

NATIONAL QUALITY FORUM

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MEASURE DEVELOPER WORKSHOP 2016

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THURSDAY
MAY 5, 2016

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The Workshop met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:00 a.m., Wunmi Isijola, Moderator, presiding.

PRESENT:

KELLY ANDERSON, The Lewin Group
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 SAMANTHA BERNS, MSPH, The Lewin Group
 ALICIA BLAKEY, MS, American College of Radiology
 KRISTEN BUTTERFIELD, MPH, Pharmacy Quality Alliance
 KYLE CAMPBELL, PharmD, MS, Health Services Advisory Group, Inc.
 PRIYA CHATTERJEE, MSPH, The Lewin Group
 CINDY CULLEN, MBA, Mathematica Policy Research
 LINDA DAILY, Livanta LLC
 MARSIDA DOMI, MPH, American Healthcare Association
 KAREN DORSEY, MD, PhD, Yale/YNHH Center for Outcomes Research and Evaluation (CORE)
 TRICIA ELLIOTT, MBA, The Joint Commission
 JEFFREY GEPPERT, JD, Battelle Memorial Institute
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 SARAH SAMPSEL, MPH, Senior Director
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 MARCIA WILSON, PhD, MBA, Senior Vice President
 REVA WINKLER, MD, PhD, Senior Director

ALSO PRESENT:

TARA McMULLEN, PhD, MPH, Centers for Medicare
 and Medicaid Services*
 MARY PRATT, MS, RN, Centers for Medicare and
 Medicaid Services*

* present by teleconference

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

2 9:05 a.m.

3 MS. ISIJOLA: Good morning, everyone.

4 Happy Cinco de Mayo.

5 (Laughter.)

6 MS. ISIJOLA: Thank you again for
7 joining us for day 2. We've covered some
8 tremendous ground yesterday. We have a few items
9 for today, but before we jump into that I just
10 wanted to review again some of the items that we
11 talked about yesterday.

12 Really yesterday was really
13 informational, letting you know some of the work
14 that we're doing here: measurement science, some
15 of the things that we're doing and how your work
16 impacts some of those areas.

17 Today it's really for the developers
18 and how you interact with NQF, specifically
19 around submissions. What we'll be doing in the
20 morning is talking through some of our submission
21 requirements. As we've heard in the past, there
22 are some revisions based on your feedback that

1 we've implemented. And we continue to do that,
2 but we wanted to showcase that to you again.

3 On our monthly webinars I know we give
4 you bits and pieces of that, but I think this is
5 an opportunity to really go through all of those
6 upgrades, but also an opportunity for you guys to
7 let us know if there is additional feedback or
8 improvements that we could continue to make. So
9 Reva Winkler and Sarah Sampsel will be talking
10 about our requirements.

11 Our appeals and endorsement process.
12 This was something that was approved by the CSAC,
13 our Consensus Standards Approval Committee, and
14 this is something we'll be rolling out shortly.

15 Also, I know I mentioned briefly
16 yesterday about our off-cycle activities, another
17 opportunity for our committee members to really
18 continue to engage with us.

19 And then we'll go into I would call
20 the critically acclaimed intended use project.
21 This is something that will become more real in
22 the near future. And Karen Johnson will be

1 talking about that, really some examples and how
2 we implement that in our new criteria.

3 We'll also be talking about our CDP-
4 MAP integration. So how does the endorsement
5 process feed into our MAP selection process and
6 how our efforts are being facilitated in the
7 future in order for that to happen.

8 And then we'll have a summary of the
9 day, but also an opportunity for you to continue
10 to provide us feedback. During the last advisory
11 panel one of the things we did was we got a group
12 of you guys to really continue to give us
13 feedback and suggestions on some of our policies
14 and our processes. So that's another opportunity
15 for you guys to engage with us as we continue to
16 make improvements through all of our work.

17 So with that being said, I'm going to
18 turn it over to Reva and she can kick off the day
19 for us.

20 Reva?

21 DR. WINKLER: Thanks, Wunmi.

22 Who's running the slides?

1 Okay. We're not going to talk about
2 absolutely everything, but we will want to talk
3 about a few things that I think have been
4 particularly of note in the last couple of months
5 as we've started this whole group of projects for
6 this year.

7 And so, the first one I want to talk
8 about is something that is underused and perhaps
9 because you're not aware of it. And so, we're
10 trying to rectify that.

11 NQF staff will be more than happy to
12 help you at any point. We call it technical
13 assistance, but you can call it whatever you want
14 to. It's pick up the phone and call us. We're
15 willing and able to help you at any point in time
16 with any questions you may have. And it doesn't
17 matter as long as it's about measures. I don't
18 know anything about football scores --

19 (Laughter.)

20 DR. WINKLER: -- but if it's about the
21 measures, I'm happy to help. And so, if your new
22 folks in your organization who are coming on

1 board -- we have new organizations coming on
2 board, new developers coming on board. If you've
3 got a new measure coming online, questions about
4 what's happening with your maintenance measure.
5 Anybody who asks, we get -- the phone rings all
6 the time. And so, we talk to everybody. But it
7 is underused by the measure development
8 community.

9 And what we've found is that for those
10 developers and measures that do come and talk to
11 us up front early on, things go a lot more
12 smoothly and we don't have sort of the train
13 wreck of time crunched stuff happening at the
14 last minute that drives us all nuts.

15 And so, I really want to invite you to
16 take advantage of it. Even if you think it's a
17 dumb simple question, I'd rather answer it well
18 in advance rather than at the last minute when it
19 may turn out to be bigger than you realize.

20 So what is technical assistance? And
21 that's help in understanding the submission
22 process and the requirements. And sometimes it's

1 a matter of what does this mean? Okay. We'll be
2 happy to help you. Understanding the evaluation
3 criteria that are used. For us, it's something
4 we deal with all day and we know the long history
5 of why they exist, but if you're relatively new
6 to this or perhaps hadn't really thought about
7 it, understanding why that's a criteria and why
8 we ask the questions we do may help you answer it
9 more on point. And so, we're happy to help and
10 help you fill out the forms, whether it's
11 technical or what words to put on the page.
12 We're more than happy to help.

13 And we can do this at any time. If
14 there's a project that your measure is involved
15 in and it's already up and running, the Project
16 Team is your first resource, but at any other
17 time we are also available. And I'll give you a
18 couple of examples of how this has worked out
19 really, really well.

20 We had some measure developers come to
21 us and say, gee, we're thinking about doing some
22 measures and -- but they were uncertain about

1 things. And their first -- and they said would
2 you take a look at our initial ideas? So Karen
3 Johnson and I looked at their initial ideas and
4 gave them feedback. And we then did that every
5 six months for three years through the
6 development of the process. We didn't tell them
7 how to develop their measure. We just gave them
8 a reaction thinking about our criteria, thinking
9 about how we are used to seeing committees. When
10 those submissions came in, they were great. They
11 were great.

12 And it removed a lot of the headaches
13 that I think we tend to run into because at the
14 last minute the submission comes in, we're
15 reading it and it's kind of like, ugh, this
16 doesn't have the information we need that's going
17 to help us get this to a committee. And so,
18 we're back at you saying an I-need-it-by-
19 tomorrow-at-2:00-kind of thing. That's all the
20 stuff that drives all of us kind of nuts.

21 So if you have any questions up front,
22 really, I strongly recommend that you come talk

1 to us. Sarah's over here nodding her head.
2 Karen's over here nodding her head. It's just
3 something that we see being so beneficial, but
4 yet not -- widely underused. And we really want
5 to encourage you to take advantage of it.

6 Now in terms of how do you get -- how
7 do you contact us? All right. As I said, if
8 you're in the middle of a specific project, that
9 project team. And the contact information is on
10 the project page. However, the default is always
11 to go to your favorite page, Submitting
12 Standards. And if you don't know this page and
13 don't have the shortcut on your computer, think
14 about it. You will see as you -- not too far
15 down the page, Technical Assistance. All right?
16 And it tells you -- gives you the email address.
17 And we will triage it to the appropriate person
18 in house and get back to you and help you out
19 with whatever your issue is.

20 So, I mean, again, it really helps us,
21 which is why we're really trying to emphasize how
22 useful it is. And I think the developers who

1 have taken advantage of it have found it to be
2 very, very useful. So for that; a plug,
3 technical assistance is always, always available.

4 Any questions about that from anybody?

5 (No audible response.)

6 DR. WINKLER: Okay. Good. All right.

7 The next thing we wanted to talk about is
8 something that's ongoing, and hopefully all of
9 you are aware of the fact that with this current
10 set of projects we've restructured the way NQF
11 evaluates measures that are already endorsed by
12 NQF and are going through their maintenance of
13 endorsement review, otherwise known as
14 maintenance measures. That's the shortcut. And
15 once NQF endorsement is granted, we do anticipate
16 re-reviewing measures approximately every three
17 years for a maintenance of endorsement
18 evaluation.

19 Things change, but more importantly
20 the world around us changes. The needs of the
21 marketplace change. And so this is such a
22 dynamic environment that it's important to be

1 sure that the measures continue to meet the
2 criteria if they're NQF-endorsed.

3 Now what we've done in the past was
4 always treat maintenance measures and new
5 measures identically as if there was no history
6 to the maintenance measure, which was sort of
7 dumb. And hearing that feedback, it's like,
8 okay, yes, that makes a lot of sense,
9 particularly since we house all of the
10 information from the previous evaluation in our
11 data system. We've got it. So it's a matter of
12 just pulling it up and looking at it.

13 So I think for those of you who might
14 be working with us with your maintenance measures
15 right now you'll find that what we're asking you
16 to do is just look at the we already have and
17 update it. Don't replace it. Just update it.
18 And that way we have the historical view of what
19 happened last time, you don't have to rework or
20 rewrite anything. Yes, we've changed a few
21 forms. It's okay. It's all about the same
22 stuff. Use the old forms. You don't have to

1 redo on the new forms. It's fine. And realize
2 that we're focusing in on things that are really
3 likely to change over time about a measure.

4 Yes, evidence can change occasionally
5 now and again, but mostly it doesn't. And
6 usually what we're seeing is the evidence -- if
7 anything else, if there's something new, it's
8 additive. It just adds something new and says,
9 yes, it's still good. It's rare that it changes
10 it dramatically. Sure, there are isolated
11 examples, but that doesn't happen in most
12 measures. And so, there's not a lot there.

13 Similarly, testing for liability and
14 validity, if you've done it well the first time,
15 you may do it again. And it's nice to see
16 updated data, but it probably will not be the
17 decision point of the measure. What's really
18 important on a maintenance measure is what's
19 happening. What's the current performance? What
20 are the results over time? How many folks are
21 using the measure? How broadly applicable is it?
22 In other words, what do we know about how good it

1 is as a tool to drive quality improvement? How's
2 it working? What are the problems with it?

3 So the focus for the maintenance
4 evaluation is on current performance, opportunity
5 for improvement and what have we learned by use
6 of the measure, really focusing in on use and
7 usability. Feedback from whoever. It might be
8 the MAP. It might be folks in the field. It
9 might be feedback from our committee members.
10 But we really want to know if it's working. What
11 are the issues? What's happening out in the real
12 world outside the Beltway? So maintenance has
13 really changed the focus of looking at those
14 measures for ongoing endorsement.

15 To help facilitate the logistics of
16 that, we created the maintenance checklist, and
17 with all of your help we've gotten through the
18 rocky early stages back and forth. We've
19 clarified some things. We've listened to your
20 feedback and hopefully I think we're in a
21 reasonably good place right now. But the
22 checklist is nothing more than the directions to

1 you all about what you need to do to update it
2 for maintenance.

3 And for a lot of measures there's very
4 little. We've had to really emphasize that in
5 order for us to see those changes you need to
6 write them in in red, otherwise they just blend
7 into the background and we don't know where the
8 new stuff is. That was something we had to learn
9 together. But if stuff hasn't changed, all you
10 have to do is say it didn't change. Nothing's
11 changed. Same stuff. We're good.

12 And so, just want to let you know it
13 was clunky to have to use the add-on extra
14 SharePoint site to do the checklist, but our plan
15 is to incorporate that within the whole OPUS
16 system with some skip logic and stuff like that
17 hopefully in the coming year. So this was a
18 temporary fix and we really appreciate your
19 indulgence in working with us, but we find the
20 information when you tell us what's happening
21 with your measure with these quick little answers
22 and following the directions on the checklist

1 limits the amount of work you have to do to
2 really get that measure ready for submission.

3 So at this point though we've done
4 several projects. We've got a lot of submission
5 deadlines coming in. Any questions, comments
6 about the change in this process that you're
7 experiencing?

8 (No audible response.)

9 DR. WINKLER: We've been getting
10 feedback on our monthly calls. We get feedback
11 from our developer Advisory Panel.

12 It's your turn. Anybody, comment?
13 Jeff, are you saying something?

14 MEMBER GEPPERT: So what can you say
15 about sort of the presumption of -- for
16 endorsement, for continued endorsement? Is there
17 an explicit or implicit presumption that in the
18 absence of positive information?

19 DR. WINKLER: Yes, I think that one of
20 the things that's happening is I don't think you
21 can have that presumption, because the
22 environment around us changes. The marketplace

1 changes. The demands of potential end users are
2 changing. And so, I think that any time a
3 measure is evaluated it has to be done within the
4 context of the environment of the time. And it
5 may be quite different than three years ago. And
6 that's the reality of this very dynamic
7 measurement world.

8 So I don't think you can say there's
9 a presumption. There is and we have said this,
10 that there is a general movement towards outcome
11 measures, composite measures, patient-reported
12 outcome measures, less so on basic simple process
13 measures. And that evolution we're seeing and
14 we're seeing that as changeover within the NQF
15 portfolio of endorsed measures.

16 So again, it's the environment and the
17 marketplace in terms of the kind of measures that
18 are proving themselves to be particularly useful
19 and valuable out there.

20 MEMBER GEPPERT: Just I think in terms
21 of the evaluation of the measure I think it would
22 be helpful to be explicit about what those

1 environmental context changes are that motivate
2 the decision.

3 DR. WINKLER: Point taken.

4 Question?

5 MEMBER BLAKEY: Hi everyone. My name
6 is Alicia Blakey. I am representing the American
7 College of Radiology. Just wanted to thank you
8 for your presentation on just the maintenance of
9 previously endorsed measures. I'm kind of new to
10 the college; only been there for probably two
11 years, and just recently had to go through three
12 applications kind of back to back.

13 So I think just in general because I
14 don't feel like the process for filling out the
15 application was as easy as it's sounding today.

16 (Laughter.)

17 MEMBER BLAKEY: You know the measures
18 have been incorporated in accountability
19 programs. Not a lot has changed. Of course
20 performance is improving. And I just wanted to
21 get just more information on kind of what -- the
22 forms online it requires you to kind of redo

1 everything again. It's not necessarily just
2 check yes. There's no -- so for example, let me
3 give you a practical example.

4 One of our measures has been a program
5 since 2000 to 2007, 2008. And we did not submit
6 any additional -- we submitted additional
7 evidence that was not necessarily systematic
8 reviews, but really talked to the use of the
9 measure and its importance in filling a gap in
10 care. And the committee, their preliminary
11 analysis said that that was insufficient
12 evidence.

13 DR. WINKLER: Yes.

14 MEMBER BLAKEY: And so you can imagine
15 if your evidence is not graded, then I think that
16 was the rationale, but something as simple as we
17 have great evidence for it was not sufficient.

18 DR. WINKLER: Yes.

19 MEMBER BLAKEY: And just even I guess
20 in general I just wanted to make a comment. If
21 you could explain a little bit more in depth of
22 the training for each of the project teams. So

1 some project teams it seems to be inconsistent
2 how they -- it seems very subjective as far as
3 how much intent they give to evidence or
4 reliability or in validity. So it's not really
5 consistent from -- like we're working on two
6 different projects at once, so I see a complete
7 difference.

8 DR. WINKLER: Okay. And we're pleased
9 to hear your feedback because that's something
10 we're actually working exceptionally hard with.
11 As Sarah and Karen and I know, we put at least
12 two to three of us doing those evaluations to try
13 and foster that consistency. But again, it's a
14 work in progress.

15 A couple of things: When you're
16 looking and answering the questions, it's
17 important that you understand what the criteria
18 are, and the criteria are very specific. And
19 that's what we're using to guide the committee to
20 do the evaluation. So for instance on your
21 example about evidence, the evidence for a
22 measure is expected to be a systematic review of

1 the body of evidence that relates what you're
2 measuring to patient outcomes. And that's what
3 we're looking at.

4 And so, it's important that you really
5 take a look at the guidance document that really
6 explains the criteria and how those will be
7 evaluated to understand. But again, we're happy
8 to help you out with a little bit of off-line
9 technical assistance any time if you do have
10 questions. No problem with that.

11 MEMBER BLAKEY: Thank you. Yes, I
12 think the technical assistance will be helpful
13 just because the process should have been a
14 little bit easier than I had anticipated. For
15 new staff who are new to measure development,
16 it's good. I think technical assistance is
17 helpful.

18 DR. WINKLER: Yes, I think for new
19 staff and new to measure development it's like
20 coming up on the on ramp on a freeway. It's
21 moving fast, folks.

22 Question?

1 MEMBER KAYE: Hi, this is Toni with
2 the PCPI. I wondered if you could speak a little
3 to have you changed the way you kind of advise --
4 have your committees and kind of train them to
5 the focus for measure maintenance?

6 DR. WINKLER: Absolutely.

7 MEMBER KAYE: I'm thinking -- first
8 example, whenever this was first rolling out and
9 the idea of if the evidence hasn't changed or if
10 it's only been added to, then don't worry about
11 it. But I think in practice sometimes we've
12 heard with committees it's more a, well, do you
13 want to review it? So there's a chance of kind
14 of being caught like, oh, we didn't know they
15 could even discuss it. So it's kind of a matter
16 of how you prepare going into the meeting.

17 DR. WINKLER: Right. I think that
18 ultimately since the committees have the final
19 say we do -- our guidance to them is, hey, guys,
20 if nothing's changed, let's not waste our time
21 here saying -- doing -- redoing work and let's
22 move on. But the committee always has -- it --

1 because it's ultimately their responsibility,
2 they always have the opportunity to jump in.

3 But we have found that; at least my
4 personal experience is, they're fairly guidable,
5 mainly because there tends to be a lot of work to
6 do. And if there's something they can like limit
7 and move onto something else, they're pretty good
8 at doing that. But it's we're trying hard to
9 guide them there, but it's not like we can
10 totally, totally force them there because we have
11 granted them the role of the oversight and the
12 responsibility.

