NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
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3:55 pm CT

Melissa Marinelarena: Hi Bill. Are you on yet?

Bill Gunner: I am Melissa.

Melissa Marinelarena: Perfect, okay great. Let us get some - and I think we can go ahead and get we'll get started in about 30 seconds.

Okay we're going to go ahead and get started. Good afternoon everyone this is Melissa Marinelarena. I'm the Senior Director for the Survey Project here at NQF. I'd like to welcome everyone to the Surgery Project Spring 2019Measure Review Cycle. This is the first meeting of the spring cycle.

We are scheduled to have an additional two meetings on July 10 and July 15 we will talk about at the end of the meeting. I'd like to welcome my team here who we can introduce in a little bit and Elisa Munthali, our Senior Vice President and of course the Standing Committee, the Measure Developers, any members of the public and our co-chairs Lee Fleischer and Bill Gunner. Now there is the agenda. We're going to going to - I'm going to turn it over to Bill and Lee to say a few words and then they're going to turn it over to Elisa to do

the disclosures of interest and at the same time we're going to take roll and determine if we actually have quorum. As about 30 minutes ago we didn't but we will see who is actually on the call and depending on the number we will either vote on the webinar or vote after the webinar we could talk in more detail about that, going to do a quick overview of the evaluation process. I feel like we just did this. A - review the candidate measures. Today we're only going to go over two measures that you're going to vote separately on two of them and we'll talk in more detail about those. Then we'll have some intra member and public comment and then again we'll talk about next steps. So I'll turn it over to Bill and Lee to say a few words.

Bill Gunner: This is Bill Gunner, starting a new cycle. We're all pretty seasoned at this, hopefully we get quorum and there's no reason to, I don't think to belabor our introduction with anything other than this is there's two establish FTS measures and two new CMS measures so we're going to walk through and I think we all know the process so Lee, anything else you want to add?

Lisa Suter: Just that we did present the measures to the CSAC and were endorsed by that body. A key - we did bring up the issue of public reporting and how the two next steps in providing us the Surgery Standing Committee back with feedback about how to interpret the use and usability. And I guess were still waiting on additional feedback since the CSAC, my understanding, but the NQF can - staff correct that has yet to finalize but is very appreciative of the questions we forwarded to them.

Melissa Marinelarena: Hi Lee. Yes so that was the 50 measures that you reviewed in the last cycle. NQF I believe is going to start - combine a test...

Woman: Yes.

Melissa Marinelarena:…to review the issues around use for maintenance measures and there's more to come on that. Today STS did have some conflicts with their experts so asked that we hold off on reviewing their measures. And we may not have time anyway because we're going to review the CRS measures, their new measures. So CMS path for use does not apply to them because they're brand-new measures. They use will pop up next week and we'll - can have that discussion again next week but…

Bill Gunner: So Melissa…

((Crosstalk))

Melissa Marinelarena:…for now it's clean slate.

Bill Gunner: Yes this is Bill again. Do you want to touch base with regarding level of analysis at the provider hospital level and what discussions are being had around that or do we need to.

Melissa Marinelarena:We can talk about it - we could actually talk about it with these measures as well when we get to the measures I think because one of the measures, the hip and knee complications measure is specified…

Bill Gunner: Right.

Melissa Marinelarena:…at two different levels of analysis and there's the provided gap information and testing for the two. Again NQF criteria requires that testing that a measure be tested at the level of (unintelligible) like the level of analysis needs to match the specification. So that is like we're going to - they have a similar measure, Yale CORE CMS had a similar measure in readmissions. And when they introduce the measure they can probably tell us more about

that and Elisa too. I didn't sit in on that meeting but it does have some massive specifications. So I think we get into the measure we can clarify anything that you need about that. But yes specifications and level of analysis and testing need to match.

Bill Gunner: And also based upon the STS and the fact that we're different today I think it would be great to really determine that one of the two next days we have a quorum and make sure. So I would ask everyone on this call and anybody who listens to the tape or by email that we have confirmation that we can achieve quorum because I think that would be fair to those STS who live through not achieving quorum in the last round.

Melissa Marinelarena: Yes. And I did email Yale CORE before the meeting letting him know that we do not anticipate having quorum as well. And I think it's fair to prepare developers ahead of time so that they don't anticipate able right away. You know, it's not the process. It's not the ideal process but letting them know ahead of time that they will not have a decision on their measure. So I do urge everyone to attend and call your friends and tell them to attend as well.

Bill Gunner: So…

Man: Could I ask…

((Crosstalk))

Bill Gunner: Oh, go ahead.

Man: Could I ask one question on that?

Melissa Marinelarena: Yes.

Man: The - I mean I don't - I'm used to actually surveying the group putting out a bunch of dates and finding and getting feedback on dates when we have the maximum number of potential attendees. Have you thought about doing that to maybe increase the likelihood of having a quorum?

Melissa Marinelarena: We have - these dates were set probably close to a year ago. They were around the co-chair's availability. And when committees are staffed, the expectation is the dates are out there and that they do attend. We are exploring different ways of scheduling our meetings so that we can achieve quorum. You know, sometimes it's like herding cats trying to get everybody because we understand that people are busy and you are, you know, you're working experts. And we ask you to take time out of your busy schedules during the day to contribute to this work.

So any suggestions you have send them our way. We are, you know, welcome to any feedback you have to try to make this process better and keep everyone engaged and participating. So anything you have send it my way. And Elisa our boss is sitting right here in this setting as well. We hear you, yes we do.

Bill Gunner: So let's just be - and for - this will be if we don't reach quorum this will now be the third or fourth meeting where we did not reach quorum?

Melissa Marinelarena: Fourth.

Bill Gunner: Correct. And I think NQF has to take a hard look at that in relationship to the participants and the committee itself and the work that we do because quite frankly I - if I - speaking it on my own, if I were - I find this frustrating. I make every effort to even on vacation to participate. I know Lee has called in

from all over the universe to participate and make sure that the - that we get quorum and the work with committee gets done.

This is all about prioritization and I think NQF needs to - they're going to look at this and they're not in my opinion they should not look at the committee behavior as being in - really in alignment with expectation. So wherever that leads I can't - none not of us can blame NQF on how they respond to that. But having four consecutive meetings out of the blue when we've been meeting for years now nobody - we don't get quorum when we have been reaching quorum for years is a statement in and of itself. So…

Elisa Munthali: Yes, thank you very much. This is Elisa Munthali from NQF. And we agree and we also acknowledge the concern that quorum or the lack of quorum does create across all of our work. I will tell you that this is unfortunately in the recent months has not been unique to surgery. So what we are doing to your point this is a commitment that standing committees make as they agree to be on committees, volunteer to be on committees. And we can't thank you enough for your volunteer hours.

But we want to make sure that, you know, the folks that have taken the time whether it's the committee, whether it's developers, whether it's our members of the public that it is worthwhile. And so we are tightening up our guidance and our requirements for participation and are very closely tracking those that are consistently not participating or dialing in or attending in person meetings. And so these new policies will be rolled out at the start of the next cycle.

Bill Gunner: That's good.

Christopher Saigal: And…

((Crosstalk))

Christopher Saigal: This is Chris Saigal. I'll make a comment about that. I think it's very good to do that. I think that you should also maybe perhaps survey the people that aren't coming to understand what the reason is because just putting the guidelines in place you must do this you might have a further problem across our committees if there's a consistent reason that is addressable.

Elisa Munthali: Absolutely. We, you know, we redesigned our process two years ago and, you know, in response to, you know, many folks wanting to have more opportunities to submit, but we know it places quite a bit of hardship and work on you as well. And so we want to balance that out and we understand that that may be a contributing factor. So we want to see where we can improve or lighten the load if all things equal were able to, you know, perhaps give you something that is not as stressful to do if all those things equal, people are still not coming and then we place those regulations on top of that.

So I think we're going to start. So thank you. I even forgot that we weren't in the meeting officially but we wanted to -I just wanted to echo Melissa's thanks to you and welcome. This is Elisa again. as Melissa mentioned we'll be combining introductions and disclosures interest. And as you remember when you first came to the committee we asked you to complete a rather extensive disclosure of interest form. And so what we're asking for you to do today is to orally disclose anything that you provided to us but only as it's relevant to the work of the Surgery Standing Committee.

