now though. So this measure is in terms of broad use. We only regularly collect the (HEDIS) data collection which is what we provided you.

But, you know, we feel it's relevant to - at the provider level as well for ensuring a new diagnosis.

Reva Winkler: All right. Okay, I think that gets us through all the measures that are on our agenda today.

Thanks to everybody for focusing the conversation so we get through in a timely fashion.

Essentially what we're going to do is summarize your work, your discussion points, your ratings for the entire committee's discussion in - at the March meeting.

The - your - as lead discussants we will be asking you again at the meeting to introduce the measure and go through the criteria as you - pretty much as you've done today highlighting the issues and focusing in on the areas where there have been - raised some concerns or questions.

If based on the - your - the discussion today you want to change some of the ratings you may have submitted, contact Katie or Jessica and they'll help you do that. We can certainly arrange that.

This effort to try and go through these measures in a preliminary fashion is really meant to share the work kind of thing and to be able to make our meeting agenda in - for the in person meeting to be efficient and so we can get through the entire group of measures.

Are there any questions from the workgroup in terms of preparing for the in person meeting, the work you've done today and where we're - what we're going to be doing at the meeting?

Dr. Norman Edelman: Well what will take place between now and the meeting?

Reva Winkler: I think essentially not a great deal if you've already had a chance to go through all of this information. I know some of your colleagues and some of the other groups are kind of still working through some of the measures.

We will provide you with the summaries and that will give you a chance to review what was discussed today. You'll have the summaries from the other work groups and you'll see what the reviews were on the other measures.

And give you a chance to prepare yourself for the discussions as well as specifically prepare yourselves to lead the discussion for the measures assigned to you.

Dianne Jewell: Is Katie there with you Reva?

Reva Winkler: Yes, she is.

Dianne Jewell: Hey Katie, it's Dianne. I have the spreadsheet that you sent out so I will just amend my comments for the PCPI measure and email it back to you so that you have it.

Katie Streeter: Okay, thank you.

Dianne Jewell: You're welcome.

Reva Winkler: Okay. Any other questions from the workgroup? All right, then Operator could we open the lines for any audience members to see if there's any public comment?

Operator: All lines are open at this time.

Reva Winkler: Great. Does anybody want to make a comment, question? Going once, going twice, all right there doesn't appear that there is any comment. Any last chance questions from the workgroup? Then I thank you all very much for the work you've been doing, the evaluation, the thoughtfulness.

I know the time that you've invested in this is not - is not insignificant. We will be in touch with you as we get everything organized for the in person meeting.

For the workgroup members if there's absolutely anything, any questions, concerns or issues that you have please don't hesitate to contact any of us. That's what we're here for and we're happy to help.

And I really do look forward to meeting with you, meeting in person and getting to know you better at our in person meeting. But I really am very thankful for the work that you've done and for today's discussions. I think they've been very helpful and very thoughtful.

With that unless there are any last minute comments we've got a few extra minutes for your day.

Female: Okay, thanks.

Reva Winkler: All right, then...

Male: Thank you.

Reva Winkler: ...thanks to everybody.

END