13 So my experience though is that
14 they're reasonably happy to be guided. I can't
15 promise that's going to happen all the time.
16 Perhaps there may be some controversial measures
17 or controversial areas, but by and large they're
18 looking to focus a lot on talking about how a
19 measure is being used. What happened at my
20 house. Or they want to tell you their horror
21 story or their -- what's going on.

22 So, but again, I think it's a work in

1 progress. We're learning. We share among all of
2 us who are doing this and leading these projects.
3 We're in constant contact. Even during a meeting
4 I had Karen emailing me, how's it going? What's
5 happening? Did this work out? Did that work
6 out? So I mean, it's -- we're making all the
7 efforts we can to use a common approach and a
8 common experience across all the teams. But it's
9 challenging because it's as new for us as it is
10 for all of you. So thank you for all of your
11 help, assistance and indulgence in doing it.

12 MEMBER KAYE: Thanks.

13 DR. WINKLER: Okay. Anything else?
14 I'm not seeing anybody.

15 (No audible response.)

16 DR. WINKLER: Okay. Next slide. Off-
17 cycle. I think I hand this one off to Sarah.

18 MS. SAMPSEL: And I'm just going to --
19 I was trying to figure out if I wanted to say
20 this or not in response to your question, Toni;
21 and maybe if I haven't had enough coffee, I
22 shouldn't say it, but I echo what Reva says, that

1 it's a learning process for us, too. I think
2 evidence is not the hard part. It's when -- I
3 think the testing updates. And so, as many of
4 you know who have been around for awhile,
5 sometimes you get an original form back that's
6 the old NQF forms, and you know they look very
7 different from the new NQF forms, which reflects
8 updated criteria.

9 And so, what we're trying to do on our
10 projects as well is get ahead of that a little
11 bit, not only go back for the history, as Reva
12 said, which is why we want to see that
13 documentation of what happened beforehand, but
14 then also being able to say, okay, they've
15 updated their testing.

16 So the maintenance checklist said they
17 updated their testing. Well, then we want to
18 know why did they update their testing? What was
19 that change? And sometimes those old forms don't
20 reflect it very well. But that's where we're
21 trying to get ahead and have the conversation
22 with you before we go to committee so that we can

1 help represent as well what that change was. But
2 again, sometimes that comes down to the technical
3 assistance. To me this is all woven together.

4 What I will also echo what Reva said
5 from her earlier presentation is new developers,
6 some of these novel new measures coming out,
7 technical assistance is key. And we really are
8 seeing, I mean, I really have to say beautiful
9 submissions. And that's hard to say, and that's
10 really geeky, too.

11 (Laughter.)

12 MS. SAMPSEL: But some just really
13 nice submissions. I go they listened to us.
14 They listened to us. And you're really happy
15 about it. And I think we all feel that's a
16 success because it helps us.

17 And we also as senior directors kind
18 of throughout the teams we want to know your
19 measures. We want to help you. We want to be
20 your partner in this and it's hard to do if you
21 don't come to us in the first place. And when
22 you get a call 24 hours before a measure

1 submission saying, yes, I don't know how to fill
2 out this evidence question. I don't know if this
3 is a process measure. Well, it's really hard for
4 me to want to help you. I mean, it really is.
5 So, anyways. But we still try and it's a give
6 and take and we understand that.

7 So off-cycle activities. One of the
8 things that we've been working on, and probably a
9 little bit slower than we wanted, but you're
10 going to start seeing beefing up over the next
11 couple of quarters are off-cycle activities. And
12 so, we started using standing committees a couple
13 years ago now, therefore we have a committee
14 that's assigned to a content area that's
15 responsible for the portfolio over time. And so,
16 and they're responsible for the full portfolio,
17 so you should have the same standing committee if
18 you come to us this year, next year, whatever.

19 There are sometimes little tweaks to
20 the standing committees, but what that also means
21 to us is we need to find a way to keep them
22 engaged. We don't want to just call them every

1 two years and say, hey, you have -- you need to
2 look at these measures again, or we have some new
3 measures for you. We want to keep them ingrained
4 in the process.

5 Again, to go back to things like when
6 we make updates to the standards, this is an
7 opportunity to educate. Hey, we know you're not
8 active right now. We know you don't have any
9 measures to look at right now, but we've updated
10 our maintenance process, we've updated X process
11 and we want to keep you informed.

12 But we also want to give them an
13 opportunity to remain aligned and engaged with
14 each other. And so, we're looking for
15 opportunities in working with our standing
16 committees. What do they want to talk about off-
17 cycle? You don't have 25 measures to review this
18 year. What do you want to talk about? What can
19 we do to help you stay up to date and current,
20 not only in NQF, but what's going on in the
21 measurement field in your area?

22 Next slide. Where did the clicker go?

1 I guess I'm in charge of next slide. Whoops.

2 So basically this is a kind of laundry
3 list of some of the things that we're thinking
4 about with off-cycle activities. Serving as a
5 clinical or a technical expert panel for other
6 standing bodies. So it could be Measures
7 Application Partnership. It could be one of our
8 white papers or other workgroups. It could be
9 kind of something new coming out, whether it's in
10 the quality innovations department, whether it's
11 the incubator, some expert panel to bounce ideas
12 off of of what's going on.

13 I'll give you an example here in that
14 we have a number of measures that were submitted
15 to Person and Family-Centered care that really
16 weren't measures, they were tools. So we had a
17 conversation with them and said we really can't
18 send these through, but we're willing to give you
19 an hour on an agenda. We have a seated committee
20 right now and the standing committee, and they're
21 going to meet. We're going to give them time on
22 that agenda.

1 But I would say in an off-cycle year,
2 an off-cycle period we would be able to convene
3 our standing committee and say, hey, we want to
4 talk about this, or, hey, we have somebody who's
5 really interested in creating a measure on some
6 kind of PROM or some kind of shared decision
7 making or something like that. This is an
8 opportunity for you to give early feedback and
9 help guide this discussion. So those are the
10 types of things that we're starting to think
11 about with off-cycle activities.

12 Connecting the standing committee with
13 external entities to discuss and identify
14 potential collaborative groups. This might be
15 the case, and again we're probably going to be
16 doing this in the renal project where we have a
17 process measure based on a PRO-PM. There's
18 really nothing wrong with a process measure, but
19 they really want to be going towards outcomes.
20 They have no idea how to do it. So why not put
21 the experts -- put them in front of the experts
22 and have the experts give them some of that

1 feedback? And we can use that. It's not measure
2 development advice, but more about these are some
3 concepts you can think about. This is what we'll
4 want to see when you come back for endorsement.

5 Sharing of innovative performance
6 measurement work done by committees. So as you
7 all know and we talked about a little bit
8 yesterday are gaps and identifying gaps. One of
9 the purposes of that conversation is to also find
10 out what's going on and what is coming down the
11 pike for future activities. This is an
12 opportunity again to share in specific ideas and
13 examples of those innovative ideas that are
14 coming out.

15 I think this next bullet is pretty
16 close to the last couple that I mentioned.
17 Educational activities and then ad hoc measure
18 review. So ad hoc measure review, some of you I
19 know who are here today and some of you may
20 experience in the past or in the future, if you
21 make a material change to a measure during your
22 annual update process, you're going to be

1 notified that the measure is now going to be
2 scheduled for an ad hoc review. We will be doing
3 some of these during the off-cycle reviews.

4 So let's say behavioral health we only
5 have one measure scheduled for review in a given
6 year, but there are a number of measures that
7 have been identified for ad hoc review. They
8 would go through an off-cycle committee versus
9 pulling the whole committee together for a two-
10 day meeting, etcetera.

11 But we would be giving you -- and
12 there will be a back and forth exchange of we'd
13 like to do it in fourth quarter. You'll hear
14 from staff. Will you be able to meet that
15 guideline? And we should also be giving you
16 feedback on why we feel that your measure needs
17 to have an ad hoc review because of some kind of
18 material change. But we would also hope that if
19 you've made the change and notified of that you
20 were already aware of what you did.

21 Next slide. So this is just an
22 example of one of the -- we just finished up an

1 off-cycle review, and it was the Care
2 Coordination Standing Committee. And mind you,
3 some of our committees the experts really just
4 like to be engaged a lot. And so they're always
5 looking for ideas of why can we meet, how to stay
6 engaged, and we're happy to kind of continue that
7 conversation.

8 But this was kind of an ideal
9 situation that when there was outreach both to
10 CMS and ONC, as well as to the co-chairs of the
11 standing committee, they were just like, hey, we
12 have this great idea. Let's talk about current
13 activities around health information technology
14 and how they relate to care coordination.

15 So basically we convened the Care
16 Coordination Standing Committee via phone. Or
17 no, they -- did they meet in person?

18 Okay. It was a webinar where they had
19 a conversation about what ONC wanted to talk
20 about and they were able to release a report.
21 It's not as thorough. It's not a 300-page report
22 like we get out of a full cycle, but to the same

1 degree it was the opportunity to facilitate a
2 discussion that was generated by ONC using an
3 expert panel and coming up with that idea of what
4 they need to -- what they would want to talk
5 about.

6 So upcoming off-cycle work that -- so
7 you should be aware. Behavioral Health Standing
8 Committee will be doing outreach to our co-chairs
9 in the -- well, it was supposed to happen last
10 week; it didn't happen -- next week regarding
11 what are potential topics to the co-chairs? And
12 we also need to assess the standing committee
13 membership because we have some folks who are --
14 their terms are up.

15 But basically, talk to them. And I'll
16 be reaching out to say what are those things that
17 are going on in behavioral health that you might
18 want to talk about that is an opportunity to
19 engage and hear from the standing committee
20 members?

21 Kind of one example that we're seeing
22 a lot of is the integration of behavioral health

1 in chronic conditions. What's going on in
2 measurement in primary care? What's going on
3 with diabetes depression measures? What's going
4 on with some of those other chronic conditions
5 and how they affect some of the behavioral health
6 measures. So that might be one opportunity, but
7 frankly, I don't know. We'll reach out to Peter
8 Briss and Harold Pincus and get their feedback on
9 what they think this group will want to talk
10 about.

11 We would anticipate pulling together
12 that webinar in the third quarter. That will be
13 released out on the -- on our web -- on the
14 project page. And then also we'll be doing
15 fourth quarter ad hoc reviews. So for those
16 measures that have been identified with material
17 changes during their annual updates or perhaps
18 they were measures that had conditions of
19 endorsement during their last phase of work.
20 Those will come back for ad hoc review. And
21 we're teeing that up to happen in the fourth
22 quarter of this year.

1 So I am staffing that as well as
2 Melinda Murphy because I'm conflicted with most
3 behavioral health measures. And I'll just say
4 that publicly. Not that I have anything against
5 them, but I worked on most of them. So it
6 doesn't make sense that I can also review them at
7 this time.

8 Similar situation with
9 musculoskeletal, that we'll be talking to the co-
10 chairs, looking at the standing committee
11 membership and coming up with some ideas to
12 reconvene musculoskeletal, because that group
13 hasn't met for a couple years. And I'm similarly
14 conflicted with musculoskeletal.

15 So I am just really conflicted, but I
16 keep coming up with a real laundry list of what
17 I'm conflicted with. Some of it's flying; some
18 of it's not.

19 So that is that. I guess what I want
20 to do: one, see if there's any questions; and
21 two, I really want to know for any of those of
22 you who have been indicated for ad hoc review,

1 are we giving you enough information? Again,
2 this is your opportunity to give us feedback.
3 Where can we do a better job and what would you
4 want to see during the off-cycle process and some
5 ideas on how to engage. And maybe some of you
6 have some ideas for some of these committees,
7 what we could be talking about.

8 Yes, Sam?

9 MEMBER SIMON: So in the vein of be
10 careful what you wish for, here's one of those
11 questions about ad hoc reviews. No, it's fine.

12 (Laughter.)

13 MEMBER SIMON: No, just generally
14 speaking, I mean, I know -- I understand what the
15 purpose of an ad hoc review is. There's a change
16 made to a measure and the committee wants to
17 understand sort of what change that -- material
18 effect that has on the measure. But just like
19 Reva gave us some broad high-level guidance about
20 what the committee looks for, what types of
21 evidence the committee looks in a maintenance
22 review, I think the same would be really helpful

1 for an ad hoc review. Are you looking for
2 performance data? Are you looking for the
3 measure developer to go out and collect
4 additional data about usability and use? I think
5 having some high-level guidance along those lines
6 would be really helpful.

7 MS. SAMPSEL: So the easy answer to
8 that is technically it would be the same as a
9 maintenance review. At the high level you're
10 still looking for usability, but you're also
11 looking for -- and this might be an interesting
12 exercise of what is a material change and -- do
13 you have something to say?

14 DR. WINKLER: I'm sorry.

15 MS. SAMPSEL: I'm just going to let
16 Reva go.

17 DR. WINKLER: Only because I got to
18 dance with the CSAC about what is a material
19 change. And the most recent guidance that's
20 posted on our web site is the most recent wording
21 they've come to conclude. And so, a material
22 change is, as everybody says, you know it when

1 you see it. Well, good luck with that one. But,
2 so I would refer you to the wording because I
3 don't have it quite off the top of my head.

4 But when we do identify a material
5 change, one of the things CSAC did say is they
6 would expect to see new results using the measure
7 with the new specifications. So they do want to
8 see some data associated with it.

9 That would be the one thing with
10 material change are the specifications that they
11 are looking for is because if - presumably it's
12 material, it's going to change things. The
13 question is how much and how significant might
14 that be? So that would be sort of the in
15 addition to just the general criteria is because
16 it's new spec you'd expect some new data to go
17 along with it.

18 Question from anybody else? Yes,
19 Kyle?

20 MEMBER CAMPBELL: So regarding
21 behavioral health we're currently developing
22 measures for CMS in the inpatient psychiatric

1 facility setting, and we have some measures in
2 the pipeline, but our understanding is there
3 isn't yet a date for a behavioral health CDP. So
4 I didn't know if there's any opportunity -- like
5 if you had any guidance about when that might
6 happen. And I think we would probably have three
7 measures ready by the fourth quarter.

8 MS. MUNTHALI: Fourth quarter you
9 said? That's good timing. We can't confirm
10 anything right now, but if you have it by fourth
11 quarter of 2016, that's good timing.

12 MEMBER CAMPBELL: Great. Thanks.

13 MS. SAMPSEL: And I do want to say
14 more globally, too, is remember that's -- the
15 issue with the standing committee is the ability
16 to always keep us informed of new developed -- of
17 new measures in development. And so, if we know
18 about it; and now we know, is then that
19 opportunity to have conversations with CMS, but
20 then also to think about integrating to off-
21 cycle, because we may be able to -- as an
22 example, when I was talking about the PRO-PMs

1 yesterday, the patient activation measure, that
2 was reviewed. That's a brand new measure
3 reviewed in an off cycle.

4 So, there might be some opportunities
5 there where we're getting them together. And if
6 it's a synergy, they may not come together in
7 person, but we might be able to do that review.

8 MEMBER CAMPBELL: Sorry, I have one
9 more follow-up question. How does the
10 integration work? So we submitted a 30-day all
11 cause unplanned readmission measure for the IPF
12 setting for the Readmission Standing Committee to
13 review. But is there collaboration between the
14 two committees, because that's something that the
15 Behavioral Health Committee was interested in
16 seeing developed for that setting.

17 MS. SAMPSEL: So I think there we
18 probably have a lot of case studies more than
19 anything else in that we all stay in tune on what
20 measures we're reviewing and what are coming
21 through our committee. And as an example,
22 Karen's Managing Palliative Care and she has pain

1 measures. I'm doing pain measures in Person and
2 Family-Centered Care. So we're trading off
3 reviews of the measures and making sure that our
4 committees are aware of what's going on. So
5 that's a really good example of now we have a
6 trigger of I need to follow up with Readmissions
7 to get that feedback from Behavioral Health.

8 Some of it's a little bit informal
9 where what we might do is -- and here's another
10 example. I have a measure, a home and community
11 based services experience of care measure coming
12 through. I've noted -- I've given the Duals team
13 and the HCBS team notification to send that out
14 to their committees to do some of the public
15 comment on those reviews.

16 So there's not always formal
17 integration because we don't want to totally
18 decimate one standing committee over the other,
19 but we do know that they have feedback and we do
20 want to get that feedback.

21 MEMBER DORSEY: I just wanted to ask
22 one question, a point of clarification around new

1 measures. So I think I heard you say that it's
2 useful for you guys to hear when we have a new
3 measure way ahead of when projects get scheduled
4 on a calendar. And then you guys can work with
5 developers to figure out when --

6 MS. MUNTHALI: Yes, it's really
7 helpful for us to know that because it feeds into
8 our negotiation process with CMS. And that
9 oftentimes helps us to prioritize which projects
10 we're going to have.

11 DR. WINKLER: Yes, I mean, we can't
12 emphasize enough that what we know that's coming
13 down the pipeline is really important for all the
14 planning, because you know there is a lag by the
15 time you organize the funding, create the
16 projects, get things going. So the more up front
17 we know when what's coming and when it's going to
18 be ready, the better we can plan to incorporate
19 it into our work.

20 So again, you don't have to wait for
21 us to ask. Please tell us. That would be very,
22 very helpful and I think it works out well for

1 all of us.

2 MS. SAMPSEL: What I'll just add to
3 that is remember in all of our project pages
4 there should be a project email box. That's all
5 you have to do is send an email to the project
6 email box.

7 MEMBER KEENAN: Do you all look at the
8 MUC list to see measures that are coming? Oh.

9 DR. WINKLER: Hold that thought.

10 MEMBER KEENAN: Okay.

11 (Laughter.)

12 DR. WINKLER: Hold that thought,
13 because, yes, and that's going to be one of the
14 important aspects of the CDP-MAP integration
15 we're going to talk about a little bit later.

16 Okay. Any other questions about the
17 off-cycle work? We're going to go into one more
18 subject.

19 (No audible response.)

20 DR. WINKLER: Okay. And that's just
21 a quick review of something that's changed this
22 year and will go into place in the last half of

1 this year. The specific date we will announce
2 when we have it finalized.

3 But just to -- remember, most of your
4 effort is always on the -- up front of the CDP
5 steps, but the back end, the later steps are also
6 very important. And for those of you who are
7 familiar with it, you know that the endorsement
8 process is essentially the committee makes a
9 recommendation, it goes out for comment, goes out
10 for vote, and then those recommendations go to
11 the CSAC, who makes an endorsement decision and
12 the board of directors ratifies that endorsement
13 decision to grant the endorsement.

14 Appeals, there's the sort of final
15 step required within the CDP process so that an
16 appeal can be submitted within 30 days after the
17 endorsement is announced. And those appeals have
18 gone to the CSAC for review and then again to the
19 board of directors for review.