Just a couple of reminders before we go around the virtual table, you sit on this committee as an individual. You do not represent the interest of anyone who may have nominated you or your employer. We are interested in both paid and unpaid activities as they're relevant to the standing committee. And

lastly just because you disclosed does not mean you have a conflict of interest. We go through this process in the interest of openness and transparency.

And so I'm going to start with your co-chairs. I'm going to first start with Lee and then go to Bill. And then I will go down the roster of standing committee members as they're reflected on the screen in alphabetical order. So Lee could introduce yourself, let us know who you're with it if you have anything to disclose?

Lee Fleischer: Yes so Lee Fleischer from the University of Pennsylvania Department of Anesthesiology. And I was a pain consultant to Yale CORE for the 90 day mortality measure on their technical expert panel. I will disclose and I have no idea whether I was actually on it that I had initially volunteered for the - to work on the MIPS measures. I attended one meeting and disengaged entirely from the process. So I do not believe that is a conflict of interest so I never saw anything beyond the first meeting.

Elisa Munthali: Okay thank you so much and…

Lisa Suter: Is that acceptable?

Elisa Munthali: Yes that is acceptable. And just for the record that Lee is conflicted on 3494. This is the hospital 90 days all cause risk standardized mortality following coronary artery bypass/surgery. So thank you for that. Bill?

Bill Gunner: This is William Gunner. I'm Executive Director for The National Center for the National Center for Patient Safety at the Veterans Health Administration. I have no conflicts of interest with either measure today.

Elisa Munthali: Thank you so much. Robert Cima? Okay, Richard Dutton?

Richard Dutton: Yes I'm here. I have worked with Yale CORE in the past two but not on these particular measures.

Elisa Munthali: Okay thank you. (Samia)? Okay I understand you'll be joining us 15 minutes late. I think (Elizabeth) isn't with us. Frederick Grover?

Frederick Grover: Yes I'm…

((Crosstalk))

Frederick Grover: ...well I'm Professor Meritus here at the University of Colorado Division of Cardiothoracic Surgery Department of Surgery. And I represent the SCS and I basically think it's probably a conflict of interest for me to discuss almost any STS measure because I can be identified so closely with that database over 20 years. And even if it isn't a direct conflict of interest it would have the appearance of one so I routinely recuse myself.

Elisa Munthali: Thank you very much. And just for the record the two measures are 0733 operative mortality stratified by five-step mortality categories and the measure 2683 risk adjusted operative mortality for pediatric and congenital heart surgery. And I don't think those will be discussed today so that's for the record for the next time we meet so thank you. John Handy?

John Handy: John Handy, Thoracic Surgeon in Providence St. Joseph Health. No conflict of interest.

Elisa Munthali: Thanks John. Mark (unintelligible).

((Crosstalk))

Woman: Call got dropped.

Elisa Munthali: Okay so Mark is letting us know that his called dropped…

Mark Jarrett: Oh I'm back on. I just got back on.

Elisa Munthali: Okay Mark.

((Crosstalk))

Mark Jarrett: Hi, Mark Jarrett, Chief Quality Officer, Norwell Health, and I have no conflict of interest.

Elisa Munthali: Thank you so much. And I understand Chris (unintelligible) is not joining us today.

Barry Markman: Yes excuse me, this is Barry Markman. Did you call me or because I…

Elisa Munthali: Actually I'm about to call you very soon. I think Chris is joining us. (Barb Levy) are you on the phone?

Barry Markman: Okay.

Elisa Munthali: And Barry?

Barry Markman: Okay, good afternoon.

Elisa Munthali: Good afternoon. If you could just let us know…

Barry Markman: I have no conflicts of interest.

Elisa Munthali: Okay perfect, that's it. Thank you. (Amy Moyer)?

(Amy Moyer): Hi this is (Amy Moyer). I'm the manager at Value Measurement at the Alliance. We're a purchasing Cooperative for healthcare and I have no conflict of interest today.

Elisa Munthali: Thanks (Amy). (Keith Olson)? Okay I didn't hear (Keith). Lynn Reede?

Lynn Reede: Hi. Lynn Reede. I'm a Certified Registered Nurse and Anesthetist in the American Association of Nurse Anesthetist and I have no conflict related to the measures that we're talking about.

Elisa Munthali: Thank you. Christopher Saigal?

Christopher Saigal: Yes Christopher Saigal. I'm a urologist at UCLA.

Elisa Munthali: No conflicts I'm assuming?

Christopher Saigal: No.

Elisa Munthali: Okay (Salvatore). Okay and Alan?

Alan Siperstein: Hi, Alan Siperstein. I chair the Department of Endocrine Surgery at the Cleveland Clinic and I have no conflict.

Elisa Munthali: Thank you so much. I understand (Joshua Stein) isn't with us today but Larissa Temple? Okay (Bobby Whitaker)? Okay A.J. Yates?

A.J. Yates: Good afternoon, vice chairman for orthopedics at University of Pittsburgh School of Medicine Orthopedic Department. And I have worked with Yale CORE on a previous hospital risk-adjusted cost measure. And I am the link behind - I am still the middle of working with Yale CORE on the technical expert panel for the patient reported outcomes performance measure. But I have not worked with them on this particular measure or its parent measure which is NQF 1550. And now that I know that Lee Fleischer got paid by them for one of those works I just want to talk to them later after the phone call.

Elisa Munthali: Thank you very much. And I just wanted…

Lee Fleischer: It's just a CMS contact just A.J.

A.J. Yates: All right, while that's the story of my life I have no conflicts. And I - that's the good news and the bad news is I have no conflicts.

Elisa Munthali: Thank you. I did hear a beep as we were going through the role. I just wanted to see if anyone has not introduced themselves? Okay so before I turn it over to Melissa if at any time you remember you have a conflict we want you to speak up. You can do so in real-time or you can send a message via the chat box on the platform to anyone on the NQF staff or to your co-chairs. And likewise if you believe that any one of your colleagues on the committee is acting in a biased manner we want you to speak up. So I'll turn it over to Melissa. Thank you.

Melissa Marinelarena: Thank you Elisa. So I just want to confirm with my colleagues that we have 12?

Woman: Mm-hm.

Melissa Marinelarena: Okay so we do not have quorum. So we're going to go ahead and do a quick review of the evaluation process since we are - you are very familiar with this. And I'm going to turn it over to (Jonakee) to do this. And then we can get started.

(Janaki Panchal): Good afternoon everyone. This is (Janaki Panchal), Project Manager here at NQF on the surgery project. I won't review all the points here but I wanted to emphasize that as a standing committee member you will act as a proxy for the entire NQF membership. You will evaluate each measure against measure evaluation criteria and make recommendations regarding endorsement and oversee the surgery portfolio of measures.

Here are some quick ground rules for today. As the committee members you should base evaluation and recommendation on the measure evaluation criteria and guidance. Please do not leave the meeting except at breaks. If you have to leave please let us know when you leave and when you join back in via chat. Additionally, if you're not talking please mute your lines. Also please use the raise hand function if you'd like to speak. This button is on the lower left-hand side of your screen. We will try to call on you in the order of who raised their hand first. That being said does anyone have any questions? Okay.

Katie Goodwin: Okay hi everyone. This is Katie Goodwin, Senior Project Manager and it's great to be working with you again for this cycle of work. To quickly review our process, as usual we'll give the measure developers an opportunity to introduce the measure for two to three minutes. And then we'll look to the lead discussions to begin the committee discussion by providing a summary of pre-committee meeting evaluation comments. And as a reminder the developers are available to respond to any questions that the committee may have.

For voting we will be taking - actually we're not voting today on the phone. When you fill out the Survey Monkey you will be voting on all the criteria. But as far as the discussion we'll be - we'll start with the importance to measure and report focusing on evidence and then gaps. Then we'll move on to scientific accessibility focusing on reliability and validity all our (unintelligible) tests. Then we'll talk about feasibility, then use. For today's measures they're new measures so use is not must have and then finally, usability.

Because we are voting off-line and I know you done this before, we will be talking about all criteria because we won't know whether or not the measure passed the must pass criterion. We do not have quorum today which is 66% of the committee but as a reminder of our threshold for achieving consensus we need to have greater than 60% on the votes. We will know if we achieve consensus after we receive all the voting letters submitted using the Survey Monkey link. Any questions?

Okay I think we can move on starting with Measure 3493. If the developers are on the line if you'd like to introduce yourself and give a brief introduction please.