20 That process was reevaluated. And the
21 question is why make any changes? Well, we
22 undergo a lot of scrutiny about our process, and

1 this one actually involved the board of
2 directors. So the board started doing a little
3 self-scrutiny and thinking that it needed to be
4 reassessed, particularly to become more efficient
5 and eliminate some redundant decision making and
6 prevent redoing and re-discussing the same thing
7 too many times and then reinforcing some of the
8 finality of decisions.

9 And so, the board came up with some
10 process improvements. And the principles behind
11 them is that the CSAC now will really -- because
12 they always have been the group that's able to
13 really look at what happened during the consensus
14 development process, that is their charge. That
15 is what they do, unlike the board of directors,
16 which has all sorts of other governing
17 responsibilities, and this isn't their main job.
18 So the CSAC it is their main job. And to
19 separate the role of the CSAC when it comes to
20 appeals, a newly created appeals board will
21 decide measure appeals. And so, appeals of the
22 endorsement decision will not go back to the

1 CSAC, but will go to the appeals board.

2 So again, so pictorially; I think I've
3 got -- yes. The process, if you notice we've got
4 one less arrow on each sign, so that's more
5 efficient. So essentially the recommendation
6 from the committee to the CSAC after voting and
7 comment doesn't change. Same stuff. But the
8 CSAC's decision is the final decision. The
9 endorsement is granted at that time. You'll find
10 it happens two to four weeks earlier than the
11 previous process. So it does shorten the whole
12 process overall.

13 The appeals process then. CSAC is
14 sort of the starting point granting the
15 endorsement. If an appeal is submitted, then it
16 is presented to the appeals board for review so
17 we don't have that multiple couple of extra steps
18 back and forth, and simplified the process
19 considerably.

20 Now the grounds for appeal were also
21 revisited. And so, if you noticed that the old
22 grounds for appeal were to be filed in response

1 to any of the endorsement decisions and it needed
2 to include some written evidence as to why do you
3 care and what are the issues? And so, but in the
4 new appeals process there are two reasons for
5 appeal, and one is around procedural errors such
6 as failing to follow the process as written out,
7 or there is new evidence or information
8 unavailable at the time the original endorsement
9 decision was made, right, that wasn't considered
10 that's reasonably likely to affect the outcome of
11 the original endorsement. So that's a relatively
12 straightforward change to the appeals process.

13 The appeals board will consist of
14 current board members, former CSAC members and
15 former standing committee members. So nobody
16 that's actively in the process but has sufficient
17 experience to understand the process and NQF's
18 activities.

19 And so, what the appeals board will do
20 is review the appeal and then make a decision
21 that will either uphold the endorsement decision,
22 overturn it or dismiss the appeal. So they

1 aren't re-litigating any of the criteria or
2 anything like that.

3 So this process has been approved by
4 the board. It will go into effect the second
5 half of this year. The exact time frame of which
6 project we're going to flip it on is to be
7 determined and -- but I think you're going to see
8 it in effect for the second half of 2016.

9 So any questions about that change?
10 I mean, we've been talking about this a little
11 bit, so you may have heard about it before, but
12 we wanted to be sure everybody's familiar with it
13 and aware of it.

14 Yes, Matt?

15 MEMBER POPOVICH: What was the
16 percentage of measures over the past two years
17 that were appealed? And then like is it a
18 significant process or is this just -- and then
19 where does the measure developer fit into this --

20 DR. WINKLER: Okay.

21 MEMBER POPOVICH: -- within the appeal
22 decision making?

1 DR. WINKLER: Actually the number of
2 appeals is relatively low. It's a handful over
3 the last two years when we've done several
4 hundred measures. So we're talking about a low
5 percentage.

6 Where does a measure developer fit in?
7 The measure developer is involved in the whole
8 process at every step along the way. As you
9 know, when we take the measures and the results
10 of comment and voting and the committee
11 recommendations to CSAC, we -- measure developers
12 are -- hopefully attend that and may have an
13 opportunity to contribute to that conversation,
14 depending on what it is.

15 Again, with an appeal the folks we
16 notify that an appeal has come in is the
17 developer, an opportunity to respond to what's
18 going on. Often -- and it's particularly
19 pertinent if there's something technical about
20 the appeal that's about the measure specs itself.
21 The developer is often the crucial responder
22 about what -- a decision is made or not made

1 about how the measure is constructed or something
2 like that. You will be less of a player if the
3 appeal is about a process or something like that.

4 So, but definitely you will be
5 involved in the whole thing and you'll be
6 notified if an appeal is submitted and that we
7 will be taking it to the appeals board. And you
8 will be notified when that happens and the whole
9 thing. It's just another lovely step of the
10 process we all get to share.

11 Any other questions? Question,
12 somebody? Jeff? Oh, okay. I saw something
13 going on over here.

14 MEMBER GEPPERT: So in terms of the
15 criteria; could you go back to the criteria, I'm
16 just wondering what new and unavailable means?

17 DR. WINKLER: How a --

18 MEMBER GEPPERT: So the difference
19 being new information that has recently been
20 generated --

21 DR. WINKLER: Yes.

22 MEMBER GEPPERT: -- which would

1 probably feed into like an ad hoc process, or
2 just information that was not made available or
3 was overlooked.

4 DR. WINKLER: I would guess it's
5 either.

6 DR. WILSON: No, it's new evidence.

7 DR. WINKLER: Okay. I'm going to give
8 this one to Marcia and let her clarify.

9 DR. WILSON: I think the intent was
10 that it is new evidence that comes to light,
11 because you figure by the time a measure gets --
12 is brought forth to NQF and goes through the
13 process some time has elapsed. So it's not like,
14 oh, we forgot to say this during the original
15 process when that measure is being seen. It is
16 truly for new evidence that would have come to
17 light.

18 MEMBER DORSEY: So that's really clear
19 and I get it, but what -- how do NQF and measure
20 developers -- how do you intend to handle when
21 appeal letters don't necessarily follow these
22 guidelines, right? Because sometimes these

1 letters the kitchen sink can get thrown into the
2 content of what's brought up. And so, then
3 what's the expectation for response?

4 DR. WILSON: One of the reasons for
5 changing the grounds for appeal was exactly that.
6 We felt that some of the appeals that had come in
7 historically were if I say this a different way,
8 I can appeal this. So that was one of the
9 reasons for changing the grounds.

10 The other thing that Reva mentioned is
11 that any appeal that comes into NQF will go to
12 the appeals board and they can determine whether
13 that appeal meets the appropriate grounds. So
14 you may -- someone may file an appeal. It will
15 -- staff will look at it. They will pass it to
16 the appeals board and the appeals board will say,
17 no, this doesn't meet the grounds for appeal and
18 then the appellant would be notified.

19 DR. WINKLER: Anything else on that?

20 (No audible response.)

21 DR. WINKLER: Great. Okay. Isn't my
22 turn over? Yes, right. But my turn's over,

1 right?

2 MS. ISIJOLA: Yes.

3 DR. WINKLER: Okay.

4 MS. ISIJOLA: So one of the things we
5 wanted to also shed some light on is our IT
6 space. Many of the ways that you contact or
7 interact with us is within your submission
8 dashboard, but also one of the things we're doing
9 is revamping that and reinventing that. So Jason
10 Johnson is actually our Vice President of
11 Information Technology and he'll go over some of
12 the changes that we'll be making and that you'll
13 see within your dashboard within the next few
14 weeks. But also this is an opportunity -- if
15 there are improvements or suggestions that you
16 may have that we can continue to reinvent the
17 wheel as we make it easier for you to interact
18 with us, he's your guy.

19 MR. JOHNSON: Thanks, Wunmi.

20 Hi, I am Jason Johnson. I'm Vice
21 President of IT. I have been in that role only
22 for about three months, but I've been here at NQF

1 for about five years. And there is a specific
2 change that we wanted to talk with you about
3 first, and it comes from the inclusion of
4 eMeasures more frequently in our work. And the
5 fact that we're in a bit of a transition period
6 where our eMeasures -- we have eMeasures coming
7 in while we have our regular measures, or what
8 we've always called measures there as well.

9 And so, what we've done is made an
10 accommodation where -- that we hope is clear to
11 you and also to our outside users, particularly
12 those people who are using QPS. Because what we
13 have now is two different formats of a measure,
14 what we traditionally called a measure and an
15 eMeasure being referenced under the same number.

16 So we may have Measure 0070, which is
17 one I just mocked up for an example. And if we
18 use that single number, how do we differentiate
19 between the two formats that we might have, the
20 eMeasure format and the format everyone has been
21 used for years and years.

22 So what we've done is tried to clarify

1 that by adding another number. So your eMeasure
2 when it comes in will also be assigned a number.
3 And what you're thinking of as your traditional
4 measure number, or traditional measure will also
5 be assigned a number. So they'll both have two
6 separate numbers, but they'll exist under the
7 regular measure number.

8 So a picture is worth a thousand words
9 and you should be able to see that a little more
10 clearly here. So here we have Measure 0070. And
11 this is what the QPS display will look like. And
12 if the user clicks on the little plus up next to
13 it, they'll see that the measure is available in
14 multiple formats. And then there will be two
15 additional measure numbers, or rather NQF numbers
16 available and assigned to that measure.

17 Now end users will be able to
18 reference either of those numbers. So if they
19 search by 0070, they will get both formats. If
20 they search by 2906 in this example, they'll see
21 all available formats as well. So we want to be
22 able to present all of those to the users but

1 still allow the individual submissions; the
2 eMeasure submission and the regular submission,
3 be referenced by a single unique number. And
4 that was the goal of what we were trying to do
5 with this system.

6 When we display this more generally,
7 you will see that we concatenate the numbers. So
8 it will always be the first number that we're
9 used to, 0070, and then there will be a colon and
10 then the additional format number, 2906. And we
11 really do expect this to be a transitional
12 approach. Overall we'd like to keep the numbers
13 that you have to reference and manage manageable
14 and as few as possible, but we think that this
15 display works best given the options available
16 for our end users. And we're also trying to make
17 it easier for you.

18 If you can advance to the next slide.
19 So within your dashboard this is what you will
20 see. The two different formats will roll up
21 underneath that same measure that you're used to
22 from your prior measure number.

1 So I'm going to pause there and see if
2 there are any questions about that or how that
3 lays out or why we made that decision.

4 Yes?

5 MEMBER CAMPBELL: So one of the things
6 that I think would be important to consider --
7 and I like this that they're linked together, but
8 I think part of the confusion in the marketplace
9 with regard to alignment relates a lot to like
10 different NQF numbers being assigned. So someone
11 sees NQF 2906 and to them NQF 2907 isn't the same
12 thing. So I'm wondering if there would be an
13 opportunity to make it NQF 0070A, NQF 0070B.

14 MR. JOHNSON: Yes, we did consider
15 that. So our intention in the marketplace is
16 that these will always be displayed together. It
17 will always be 0070:2906, so that we can that
18 reference point. Or it would be 0070 alone,
19 referencing the entire -- both formats.

20 We intentionally avoided adding
21 extensions. We considered adding an E to the
22 end, considered A, B, C for multiple formats.

1 And what that begins to do is cause problems for
2 some of our end users who are used to downloading
3 this and working with it in Excel. As you begin
4 to mix alphanumerics it can begin to cause some
5 sorting issues for folks. And we didn't find
6 that quite as useable. We also have a number of
7 internal processes that are heavily Excel-
8 dependent and we thought that would make it a
9 little more troublesome for us as well. So
10 that's in terms of adding just alphas.

11 In terms of adding an extension like
12 an E or something like that, we were concerned
13 about overloading the number with too much
14 meaning. We wanted the numbers to stay -- from a
15 purely data perspective it's not wise to begin
16 adding meaning into the number if you can help
17 it. So we intentionally shied away from that as
18 well.

19 MEMBER CAMPBELL: So one thing then I
20 would encourage, because I think it sounds like
21 from an internal perspective it works really
22 well, but from a patient or a stakeholder

1 perspective when these measures get publicly
2 reported by CMS and you have to go and the
3 patient has to see NQF 0070:0296, 00 -- whatever
4 it is, I think part of the problem that we're
5 having in the marketplace and patients and
6 stakeholders are understanding measures is a
7 confusing numbering system.

8 MR. JOHNSON: Well, we hope that 0070
9 is the way that most are going to reference it
10 and that the different formats are really more of
11 an inside baseball-kind of piece, but I totally
12 understand that approach.

13 The other thing that we believe is
14 that this will go away, that this is a
15 transitional issue and that over time each of
16 these will only have a single format again, and
17 that would be the eMeasure format.

18 MEMBER CAMPBELL: But I think it does
19 go beyond the eMeasure format and that you might
20 in the future -- as measures become more aligned
21 across settings and across the payers you may
22 have a situation where you have a physician group

1 measure that's 0070 and then you have a plan
2 level measure. And I think the more that you can
3 align that across the marketplace and across the
4 settings of care so they roll up to -- because I
5 mean, if you think about it, the underlying
6 evidence for a hemoglobin A1c measure, regardless
7 of what layer you report it at, is the same,
8 right? So it's really just the testing results
9 and the adaptation to a data source that's
10 different.

11 And what we're seeing -- we're doing
12 the National Impact Assessment for CMS. What
13 we're seeing is there's a lot of confusion
14 because a measure in a given reporting program
15 has a completely different NQF number even though
16 conceptually it's very similar. So just
17 something to think about beyond the eMeasures as
18 you guys sort of build this, because I know the
19 behind-the-scenes part is hard and how it all
20 links to all the systems you have.

21 MR. JOHNSON: Okay. No, thank you.
22 That's very helpful. Any other questions about

1 this part?

2 Yes, in the back?

3 MEMBER McKIERNAN: So can you talk a
4 little bit about what will happen when measures
5 are retired or if one measure -- either like the
6 paper-based measure or the eMeasure lost
7 endorsement how that process would be handled?
8 If the eMeasure was maintained, for example,
9 would you continue to use both numbers or would
10 it revert back to the original number?

11 MR. JOHNSON: It would revert back to
12 the original number under the current plan.

13 MEMBER McKIERNAN: Okay.

14 MR. JOHNSON: The reasoning behind
15 that is there's a lot of history behind that
16 number and we want to retain that history. And
17 we think that's going to be the clearest for
18 outside end users, maintaining that continuum.
19 Because again, we're really thinking about this
20 NQF less as a measure number and more as a -- the
21 NQF number associated with that format of that
22 measure.

1 MEMBER POPE: Can you explain a little
2 bit about how you came up with 2906 and 2907? Is
3 there meaning behind that?

4 MR. JOHNSON: There is none, and
5 that's intentional.

6 MEMBER POPE: So --

7 MR. JOHNSON: It's -- they're largely
8 sequential.

9 MEMBER POPE: If that just gets
10 separated, you wouldn't know that's related to
11 0070?

12 MR. JOHNSON: Correct.

13 MEMBER POPE: But you're not planning
14 for it to get separated, I guess.

15 MR. JOHNSON: Well, we're not planning
16 for it to be separated and we're also making it
17 referential by that number. So if you were to
18 come to QPS and search for 2906, it will bring up
19 0070 as well and tell you that there's that
20 relationship.

21 MEMBER POPE: But in other instances
22 they won't all start with 29, you're saying?

1 It's purely random?

2 MR. JOHNSON: Correct. It will --
3 we'll get into the 3,000s and 4,000s.

4 Any other questions about this part?

5 (No audible response.)

6 MR. JOHNSON: Okay. Well, I will
7 explain a little bit more about some of the
8 changes that have happened and that are coming to
9 the dashboard. Some of you may have seen we
10 added a developer section to the bottom of the
11 dashboard where we can update and post materials
12 specific to you.

13 But starting in August and through
14 probably about October of this year our current
15 intent is to begin working on changes to the
16 measure submission form. And these changes will
17 involve some changes to the taxonomy that we're
18 using, but also improvements focused largely on
19 trimming the length of that form, reducing the
20 number of questions and making it a little easier
21 to move through, either through in-line help or
22 skip logic.

1 And so those are the two current areas
2 of focus. And of course we're working closely
3 with the QM Department on those. But the more
4 feedback that you provide as you go through the
5 process to the project teams, that will all
6 filter up to us. And if you have any direct
7 feedback, you can always send it to
8 info@qualityforum.org. That always routes up to
9 the IT folks as well.

10 So any questions about that? Yes?

11 MEMBER BERNs: Hi there. This is
12 Samantha from Lewin. I think that adding in some
13 sort of skip logic is a great idea, but I think
14 it would be helpful to post in like a PDF or Word
15 format also how that logic is applied, since I
16 know a lot of us work on the forms off-line and
17 then upload them into the portal. And so, it can
18 be difficult to -- even when we do it now, we
19 have a bunch of sections that are repeated then
20 actually show up once. And so, I think that
21 having some sort of user guide or information
22 about how that's going to be flowing would be

1 really helpful.

2 MR. JOHNSON: Okay. Thank you. Very
3 helpful.

4 Anything else?

5 MS. ISIJOLA: Are there any questions
6 regarded to your dashboard? I know that's the
7 way that you are going into your forms. Is the
8 information on your dashboard accessible or
9 informational for you? Would you like to see
10 other things?

11 Is there anyone the phone who have
12 comments or questions? Operator, can you open the
13 lines, please?

14 OPERATOR: Yes, ma'am. At this time
15 if you would like to make a comment, please press
16 start then the number one.

17 (No audible response.)

18 OPERATOR: Okay. At this time there
19 are no comments.

20 MS. ISIJOLA: Great. Again,
21 info@qualityforum.org. We're trying to make it
22 as easy for you as possible as you work through

1 your submission forms, as you gain the
2 information. Again, was Reva mentioned, a lot of
3 this information is on the submitting standards
4 page. So if you can't find it, let us know. But
5 as always, we do have our guide book that gives
6 you all of this information about where to find
7 things and how to find things. So let us know.

8 MR. JOHNSON: Thank you, everyone.

9 MS. ISIJOLA: Thank you, Jason.

10 Okay. Well, I think we're going into
11 our next discussion item. We're going to talk
12 about assessing validity, providing -- no, that
13 was a test. We're actually going into our
14 intended use segment.

15 You've been hearing about this for
16 some time. It's becoming real. Our board has
17 approved it. So Karen and Helen will be giving
18 us an overview of what that means.

19 DR. BURSTIN: Good morning everybody
20 again.

21 So we're going to talk about this
22 whole intended use project we've done over the

1 last year or so and really what it's resulted in.
2 And I'll tell you that the actual implementation
3 of this is not going to be immediate, but there
4 are some steps that will happen sooner than
5 others that Karen will talk through with you.
6 I'll go over more of the overview of why we did
7 this, how this all began.

8 So the Consensus Taskforce was a group
9 we convened for the board for awhile really
10 trying to think about how do we handle what is
11 often in committees a difficult issue, and
12 certainly Karen Dorsey and some of our friends at
13 Yale and others experience this a lot, which is
14 it's very hard at times for committees,
15 endorsement committees to look at a measure
16 completely in isolation as if they don't
17 understand the broader context in which the
18 measure will be used, i.e., a measure may be used
19 for a penalty program. Is it getting kind of a
20 harder look than it might get if it was something
21 perhaps used as part of more of a reporting
22 program? So we want to be honest about this and

1 just have that discussion.

2 Now we can't sequester committees like
3 juries. We can't put them away and say don't
4 consider this. They all know it. It obviously
5 exists. It comes up at all these tables. So one
6 of the questions was should we think about having
7 a more nuanced approach to our endorsement
8 decision rather than a binary yes/no and
9 potentially yes for this purpose, no for that
10 purpose. So we had a recommendation to have a
11 committee consider this issue whether we would
12 endorse for intended uses or come up with
13 different levels or grades of endorsement.

14 So ultimately we pulled together a
15 really remarkable panel; I'll show you in the
16 next slide, including numerous developers to help
17 us think this through, to think about what are
18 the various use cases for how NQF measures are
19 used, thinking about whether there are enough
20 distinguishing factors among the use cases,
21 particularly around the science around
22 reliability and validity and evidence, that you

1 might think about them differently.

2 And then think about the need for
3 potentially how you look at different measure
4 attributes depending on use. For example, would
5 you expect a higher threshold for reliability and
6 validity for a measure that might be used in
7 payment was sort of one of the opening thoughts
8 about this. And then think about whether we need
9 to update our criteria and then think about what
10 the pathway forward would be and how we would do
11 this.

12 This was the panel that we had. So
13 really just some great, great folks including
14 several developers at the table, end users and as
15 well as experts who have studied this and
16 published on what do we know about the
17 association of use of measures for reliability
18 and validity. People like Andy Ryan, Beth
19 McGlynn and Rachel Warner and others.

20 So here are the five recommendations
21 from the panel that came out. We're going to --
22 Karen's going to hone in specifically on No. 2

1 for you, but ultimately what came through was
2 that NQF should not try to distinguish between
3 the measurement needs of these different programs
4 and different accountability applications. And
5 frankly, the science just isn't there to say this
6 measure should have this level of reliability,
7 this should have this depending on intended use.

8 They did say however; and this was
9 sort of what we had worked through as one option
10 moving forward, is that we would consider a new
11 designation for endorsed measures that exceeds
12 our current criteria and also includes a new
13 requirement that Karen will talk more about
14 around this idea of a requirement for vetting by
15 those being measured and others.

16 They again reaffirm that our
17 endorsement work should really be mainly focused
18 on accountability applications. We talked with
19 the panel about whether for example we should
20 come up with a QI pathway and what those criteria
21 -- less stringent criteria would look like. And
22 the thought was there are thousands of those

1 measures out there. The world still needs NQF to
2 really focus on accountability. So we abandoned
3 that pathway for now.

4 And to specifically then encourage the
5 MAP to think about how this new designation is,
6 Endorsement+; we can't figure out a better name
7 for it -- could be used as they think about the
8 measurement selection program.

9 And the other thing that became very
10 interesting, and this is this last recommendation
11 about considering the interaction between the
12 measures attributes and the program attributes,
13 is there's probably some good measurement science
14 to do there.

15 So for example, if you're looking at
16 a measure in isolation at Endorsement Committee
17 you don't actually know enough about how the
18 program is structured and the way it will be
19 used. Even if you say it's for payment, you
20 don't know, for example, is it a threshold? Is
21 it a percent improvement? Is it a ranking? So
22 without knowing the program attributes, simply

1 applying a use case on the measure attributes in
2 isolation didn't make sense.

3 Now with the MAP tables that's flipped
4 a bit, because they were looking at the program
5 attributes. And so, the question is how would
6 they use this as part of their thinking? And we
7 are going to try to pursue that additional work
8 of thinking through how those two logically would
9 come together.

10 Am I giving this to you now?

11 (No audible response.)

12 DR. BURSTIN: Okay. Karen's going to
13 continue with what we're thinking of around this
14 Endorsement+. Now is as good a time as any.
15 Here you go.

16 MS. JOHNSON: Thank you. All right.
17 So Endorsement+. So one of the things that if
18 you want to give us ideas about a better name
19 than Endorsement+, we're all ears. We've been
20 through several and this is where we've landed so
21 far.

22 So here are the criteria for achieving

1 this new label. So this would be applied to
2 endorsed measures. It's just an extra label that
3 would go on there. So it has to meet evidence
4 for the measure focus without an exception. So
5 it can't be -- it can't go through our
6 endorsement process with the evidence exception
7 on it. Okay?

8 Reliability has to be demonstrated at
9 the score level. All right? The score level.
10 Validity also has to be demonstrated at the score
11 level and it can't be face validity. Right? So,
12 and these three here we already have in our
13 criteria. And to some extent it's pretty
14 objective, right? We'll know if testing is done
15 at the score level, that sort of thing.

16 The last one is the new one. The
17 candidate measure is well-vetted in real world
18 settings by those being measured and other users.
19 So that's the new thing that the advisory panel
20 thought was really important. And this is what
21 our board approved.

22 So what we had to think about is what

1 do we do with this last one? And number one, how
2 do you define what's well-vetted? Who are
3 others? What's real world settings? Do we need
4 to include this in our criteria? Those are some
5 of the questions that we walked through.

6 And this is the punch line of the
7 story, basically. We will be adding this vetting
8 as an additional sub-criteria to the usability
9 and use criterion. Okay? You guys know that at
10 least right now that is not a must-pass
11 criterion. We realize that this vetting business
12 is as bit of a stretch. It's not necessarily
13 something that everybody does. So it is our way
14 to signal that our board and others think that's
15 it's an important way to go forward in the
16 development process, hence adding it to our
17 criteria. And the definition of what we mean by
18 vetting is here in these sub-sub-criteria.

19 So first, those being measured have
20 been given performance results and data as well
21 as assistance with interpreting the measure
22 results and data. Those being measured and other

1 users have been given an opportunity to provide
2 feedback on the performance and implementation.
3 And then finally, the feedback has been
4 considered when changes have been incorporated
5 into the measure. We're still working on that
6 language on that last one a little bit, but the
7 idea is you don't just give people a chance to
8 give feedback, but you actually use it to the
9 extent that it could. Yes. Yes, you listen to
10 them as Reva says. So this is where we are.
11 When are we going to implement this? Probably
12 later in the summer. When we put out changes to
13 our submission forms you'll be seeing this.
14 We'll be updating our criterion guidance
15 documents, et cetera. You'll be seeing this.

16 So let me stop there and see if you
17 have any questions. Yes?

18 DR. BURSTIN: So, thanks, Karen. Just
19 one more thing to add. And we had a big debate
20 about whether to add this new sub-criterion under
21 validity, because you could also make the
22 argument that part of the validity of a measure

1 is that those being measured and others think it
2 actually measures what you hope it's measuring.
3 But then it would be a must-pass. And so we're
4 putting it here for now, I think, as really a
5 signal, kind of a signal to the field saying
6 people agree.

7 Really important, half of the debates
8 we have around some of the measures being used in
9 payment frankly are about the fact that those end
10 users haven't really been engaged before they hit
11 our tables. So some of this is really to think
12 about how we get ahead of this storm, but we're
13 not making it a must-pass. We're putting it out
14 there as sort of a signal early on as we've done
15 in the past around evidence and testing, but more
16 so so that you can begin preparing to think about
17 how you'll do this.

18 And we know this won't be easy for
19 some, but would love your thoughts and
20 suggestions. Is this too high a bar? Is this
21 something you could work towards? And we'd just
22 love your discussion.

1 I think Jeff had his hand up first.
2 Did you have a comment? Okay. Go ahead. Yes.

3 MEMBER HIBAY: This is Sharon Hibay
4 from Livanta. So I look at that -- the three
5 criterion and each one of those could apply to an
6 institution. So I think of when I was at NQF,
7 just a network, a hospital, Boston Children's
8 could submit this information. Is that
9 appropriate? Is that defined as -- so when you
10 think about what is vetted, it doesn't really
11 give some sort of gradations or doesn't say in a
12 network. It doesn't say on a state. It doesn't
13 in some sort of national program, quality
14 program. It doesn't say an HHS program. It
15 doesn't say in a payer program.

16 So I could look at a Boston Children's
17 measure; and we looked at some in cardiology, and
18 I could say, yes, that meets the criteria as it's
19 defined. So is that your intent that vetted
20 could be at a network or a hospital level?

21 MS. JOHNSON: Sharon, the way I think
22 about it is you're asking how much vetting do you

1 have to do? In other words, does it have to go
2 out --

3 MEMBER HIBAY: Absolutely.

4 MS. JOHNSON: -- to everybody that's
5 being measured or can you have like some testing
6 data or something smaller? And that's one of the
7 things that we've talked about. I think at least
8 right now where we're at is -- and, Helen,
9 correct me if I'm wrong. I'm thinking that
10 Boston Children's would be a possibility. Just
11 like anything else that the committees look at
12 and think about that way, how wide was your
13 scope? How reaching was it, that sort of thing.
14 And they may or may not feel as happy with a
15 Boston Children's as they would the whole nation.

16 MEMBER HIBAY: Absolutely.

17 DR. BURSTIN: I think we've left it
18 intentionally somewhat vague.

19 MEMBER HIBAY: Okay.

20 DR. BURSTIN: I don't think going --
21 for example, if you're the developer of Boston
22 Children's and you're going to just the docs of

1 Boston Children's, that's probably not really the
2 spirit of what we're trying to get at here, but I
3 don't think we're being prescriptive and saying
4 you have to go out and do 100 hospitals or 100
5 end users. We also recognize that at least for
6 the measures going through CMS for payment often
7 times they'll have a full dry run that's
8 supported and funded by CMS.

9 So we're not expecting you to be able
10 to do a full dry run, but it would be nice to as
11 part of this process to get input from those who
12 will be measured in particular. We added and
13 others, because I think others who would like to
14 use the measure ultimately, like purchasers or
15 regional collaboratives, would also welcome the
16 opportunity to provide early feedback on some of
17 these measures. So again, the idea is to just
18 push the measurement earlier -- the feedback
19 earlier and earlier in the process.

20 MEMBER GEPPERT: Yes, my second
21 comment was related to that. Those being
22 measured could be a pilot study, could be some

1 subset.

2 So my first question is about the
3 validity testing. So there's multiple pathways
4 beyond face validity. So one pathway is
5 criterion validity, which could involve a chart
6 abstraction for like a patient safety measure or
7 comparing a risk model from claims versus a
8 registry. And then there's a construct validity
9 path. But do both of those pathways count?

10 MS. JOHNSON: Yes.

11 MEMBER GEPPERT: Okay.

12 MS. JOHNSON: It's not face validity.

13 MEMBER PANCHOLI: Hi, so I'm Mamatha
14 Pancholi and I run the quality indicators at
15 AHRQ. And I'm curious to get a more concrete
16 sense of what we mean by giving the users their
17 performance results in data when you're not CMS.
18 So where is there -- so as AHRQ, I don't have
19 hospital data. I'd have to go through a process
20 of collaboration and getting folks on board with
21 us. So are you thinking that as part of the
22 submission process we would need to ahead of time

1 go through our process of providing folks with
2 our specifications, having them run their own
3 data and find out what their rates would be and
4 submit that information back to us, so it's part
5 of a feedback loop? Is that what we're thinking
6 or is there -- or am I misinterpreting what
7 you're --

8 DR. BURSTIN: Well, that's a literal
9 translation, Mamatha.

10 MEMBER PANCHOLI: Right.

11 DR. BURSTIN: I mean, obviously that
12 would be hard to do.

13 MEMBER PANCHOLI: Difficult.

14 DR. BURSTIN: And really difficult.
15 I guess the question would be are there ways --
16 and I'll think about it in the AHRQ/PSI context
17 because I think it's an easy one in some ways,
18 because it doesn't fit the model as well, right?
19 You have state data. You have state databases.
20 But at the same time AHRQ does a lot of work with
21 states and with hospitals. Could you have just
22 some input from hospitals? Even as you've shared

1 results in past years, input you've heard from
2 hospitals, how have you -- and particularly I
3 would think with the PSIs you did a ton of this,
4 in fact as part of our last Safety Committee, as
5 you know very, very well around PSI 90 --

6 (Simultaneous speaking.)

7 MEMBER PANCHOLI: And we'll be doing
8 it again soon.

9 DR. BURSTIN: But the key thing there
10 was that that feedback was incorporated into the
11 measure and the measure changed.

12 MEMBER PANCHOLI: Right, so if that's
13 what you mean --

14 DR. BURSTIN: So you're kind of a
15 poster child, I think, actually.

16 MEMBER PANCHOLI: Yes, so if that's
17 what you mean, then that's fine. You're right,
18 I'm interpreting it literally as --

19 DR. BURSTIN: Yes.

20 MEMBER PANCHOLI: -- a step forward,
21 but it would be --

22 DR. BURSTIN: I mean, in some ways is

1 there some way as part of your development or a
2 refining --

3 MEMBER PANCHOLI: Okay.

4 DR. BURSTIN: -- of the PSIs as you go
5 forward share their information with a few states
6 who might be able to get feedback from their
7 state hospital associations, whatever the case
8 may be, so you could indicate that before they
9 hit our tables and you get the slam back from any
10 at the table? Can you at least kind of try to
11 head off some of those issues of the past, I
12 guess?

13 MEMBER PANCHOLI: Right. Thank you.

14 DR. BURSTIN: Yes.

15 Yes, please?

16 MEMBER PEZZULLO: Lynn Pezzullo, PQI.

17 So I think some of these questions are similar to
18 what I'm trying to understand. I guess how
19 structured or formalized of a process should this
20 be? Is it enough to have an open public comment
21 period that is distributed, the notice of that
22 comment period is distributed specifically to

1 those users or those being measured, or should it
2 be something more like convening a panel of those
3 groups or individuals? So I just want to make
4 sure that if we're considering this we're
5 thinking through how do we really meet this
6 criteria?

7 DR. BURSTIN: I think the answer is
8 still kind of fuzzy, to be honest. This is brand
9 new. That's why we're bringing it to you for
10 your thoughts.

11 My personal sense would be that simply
12 doing it as part of what you would already do as
13 part of your comment period -- I don't think
14 would necessarily satisfy this. You won't
15 necessarily have as part of your comment period
16 -- again, I could be wrong. I mean, I don't know
17 how many for example pharmacists are responding
18 back on PQA comments. So I think the question
19 would be can you also build in -- and it doesn't
20 have to be a separate panel, but is there some
21 way as part of the process to begin doing
22 something that's saying direct to those being

1 measured, I would say, in particular and say can
2 you provide your feedback on this as we're moving
3 through this process?

4 It may be later in the process that
5 you might put out for public comment, but perhaps
6 earlier than it hits our tables. And again,
7 we're not making this a must-pass, but it's just
8 something to at least begin to see the kind of
9 information we get in. And I think what we'll do
10 over time with you is try to be more clear. But
11 this point we're leaving it open to your ideas
12 and suggestions so we can see what comes in.

13 We're very much trying to handle -- I
14 think at times we're just -- the measures that
15 hit the tables where the end users are sitting
16 and they create this kerfuffle that I think we'd
17 love to have you kind of get a handle on before
18 you hit those tables. And frankly, it may make a
19 better measure by actually taking in some of
20 those thoughts they have about issues that were
21 raised.

22 And some of you may know the very long

1 process we had with the dialysis readmission
2 measure last year, two years ago, Marcia, that
3 Marcia sort of walked us through, in terms of
4 bringing the appellants and CMS and the measure
5 developers together. And at the end of the day
6 there were a couple of pretty significant issues
7 from the dialysis facilities that CMS was willing
8 to accommodate, at least for the first couple of
9 years of the measure being out there.

10 And so again, I think that early input
11 from the dialysis facilities themselves saying we
12 often don't see people for the first three days
13 after they're discharged. How can I be held
14 accountable for the readmission when I didn't
15 even know they were in the hospital yet? You
16 know, that kind of feedback is the kind of thing
17 we'd like you to begin thinking about how to
18 incorporate.

19 If a small workgroup of you want to
20 help us think this through, we'd be delighted.
21 Because again, it's brand new. It's just a way
22 of kind of almost giving you insight into where I

1 know we're going so we can collectively think
2 about how to make this work.

3 Did you have a comment, Kyle?

4 MEMBER CAMPBELL: Yes, I'm just trying
5 to think of this in the context of the example of
6 our current readmission measures. So I think we
7 would -- we start with an academic medical center
8 and maybe like a very small sample that might get
9 at this, but later in the process we'll be doing
10 a national dry run, which I think speaks exactly
11 to what you're trying to get at here. So is
12 there a pathway or has there been thought about a
13 pathway like we kind of have to get you the
14 measure when it's on the timeline for the
15 project, but maybe within a year we'll have sort
16 of all this information to get at NQF+. And so,
17 is that something that you guys are thinking
18 about in terms of additional information?

19 DR. BURSTIN: Yes, and actually one of
20 these we are thinking -- we didn't really speak
21 much to this because we're mainly focusing in on
22 this particular issue today -- is that the

1 Endorsement+ will be something you could come
2 back for over time. So you could -- a measure
3 gets additional testing. Measure's out there.
4 It's being vetted. You now move up that
5 criterion, those criteria and then you can be --
6 and then you could get Endorsement+. So it
7 doesn't have to be something just at the initial
8 submission. Potentially off-cycle, or
9 maintenance cycle, or whatever it may be.

10 And part of this; actually it was
11 interesting, was Beth McGlynn, who's on our panel
12 and the chair of the MAP, who actually made the
13 point that one of her hopes was that if
14 Endorsement+; again, we'd love a better name --
15 if Endorsement+ is something that will be viewed
16 as valuable in terms of people selecting measures
17 for particular programs and that's something you
18 would shoot for, then will that be again a
19 potential sort of driving force to have maybe
20 maintenance be a bit more meaningful, right?

21 If there's an opportunity to move to
22 that upper level, then you could work with those

1 who fund you and others to say we really want to
2 shoot for that because that would really help us
3 moving forward with end users and the specific
4 programs in which they might be used. But great
5 suggestion.

6 Please?

7 MEMBER KEENAN: So just as a follow-up
8 to that, there are some measures where there's
9 not data currently available. And so, it's not
10 possible to really calculate the measure and
11 distribute performance results before the measure
12 is kind of out there in use. So do you mind
13 speaking to that a little bit?

14 DR. BURSTIN: I mean, our preference
15 is you give them performance results and data,
16 but I think if nothing else you could give them
17 the second part there, which is at least feedback
18 on the measure itself as an opportunity to get
19 their thinking even if you can't yet give them
20 data.