Lisa Suter: Hi. This is Lisa Suter. I'm here with many of my teammates from Yale CORE. I am happy to do an extended conversation in response to specific questions from the committee. I think the important aspects of 3493 which is hip knee complications measure is this is a re-specification of a measure that was originally built at the hospital level. It uses the exact same set of patients and risk adjustment model but uses a different attribution.

In addition to our technical -our unpaid technical expert panel we also spoke with representatives from each of the four main orthopedic societies AAHKS, AAOS and the Hip and Knee Society to ensure society input on the attribution to the clinician which is the billing surgeon for this measure. I think there are a few other questions that came up in worksheet but I'm sure that it might be easiest for me to answer those or our team to answer those in sequence in response to questions that the committee raises during the discussion. Thank you.

Melissa Marinelarena: Lee are you facilitating this discussion I can turn it over to you?

Lee Fleischer: Yes so…

((Crosstalk))

Lee Fleischer: Okay.

Melissa Marinelarena: Hold on one second. Go ahead. Just a reminder if you're not speaking if you could put your phone on mute please. Okay, go ahead Lee.

Lee Fleischer: Yes, great. So we do have a primary discussant. Are they on the…

A.J. Yates: Yes, I'm here.

Lee Fleischer: Great.

A.J. Yates: This is A.J. Do you want me to go ahead?

Lee Fleischer: Sure, unless the Yale CORE - unless you'd rather have Yale CORE present…

A.J. Yates: I think Lisa just…

Lee Fleischer: … developing …

A.J. Yates: I think Lisa just did. And I've already prepared a typed out script in accordance with the guidelines for this presentation. So I'm…

Lee Fleischer: Okay so go ahead A.J.

A.J. Yates: Yes and I…

Lee Fleischer: Great.

A.J. Yates: …like I said this has been a completely prepared in advance but off-the-cuff I just want to point out that I believe Yale has gone Hollywood in that this is summertime and it's a time for sequels. And NQF 3493 is basically a sequel of the NQF 1550 if you will but it has been re-specified to be attributed to individual surgeons and/or their groups in terms of (TIN) and MPIs.

So the - some of the things that I should mention as we look to the portion on evidence and gap the numerator does not include mortality. It captures the described time-dependent complications used in the hospital measure variably from seven days out for instance for pneumonia out to 90 days which includes all mechanical and infectious complications of the surgery itself after total hip and total knee surgery.

The denominator differs from the hospital measure in that it uses CPT codes appropriate for total knee which would be 27447 and partial knee 27446 and total hip 27130. It differs from the hospital measure in that it does not use the DRGs. It leaves out 27132 which is a conversion of previous hip surgery to

total hip but it should be noted that this CPT code is more - is effectively rare and underutilized and probably does not impact this measure immensely.

They provided algorithm just in terms of separating the assistance surgeons from primary and to make attribution in less than clear billings. Ultimately if it's not clear as to who's the attributable surgeon the case is excluded. Again the intent is to use both the NPI and the (TIN) identification. Dominator exclusions include lack of Part A billing evidence of follow-up, in other words someone doesn't come back to the office after surgery; number two transfers to the index hospital; number three AMA discharge and number four more than one primary billing within the admission. And then five again lack of clear attribution. It should be noted that hip fractures and tumors are not excluded in this measure.

The developers quote literature describing variability. And the highest variation that they quoted for mortality it ranges from 0.7% up to 2.7% and bleeding and hematoma from 0.9% to 1.7%. Evidence specific to this measure was submitted that being overall complication ranked median of 2.7% with the lowest and the highest 10th percentile values around that 2.7% of 1.9% and 4.3%. It should be noted that this represents a very narrow and sharp shouldered distribution similar to the hospital measure.

The evidence and performance gaps were given moderate support of the preliminary evaluation, disparity issues were addressed with dual eligibility and AHRQ ZIP Code income analysis and found to be small if measured at the lowest concentration for provider versus highest. That's the end of the evidence in gap. If we're at this point my recommendation would be to accept the evidence in the gap as was predetermined by some of the work going into the meeting. Do you want to discuss Lee or do you want to keep going?

Lee Fleischer: Any concerns with that? I think it was nicely outlined. Yes hearing none and have more people joined the call? Anyone new join? No. Go ahead A.J.

A.J. Yates: Okay-doke. So the next…

Bill Gunner: This is Bill Gunner, sorry AJ. So a question for NQF just for me because I guess I haven't - so how do you view so a measure that has a hospital version of it? And this is actually in support of the merit-based incentive payment system. I guess and there may be provider - and I know they make adjustments at the - for the provider - the number of providers if I'm not mistaken. So if you had one provider with I guess the hospital and the - this measure would be in accordance.

How does NQF view this? Does it - is it viewed as added value? Is it - are the distinctions so great in driving improvement that it justifies a provider in a hospital version? I don't know if Melissa you want to talk about this because it feeds into the conversation around whether you're analyzing at the provider or at the hospital level.

A.J. Yates: Hey Bill, this is Yates. I think I can answer that and it's because in the looking in yet another technical expert panel I was on there was an analysis of the gaps in MIPS. And in that analysis there is a big vacuum within MIPS in terms of orthopedics and in terms of outcome measures that are being - that are available to be utilized. CMS has felt that gap and I think that this is more a question of what's of value to CMS in terms of filling in the gaps for MACRA rather than being a another project that somehow correlates with the hospital measures. The hospital NQF 1550 is being used in value-based purchasing and in the star ratings at least currently up until another year or two.

This one is proposed for what is supposed to be bylaw elective selection by the surgeon to use as one of their quality measures as one of the six they have to submit for macro. So the difference being that this is going to be generated solely by administrative data set recording and that it will be - there's the potential for it to be used in different ways but that would come up under usability. But there - the issue is at a national level is a big gap in terms of anything to present within MIPS for orthopedics.

Bill Gunner: So let me ask it from a - from then a, you know, a surgeon perspective is - does the orthopedic surgeon believe that their activity or their outcomes or are - is it, you know, in cardiac surgery you may say well, you know, I - this is really a team-based sport, right? I mean that's where we do risk adjustment and there's - you can be a, you can have an excellent outcome in one hospital and then go to another hospital and your outcomes could be far different. So from in the orthopedic surgery world is it - is there a much - is the feeling that there's a direct correlation between my abilities and to manage the procedure and its surroundings such that provider ownership of this is actually appropriate? Does that make sense?

A.J. Yates: That's a good question but there is a - if allowed to be an elective selection for MIPS you will find that those hospitals and surgeons that are collectively doing very well are more likely to select this measure than those hospitals that don't feel like they're getting a fair shake from their - or those surgeons the feel like they're not getting a fair shake from their hospital's collective performance.

Bill Gunner: Interesting.

((Crosstalk))

A.J. Yates: So that's under ability…

((Crosstalk))

A.J. Yates: ...then could be a question as to whether, you know, it would quickly top out if those people that already know what their complication rates are from the hospital scoring decide to report something that's a done deal. So I'm a little concerned about how that under the current ramifications of MIPS which is supposed to be elective selection is going to work.

Now there are other things afoot such as the cost measures that are going to be surgery specific or procedure specific. Then knee one just passed NQF last week. And the question - and there's always been this question of what quality metrics get attached to the cost measures? And what I would argue is, is that then you're looking at the possibility that if you want to be measured under episode of cost that all of a sudden you may be required to use this measure or it may be that this measure is used in physician compare somehow.

As stated, this is intended for the MIPS process within macro which is supposed to be voluntary. So there's a certain amount of caveat emptor up to the surgeon to select it. But it's potential is, is that it then gets transformed into something that's used regardless of you wanted to use it or not at which case - in which case you may be captured as a surgeon within a poor environment and judged maybe in a way that you wish you hadn't been. But that's a - that's not the point of this particular section of the presentation.

Woman: Great.

((Crosstalk))

Man: Lisa did you want to say something?

Melissa Marinelarena: This is…

Man: …Did I hear?

((Crosstalk))

Man: Go ahead…

Melissa Marinelarena: This is…

Man: …NQF.

Melissa Marinelarena: This is Melissa from NQF. So even though the title says MIPS is, you know, we talk about MIPS during MAP. So we can talk about more acronyms during MAP season which is in December. And that's when we talk about the measures that are proposed for these type of programs.

This committee is - your duty is to look at the measure to see if it meets the criteria which is the technical criteria that I know is hard to separate how it's going to be used because we actually have the criteria that says use and usability. But right now we're asking you to consider is there evidence?