21 MEMBER POPOVICH: Yes, so during the
22 committee meeting who came with Endorsement+ --

1 and I like the name right. So I endorse
2 Endorsement+.

3 MEMBER POPOVICH: What percentage of
4 measures did the committee believe could reach
5 the status of Endorsement+ right now? And then
6 what's the scaling factor over the next two to
7 four years of what would be expected?

8 DR. BURSTIN: It's a great question
9 and we probably need to go back at some point and
10 do that analysis. We think very few measures
11 right now, Matt, would meet this bar,
12 particularly because of this one. I think we
13 have a fair number of measures that on the other
14 ones around testing, reliability, validity and
15 evidence -- a handful of those, maybe 5 or 10
16 would fit that. But some of those haven't been
17 vetted. So because it's the new addition of the
18 vetting, I think over time we'll see that
19 increase.

20 MEMBER POPOVICH: So this criteria is
21 one that they thought was probably going to be
22 the higher bar?

1 DR. BURSTIN: They thought it would be
2 the new bar to meet, the challenge. Although I
3 will tell you; and we've had lots of discussions
4 as part of our measure developers meetings and
5 others, getting to actually doing formal testing
6 of validity is not easy either, particularly for
7 outcomes. And we've heard you there.

8 So we'd also love to collectively
9 think about what are other ways some of that
10 validity testing could be done in ways that may
11 not be quite as onerous, but at least get the --
12 I mean, many of you have heard it: committees
13 just don't like face validity. They don't kind
14 of buy it. How is that a valid representation of
15 quality? Because a group of folks said it was?

16 So we accept it. We think it's a
17 reasonable starting point, but just the reality
18 is I think as quality measurement has kind of
19 gotten ratchetted up as being more and more
20 important in the broader scheme of things, I
21 think it's not surprising you would see more of a
22 forcing function on wanting to see the measures,

1 particularly those that might get used for those
2 somewhat higher stakes uses, people selecting
3 doctors, people -- hospitals getting paid, et
4 cetera.

5 But I think there might be a need to
6 kind of ratchet that up a bit. But we recognize
7 this won't be easy, which is why we're not making
8 it a must-pass. It's kind of more of a signal to
9 you to work with us, help us think through how to
10 do that.

11 So, an opening.

12 MS. JOHNSON: Other thoughts?

13 Question from the --

14 MR. TILLY: Right, Amy Bennett asks
15 why are measures endorsed with an exception to
16 evidence not eligible?

17 DR. BURSTIN: Yes, I think the thought
18 is that we want to have measures that are --
19 truly meet the highest bar across the board. And
20 an exception for evidence would not, in our
21 esteem, be measures that would be at that level.

22 I think one of the challenges has been

1 that this whole evidence question is something we
2 still need to wrap our heads around. At times
3 particularly for some of the more cross-cutting
4 measures, less clinical measures it is harder we
5 know to get the evidence. And so those are the
6 ones I think at times very likely to get
7 exceptions. I think an early example in
8 palliative care was spiritual counseling for
9 palliative care. I mean, what kind of evidence
10 are you going to need to get to that? And yet a
11 fair amount of evidence that it's a good thing.

12 But I think what we don't want to do
13 is have measures move forward for which the
14 clinical evidence in particular isn't there, or
15 it's equivocal. I think that's the hardest time.
16 And the thing we often collectively get the
17 greatest heat for is when clinicians and others
18 are told to do something when the evidence is in
19 play, when one week we read estrogen is good;
20 next week estrogen is bad; next week estrogen is
21 good and bad. That's probably not the right time
22 for a performance measure, so we would think

1 those would be ones that don't quite reach that
2 threshold.

3 Anything to add?

4 MS. JOHNSON: Outcomes measures
5 deliver --

6 DR. BURSTIN: Right. Good point.
7 Karen mentions outcome measures don't have that
8 problem because we don't require quality,
9 quantity and consistency evidence for outcomes,
10 just the rationale.

11 MEMBER KAYE: This is Toni again from
12 the PCPI. Thinking on that evidence exception
13 question, as a lot of the gaps in programs
14 there's really a push for things like patient
15 engagement and care coordination, and those
16 happen to be the things where you don't generally
17 get that grade A randomized trial evidence. So
18 do you worry that -- I think it's likely that a
19 lot of the Endorsement+ measures could wind up
20 being those clinical process of care or outcomes
21 as they come, so it might be harder if programs
22 are simultaneously encouraged to use maybe

1 Endorsement+ measures as meeting the highest bar,
2 but very few measures that maybe meet those gap
3 areas. I think they're kind of disadvantaged
4 from the start to meet that criteria, so I think
5 it could make the gaps worse.

6 DR. BURSTIN: I think it's a fair
7 comment and it's something we'll keep an eye on.
8 Again, we want to emphasize as well endorsement
9 is great, right? I mean, that's a great bar.
10 We're not saying there's anything wrong with that
11 bar, but I think the question is particularly for
12 some programmatic uses at times might there be
13 any -- and I think we'll see it, right, if we
14 really begin to see that there's a need for some
15 of those really important gap area measures in
16 the higher stakes programs.

17 Will that -- again, we're open to it.
18 It's just our thinking at point A fully
19 recognizing a lot will change I think in all of
20 our worlds around measurement and measure
21 development in the next couple years. But great
22 questions. We hear you.

1 All right. I think we're done. Back
2 to you.

3 MS. ISIJOLA: Okay. So we're going to
4 go to a 15-minute break and we'll be back in 15
5 minutes. Thank you.

6 (Whereupon, the above-entitled matter
7 went off the record at 10:35 a.m. and resumed at
8 11:00 a.m.)

9 MS. ISIJOLA: All right. We're going
10 to go ahead and get started. So just a few
11 housekeeping items.

12 Again, the slides are actually
13 available on the webinar if you are dialed in or
14 logged in via the webinar, but we will also send
15 them out following this workshop, including the
16 recording for your use.

17 Also, on our agenda it does say
18 networking lunch. We're going to do a working
19 lunch so we can kind of get you guys out of here
20 earlier. I think that will be helpful for
21 everyone.

22 But now we're just going to turn it

1 over to Karen Johnson and she's going to talk
2 about assessing validity.

3 MS. JOHNSON: Thank you, Wunmi.

4 I am very excited about talking about
5 validity, but I'm one of the geeks of the group,
6 so we'll see if we take our whole hour or not.
7 And we don't have to if you don't want to. But I
8 hope you'll play with me. I have a few
9 discussion questions throughout and I'm really
10 kind of interested in hearing what you're
11 thinking about validity.

12 So, I'm going to start out by
13 reminding everybody where validity fits in our
14 criteria. It's the second sub-criterion under
15 scientific acceptability. And you notice that I
16 like to use color. So when I think about our
17 criteria, I really do think of three separate
18 pieces to validity. One has to do with evidence.
19 Are your specs consistent with evidence? One has
20 to do with testing. That's the second one there
21 in orange. And then the other ones we grouped
22 together and we call those threats to validity.

1 So recently somebody asked me -- I've
2 never heard of this, threats to validity. And I
3 don't know that we actually use that term very
4 much externally, but I'm using it today. So if
5 you hear us talk about threats to validity, this
6 is what we're talking about. Exclusions. We're
7 talking about risk adjustment, meaningful
8 differences, missing data, comparability.

9 Okay. So again, just a reminder. I
10 know you guys know this and if I gave you a quiz,
11 you would be able to tell me all of those threats
12 to validity, right?

13 All right. I'm also showing you
14 exactly what we state in terms of what we're
15 looking for in our criterion guidance. Some
16 people I think, and probably rightly so, find it
17 hard to find stuff from NQF. So I just wanted to
18 tell you that in our 2015 criterion guidance
19 document, pages 12 to 14, you will find what
20 we're looking for in terms of validity. And
21 again, I've used color to pull out a couple
22 things that I think is really important. Data

1 elements, measure score, face validity. So other
2 important things in there, too, but those are
3 things that we're going to kind of focus on
4 today.

5 Any questions about this? You guys
6 know what I'm talking about when I say the 2015
7 evaluation and guidance document? I see some
8 yeses. Any nos?

9 Okay. Good. All right. So testing.
10 And today's talk is going to be mostly about
11 testing, even though all that good stuff about
12 threats to validity is in there, too.

13 So testing key points. You guys
14 already know this. Validity we think of as
15 referring to the correctness of measurement. And
16 we are interested -- and we allow two different
17 kinds of validity testing.

18 Thank you, Reva.

19 Reva is keeping me honest up here.
20 One is empirical analysis, and that can be done
21 at either the data element level or the score
22 level. Score, I tell our new people that come in

1 that's the results of the measure, because
2 sometimes that word is even a little strange,
3 right? NQF-speak.

4 It's important that the testing be
5 done for the measure as specified. So that's one
6 of our things that we actually do require. It
7 has to be as specified. Face validity and the
8 measure score is also accepted.

9 Okay. Any questions about this?

10 All right. This is old hat. All
11 right. So let's talk about data element
12 validity. Usually it uses patient-level data,
13 right? So we're looking at the actual data from
14 your patients or the data that's being aggregated
15 up. We would like to see testing for all of the
16 critical data elements, not just one overall kind
17 of result. At minimum, however, we would like to
18 see it for numerator, denominator and exclusions.
19 So possibly three groups.

20 And when there's data element validity
21 going on, we actually expect to see high
22 agreement, right, because we're looking for

1 accuracy. Okay? So again, that's what we're
2 looking for in terms of results. If based on an
3 instrument or scale, we're looking for validity
4 of the instrument or scale. So that would count
5 as data element validity for those kinds of
6 measures.

7 And you guys probably know this and
8 probably have taken advantage of it, if you've
9 demonstrated data element validity, we don't
10 require additional data element reliability. So
11 you can get two birds with one stone on that one.
12 Okay?

13 Now this is the fun part. What we
14 often get is some percent agreement and nothing
15 else. Who knows what the problem with percent
16 agreement is?

17 (No audible response.)

18 MS. JOHNSON: Elisa and I could be
19 talking about something that I absolutely know
20 zero about, but we could agree on it quite often
21 if it's just a yes or no, right?

22 Sam?

1 MEMBER SIMON: Basically it could be
2 thrown off by low frequency.

3 MS. JOHNSON: Prevalence has a lot to
4 do with it, too, right. Right.

5 So then we say how about kappa scores,
6 kappa statistics? What's that do for us? You
7 guys didn't know there was going to be a test,
8 did you, a quiz?

9 Okay. That helps us with that chance
10 agreement. Even if I don't know anything about
11 anything, I could still agree probably half the
12 time, right, if it's a yes or no option. Right?

13 Okay. So kappa statistics is better
14 than just percent agreement by itself, but
15 probably still not exactly what we're looking
16 for, although we usually let it slide by. What
17 we'd really like to start seeing is sensitivity
18 specificity, negative and positive predictive
19 values. Now I'm not going to quiz you on that
20 because I don't remember the details of how you
21 calculate all these things.

22 Yes, it all comes from the kind of two

1 by two tables, right? So if you can get the
2 kappa statistics you can get the sensitivity
3 specificity, right? Okay. So this is what we
4 would like to see more of. So maybe you guys can
5 be helping us out on these.

6 The other things that we often get is
7 very little explanation of the method. We
8 computed some kappa statistics and here you are.
9 And I'm not really being that facetious.
10 Sometimes it is that brief. But having things
11 like how big of a group did you look at? What
12 were you pulling your data from? What methods
13 did you use? And are you considering XYZ the
14 gold standard? Otherwise, we have to assume, and
15 sometimes we assume incorrectly, right?

16 But if you tell me that you had an
17 expert nurse doing some abstraction, is that the
18 gold standard? Why don't you just say that it's
19 the gold standard? Then everybody understands
20 and it's very transparent about what you did and
21 what you're expecting. Right?

22 We often, as I mentioned before, see

1 one value with no explanation. So you might have
2 six critical data elements, but I see one kappa
3 statistic. That's not uncommon. But I don't
4 know what the kappa statistic is for, and neither
5 will the committee. But you guys will know,
6 right? This is your stuff. Right? But it's
7 like when you write something, you can't tell if
8 you've like made a typo or you've left out a
9 word. Somebody else has to look at it sometimes.
10 But that's what happens. Sometimes we get this
11 stuff and we don't quite understand.

12 Finally, no interpretation. We have
13 to put this into some kind of perspective for
14 people, especially people who aren't stats people
15 on our committees. Is a kappa of 0.5 good? Is a
16 kappa of 0.75 good? Right?

17 All right. So any questions or
18 comments about this? You guys may be -- you're
19 looking a little bored. I don't want to belabor
20 this. The only thing down at the very bottom,
21 and I almost forgot it, is values aren't great.
22 At minimum we'd like you to speculate why or why

1 not. If you don't have good values, it tells me
2 that it's not valid, right? So do we want to
3 endorse a measure that doesn't look valid?

4 And then sometimes you might
5 speculate. Do you go back and retest? Again, I
6 do understand that things cost money and it might
7 be hard to do, but it is a question that comes
8 up. You've demonstrated that something isn't
9 working the way that you had hoped. You fixed
10 it. Did you fix it? Right?

11 So any comments on this? Does any of
12 this surprise you? Kind of what we're getting --
13 I know none of you guys are the ones that are
14 giving me one value with no explanation, right?

15 Is there anything that we can do to
16 make it more clear what we're looking for?

17 Ah, Karen. Yes?

18 MEMBER DORSEY: So probably everybody
19 here tries to their best due diligence to provide
20 all the information that you all need, but I
21 wonder what importance emphasis you all put on
22 the length of these. I feel like over time the

1 length of these submissions grows. We give more
2 specific and more detailed information for the
3 committees to consider. I mean, there's always
4 been some guidance about length, but I'm just --
5 how are you all thinking about that?

6 MS. JOHNSON: I'll tell you what my
7 interpretation is, and it might be interesting to
8 get Reva's or Sarah's or somebody else's. I
9 think it should be as long as it needs to be to
10 be clear about what you did, and no longer. Yes,
11 says the people that read them. You know, a lot
12 of times I don't think necessarily it's the
13 testing pieces that are too long. Often we get
14 really, really long evidence pieces and it's
15 because it's that old -- when you're a freshman
16 in college and you write a paper and you're not
17 quite sure what you're supposed to say, so you
18 say everything that you know and you hope that
19 that is it. Sometimes that happens. And that
20 really lengthens the submission.

21 So when we say with evidence -- and
22 I'm kind of getting off track here. When we say

1 with evidence we want a summary, we really mean a
2 summary. We're expecting a paragraph or two.
3 We're not expecting pages. We're not expecting
4 pages of citations, that sort of thing.

5 So I don't know if that helps or not,
6 but brevity -- we still have -- I don't know how
7 many people are using it, the What Good Looks
8 Like document for the testing. And almost
9 everything in there is short, short, short.
10 There's hardly anything long in those docs.

11 So, Sam, I just saw you get a
12 microphone. You got a question?

13 MEMBER SIMON: Just a quick one. Does
14 the committee ever ask to see a power analysis?
15 I mean, you could do an abstraction on 20 cases
16 and get great agreement, but it may not be
17 sufficiently powered.

18 MS. JOHNSON: Right. I think I've
19 seen it or heard it once or twice. In general
20 they don't ask for that. We have toyed with the
21 idea is that something we want to ask you guys
22 for and make that kind of bring it out more. And

1 so far we've decided not to because we do
2 understand that your power analysis might tell
3 you need 300 and you can only realistically get
4 50. So we don't require it because at this point
5 it might be a little hard. This is for data
6 element testing.

7 For score level testing I think none
8 of that matters, right? I mean, you're going to
9 have -- if you're going to do score level
10 testing, you've got a lot of data is our
11 assumption. You agree or -- Sam said he was
12 going to agree with everything, but I kind of
13 don't --

14 MEMBER SIMON: Well, I think maybe
15 what could be done is to say how much power you
16 have given the sample you have.

17 MS. JOHNSON: Ah, yes.

18 MEMBER SIMON: So that might be --

19 MS. JOHNSON: Yes.

20 MEMBER SIMON: -- something else to
21 consider.

22 MEMBER SIMON: That kind of stuff I

1 think is very helpful. What we usually have on
2 our committees, to be honest, is some people who
3 haven't ever taken a stats class and don't really
4 get it, but there's going to be some people who
5 may as well have a Ph.D. in stats, because
6 they're going to be looking at everything. And
7 we all have our strengths and weaknesses and
8 things that kind of jump out. So to the extent
9 that you can satisfy that one person who's going
10 to be looking at every detail, I think it's a
11 good idea. Yes, right now we're not requiring
12 it.

13 MEMBER SIMON: Okay. Great. Thanks.

14 MS. JOHNSON: Yes. Any other
15 questions? Yes?

16 MEMBER GEPPERT: Just wondering about
17 your experience of people submitting sensitivity
18 and specificity data.

19 MS. JOHNSON: Yes.

20 MEMBER GEPPERT: And, I mean, is it
21 sensitivity I think that's particularly difficult
22 to estimate sometimes trying to identify --

1 MS. JOHNSON: Yes, I've actually never
2 actually done a sensitivity analysis, I'll be
3 honest with you. So I don't really know how hard
4 it is. I know sometimes what we have seen is
5 people pulling from the literature. You see it
6 more I think -- I've seen it mostly the claims
7 kinds of data.

8 PARTICIPANT: Compared to the chart.

9 MS. JOHNSON: Yes, claims compared to
10 the chart, and there are lots of papers published
11 on that sort of thing. And, yes. Yes. So I
12 guess I'm not quite sure why it's particularly
13 hard. Prevalence has something to do with it
14 and --

15 MEMBER GEPPERT: Well, I think
16 particularly for a claims based measure, for
17 example, if you identify a case in a claim, then
18 you can go and pull the chart and determine
19 whether that's a false positive or not. But it's
20 hard to find things that you're not --

21 MS. JOHNSON: Yes.

22 MEMBER GEPPERT: -- identifying in

1 claims.

2 MS. JOHNSON: Well, you get this thing
3 -- you know, when we said earlier that Reva and I
4 are constantly emailing back and forth and some
5 of us, I'll be doing one of the PAs and I'll say
6 they didn't do all the critical data elements.
7 And Reva will bring me down and she'll say they
8 probably used claims to find their denominator.
9 And then I'm like, okay, I'd still like to see it
10 for the denominator, so I'd really like you to do
11 a random sample of your medical records and go
12 that way. And Reva's like get real, Karen,
13 that's not going to happen.