And it's answering the question that you asked Bill is there something that a surgeon or a group of surgeons can do to impact the outcome? And the bar is usually a little bit lower for outcome measures because for process measures we ask for guidelines and, you know, a systematic review. So for an outcome measure we just ask that there is a connection. And we've asked that in, you

know, they provided the evidence and we asked the committee to either agree or disagree if the two different levels of analysis meet that threshold.

I don't believe and I'm not sure I don't, believe this measure has been proposed for (BPS) yet. That's a conversation that happens in December but we ask that you consider the measure again for each criteria, does it meet, you know, evidence? Is there a gap in quality related to surgeons around hip and knee complications?

When we can think about what value-added is there when we talk about related and competing measures. So this is a related measure to the hospital measure so where is the value added? And there are other similar measures and the developer did provide some information around that. And also we can talk about that but we have to look at the measure does it meet all of our criteria on its own and then we can talk about in relation to the entire portfolio. And, you know, we talked about that with the other measures when we had 15 related measures as well and what is the value-added?

Lee Fleischer: Great. So are there other questions?

Barry Markman: Yes Lee I have a question.

Lee Fleischer: Yes.

Barry Markman: This is Barry Markman.

Lee Fleischer: Sure.

Barry Markman: You know, I was reading through this and I didn't get a very crisp view of the numerator of what were the complications. And second are these

complications, you know, is there a certain, you know, a small hematoma versus a large hematoma that had to go back to the OR? Was it a skin infection or was it a prosthetic infection? Is that in there A.J.? I mean maybe…

A.J. Yates: Yes.

Barry Markman: … I missed it.

((Crosstalk))

A.J. Yates: It - Yale can correct me if I'm wrong but it's coding or readmission with coding for the first seven days for pneumonia or sepsis, 30 days for pulmonary embolism and/or bleeding complications i.e., hematoma and after 90 days for any sort of mechanical complication or infectious complication such as dislocation, infections, fracture requiring further surgery and readmission. And they're triggered by the coding of the - of whatever happens in house or on readmission through the hospital billings. So that's my best answer and I believe that's correct is that right Lisa?

Lisa Suter: Yes this is Lisa. I just want to make a clarification. So within the first seven days after the surgery AMI so heart attack, pneumonia or a coding of sepsis or septic shock is considered in the complications outcome. During the first 30 days surgical site bleeding, pulmonary embolism or death so just to clarify that mortality is in fact captured in the measure numerator. And surgical site bleeding is defined as Dr. (Yates) said by your coming back to the hospital and not only do you have a code for bleeding but you have a procedure code for...

Barry Markman: (Unintelligible).

((Crosstalk))

Lisa Suter: ...you know, site specific intervention. So these are not just bruises these are people coming back…

Barry Markman: Right, right.

Lisa Suter: …who have interventions.

Barry Markman: Okay.

Lisa Suter: And then the 90 day period is mechanical complication or prosthetic joint infection again with admission with an associated surgical procedure, so a revision, a clean out, you know, a state of removal with spacer, et cetera. So this is a very high bar and the rates are low for that reason. We worked with a number of orthopedic surgeons for the development of the original hospital level measure and chose a pretty high bar for defining complications in order to avoid some complications that like UTI or DDTs where…

Barry Markman: Right yes.

Lisa Suter: ...the result that might be - there might be screening bias or other issues. So it's a quite high bar but it's quite specific and has been validated in chart review.

Barry Markman: Okay,, you know, that's a good clarification. It's, you know, it's a more serious complication which I got it. Okay thanks.

Melissa Marinelarena:Lee…

Lee Fleischer: Great. A.J., Alan...

((Crosstalk))

Melissa Marinelarena:...Siperstein and Barry Markman have their hand raised.

Alan Siperstein: Oh hi, Alan here.

((Crosstalk))

Alan Siperstein: I just want to jump back very quickly to Bill's question and answer it in a slightly different way. I've been working with the American College of Surgeons previously on their Performance Measure Committee which was designed to create a matrix of performance measures to interface with the macro program. And the feeling was that there was a great value and having provider level outcomes data available and that that was an important thing to have to move the quality needle forward. Whether a given physician decided to use it or not as part of their individual reporting is one question but knowing what your results are in and of itself is thought to be helpful.

A.J. Yates: And I just want to add that the question was is there anything that is actionable by the surgeon and there - it definitely is the case that participation in pathway development, compliance for pathway development, being a surgeon that it helps to create a team within a team do - just there's there are a number of things that can bring down complication rates by standardization of process. And it's been demonstrated. It's also volume has a lot to do with it but it turns out that it's not just volume. It's actually having good processes that might drive the boat more than the volume itself. And so there are things

that can be done and they can be done because of work by individual surgeons or a group of surgeons as would be demonstrated within the (tent).

Alan Siperstein: Thanks.

A.J. Yates: And so…

((Crosstalk))

A.J. Yates: ...I'm not saying if they die after 30 days though it doesn't count correct?

Lisa Suter: That's correct. Death after 30 days are not captured in the current measure.

A.J. Yates: Okay.

Lee Fleischer: Great. Do you want to continue A.J.?

A.J. Yates: Sure. Under reliability the reliability was felt to be adequate by the panel and the Methodology Committee. And so that was felt to be at a moderate level. The ability to adequately separate percentile differences between providers for a very low rate of complications was raised. The C statistic continues for the risk adjustment model the C statistic says just based on mostly HCC variables it still only 0.65 which is considered low and the same for the hospital measure for which has some mitigation because of its higher numbers of - in volume as a hospital.

Now I'm only going to quote the AMA statement at the end because of their status and their - they wrote an extensive note so I'm just going to quote them for the sake of the committee. They made a public comment which reads - and I'm only taking all part of what's two pages. The AMA is concern is the

developer has not provided physician information on the range or the measures or reliability results which is needed to understand whether the minimum case number of 25 patients is acceptable.

We believe that measures must meet accessible thresholds of 0.7 for reliability. During the public comments period in December 2018 the range when applying this measure to eligible clinicians with more than 25 admissions was 0.582 to 0.988 and 0.4632 0.996 for eligible clinician groups. We request that the standing - this was the direct request. We request that the standing committee evaluate whether the case minimum of 25 patients is acceptable given the low reliability results.

And what I can say is is that people did make a comment in their preliminary review that they thought 25 patients was acceptable. And apparently the Methodology Committee felt so as well. But again because of the AMA stature I thought I would just throw that out that they were calling on us to make a comment.

Alan Siperstein: And to NQF staff we've never established a threshold for a C statistic correct?

Lisa Suter: That is correct.

A.J. Yates: The fee statistic and this is the same as in the hospital measure and it said the work panel group for the technical expert panel that helped to advise.

Alan Siperstein: Right. I'm just confirming that the comment about the .7 I didn't…

A.J. Yates: Yes that's…

((Crosstalk))

A.J. Yates: …yes that's part of the 25 patients or 25 cases.

Alan Siperstein: Right.

Lisa Suter: Yes that's correct. We don't have any thresholds in this measure and the next one were both reviewed by the scientific methods panel.

Alan Siperstein: Great. Any comments or concerns or responses to the AMA that anyone would like to articulate?

A.J. Yates: I would agree with…

Alan Siperstein: And then…

A.J. Yates: … The finance committee.

Melissa Marinelarena: And as a reminder of Fred, (Amy) and Alan were also lead discussants on this measure if they would like to add anything. And then John, Rick Dutton was also on as additional reviewers if they would like to add anything.

Alan Siperstein: That's great. Why don't we add it as we go through each section if anyone else has anything additional?

Lisa Suter: And this is Lisa Suter from the developer. May I add a comment?

Alan Siperstein: Please.

Lisa Suter: So in response to the AMA I think one of the things that came up a lot with our technical expert panel was the desire to actually measure small volume

providers. There was a lot of discussion about the tension between having a minimum number of patients for reliable measure versus capturing smaller value providers where we know that surgical volume actually is associated with technical quality in that lower volume providers do have worse outcomes.

And so there was a real - there's a lot of discussion among the technical panel about this balance between having a reliable measure but also having a measure that captures lower volume providers. So, you know, where we picked 25 because it gave us acceptable reliability but also that 25 over three years of surgical procedures we thought it also met some of the kept members real concern about wanting to keep lower volume providers in the measure.

Alan Siperstein: Thank you. It sounds like an important criteria from our perspective so prudent goal. Any other comments from the committee for the other reviewers? Okay AJ do you want to continue?