14 So, yes, you are correct. When you're
15 doing it that way, when you're using claims or
16 some other -- a registry or something to do data
17 case finding, yes, it can be --

18 MEMBER GEPPERT: And you approach that
19 scene with some sort of stratified sample where
20 you try to identify a smaller group that is very
21 -- has a high likelihood of being --

22 MS. JOHNSON: Yes.

1 MEMBER GEPPERT: -- a false negative
2 and then --

3 MS. JOHNSON: Yes, so that you can
4 make sure.

5 MEMBER GEPPERT: -- and then maybe a
6 larger part of the sample that has a very low
7 probability.

8 MS. JOHNSON: Yes. I mean, it is
9 harder. I'm looking at a couple of measures
10 right now where they didn't do case findings, so
11 my question to the committee is are you -- do you
12 feel pretty confident that that can be reliably
13 extracted kind of in -- without that empirical
14 data. They haven't done that kind of pulling of
15 records that you're describing.

16 So, yes, but you're right. Reva has
17 -- we have harder graders here sometimes and
18 easier graders, and we really are trying very
19 hard to be consistent among staff. So I've
20 gotten a little easier on my grading and testing,
21 probably a little harder on me grading for
22 evidence. So that's how it works.

1 So I have kind of like skipped myself.
2 Any surprises as to what I've mentioned so far
3 just in terms of our criteria, what we're looking
4 for, what we've found? How many of you usually
5 do data element validity, or are you guys just
6 now just skipping to score level? What do you
7 think about data element validity? Is it valid?
8 Do we need to care? What other stats or methods
9 might work? I've mentioned a few. Do you buy
10 the kappa? We kind of let kappa go through. Our
11 notes would say kappa is not good enough. We
12 really want sensitivity specificity, that sort of
13 thing. Any -- yes, Karen?

14 MEMBER DORSEY: Since we mostly work
15 with claims, we don't really need to deal with
16 data element validity except for hybrid measures
17 that come forward. And it seems to me that it's
18 still useful to demonstrate data element validity
19 for EHR data elements.

20 I mean, I think that whether or not
21 you can use sensitivity specificity depends on
22 whether you can identify some kind of gold

1 standard or conceptually set up the question that
2 way, which is not always a natural fit for EHR
3 data elements. The approach that we've taken is
4 to say that the most important thing is that data
5 values match, but that's at the data element
6 level, not at the -- like an eCQM score level.

7 MS. JOHNSON: Right.

8 MEMBER DORSEY: So I mean, it's hard
9 for me to wrap me my head around a statistic if I
10 can't put together a conceptual framework for how
11 there's a gold standard to compare to. I agree
12 kappa is -- doesn't feel very satisfying.

13 MS. JOHNSON: Yes. So I'm a little
14 curious, and I want to pick at it just a little
15 bit, do you feel like the EHR data are not the
16 gold standard? I mean --

17 MEMBER DORSEY: Sorry. So I'm talking
18 about when we're validating extraction, right,
19 saying that, yes, you can extract through
20 electronic query accurate data elements as
21 compared to the front of the chart --

22 MS. JOHNSON: Okay.

1 MEMBER DORSEY: -- where people are
2 actually entering the data. So that's the
3 validity I meant when I was talking about --

4 MS. JOHNSON: Okay.

5 MEMBER DORSEY: -- EHR data element
6 validity. And in that instance I guess the front
7 of the chart is technically the gold standard,
8 but it's -- I mean, you're kind of stretching the
9 intent, right, of sort of the conceptual test of
10 sensitivity specificity to apply it. It feels
11 kind of arbitrary and unnecessary when all you
12 really care about is that the data elements
13 match --

14 MS. JOHNSON: Right.

15 MEMBER DORSEY: -- and that you have
16 done it in an adequate sample.

17 MS. JOHNSON: Right. You can tell I'm
18 not a clinician because I've never actually had a
19 chart either.

20 MEMBER DORSEY: Right.

21 MS. JOHNSON: I know that there's a
22 difference between the front and the back of the

1 chart, so apologies there.

2 Sam?

3 MEMBER SIMON: I think -- so for the
4 EHR measures that we're testing we are -- I think
5 this brings up the point that it would be really
6 helpful if measure developers explain,
7 contextualize what do their validity results
8 mean? Are they taking results from the front of
9 the chart? Is this sort of a broader view across
10 -- like we're comparing extracted EHR elements
11 from everything that's in the EHR --

12 MS. JOHNSON: Right.

13 MEMBER SIMON: -- so whether
14 something's written down in a notes field, the
15 idea being that our validity results will tell
16 you if you rely on just structured elements, are
17 you getting the whole story or not?

18 MS. JOHNSON: Right.

19 MEMBER SIMON: So having that -- some
20 narrative. I don't want to make the forms longer
21 than they are, but it does kind of speak to why
22 some narrative is probably the right thing to ask

1 for --

2 MS. JOHNSON: Right.

3 MEMBER SIMON: -- about how to
4 interpret your results.

5 To answer your question about kappa,
6 I totally understand why you would want -- why
7 kappa alone is insufficient. I mean, I think you
8 want -- the whole idea is you want the whole two
9 by two table, right? So that's what the
10 sensitivity and specificity --

11 MS. JOHNSON: Right. Right.

12 MEMBER SIMON: -- results give you.
13 So I think it makes sense to ask for those.

14 MS. JOHNSON: Yes.

15 MEMBER SIMON: And really for
16 eMeasures the thing we run up against is that
17 doing -- we would love to be able to do measure
18 level scores.

19 MS. JOHNSON: Right.

20 MEMBER SIMON: And we just don't
21 always have -- sometimes there's not a great
22 thing to test, but how do you measure for measure

1 of care coordination? We can usually give you
2 the data element validity; less so with a great
3 outcome to really benchmark those scores against.

4 MS. JOHNSON: Right. And you're
5 stealing my thunder. That's the next set of
6 slides, or almost the next set.

7 Yes, let's go on. We can't stop until
8 we talk about face validity, right, and get into
9 the juicy stuff.

10 So face validity, judgment of whether
11 on the face it the results appear to reflect
12 quality of care. Right? So again, we're
13 remembering that we want our results to be --
14 allow for accurate conclusions. So that's where
15 accuracy correctness comes in.

16 It is subjective. It is the weakest
17 form of validity. And why? Because one set of
18 experts may not agree with the next set of
19 experts. Right? And Reva's saying that's what
20 happens when you get on the committee because
21 you've got a different set. You may not agree
22 that something is valid.

1 So what are our requirements? We do
2 allow it. We have toyed with getting rid of it.
3 So far that hasn't happened. We'll see if it
4 ever happens. We don't know. But right now we
5 are saying that it is a -- we want to see a
6 systematic assessment of the score from the
7 measure as specified. So this is -- we want to
8 know if the results are an accurate reflection of
9 performance and whether the results can
10 distinguish good from poor performance.

11 So what we sometimes get; this is fun,
12 we get people to tell us whether their experts
13 thought the measure was a good idea. And again,
14 I'm not being facetious on some of this stuff.
15 We get a lot of face validity about the
16 construction of the measure. Did you use the
17 right ICD codes? Do you think you can collect
18 that denominator? That sort of thing.

19 But remember, we're looking for face
20 validity in the measure score, not the
21 construction of the measure. Right? We get
22 feedback on the feasibility of the measure. It's

1 not bad information. It's just not what we're
2 looking for for validity. No description of the
3 experts involved.

4 Sharon, you're smiling.

5 Little to no description of what was
6 assessed. A general statement of results.
7 Everybody thought it was great. I'm being a
8 little facetious on that one. Or sometimes no
9 results at all. We did face validity, period.

10 Yes. Yes. Going back to your
11 original question about how long should the form
12 be, I probably have a little bit different flavor
13 maybe than Reva, but I really like the idea of
14 transparency and I really want people to be able
15 to go back to the forms even a year or so later
16 and understand what happened. And it's kind of
17 the same thing Reva was saying, but, yes, if you
18 know the literature, you may know that this panel
19 thinks this is great and they really did a great
20 job, but somebody going back later that doesn't
21 know that literature and doesn't have that paper
22 by Dr. So-And-So in front of them won't know

1 that. So that's why we like to see the actual
2 results.

3 And I don't know if I -- yes. So what
4 we'd like to see. Details about what was asked
5 and how the assessment was done. A list of the
6 experts involved with their credentials. And
7 then actual results of the assessment. So here's
8 an example. Nine out of the ten experts agree
9 that the measure reflects -- measure results
10 differentiate good from poor quality. None
11 disagreed, or whatever you got to. Right?

12 So any surprises on this? How many of
13 you guys do face validity only? Not any -- and
14 it's not -- don't be embarrassed. It is a valid
15 form of validity and it is something that NQF
16 accepts. How do you decide whether to do face
17 whether empirical? Is it money? Is it sample
18 size? Data? You flipped a coin that day and
19 this is what you ended up with?

20 MEMBER GEPPERT: I do see a little
21 inconsistency with -- the vetting is a good idea
22 and an important new component to validity, and

1 yet somehow a structured face validity process is
2 no longer useful. I mean, I'm not seeing a huge
3 difference between those two processes --

4 MS. JOHNSON: Yes.

5 MEMBER GEPPERT: -- and at least the
6 face validity process, if it follows something
7 like a delta, or something like that --

8 MS. JOHNSON: Right.

9 MEMBER GEPPERT: -- it's very
10 structured, it's multistakeholder --

11 MS. JOHNSON: Right.

12 MEMBER GEPPERT: -- you're not dealing
13 with biases. I mean, it could potentially be
14 more useful than simply getting some unsolicited
15 comments from people that are -- could be
16 negatively impacted by a measure.

17 MS. JOHNSON: Right. Right. It's a
18 good point. Yes, I mean, we spent a lot of time,
19 to tell you the truth, and I don't know how I
20 forgot to tell you; Helen took care of it, but we
21 really were thinking that the vetting thing would
22 go under validity because we kind of saw it as a

1 face validity, if you will, of the people being
2 measured and others, which I keep forgetting to
3 add on, but -- the "and others" part.

4 But again, you saw that we put it in
5 usability and use instead. There was actually an
6 extra piece of it that -- of the definition that
7 we ended up not doing because that was kind of
8 pushing way too far. So I don't know if that
9 quite gets --

10 Helen, do you have anything to add?

11 (No audible response.)

12 MS. JOHNSON: Any other comments about
13 face validity? Yes.

14 DR. WINKLER: Just in response to you,
15 Jeff, the face validity here and what we tend to
16 see tends to be people that are very much
17 involved and proximal to the measure development
18 process. So the expert panel, the advisory
19 panel, the whoever. Now sometimes they'll go to
20 -- and I've seen face validity assessed at say a
21 subcommittee of a specialty society that weren't
22 necessarily developing the measures, but they go

1 to their -- to another committee and have them do
2 it. Great. Super.

3 But again, it tends to be folks that
4 tends -- that have that frame of reference as
5 opposed to the vetting, which is of those being
6 measured. And I think that's the critical
7 difference. I mean, your expert panel advisors
8 may ultimately end up being measured, of course,
9 but nonetheless I think the target and the -- for
10 the concept is what's the critical difference
11 between the two.

12 MS. JOHNSON: Thanks, Reva.

13 All right. So empirical testing and
14 the measure score. So this is where I'll give
15 you some of our philosophy and you guys can push
16 back, if you want to, or maybe you'll agree.

17 I would say that to some extent our
18 thinking has evolved. And, Kyle, I think it was
19 you that talked about different types of
20 validity. We have that whole little list of
21 criterion, predictive, concurrent, all those
22 things that you learn and then you forget until

1 you have to apply it or something like that.

2 Now when I look at things, I don't
3 really care what label you put on it, if you call
4 it predictive or whatever. I think of it really
5 all as construct personally. And the difference
6 is what are you comparing it to? If you're
7 comparing it to some kind of gold standard, then
8 that becomes what people sometimes call criterion
9 validity. Right? So that's how we're thinking
10 about it. Different ways to validate, but all
11 assessing some kind of hypothesized relationship
12 or relationships on the measure results to the
13 results of another measure or measures based on
14 the knowledge of the underlying constructs.

15 So don't get too bent out of shape on
16 the word "hypothesize." We're not necessarily
17 saying it has to be hypothesis testing in the
18 stats sense of the word. We see it as a
19 theoretical exercise. And I think many of you
20 have already talked about this. Sometimes what
21 we hear is I can't really talk to you about
22 validity because we have to get our statisticians

1 on the phone.

2 And we would say the statisticians are
3 there to help you crunch the numbers and maybe
4 come up with your methodology, but you guys as
5 the developers, the subject matter experts,
6 should be the ones who are coming up with those
7 relationships and deciding what you should be
8 looking at, or maybe what you shouldn't be
9 looking at, right, and what you should expect to
10 find.

11 So here's how we see it: Link a
12 concept of interest to some other concept by
13 hypothesis or a construct. Usually there are
14 many and we might -- I might get some pushback on
15 that, because I've often heard that there's not
16 any, right, or not any that you can actually do.
17 But we'll talk about that.

18 The hypothesis should indicate the
19 direction of the relationship. Do you think
20 things are tracking together? Do you think
21 they're tracking differently? Tell us, right?
22 And it's theory. You should have some idea about

1 the strength, the expected strength. And we'll
2 do some examples so this makes a little bit more
3 sense, but the idea there is do you really -- if
4 you're looking at a gold standard, you probably
5 expect a pretty strong relationship, right?

6 That's what you're hoping for. You want to
7 validate, right? But if you think what you're
8 looking at is maybe related but maybe a little
9 weaker, well, you should be able to articulate
10 that.

11 So you link it in your mind. You do
12 something with it with some numbers and some
13 data, some kind of method. And then you look at
14 what you found. You could do formal statistical
15 testing and look at significance. You can look
16 at your effect size. You can look at directions.
17 This works with correlations, those kinds of
18 things as well. Right?

19 If the expected relationship is found,
20 then you at least have some comfort in thinking
21 that your hypothesis may have been correct and
22 that your measure is valid. Okay? If you don't

1 find what you expected, it could be a problem
2 with your measure or possibly your hypothesis, or
3 both. Right? But validity is really -- there's
4 not really one -- there's usually not going to be
5 one major analysis that's going to totally
6 validate a measure. Validity is -- I think of it
7 as like a brick in a wall, right? You just keep
8 kind of adding to it so that you feel more and
9 more comfortable over more and more tests that
10 you have a valid measure.

11 Now I also realize that in the real
12 world you may only have one brick, but at least
13 theoretically you could continue to add things
14 on. You're doing measure instrument development.
15 You might look at it in one population versus
16 another population with English and Spanish,
17 etcetera, etcetera, and you'd validate in all of
18 those areas. Right?

19 All right. So that's our thinking.
20 I've already hit this. Different methods could
21 be used. Correlate. Look at differences and
22 means, progressions, whatever. And what you pick

1 depends on what kind of data you have and what
2 your level is that you're testing type of data.
3 So I kind of merged in a little bit of data
4 element testing here, but -- and of course your
5 type of data.

6 Let me stop there and see if this at
7 least seems reasonable. Maybe this is not how
8 you've thought about it yourself. Maybe you have
9 other words that we should take instead of these.

10 You want to do an example first and
11 then we'll come back to it? Let's do an example.
12 Okay.

13 Very recent example. This week, as a
14 matter of fact, we had a couple of these come
15 through. They did some really nice score level
16 testing. So the hypothesis was -- so the measure
17 was about NICU admission temperature of low birth
18 weight babies. But the hypothesis was that
19 hospitals that had more babies with low temps
20 when they're admitted to the NICU will have a
21 higher NICU mortality rate. Okay?

22 So they've come up with this

1 relationship. They think there's something going
2 on between -- and the literature supports it,
3 which is always good. Right? So they have a
4 relationship there. They have a direction. They
5 say it should be higher. Right? It's a positive
6 relationship. They don't really talk too much
7 about the strength size that they're expecting.
8 I guess they could have gotten even more
9 specific.

10 But here's the results. Three
11 hospitals. They actually found a dose response
12 relationship here. The lower the temp, the
13 higher the mortality.

14 And, Reva, do you want to -- this was
15 your measure.

16 DR. WINKLER: Yes, this was a -- it
17 was very elegant. Small number of hospitals, of
18 course, but essentially what it was is the larger
19 the number of babies, the higher the mortality.
20 Duh. Therefore, as a proxy for predictive
21 mortality, neonatal temperature on admissions to
22 the NICU is looking to be a very valid assessment

1 of the care provided. And so it was a very
2 elegant, very simple, not a lot of data, but told
3 the story quite nicely.

4 MS. JOHNSON: If they had messed up
5 somehow or another; it's hard to imagine with
6 this measure because it's a pretty simple
7 measure, but if they've messed up the
8 construction of the measure or something, some
9 kind of goofball thing happened, and the results
10 didn't show that, you would -- what would you
11 think? Would you change your hypothesis or would
12 you think, boy, something's wrong with maybe how
13 I constructed my measure perhaps? Or maybe I
14 have to go look at a couple other hospitals
15 because there's something weird with these
16 hospitals and luck of the draw got me three
17 weirdos.

18 Okay. Is this making sense now as to
19 what we're talking about? Let's do one more.

20 Unexpected complications in term
21 newborns. We predict that our measure will be
22 highly correlated with a neonatal admission to

1 the NICU. This was a different measure.

2 So what they did is they showed by
3 week, which is actually very nice, the -- I think
4 these are odds ratios of expected -- unexpected
5 complications.

6 Is that what this was? Do you
7 remember?

8 (No audible response.)

9 MS. JOHNSON: I should have put that
10 on my table. Yes, it looks like them.

11 And so, unexpected complications.
12 Admissions to newborns. And what you see here is
13 a dose response, but really a U-shaped curve.
14 Woo hoo. And there you are. There's your U-
15 shaped curve. It's doing what they expect it to
16 do. They have validated their measure using a
17 measure score. This one in particular I think;
18 Reva, remind me if I'm wrong, they didn't have
19 this data in house, right? Did they -- is this
20 the one that they borrowed data or had somebody
21 else run some data for them?

22 DR. WINKLER: (Off microphone.)

1 MS. JOHNSON: No, this is -- okay.

2 DR. WINKLER: (Off microphone.)

3 MS. JOHNSON: Okay. All right.

4 Apologies. I was thinking there was one that
5 they actually used somebody else's data to help
6 them validate.

7 DR. WINKLER: The interesting thing
8 about this is this U-shaped curve has been
9 applied to just about every outcome in obstetrics
10 when you relate it to gestational age. So that's
11 what makes this particularly an elegant result.

12 MS. JOHNSON: So we're now co-
13 presenting.

14 (Laughter.)

15 MS. JOHNSON: All right.

16 Interpretation. So they gave us some tables with
17 some numbers in them. They gave us a pretty
18 chart. We can therefore conclude that severe and
19 moderate -- I'm not going to read this out. So
20 they gave the interpretation and then they went a
21 little further and they said this demonstrates
22 that our metric successfully captures and

1 quantifies neonatal morbidity in term newborns.

2 So they really laid it out. They really

3 interpreted it for us.

4 They also note that what they found
5 matches the LIT. And they did another test of
6 correlation. Both sets of -- this is referring
7 back to the table. Both sets of odds ratios,
8 there we go, demonstrated high positive
9 correlation after further reinforcing results and
10 conclusions. So basically the had one
11 hypothesis, but they did two separate analyses to
12 look to see if what they were expecting actually
13 happened.

14 All right. So just for a second; and
15 I realize I'm preaching to the choir here, but
16 let's go back. Here we go. Linking a concept to
17 some other concept by hypothesis. That's really
18 like highfalutin sounding, isn't it? But really
19 they just said we think this should track with
20 this other thing over here. They did some
21 testing and then they looked at the results and
22 made some conclusions.

1 All right. What do you think? I
2 think I'm at my what-do-we-think stage.

3 Sorry. This thing is really slow.

4 Oh, I was going to tell you some of
5 this. Let's come back to that in a minute.

6 Any surprises thus far? We'll go back
7 and I'll tell you what we sometimes get.

8 Thinking of this as assessing
9 relationships, does that help when we -- when
10 people ask us what do we mean by score level
11 validity? Does that make sense? Is that
12 language working? Is that how you think of it?

13 Kyle?

14 MEMBER CAMPBELL: I think it makes a
15 lot of sense the way you have it laid out. And
16 you asked sort of like when do we consider face
17 validity? And I think it sort is the last
18 result. If we don't have an opportunity where we
19 think that we have something that we can compare
20 against and there are those -- particularly the
21 outcome measures, there are those issues where
22 there isn't something suitable as a comparator to

1 do this type of work, that's kind of when we
2 would rely on face validity. And we probably
3 would do face validity anyway, because we're
4 interested to see what the panel thinks.

5 MS. JOHNSON: Yes.

6 MEMBER CAMPBELL: I think you have it
7 -- I think you've captured it really well. And I
8 think the important thing is the conceptual
9 relationship, right?

10 MS. JOHNSON: Right.

11 MEMBER CAMPBELL: So if you had a
12 strong correlation but conceptually it didn't
13 make any sense, you could put it down, but what
14 would it mean? So I think understanding that,
15 what is that relationship telling you as you go
16 in? Your hypothesis is really important.

17 MS. JOHNSON: Right.

18 MEMBER CAMPBELL: Yes.

19 MS. JOHNSON: And you got to my -- the
20 last bullet there, what are some of the barriers.
21 So we have heard that it's hard sometimes to find
22 other measures to compare to. So I would say one

1 thing, an outcome doesn't have to compare to
2 another outcome. You can link it back to process
3 measures, if you have them. Right?

4 But are there other barriers? Is that
5 the big one? Is that insurmountable? Does it
6 depend?

7 Oh, we have a question. Yes?

8 MR. TILLY: So, yes, perhaps related
9 to barriers. Purna asks how do you do empirical
10 testing when you don't have the right data
11 elements?

12 MS. JOHNSON: Okay. When you don't
13 have the right data elements? Yes, so I think
14 what she means is -- she doesn't have the right
15 data to do score level testing, is probably what
16 she means. And I think that is the barrier, that
17 people are saying they don't have the data. If
18 you think that you're admissions are related to
19 your discharge planning and you don't have that
20 information, you can't do that analysis. I think
21 that is the problem. And that is where Kyle goes
22 back and -- you always have face validity to fall

1 back on. Yes.

2 How many of you actually are running
3 into this problem? You would love to do this
4 kind of stuff, but you don't have the data?

5 (No audible response.)

6 MS. JOHNSON: Okay. Sam, is that in
7 eMeasure kind of world?

8 MEMBER SIMON: (No audible response.)

9 MS. JOHNSON: Okay. So you don't have
10 data anyway, right?

11 (Laughter.)

12 MS. JOHNSON: Sorry. I couldn't
13 resist.

14 Now it surprises me a little bit
15 sometimes when people have claims data or
16 registry data and they can't do it, or they --
17 but again, you have to have the right
18 relationships, the ones that make sense. So I
19 can certainly see it.

20 Anybody else want to -- have you
21 thought about getting data from other people if
22 you don't have it?

1 (No audible response.)

2 MS. JOHNSON: So I don't think I've
3 answered this question, unfortunately. That's
4 why you guys are here to help us answer.

5 Reva, do you have a --

6 DR. WINKLER: (No audible response.)

7 MS. JOHNSON: No answer? If you don't
8 have the data, you don't have the data. I would
9 say don't necessarily say it has -- it doesn't
10 have to be criterion validity. Right? It
11 doesn't have to be outcome and outcome. It could
12 be -- like one that we see every now and again is
13 -- the fancy term I think is -- what do you call
14 it, the group, differentiating group's validity?

15 So if you know that you've got
16 certified recognized stroke centers versus others
17 that aren't, you would probably expect your
18 measure to be higher in your recognized centers
19 than your not recognized centers. That could be
20 one. That might take a little bit of outside
21 data to know which one is which.

22 Hey, you guys must be getting tired.

1 Hungry? Okay. All right.

2 Let's go back and I'll tell you a
3 little bit of what we often get. Let's see, did
4 I miss any? No. Okay. What we often get. We
5 get a naming of a method. Usually the naming of
6 the method is correct. Not always, especially
7 when it comes to things like predictive validity,
8 because different people mean different things
9 when they say predictive validity. Right? They
10 might actually mean concurrent validity, but I'm
11 using some kind of regression model. So I'm
12 predicting something. Right? Which is fine.

13 A correlation table but no explanation
14 and little interpretation. So here's my -- I
15 copied it from SAS. Here is it. Yes. What we'd
16 like to see. Description of the hypothesized
17 relationships. Which measures did you choose and
18 why? Don't assume that everybody's an expert and
19 would know your thinking. Let us know why you
20 thought that that was the case. Let us know what
21 you thought the case was. If you expected it to
22 be positive, negative. You expect to see a high

1 correlation or a strong association. Or maybe
2 not so much. But you should know that a priori,
3 right? You guys are the experts, so you would
4 know this. Right?

5 And then interpretation of findings.
6 How are -- does or doesn't this validate your
7 measure? Little bit tricky if it doesn't. But
8 even if it didn't, you may say on reflection this
9 may not have been the strongest hypothesis or,
10 yes, the expert panel -- yes. Often go to the
11 expert panel. So these are some of the things
12 that we would like to see to really round this
13 out.

14 Otherwise, what happens is we have to
15 assume. We're writing these preliminary
16 analyses, so we're making assumptions about what
17 you're thinking. Or we're chasing you down. It
18 doesn't always work well when we make assumptions
19 because we're wrong sometimes. Or the committee
20 is confused, what have you.

21 All right. Is there anything left of
22 this? Everybody's hungry.

1 Extent of validation. I've already
2 mentioned this. Often demonstration of validity
3 should come from a series of studies. And this
4 is just kind of typical. If there isn't a gold
5 standard, then you would expect that you would
6 need to do this more and more to really build
7 your case of validity. Again, I understand there
8 may not be money or whatever to do this, but in a
9 very kind of theoretical kind of world this is
10 what we would do. Right?

11 More studies strengthen the evidence
12 of validity and it's built over time. This one's
13 a little tricky. Even one study with unexpected
14 results with respect to a gold standard may
15 invalidate the measure. But that's what you want
16 to know, right? You guys don't want to put
17 forward and invalid measure, because what we want
18 to do is drive improvement. We don't want to --
19 so this is why you test.

20 And then NQF criteria also require
21 consideration of potential threats to validity.
22 So we are going to talk about threats to validity

1 very quickly. I've already mentioned those.
2 They're listed in our criteria. Patients
3 inappropriate excluded. Differences in patient
4 mix. Scores that are generated with multiple
5 data elements or sources or methods, and then
6 systematic error. That can be unintentional or
7 intentional. Lots of different ways that
8 validity can be threatened.

9 We ask you to assess potential
10 threats. That's what we're asking for.
11 Mitigate them if you can. And some people do,
12 right? You might impute if you have a lot of
13 missing data, for example.

14 So what would we like to see? So for
15 exclusions at minimum we'd like to at least know
16 how many you're excluding. It would be even
17 better if we knew the variability across measured
18 entities. Now if you're excluding hardly any, it
19 kind of doesn't matter, right? But if you're
20 excluding a pretty good portion, then is it
21 uniform across entities or not?

22 Preferability sensitivity analysis of

1 results with and without exclusions. That's not
2 always possible. Sometimes you don't even have
3 that data if they're excluded in the first place.
4 But sometimes people can do it and they will say
5 it doesn't matter, or it mattered a little bit,
6 but not too much, or whatever.

7 Risk adjustment for outcome resource
8 use. Some process measures. As Lynn and PQA
9 folks told us yesterday, there are adherence
10 measures we initially considered at process
11 measure, but they've realized that risk
12 adjustment is probably appropriate there.

13 We want to see empirical analysis to
14 demonstrate that risk adjustment isn't needed, so
15 it is possible to put forward an outcome measure
16 that doesn't have risk adjustment. We have to
17 convince people that you don't need to risk
18 adjust, right? So we want to see data.

19 And then if you are planning on risk
20 adjustment, particularly in light of our SDS
21 trial, we would like to see conceptual and an
22 empirical approach. So the conceptual piece is

1 the rationale for the SDS factors. And we want
2 to see that even if at the end of the day you
3 decide that you're not going to put them in there
4 anyway. We want to know why you considered them.

5 And then discrimination calibration
6 statistics. Is your modeling -- it's usually
7 modeling. We don't see very much risk
8 stratification. It's usually statistical models
9 of some sort. Is it doing what you want and does
10 it fit the data well?

11 Meaningful differences. At minimum
12 we'd like to see variation amongst the measured
13 entities. Even better would be some kind of
14 statistical analysis, not just saying that
15 they're different, but they're really different
16 in some meaningful way, either clinical or
17 statistical, or both. Right? Sometimes we get
18 things that are statistically different, but not
19 meaningful in some kind of clinical way.

20 Comparability if multiple data sources
21 or methods are used. I'll admit that this is one
22 that we hardly ever see anything on. It makes me

1 nervous if a measure is specified at claims and
2 some other way, because how do I know that it's
3 fair to compare this one and this one? And we
4 would like to see that.

5 Missing data. How frequent are they?
6 How are they handled? Demonstration that results
7 are not biased.

8 Any surprises here on what we're
9 looking for?

10 (No audible response.)

11 MS. JOHNSON: Often we'll get NAs and
12 people will say, yes, I had a bunch of
13 exclusions, but I'm not going to tell you
14 anything about them.

15 Okay. We've got a couple minutes
16 left. If you could change anything we do
17 regarding validity, other than not asking you
18 about it in the first place --

19 (Laughter.)

20 MS. JOHNSON: -- what would it be?
21 Any ideas? It could range from you're doing it
22 perfectly, good job to get rid of face validity.

1 So, Kyle, have we got you or what? Any ideas?

2 Oh, we have a question. Yes?

3 MR. TILLY: Yes, Purna again asks is
4 risk adjustment still needed if a measure is just
5 to be used for reporting purposes and not for
6 accountability?

7 MS. JOHNSON: If it is an outcome
8 measure or a resource use measure or even some
9 process measures that you feel like that patient
10 characteristics could bias the results, then yes.

11 Oh, let's hold on a minute. I haven't
12 got anything from our audience about what you
13 would do if you were NQF and you could change
14 anything you wanted. There's got to be at least
15 one idea.

16 Jeff, yes?

17 MEMBER GEPPERT: Throw out an idea.
18 So for both reliability and validity we sort of
19 -- we treat them like thresholds, right?

20 MS. JOHNSON: Yes.

21 MEMBER GEPPERT: You're either
22 reliable or you're no.

1 MS. JOHNSON: Yes.

2 MEMBER GEPPERT: You're valid or
3 you're not. And that's probably not true.

4 MS. JOHNSON: No.

5 MEMBER GEPPERT: They're more like --
6 it's aggregation.

7 MS. JOHNSON: Yes.

8 MEMBER GEPPERT: So I think that
9 introduces some unpredictability of the -- into
10 the process where one committee might consider
11 something reliable and valid and another
12 wouldn't. And so I think anything we could do to
13 help standardize those type of assessments would
14 add to the process.

15 MS. JOHNSON: We've actually thought
16 a lot -- you probably have noticed, I think other
17 than our EHR testing where we say it has to be
18 more than one, I think that's the only threshold
19 that we put on anything. And the reason is that
20 nobody can agree on the thresholds. So if we
21 said we have to have a 0.7 of reliability,
22 there's going to be people saying we'll never get

1 to that, but it's still a reliable measure. And
2 that's a rule of thumb that has not basis in
3 reality. So it's been really hard. You're
4 right, that would really help.

5 What we're trying to do and what we're
6 hoping -- it would be interesting to see if you
7 guys think it's working, is the preliminary
8 analysis that we're doing. We're trying to be
9 more consistent internally. We've already
10 admitted that we're -- some of us are different
11 graders and we're trying to be more consistent
12 here. We're hoping that that's making our
13 committees more consistent in what they're
14 thinking about and how they're ultimately voting.
15 It would be interesting to hear your feedback on
16 those things.

17 But if you have ideas about how we
18 could come up with thresholds, that sort of
19 thing, I mean, we're willing to think about it.
20 The last time -- we tried about two years ago and
21 it didn't fly. They didn't like that.

22 MEMBER GEPPERT: Actually I'll go the

1 opposite direction.

2 MS. JOHNSON: Oh, okay.

3 MEMBER GEPPERT: I would embrace the
4 continuity of the concepts of reliability and
5 validity.

6 MS. JOHNSON: Yes. Okay.

7 MEMBER GEPPERT: And then I would try
8 to incorporate that into my sort of decision
9 making process.

10 MS. JOHNSON: I think it's -- that
11 actually works a lot better when people interpret
12 their results, but often all we get is our
13 reliability estimate was 0.63. Our c-statistic
14 was whatever it was. So you might be right.

15 I think the other thing that is
16 interesting, we really do think of reliability
17 and validity as context-specific. So we talk
18 about it. And we're kind of lazy in our
19 language. We talk about is a measure reliable or
20 is it valid? And really it might be reliable
21 with this piece of data at this point in time and
22 not so much over here. We understand that.

1 Right? We sort of understand that. And we kind
2 of let that go, because we're never going to be
3 able to test every possible permutation of
4 everything. So that's why some of us think NQF
5 stuff is the low bar.

6 But any other ideas?

7 (No audible response.)

8 MS. JOHNSON: Intriguing idea, Jeff.
9 We'll think about it. Like how can we do that?

10 DR. BURSTIN: One option might be to
11 just pass out cards so you don't have to raise
12 your hand and say what you want us to change. I
13 mean, you could do it during lunch and we'll
14 collect them. So you could -- feel free to say
15 whatever you like. I mean, about validity would
16 be nice, but more broadly would be nice as well.

17 MS. JOHNSON: Sure. Yes. Yes, we'd
18 love to know your feedback. It would be
19 interesting for us to know if you guys think
20 we're on track with what we're asking for. We do
21 realize that you guys think -- and it is
22 burdensome to fill out our submissions, our

1 forms, etcetera. We're trying to make that
2 easier. We feel like for the most part that
3 we're asking you things that are important to
4 ask. So if you don't think so -- when we have
5 people thinking about their reliability and
6 validity testing particularly, usually what we
7 say is think about the data that were used and
8 how kind of -- what's the scope of that data?
9 Think about the method. Was it appropriate.
10 Think about the results. Does it seem
11 reasonable? And that's kind of our guidance.
12 It's not rocket science really. I don't know.

13 Anybody else have any final thoughts?
14 We'll give you cards. Looks like lunch is coming
15 out.

16 Thank you guys for talking back to me.
17 It made it a little more fun for me. We would
18 look to you to give us any feedback you have. If
19 you have it, we'll consider it. Thanks.

20 Oh, that's right. I forgot to pass.

21 (Laughter.)

22 MS. ISIJOLA: Okay. So we're going to

1 break for lunch and spend about 15 minutes. You
2 can grab your lunch and then come back and then
3 we'll go into our next session. Thank you.

4 (Whereupon, the above-entitled matter
5 went off the record at 11:56 a.m. and resumed at
6 12:19 p.m.)

7 MS. ISIJOLA: Okay. Thanks everyone
8 for holding on. So just some housekeeping, some
9 more housekeeping. Jean-Luc actually just placed
10 some cards at your tables. I know there was some
11 discussion of providing some feedback, so that's
12 an opportunity for you. If you don't want to
13 state it publicly, use the cards and provide that
14 feedback to us and we'll use that and integrate
15 it as we continue to improve our work.

16 Also, following this workshop we'll be
17 sending out a survey, and that will help us
18 really continue that effort. Your participation
19 in this endeavor is really crucial to how we do
20 our work, so we'll be sending a survey. What
21 worked for you during these past two days, what
22 hasn't, what are some of the things you would

1 like more information? I know Amy Miller
2 mentioned some of the discussions.

3 And sorry to call on your, but some of
4 the discussion is meaningful to some of your
5 colleagues.

6 One of the things we'll be doing is
7 putting some of these recordings on our pages and
8 have it as an on-demand. So it may not be useful
9 for you per se, but it may be useful for your
10 colleagues who work with us, really thinking
11 about the testing or the validity. So stay tuned
12 for more there.

13 And with that being said, I'm going to
14 turn it over to Reva. I know over the past two
15 days we've talked about CDP and MAP integration,
16 and this is an opportunity to talk through that.
17 Reva will speak as well as Sarah Sampsel. And we
18 also have one of our CMS colleagues who will be
19 able to join in on that discussion as well.

20 Reva?

21 DR. WINKLER: Well, it wouldn't be
22 Washington without the alphabet soup. And so,

1 CDP, the Consensus Development Process. I don't
2 know familiar you all might be with the term that
3 we use very readily internally, but that's our
4 endorsement process. CDP has three letters.
5 Endorsement has many more. So CDP it is. And
6 then MAP, the other process. We work together on
7 both of them. Let's just talk about what those
8 two entities are.

9 They are two distinct multistakeholder
10 processes here at NQF. So the consensus
11 development process, or CDP, is our formal
12 process to evaluate and endorse measures. This
13 is what we have done since the beginning of NQF
14 back, oh, 2001 or so. It's focused on NQF's
15 measure evaluation criteria. And the timing of
16 the CDP projects is not as predictable. It has
17 to do with the various scheduling and the
18 contracting for funding. And so, we do issue the
19 periodic calls for measures to bring them into
20 the CDP process. So that's -- and it is based on
21 using the NQF membership and other members of the
22 public in a very multi-stakeholder fashion to

1 contribute to building consensus around what
2 measures should be endorsed.