A.J. Yates: All right the next part of the script would be validity. The validity was rated moderate by the panel and the Methods Committee. It relies on part of the face validity of the technical expert panel. It should be noted and this was something I have raised before that the database is the administrative database for CMS based on submitted diagnosis codes with billings which has been challenged in the literature several times as being less valid than registry data.

Actual validity testing with chart review was not offered for this measure but has been done once and at least published once for the hospital measure. And even with some dropping some complications there was still an attribution error rate that was of concern. They have discussed this before in this committee for NQF 1550 and I don't want to raise that again because that measure passed validity at that time.

We, the AMA again commented in part and I'm only quoting a part of a two-page response, but again because of their status I'm going to read this three sentences. Additional testing is needed to evaluate clinical factors in co-conjunction or in conjunction with social risk factors as opposed to the current approach that prioritizes clinical factors.

Even though the fee statistics were not improved and the absolute change in the rates appear to be small it would be useful to understand how these shifts could potentially impact the points physician score in the quality category in MIPS and as a result either positively or negatively impact the overall penalty or incentive they receive and the resources available for those individuals and groups who serve larger numbers of disadvantaged patients.

Again, the last three sentences were a quotation from the AMA comment and they were kind of challenging the committee just to discuss that. Again, the validity pre-meeting today was rated moderate by the panel on the methods committee.

Man: A comment first from the other reviewers.

Alan Siperstein: Alan here. There's an interesting phrase, although the grammar may not be perfect, on page seven under the validity when - I'm just mentioning this to condemn it in my own mind - in that they're saying that there is obviously a positive correlation between volume and quality, and they're questioning if I'm reading the English properly is whether the volume should be an additional risk adjusting factor.

And I think it's kind of a confusing of a dependent and an independent variable in all of this. So I would argue very strongly not, you know, not to

tread into those waters where individual provider volume becomes its own risk adjustment factor for outcomes.

Rick Dutton: I agree, this is Rick. I think if you include volume as risk adjuster, you cover up the very modifiable risk factors that you would like the measure to identify.

Alan Siperstein: Yes, that's the exact phrase. I agree, it's the modifiable risk factor.

Man: And I that should add, that's not the developers' language, that was something that was a comment.

(Crosstalk)

Alan Siperstein: I thought it was important to you know, put that on the table.

Man: Yes, no, I agree. I would argue against it as well.

Lisa Suter: We agree with you guys. This is Lisa, the measure is not risk-adjusted for volume. And I'll just add too, I think, there was a concern earlier just about clinical validity - does this measure include fractures and metastatic malignancy patients with many metasticies. It does not. It has the same exclusions as the hospital-level measure. So it really is focused on primary elective procedures. People who are coming in for an initial, not revision, total hip or knee replacement without complications like that.

Man: That's a relief Lisa, because on the - a measure form that we were given, those two were not listed as exclusions.

Lisa Suter: We apologize for that oversight. And I'm glad you raised it so that we could clarify it.

Man: Okay. So it is consistent with the hospital measure, which excludes cancer cases in fractures.

Lisa Suter: Absolutely.

Man: Yes. Well that makes it - that makes me relieved to hear that,

Lisa Suter: Us too.

Man: Okay. Any other comments?

(Amy Moyer): This is (Amy). I saw the issue raised a couple of times and the discussion around the Medicare Part A enrollment as a requirement. Correct me if I'm wrong, but that's the data source for the measure, both for the initial procedure and for those complications. So I think having that as a requirement, which is per se, if a patient drops out of Part A, they're excluded from the measure. I think it's a pretty common thing. You wouldn't know about complications if the enrollment had changed.

Man: Lisa, any comments?

Lisa Suter: So this is correct. So, it's not a question of whether you got follow up, it's whether or not you're enrolled afterwards. So we do require that you have continuous enrollment both before your hospitalization for the 12 months so that we can capture adequate co-morbidities for risk adjustment, as well as for the period of time that we're evaluating those for complications.

So there are some patients that get excluded based on this enrollment requirement, but we agree with the committee member that you couldn't

adequately assess complications unless you knew that your denominator was consistent through that - throughout that period of time with consistent data.

Rick Dutton: This is Rick. I get that. That makes a lot of sense. Just a question. does this require enrollment in Medicare in general under any mechanism or does it have to be a consistent coverer? So the patient moving from one region to another or into or out of Medicare Advantage would get lost?

Lisa Suter: So at this point the measure is specified for fee-for-service beneficiaries. It does not capture Medicaid, sorry, Medicare Advantage patients. That is something that we're looking into. But at this point, the measure is specifically for fee-for-service providers, but regardless of what clinician or service provider you seek care from, you are included as long as you're enrolled as a fee-for-service beneficiary.

Man: I just want to add that in those parts of the country where there is tremendous penetration by Medicare Advantage, like our area where it's two-thirds of our Medicare-age population seems to belong an MA program as opposed to Medicare fee for service. They do so because it's so much more cost effective for them in terms of not having to pay the higher premium for a Part A supplement.

And one of the things that I wonder, and it may be something worth researching down the road by NQF socioeconomic group, is whether or not we're seeing a split between these patients that get put into Medicare Advantage out of default because it's less expensive for them because they're not able afford the supplement versus those that can. And maybe that some of those socioeconomic risk adjustment is being blunted or maybe some of the differences is not as apparent because of that difference.

Anyway, that's just a thought out loud, but if this is about one-third of our Medicare-age populations in our system in western Pennsylvania.

Woman: Alan has his hand raised again?

Man: Great, Alan?

Alan Siperstein: Well, no, but it was still up, sorry.

Woman: Oh, okay. Is that everybody who had their hand raised? Rick, I saw that you, did you, were you able to make the comment that you wanted? Okay, great.

Rick Dutton: I'm fine.

Woman: Okay, great.

(Crosstalk)

Man: Basically one sentence under feasibility, it's already been done in the original movie, if you will. The data's already harvested. The preliminary evaluation was rated high by the members, so that would be feasibility. I'll stop there for a second. Go ahead?

Man: Go ahead.

Man: Okay. Usability in this will complete the review today. Right now there are no current public reporting targets. It's to be potentially offered in the MIPS program. If allowed to be voluntary as other MIPS measures are used in the value sector of macro, I think it's reasonably fair if - these are now my opinions. If mandated in some fashion, I'm not sure if it’s clear.

Given the issues with attribution is it sufficiently - is it a sufficiently accurate tool to distinguish between percentile rankings across a tenth of a percent incidence. It is a magnifying glass being used for a subject better examined with a 100 power microscope with oil. Again, that's my opinion.

If there is even a perception of poor risk adjustment given the competition to reach higher percentiles of performance for rare events, I worry about the risk of unintended consequences of avoidance of marginally higher risk patients by condition or socioeconomic class, i.e., cherry picking or lemon dropping.

Again, as an elective chosen MIPS measure, it would be up to the surgeon to engage with the measure and I think that's a very useful and potential target mandated or used within physiciancompare.gov would not be advised by this reviewer. But this is not the place or time to fight that battle because unfortunately maybe we're not asked to do that.

Man: Thank you.

Man: Great, but we're not into how it's used, at this time.

Man: Understood but right now there's (unintelligible) but it is potentially very usable as a MIPS measure.

Man: Great. Any other comments from any of the reviewers? A.J. is doing such a thorough job. Thank you. So…

Man: Yes, thank you A.J., outstanding.

(Amy Moyer): This is (Amy). I would just add recognizing the constraints of the funding for developing the measure, even better as we were able describe a broader swath of patients. And you know, we heard the Medicare advantage discussion earlier. We're seeing a lot of joint replacements younger, happening on commercial insurance. So it'd be really wonderful to be able to expand this to all payer or to a broader population. Recognizing that I think this was funded by CMS and they're going to use it.

Man: And I've already said, I just have one more thing to say, (Lee). I've already said this to CMS and other venues in other environments as recently as three weeks ago at HHS. But the - I think it's more important that we move on to those things that happen to every patient, which is their cost and their patient-reported outcome in terms of what they got for the quality of life surgery they've gone through for a total knee or total hip.

And their perceived outcome and patient-reported outcomes is ideally something that you capture and you measure the outcome of because that's occurring across 100% of the patients as opposed to trying to measure very rare events at the other end. And so, as we move towards - a bias towards this, but as we move towards patient-reported outcome performance measures and as Medicare learns how to use their database to collect them reliably, I think we're going to have a better way of measuring quality. So anyway, that's my soapbox. But CMS may be on the line, so I want to put it in there again.

Man: I think it's actually, so Lisa you want to comment about the collaborative teams being developed by AHIP working with NQF?

Woman 2: Lisa is not in here.

Man: But there's more and more work around trying to get measures across multiple payers and AHIP and NQF are working on this. Another comment that I heard?

Woman: Rick you have your hand raised?

Rick Dutton: Yes, this is Rick. I just wanted to second what A.J. said. I'm 100% in agreement. We should look for measures that apply to every patient. We push anesthesia patient satisfaction measurement very hard. And we found it to be a big differentiator. And we are easing into actual patient-reported outcomes after surgery, you know, willingness to have the operation again, time to return to work, normal activity, that kind of thing.

And I think as our technology for measuring that gets better, those will become more and more important. That is something NQF should look for.

Melissa Marinelarena: Thank you Rick. Is there anything else? This is Melissa from NQF. As a reminder, when you vote on this measure you're actually going to be voting twice because the similar measure in readmission project about a week ago, a week and a half ago, voted on all the criteria separately for the two levels of analysis. So in order to be consistent, we are going to do the same thing.

So you will vote on each of the criterion separately for individual clinician and then for the group. So the survey that you get, today will be - include three measures, that two of them will be for this measure and then for the one that we're going to discuss next. Anybody have any questions around that?

Okay. So now we're going to turn it over to (Bill) to facilitate the next conversation. And then (Bill), you can turn it over to the developers to introduce the measure.

Bill Gunner: This is Bill Gunner, the next measure - if I'm supposed to see anything being displayed I'm not seeing anything. I'm on the - I see the little button. But if you're presenting anything, I'm not seeing it anyway.

The next measure is 3494. Hospital 90-day all-cause risk standardized mortality rate, following coronary artery bypass surgery from CMS. I know we have, lead discussants are John Handy, (Richard Dutton), (Barbara Levy), (Barry Markman) and (Lisa Deluris) at Temple, but we don't have (Marisa) and I know we don't have (Barbara), so I'm turning it over to the developers for their introduction if they'd like.

Lisa Suter: Great, thank you. This is Lisa Suter again from Yale core. Similar to the last measure this is again a measure that originated from - a hospital-level measure. It is also a hospital-level measure. It was a re-specification of an existing NQF endorsed in-use hospital-level measure of 30-day all-cause mortality after isolated CABG surgery. The measure in front of you extends the post-procedure period to 90 days. And we were asked to develop this measure on behalf of CMS for use in episode payment and other alternative payment model.

And I'm happy to as before answer specific questions as they come up. The measure ended up itself including the cohort of isolated CABG, which removed valve replacement patients concomitantly with bypass surgery patients. Those are also excluded from the measure similar to the existing readmission mortality measures in use, and similar to the 30-day measure it is harmonized with the STS measures to the extent possible given that that's a registry-based measure and this is a claim-based measure.

Bill Gunner: All right, our lead discussant, I believe is John Handy, is that correct?

John Handy: Yes.

Bill Gunner: Great, John, you're on.

John Handy: All right. Well, so, this is a new measure. So everything, this is, everything is new and the primary difference from the multiple related majors, which we'll talk about at the end, is the 90-day timeframe, which has got a very solid rationale behind it because this has been looked at in cardiac surgery fairly rigorously - is that you extend the observation period about, and this is a very discrete outcomes measure because mortality is not a debatable endpoint.

If you look at it over 90 days and you have an - you have more mortality than you look at it if you only look at it for only 30 days or even 30 days in hospitalization. So that is the rationale for it. And the numerator is all-cause mortality over these 90 days of Medicare patients that undergo isolated coronary bypass and the exclusions are if you and the denominator is anybody undergoing isolated coronary bypass.

And the exclusions are if you have poor data, if you left the hospital AMA or if you're getting serial CAB procedures after your original CAB procedure, which certainly is not mortality, but it's some substantial morbidity that usually means your first CAB turned out poorly. That a really small cohort, however, just from personal experience.

It's claims data and it's at the level of the hospital and as I mentioned, it's an outcomes measure.

Woman: Hi, we have (Amy Moyer), who has her hand raised. (Amy). (Amy), did you want to - did you have a comment?

(Amy Moyer): I just had a quick question. When you mentioned this was to be tied with payment, I wondered if the 90 days was also meant to harmonize with the global payment period for surgery.

John Handy: It looks like to me (Amy) that it's not tied to payment. It's postulated that it may be tied to payment in the future. This is primarily a quality improvement proposal at this time.

Lisa Suter: This is Lisa Suter, that's correct. At this time we have no indication of what model this is or will be eventually used in. We were asked to think about a longer time frame in the context of a broader, you know, payment model such as, you know, some of the models that exist currently like bundled payment, but this measure was not built specifically for a unknown or described, payment model.

(Amy Moyer): Okay. Thanks. That's helpful. I know we always have to pick a time period. I was just curious.

John Handy: Part of the evidence is the gap and actually in the evidence discussion, there is a gap that's inherent in there and that when you look at different data sources or even within the CMS, that the 30-day mortality is 3.2%, whereas the 90-day mortality after (unintelligible) CABG is 4.8%. So there certainly is a difference that justifies the metric. And let me get down here to the gap itself.

One of the questions in the evidence that that was posed to the committee from the staff, is there one thing that the providers can do to decrease the risk of mortality after discharge after CAB? Now this is - that's a little confusing because this is a hospital-level metric, not a provider per se. The whole team -

it's kind of incumbent in cardiac surgery, and I would say that's not really directly addressed in this, in the discussion here by the developer.

But there certainly are follow-up interval guideline adherence and care coordination. Care coordination would be especially relevant (unintelligible) hospital. So the use of specialists, home healthcare, phone calling, et cetera.

So the question is, is there a gap that warrants national performance measure? I would say the answer to that is yes. So evidence is good, gap is there.

Bill Gunner: Any other discussion on evidence. Hearing none I think - can we move on to reliability?

John Handy: Yes. So in reliability, this was looked at by the - once again the scientific methods panel using a split sample noise signal, signal-to-noise analysis with the 25 admissions as per AJ's discussion of earlier. And they felt that the - and the staff rated the reliability of this methodology as high.

Bill Gunner: And any other discussion on reliability?

Melissa Marinelarena: And this is Melissa from NQF. This measure was also - the reliability and validity was also reviewed by the scientific methods panel. So this is a summary of their review right here.

Rick Dutton: This is Rick. My only comment is, the numerator is based on administrative data, some serious complications that come through as ICD-10 for PSI codes, patient safety indicator codes. And I wonder if there has been good work validating those with the original charts to both make sure they happen and to find other ones that haven't been identified.

Lisa Suter: This is Lisa Suter. Is it okay if I respond?

John Handy: Yes, please do.

Lisa Suter: Sure. So we did not do chart-level validation for this measure. I will say that the risk model and the original 30-day measure was validated using registry data, the state registry data, not national registry data. The original 30-day and mortality and readmission measures were developed in combination with Society of Thoracic Surgeons. They were building a registry-based readmission measure at the same time.

And so we had a joint work group that weighed in on all measure decisions including the risk model. And we use the same principles and many of the same risk factors, in this model, in this measure, based on that input. And we also had representatives from STS in our technical expert panel to make sure that, and our work group, to make sure that that input carried over for this measure. But we did not - we did not do chart validation per se.

I will say that in terms of thinking about complications, what we've learned, from number of years working with claims-based data, both through chart validation and other registry validation projects, is that we've developed an algorithm that is now augmented by - present on admission indicators so that we're risk adjusting to the extent that we can for the clinical status of the patient when they walk into the hospital.

So we know patients that come in for isolated CABG and are in extremis and are in shock. We have the capability of capturing that information versus patients who come in relatively stable and have some sort of catastrophic complication during surgery and then develop shock. So this model as specified allows us to distinguish that.

Is it as good as, you know, clinical data? We have not done that validation, but our experience working with the STS registry and the New York cardiac surgery registry is that the predictive model is very, very similar, for the 30-day measure. And we would anticipate based on the performance from our analyses that we would predict similar performance with the 90-day measure.

Woman: It looks like (Barry Markman) has his hand raised. (Barry), did you have a comment?

(Barry Markman): Yes, well I lowered it. That was my same question too because you're using the claims data and chart map and chart validation, but you did a good explanation on it. So, I'm okay with it.

John Handy: So it started to spill over into validity, which I thought was interestingly done. First off, the technical expert panel looked it over. And 78% felt that this would be a discriminating measure between better or worse performing hospitals. And then empiric testing was done on hospital-wide mortality. And then interestingly enough compared to the STS star ratings of CAB for the particular hospital and they were correlated. I thought that was a very interesting thing to do to sort of look at an outside source and use that as a standard to compare it.

And then finally vis-à-vis the risk adjustment that was just spoken of, 27 co-variants based on the hierarchical condition category was used for the risk adjustment. And it sounds like the risk adjustment is pretty mature. So this - the rating for both reliability and validity from the NQF staff was high for both of them.

Bill Gunner: Any other discussion? Hearing none, feasibility.

John Handy: Okay. So feasibility, I mean because this is already a well-plowed field with just a different timeline and the data elements are there and the discussion regarding claims-based or administrative data versus clinical databases notwithstanding, the feasibility was considered high by the NQF staff.

Bill Gunner: Any discussion? Very good, use.

John Handy: So usability, this is not publicly reported and has not been proposed to be publicly reported. And it's planned use as an accountability program was mentioned at the onset of the discussion for a quality metric and the improvement project. It might end up being used in a payment - a program such as hospital value-based purchasing, but that's more of a thought than an actual plan. So that is usability.

Bill Gunner: Anyone else talk about use? Usability.

John Handy: I mean, I'll just say paranthetically that the - I'm not personally involved in the STS database, but I'm a user of the STS databases and that this has been bantered about a lot in the STS is to increase the timeline to 90 days for composite measures for morbidity, mortality, just because it's a more realistic reflection of the patient experience. So this seems to be a well-conceived effort in my opinion.

Bill Gunner: So from a use and usability point, and again I apologize if I missed this, what's the time - so if I had a death in - how often is this data rolled up or planned to be reported from CMS? What's the thought about, how often would I receive this data and what would be the delay between the actual event, the death and my receiving that information? Is it user or as a public - actually the public.

Lisa Suter: So this is Lisa Suter from the developer. That's a great question. Because it has not been implemented and CMS has not told us exactly how they're going to use this measure, I can't respond directly. What I can tell you is that because CABG surgery, you know, the number of hospitals across the country that performed CABG and the number of patients undergoing them is smaller than the number of hospitals in the country, our 30-day measure utilizes a three-year, so a 36-month time period for measurement in order to capture enough data to produce reliable estimates.

And the information in measure development was for the most part done to mirror that same 36-month expectation. In the 30-day measure that is publicly reported, that data is approximately a year old. So there's a year's delay in terms of when those publicly reported results are available. So you are correct in that one of the downsides of high feasibility claims-based measure is the inflammation is older and less nimble in terms of allowing hospitals to pivot or react to quality data.

John Handy: No, from a - and I completely understand. I mean, I just wanted to confirm what I thought was the case. The question is then who's the audience for use and usability then?

Lisa Suter: I'm not sure if we have anyone from CMS on the line, so I'll pause for a moment to see if CMS has the call and is able to respond directly. But otherwise, I think, you know, much of the conversations that took place with the technical expert panel pivot around a circumstance where a hospital was in a payment model, for example, a bundled payment program where they were receiving a lump sum for care of patients undergoing isolated CABG procedure.

And that the anticipation was that that would be a model that would look for improvements over time in both quality and cost. And that this measure would both allow CMS to track quality both to ensure that and explore whether or not called quality improvements were being made but also as a balancing measure to ensure that if this were being used in an accountability measure where payment - you know the effort was trying to reduce costs, that we were sure based on this measure, the results of this measure, that quality was not deteriorating in the context of tightening costs. (Kim), do you want to add something?

(Kim): Yes, I mean I'm just going to add that, you know, when we're thinking about initial endorsement of a measure just from our point of view, that the bar that we're trying to focus on is sort of the potential use and usability of a measure, which I think has already emerged in your discussion of this measure - sort of alignment of the longer outcome period with what clinical experts in the field think is appropriate.

And so, you know, an initial measure endorsement, which often proceeds formal announcement of a plan to implement the measure, often, you know, we're talking about use and usability in the theoretical based on the scientific accessibility of the measure, and to some degree on its clinical applicability, which you all are already discussing as a group.

I think it's a different exercise when we bring something back in endorsement maintenance, where we have some experience of it in a program and then we can have a more robust discussion about how well it fits and whether or not we find anything in terms of unintended consequences or feedback from stakeholders.

So I think we're in that theoretic space and you know, much of what's already been discussed on the committee speaks to that.

Man: Yes, this is (unintelligible), I'm one of the listed discussants and I just want to point out that it wasn't very long ago, about a two and a half years ago, rules proposal was going to expand on the mandatory CJR bundle and extend it to different models. They were going to have mandatory models within the cardiac world. And that rule proposal never came to fruition. In the final rule, they dropped it.

But there's been this bubbling up of wanting to have maybe something similar to the CJR. CJR as a bundle for hip and knee replacement can't exist without something to measure quality. And it just so happens NQF 1550 was available to apply to the CJR bundle. So the complications measure we talked about just a little bit ago, but at the hospital level, was applied. I think, and 90 days is the magic number for most of the bundles and I think that if there's going to be BPCI cardiac bundles for Medicare or even a revisiting of mandatory cardiac bundle, this is a measure that's going to have to be on the shelf if they want to be able to at least capture the most fundamental of the quality outcomes.

Man: I would say a more concrete answer to (Bill)'s question is that it has to be the hospital bill because this is the level of the analysis and so then each local, micro environment is going to be left with, well, are we winning? Are we losing? Do we have one group practicing here? Do we have three groups doing cardiac surgery here? But it's coming back to the hospital that they either win or lose.

Man: And my answer is that in the mandatory bundle, the hospital was the required convener of risk. So it's going to be at a hospital level if it's going to be a

mandatory bundling as opposed to surgeon-driven BPCI, at least the original BPCI's surgeon convener risk.

But we're going off track. I'm just saying that having this on the shelf makes any one of those at least possible with the hospital, at least in terms of the hospital's risk.

Bill Gunner: Yes, and I guess - this is (Bill) again - I was also trying to introduce the concept of, sometimes you look at - there, I'm not saying this group, but I know that people have been critical of CMS in the past because of the amount of timeline - the timeline it takes to get the data, you know, in and claimed and analyzed, and then - the reporting cycle could be. So you're enacting, fundamentally, you're looking at data that can be quite distant in the past, but the fact is, is that, you know, yes it's true, quality improvement, you'd like to shorten that timeline up.

And I'm sure in an ideal world that in fact you'd like to get that improvement loop is tight as you can. But the fact is that this doesn't mean that the - you know, you would ignore measures that have a longer horizon, because over time it has the potential of moving the needle in the positive direction.

That's all. I sort of wanted to introduce conceptually this idea. If you're driving quality, how do you eliminate the sort of - the CMS administrative data with a long lead time? And I think, we've never, I guess the question for NQF is that how has this been addressed elsewhere. Do other committees look at this, you know, do they - has anyone had this discussion? Just bringing it up from a theoretical point of view and a point of discussion around timeline of data and its use and usability. Does that lead time, does that quality improvement loop time, does it impact measures and their endorsement?

Melissa Marinelarena: Hi, (Bill), this is Melissa. Well there has been a discussion but not just with CMS measures. I noticed some of my other projects, some with different registry measures, around different specialty societies, depending on how the registry works it takes a while for them to get the data. And it's sometimes when we talk about it in GAP and the committees will ask, well why is this data so dated? And they expect or they want to see more recent data.

And, but that is also tied into usability, because even though the criteria are all different, they are connected. And that's just something that the committees have to decide. I mean, we look to you - is this sufficient, you know, does data - and sometimes I've seen it, and it's been a while. I can't speak of exactly - the data could be three or four years old before, you know, if they have like a reporting period at the end of the year and by the time it's collected and it's analyzed and it comes to us, it's several years old.

So is it a true reflection of quality now? You don't know, you know, it was a gap at that time.

Man: (Bill), can I ask a question or make a comment that's not specific to this metric and therefore the conflict. Yes, I mean there's - we're getting into a various philosophic question, does metrics alone and the way we do it work, which I think is a much bigger question than, you know, I'm for full disclosure, I'm writing a paper for NQF and health affairs on the history of the quality, this will go back 20 years. The question of was this the right decision to create this NQRMS as it is called by the Strategic Framework Board.

So I think we're moving into pretty philosophic questions that I'm not sure this committee can ask, but it's great - can answer, but it's great that we can ask it. That makes sense.

Melissa Marinelarena: Yes. And we capture all of this, you know, all these conversations in our technical report. I have not seen a measure failed based off of just that. Again, it's usually a - the discussion is around gap and why do we not have more recent data? NQF does not have a position on it that I'm aware of. It's just something the committee has to determine.

Man: I would add that the, you know there's the question of trying to make it applicable for any particular fiscal year or calendar year and that you have a delay in outcome in terms of what you know. But that's a question of computer programming and will as to how well you capture data on a rolling basis so that you can see data in real time as it rolls in at the end of each 90 day period.

And in situations where you have a large enough volume for a hospital or provider, that rolling data is something that if it's a - if it's of reason, if there's a reason for a flag to go up, that rolling data should be able to raise a red flag without waiting for an incremental analysis.

So it's outside of the scope of whether or not this measure is feasible and usable. But it's a, I'm just trying to address the issue of the timeline.

Bill Gunner: So, yes, this is (Bill), it's also interesting in this measure because you take what typically is a 30 day mortality for CABG. And if when you look at 90 days, it is true, and I wrote about this actually and published about linear relationships over the first year following - mortality by decile of risk. And so CABG fits into that as well. That there's a - that over the first year there's a, except in the most ill, there's a linear relationship.

The question is, is that can the hospital or the provider as they get outside that, you know, as you lead it, as you go from one week to two weeks to three

weeks and beyond, the patient transitions to home and a lot of other things influence the outcomes of those folks that are maybe beyond the scope of what it is that the CABG was, you know, provided for them and their health benefit. Now they're having issues of - that maybe not CABG-related as you extend that timeframe.

So, and then you add on top of that the lead time of getting that, you know, if actually having an event being reported, tracked. And then, so there's a lot of pieces here to this that actually -that are not just philosophic. There's a reality of how you connect - how does NQF assign relationships between what the, you know, the intent, which is to drive improvement, and to notify the public of outcomes and the actual ability of those, either providers or hospitals, to manage that and improve it. I guess that's my point.

Where in the cycle can a hospital or a provider intervene and actually make - and show that they can make adjustments and improve their outcomes. And how does that relate?

John Handy: Well, I would say one answer to that (Bill) is, is there something that the providers can do that I had mentioned to you before? So things like follow up interval, guideline adherence, care coordination. When you look at the readmissions literature, which is a robust literature, other - in other words, things that were completely unrelated to the surgery is usually like the second or third most common reason for readmission, but that would sort of even out over the course of the field since you're comparing apples to apples.

Bill Gunner: Yes, there's a lot written now on readmissions, so both for and against its benefit as a driver of quality.

John Handy: I was just using that as an example, saying that if you look at something as discrete as that - the completely unrelated. So you got sent home for your coronary bypass and broke your ankle, you know, that had nothing to do with your readmission for your coronary bypass. But as an example for - other is a common reason.

Bill Gunner: So Fred Grover is on the phone and maybe you want to comment, but I mean the thing that most often as attributed to, you know, to readmission is atrial fibrillation, I don't know anything in the literature that will help me benefit my post-op a-fib rate or occurrence rate. And yet it's associated with readmissions and morbidity. I don't know, Fred, if you're still on. If you are, you're talking to mute.

Fred Grover: Can you hear me now?

John Handy: Yes.

Fred Grover: Yes. Oh, damn. No wonder I've been having trouble on the call. No, I think it's what John says. I mean, to me just putting this out informs the hospitals that they're going to be tracked for 90 days. And I think in itself, at least if I were seeing this coming out as a CMS measure, I would say take a hard look at how we're doing in terms of our follow-up of our patients after they're discharged. And a lot of that has to do with our calls and contacts and particularly out here in the west where they travel large distances because of the lower density population.

It becomes very important, and so I think right off the bat, you know, if this is released and they accrue data to that, that in itself will show another sign of being measured. And all of us are pretty competitive. And I like to think that we're doing the best work we can and that tends to promote people taking a

look at how they can tighten things up and do better. And to me that's the value of this type of thing.

And as John mentioned, the STS is going to longer and longer ones too. And it's interesting (Bill) that (Laurie Shroyer), you know, when we were all working together on the VA system, actually was measuring in six-month outcomes and there's quite a difference there too.

So, these are good measures I think. And Lisa, are you still around, you still on?

Lisa Suter: I am, Fred.

Fred Grover: I just want to say your voice reminds me of those 6:30 AM phone calls I had for a year and a half or so with you, and Yale and CMS on the readmission effort. So.

Lisa Suter: It was an honor to work with you guys.

Fred Grover: Likewise.

John Handy: Well as time is growing short, I'm going to polish it off with talking about related measures and harmonization. So there's a whole bunch of measures out there that have either the same target population but different measures. So the 30-day mortality for CAB all cause readmission rate after CAB, I believe there, I thought there was a composite measure too. And then different target populations.

So all-cause mortality 30 days after acute infarction and then different populations but the same measure, AVR, NBR CAB, NBR repair, I mean

mitral valve repair and CAB. And so in essence, this doesn't really compete with - it actually supersedes it. It's sort of, it takes a bigger lens. Since this is a 90 day - everything here is 30 days or hospitalization. So I don't see any - I don't think there's any, it's not redundant in any way.

Bill Gunner: So thank you, thanks for all of that. I just want to make sure we had touched on topics for those who are going to join or review this recording in making their decisions and votes. I can't think of a topic that we have now yet touched on, unless anybody else can around the measure. All right. Melissa, back to you and (Jackie) and I think this is done. This one's in the books.

Melissa Marinelarena: Thank you (Bill). So we will now open the call for NQF member and public comment. If there's anyone on the line who would like to comment, please feel free to do so. You can also submit a comment to get a chat box.

(Karen Rubin): Hi, this is (Karen Rubin) from the American Medical Association. Hi, thanks for providing the opportunity to comment. I just want to clarify that in regards to historically, if it's an administrative claims measure CMS automatically attributes the measure to the physician based on the attribution model and meeting the minimum sample size, and that it's not a choice.

So for example, within MIPS you have the all-cause readmission measure that's attributed to physicians regardless if they choose it or not since it's administered through and determined based on (unintelligible). And thank you for considering and discussing our comments.

Melissa Marinelarena: Thank you, (Karen). Is there anybody else that would like to make a comment? Okay, hearing none, so just to recap, we discussed two of the CMS measures today. You will receive a recording of today's meeting plus a survey to submit your votes. You're going to vote on the two different levels of

analysis for the hip and knee measure and that is aligned with the readmissions project the way they did it for a similar Yale core CMS measure.

We don't want to do things differently. So you're going to receive that later today as soon as we are able to download the recording of today's meeting because we did not have quorum. And then we will ask for those results by Friday. It's usually 48 hours, but we have the holiday so he can return until it's no later than Friday COB.

And our next meeting is on July 15, next Wednesday from two to four.

Bill Gunner: (Unintelligible).

Melissa Marinelarena: I'm sorry, July 10 from two to four. We have already sent out the two STS outcome measures to you and you provided the comments. There are an additional three STS measures. They are participation in a registry. We are going to send those out today as well and ask you to provide your pre-evaluation comments. We're going to send it in a separate email to avoid any confusion with what we're asking you to do post-webinar today, and then ask you to provide those pre-evaluation comments. That will be very clear in the instructions. We just want to keep it separate.

The plan is to review the five measures next week. If we do not get through the five measures, we still have another meeting on the calendar for July 15 from 2 to 4 PM. The next measure is - the STS measures that we're revealing are maintenance measures. So you know, the criteria is a little different. But we'll see how we do next week and if we need to then we'll reconvene on July 15. Does anybody have any questions about that?

Okay. If you're going to attend or not attend, if anything changes before next week, let us know so we can keep track of quorum and let the developers know and so we can plan ahead as well. And if anybody has any questions, please do not hesitate to either contact anyone here on the team or (Bill) and (Lee). I'm also volunteering them as our as our co-chairs and then they can always contact us as well.

Thank you all of you for giving up a couple of hours of your (unintelligible) and I want to thank that developers as well. And we will talk to you soon.

(Group): Thanks. Thank you. Thank you.

END