3 The other entity at NQF, other large
4 entity at NQF that is another multi-stakeholder
5 process is the Measure Applications Partnership,
6 or the MAP. And the MAP began about five-and-a-
7 half years ago to provide annual input to HHS on
8 the selections of measures for use in federal
9 programs. All right? So where the other is
10 around endorsement, this one is around selection.

11 And the measures under consideration
12 by HHS for possible use in federal programs later
13 on is a very tightly scheduled activity. The MUC
14 list is released every year by December 1st and
15 the Measure Applications Partnership, or the MAP,
16 provides feedback no later than February 1st. So
17 you can count on those. It's an over-the-
18 holidays, over-the-new-year cram and jam. So,
19 but it's very predictable because MAP season has
20 replaced holiday season for most of us.

21 (Laughter.)

22 DR. WINKLER: So, and it's the

1 focusing on the use of measures in specific
2 federal programs. And so, you're aware that
3 during the course of evaluation for endorsement
4 while we talk about use and usability, we really
5 aren't talking about use in specific programs.
6 Very different from the MAP, which is looking at
7 specific programs. So these two processes were,
8 especially when the MAP first started, relatively
9 distinct here at NQF. I mean, they actually
10 lived at the other side of the building and the
11 staff were distinct. But it didn't take too long
12 for us to figure out how much we needed each
13 other to understand the activities of one and the
14 information that needed to flow back and forth.

15 And so over time, and particularly
16 over the last two years, we have really made
17 concerted efforts to integrate the communication
18 flow between these processes. And so, you will
19 be involved as developers in some of this
20 information flow. And I'd like to try and just
21 describe it to you.

22 And so, I've got various versions of

1 this, because it's a circle and it's an ongoing,
2 multi-directional simultaneous communication
3 information flow thing. Okay? It doesn't fit
4 very well on a two-dimensional surface. But if
5 we just start at one point, if you will -- and
6 that's with measures that have been through the
7 consensus process and they're endorsed by NQF.
8 Okay. Well, sometimes those measures end up on
9 the MUC list. Yay. And so what we are making a
10 more -- much more concerted effort is to provide
11 the information that the steering committee,
12 standing committee used to evaluate that measure
13 to the MAP. And how that the MAP has seen it,
14 oh, my God, their appetite for it. They're
15 voracious. Okay? It's like I want all that
16 stuff.

17 So one of the things that we really --
18 it's now standard process for us for any of the
19 measures that are endorsed by NQF that go to the
20 MAP is that all the information from the
21 endorsement process: all of the comments, all of
22 the evaluation, all the voting, all the

1 everything that happened, they have access to all
2 of that. So, and we believe that that's a
3 particularly useful input to the MAP.

4 Now, the MAP has a lot of conversation
5 and a lot of opinions about use of those measures
6 in very specific programs. And as part of the
7 MAP discussion there's a lot of feedback.

8 There's a lot of, gee, did the committee think
9 about that, or, gee, it would be really nice if
10 the committee would consider this, or, gee, we
11 really think you didn't mention this and it's a
12 problem because of X, Y, and Z.

13 And so, that feedback from the MAP
14 will go back into the measure endorsement and
15 maintenance process so that it tends to be a
16 circular kind of flow of information. It's
17 possible that the MAP feedback is such that we
18 need to do an ad hoc review of the measure. We
19 would obviously notify you that that's where we
20 were going with it, but sometimes the concerns
21 around the use of certain measures in certain
22 programs have prompted sufficient questions that

1 we need to kind of stop and take another look.

2 So because we have standing
3 committees, that becomes an -- we now have sort
4 of the vehicle by which we could do that ad hoc
5 review. If not, if it's just good information,
6 good feedback, it becomes one of the most
7 important feedback loops that we currently have
8 to understand what's going on around the use of
9 the measure. And that information gets fed back
10 to the committee at the time of the next
11 maintenance review.

12 So the flow of information between the
13 two is intended to be continuous. And this
14 happens all the time because the CDP processes
15 are not tightly scheduled. They're happening
16 pretty much all the time. So we're constantly
17 pulling the MAP input in. So this is happening
18 on a regular basis. This is not even close to
19 being linear.

20 Okay. So what are other options?
21 Well, we know that on the MUC list when it comes
22 out every year there are a lot of measures that

1 have never been through NQF. Okay. So they come
2 into the MAP and the MAP is sitting there going,
3 hmm, okay. And one of the struggles they have is
4 they don't have the information that we -- the
5 depth of information and the details that we
6 have. And they really -- they like that. They
7 like it a lot actually.

8 But what happens is if the MAP is
9 looking at a fully developed measure, they may
10 say, okay, we support it, but conditional on it
11 going through NQF so that it can have a more
12 vigorous look at the measure and the measure
13 characteristics. And so, what we are doing new,
14 if you will, is to reach out to the developers of
15 those measures and said look, the MAP said, hey,
16 this would be a great measure, gave it a
17 conditional support. We are going to try and
18 bring this into NQF at the next available
19 opportunity. And so -- and make sure that you're
20 aware that that is the situation and we may or
21 may not know what our upcoming projects are,
22 depending on where we are in a contracting cycle,

1 but to let you know that you're on our radar.

2 Our funding proposals are also now
3 aware of these measures so that we can talk with
4 CMS and some of our other funders about saying,
5 hey, there are these measures out here that were
6 proposed and the MAP liked them and we really
7 need to bring them in through the endorsement
8 process. And so, that can help drive or
9 structure some of our upcoming projects. So
10 that's a relatively new thing we're using to try
11 and help establish the upcoming project cycle and
12 topic areas. And then whatever feedback the MAP
13 have had about a measure is fed back into the
14 committee when it goes through the CDP for
15 potential endorsement.

16 So as you see, between MAP and CDP
17 there is an important flow of information. Both
18 are informing the other. And the thing that's
19 made this work particularly well over the last
20 year or two is the fact that we no longer have
21 distinct staff. We all work on both. And so, we
22 don't have to -- we know where the information on

1 one is -- could be found for the other. It's not
2 a -- they aren't separate entities in house
3 anymore. They are all just part of our Quality
4 Management -- our Quality Measure Department
5 activities.

6 And so, I did want to talk a little
7 bit about some of the specifics very briefly,
8 because you as developers might get pulled into
9 some of this, and you certainly would want to be
10 aware of what might be happening with your
11 measure as it's flowing around NQF. And so,
12 realize that the endorsement evaluation will go
13 to the MAP, and the MAP may provide feedback on
14 endorsed measures.

15 So it's very possible, as I had to do
16 after the clinician MAP this year, is go to a
17 couple developers and say, yo, the MAP is --
18 raised concerns or issues or questions around X,
19 Y and Z. Your measure is up for maintenance this
20 year and we will specifically ask the committee
21 to address those things raised by the MAP. And
22 this is something we're doing right now. It's

1 currently happening.

2 If it were to be something really,
3 really big and the measure was not up for a soon
4 evaluation, it might prompt an ad hoc review. Of
5 course we would tell you that and you would be
6 part of that process. So realize that we really
7 -- we have to really see what the situation is
8 with the measure and with the issue, but either
9 of those things is likely going to happen, and we
10 have several examples ongoing right now.

11 So when you look at the measures on
12 the MUC list -- because I'm sure you're all aware
13 CMS sort of has an open call for measures that's
14 currently open right now and through I guess July
15 15th. And so, HHS creates the Measures Under
16 Consideration list; we so love it, the MUC list,
17 and that is what goes to the MAP.

18 The MAP may, as I said, recommend the
19 conditional support. And if that's the case, as
20 I said, we would want to do the outreach to you
21 all and let you know that that's what's
22 happening.

1 Now, one of the comments we had
2 yesterday was interesting, because what we're
3 seeing, particularly on the clinician side, maybe
4 a little less so in hospitals, but certainly some
5 on the PAC/LTCs -- we're seeing a lot of measures
6 come to the MAP that are not fully developed.
7 They're still in process. The amount of
8 information we get that's on the MUC list about
9 that is so minimal we really don't know what that
10 means. We just know they haven't checked the box
11 saying fully developed and tested. It's maybe
12 there's alpha testing, maybe there's beta
13 testing, maybe this and that.

14 I know I tried to reach out to the
15 developers last year and I would hear, yes, the
16 measure is being tested in the upcoming year in
17 your registry. Okay. Great. But it wasn't done
18 yet. So one of the things that the MAP overall
19 and the Coordinating Committee struggles with is
20 the fact that some measures just aren't ready to
21 be implemented in programs yet. We need a little
22 bit more time to finish the development. So

1 we're struggling with some of that limited
2 information that's available about some of these
3 measures, because frankly for some of them
4 there's not a lot more than the title
5 description, numerator, denominator and we're
6 done. So it is a little bit difficult.

7 But we will be wanting to interact
8 with the developers of those measures, and
9 particularly the developers of the measures where
10 the MAP feels warm and fuzzy about the measure,
11 at least in concept, but if it isn't fully
12 developed yet, where are you in the development
13 process? And then the added nuance, which I
14 probably need to update, is the thought of, well,
15 if you're still really early on in testing and
16 perhaps need some assistance with testing, and
17 it's a really great measure, particularly if it
18 would make a really good eMeasure or something
19 like that, perhaps we can connect you up with the
20 incubator. So we do want to integrate all of
21 these processes within NQF to take advantage
22 regardless of where we are in these -- whether

1 it's MAP or CDP or the incubator or whatever else
2 we're happening to do.

3 I want to now turn it over to my
4 friend Sarah who's going to tell you a little bit
5 about how this integration with the CDP, a
6 specific -- one of the standing committee and the
7 PAC/LTC MAP Workgroup function over some of the
8 measures in that particular topic area.

9 MS. SAMPSEL: Thank you. And so, I'm
10 going to make a couple of statements and kind of
11 tell the story of what's been going on over the
12 past couple of years between person and family
13 centered care and the PAC/LTC. But then our
14 colleagues from CMS are on the phone, Mary Pratt
15 and I believe Tara McMullen and perhaps some
16 others who represent the actual programs, so work
17 across both committees as well.

18 To cut to the chase, the biggest issue
19 is communication. And so, it's not only those of
20 us at NQF understanding the measures and the
21 programs on the PAC/LTC side or on the CMS side,
22 but then understanding kind of the timeline and

1 how they're coming through our CDP process as
2 well.

3 So really a shining example is the
4 implementation of the IMPACT Act. And for those
5 of you who are not familiar with this, which I
6 was not familiar with up to a couple years ago,
7 this was a bill passed in 2014 and signed on
8 October 6th, 2014. And what it requires is
9 standardized patient assessment data that allows
10 data element uniformity, quality care and
11 improved outcomes, quality -- comparison of
12 quality care across post-acute settings, improved
13 discharge planning, exchangeability of data and
14 coordinated care. That should be really easy,
15 right?

16 And so, what we were finding and have
17 been experiencing is as CMS has been going on
18 their timelines and implementing the quality
19 measure domains and the respective timelines for
20 implementation into the programs these measures
21 were starting to come through the endorsement
22 process as well. And so, while the PAC/LTC MAP

1 was educated on the IMPACT Act and understood why
2 the considerations for the measures and why, as
3 Reva just referred to, there might be measure
4 concepts, there may be measures earlier in
5 development, they were really just CMS alerting
6 these measures are coming forward.

7 But then on the endorsement side -- so
8 on the CDP side these all came through Phase 2 of
9 person and family-centered care, which was
10 focused on functional status. All of a sudden we
11 had 28 functional outcomes, functional status
12 measures being brought to a CDP project.

13 And so, our committee members were --
14 some of them were certainly well aware of the
15 IMPACT Act, but it was bringing those pieces
16 together and working with our colleagues at CMS
17 to say, hey, can you come and talk to us about
18 the IMPACT Act and would you just make sure that
19 when we're in deliberations -- because one of the
20 questions then comes up during the CDP process,
21 especially on usability of use, how are these
22 measures going to be used? As these QI measures?

1 Are these reporting measures? Are these pay-for-
2 performance measures? Those are really things
3 that we need the developer to answer and should
4 not be NQF.

5 So a couple things happened. One the
6 CMS representation along with their developers at
7 the panel meetings, but in addition to that
8 during the previous MAP process and now current
9 MAP process; I'm a senior director, or had called
10 in to be able to listen to and provide that
11 direct feedback from the MAP. And that's a
12 process that Reva just explained is always
13 improving, always evolving.

14 But as we're getting ready for our
15 next phase of person and family-centered care
16 work, while these measures aren't coming through,
17 it's a great opportunity to keep the standing
18 committee informed of what's going on, what they
19 may see in the future, what happened in the past,
20 kind of what's the steering, what are those gaps
21 even identified by the PAC/LTC, the duals, and
22 some of those workgroups that filter over both?

1 So really kind of what happened. And
2 this is the simplified example. So quality
3 measures were introduced on the MUC list for
4 PAC/LTC programs. The programs that we look at
5 for post-acute and long-term care are SNF, in-
6 patient rehab, home health, long-term care. We
7 also look at hospice, but that's not covered
8 under the IMPACT Act. The vast majority, if not
9 all, were encourage continued development.

10 Some of them were adaptations of
11 endorsed measures, which we talked about
12 yesterday in the variation conversation, but
13 really we want to see more setting-specific
14 testing before we make these recommendations for
15 approval in the program. Thus, those should come
16 back at some point to the endorsement review and
17 the ability for person and family-centered care.
18 But that again is that feedback loop. Now we
19 need to update when they come back, this is what
20 the MAP said about these measures.

21 Overall what we think the benefits
22 are: first of all, understanding the intent of

1 the measures. So when you're filling out your
2 measure information form, when anybody's filling
3 out their measure information form, what is the
4 current use of the measure, what is the planned
5 use of this measure? This is one of the areas we
6 can pick that up. We know that CMS is planning
7 to use this in a program or has already put it in
8 rule or whatever. But knowing that really helps
9 our committee understand what's going on and how
10 the measure will be used.

11 It also helps us -- as I already
12 mentioned, what's coming down the pike? So by
13 following what's happening on the MAP, looking
14 forward to the next year, next two years, again
15 our negotiations, our discussions with CMS.
16 Well, then we can plan projects around this. We
17 know what's coming up. We know we're going to
18 get at some point in the next couple years
19 another 20 measures or whatever that is.

20 And that's not a hard number in any
21 way, but just saying that we have an idea of
22 what's coming forward not only for perhaps the

1 most relevant committee, but maybe there are some
2 other ones that are filtering to other committees
3 as well. And that way we can start preparing
4 internally on education to make sure that other
5 folks don't have the same experience of kind of
6 catching up behind the scenes.

7 And then as already mentioned, the use
8 and usability, implementation information,
9 overall intent rationale for the measure is huge.
10 And that's where we really -- it does help to
11 learn kind of what is CMS doing? What are they
12 working on? Where are they going with these
13 measures? Because it ends up impacting the
14 overall endorsement process. And we had some
15 issues with appeal -- measures being appealed for
16 some of these issues here, which we then
17 identified as maybe these folks don't really
18 understand how this all works together and how we
19 are sharing information.

20 So on my part I wanted to go ahead and
21 pause, but wanted to make sure that the mics are
22 open for Mary and Tara and others at CMS who

1 might have additional thoughts and comments on
2 the process.

3 MEMBER PRATT: This is Mary. Thank
4 you. This was very thoughtful conversation and
5 information that you're presenting. And Tara
6 McMullen and I are here.

7 I guess, well, one potential aspect to
8 point out with the IMPACT Act is that it's not
9 always the case, but in this case we had a clear
10 mandate for what we were building and what we
11 were supporting in that development of the
12 measures. So we were able to have a source where
13 we could turn back and look to time after time to
14 say are we meeting the intent, or are we straying
15 from it? And that gave us a real solid
16 foundation.

17 As huge as the IMPACT Act is in terms
18 of what it encompasses for the post-acute care
19 settings and with delivery of quality care to
20 beneficiaries and others, we at least have a
21 starting point. And we found that orienting the
22 MAP and as many stakeholders as possible to what

1 we were doing and why kept the engagement of
2 people involved in the process and helped us
3 along the way.

4 And now Tara McMullen is here and she
5 and Alan Levitt attended a workgroup with our
6 contractor and she has similar points to make, if
7 there's time.

8 MS. SAMPSEL: Sure. Please go ahead.

9 MEMBER McMULLEN: All right. Hi,
10 Sarah. It's Tara. And thanks to Mary. And I
11 think Sarah and Mary kind of teamed on it.

12 The IMPACT Act is kind of -- it's put
13 us in a new direction where we do have a solid
14 foundation, or like kind of we have a flight path
15 for the work that we are to complete within a
16 certain and specified amount of time. But at the
17 same time it has put CMS and NQF with the MAP in
18 a position where there has been an increase in
19 measures to be reviewed, an increase of work,
20 and, many times something that we heard from the
21 last MAP, an increase in understanding in where
22 CMS is going with the measures and why these

1 measures?

2 Overall the 2015 MAP, Alan Levitt and
3 I took away that it was a really great meeting.
4 WE thought that it was the best MAP meeting that
5 we've been to, and we've been to every single
6 MAP. The dynamics of the panel were really nice.
7 We felt that -- a complaint that we've had in the
8 past had been time management, and we felt that
9 it was under control. And we felt that this was
10 the most prepared CMS has been and that there was
11 a really solid interaction between CMS and the
12 MAP panel members. And we really actually
13 enjoyed ourselves. And we hope that the 2016 MAP
14 is the same way.

15 And there were a couple things that we
16 wanted to bring up in the light of the IMPACT Act
17 under the guise that there is an increase in work
18 and the increasing amount of measures that we
19 will submit to the MAP probably won't subside.
20 We will probably be increasing many, many
21 measures in the years to come. And these
22 measures not only are measures developed under

1 the IMPACT Act, but they're measures developed
2 for quality reporting programs.

3 And that kind of drives home -- the
4 first point I want to make is that the focus for
5 CMS for the Measure Applications Partnership is
6 that we're submitting measures to the MUC list to
7 be reviewed by the MAP to get some feedback on
8 the measures that we're proposing to use
9 potentially for our quality reporting programs.
10 So at least Alan and I have not seen this as an
11 endorsement mechanism.

12 We hear the word "endorsement" a lot.
13 This is our pre-rulemaking process. And we are
14 attending the MAP to gain insight into how the
15 panel members feel the process is or how our
16 measures would actually enhance our quality
17 reporting program. And that's one thing that we
18 took away this year was that we felt as if we
19 were having to walk through the measures, which
20 isn't an issue, but walk through the measures as
21 we were facing an endorsement panel, the panel
22 that we actually submit our measures to for the

1 consideration of endorsement.

2 And we were wondering if we could have
3 some discussion about that, really about the
4 intent of the MAP. And if the intent is now to
5 -- if it is kind of more like an endorsement or
6 are we viewing our measure submissions as
7 submissions to enhance our quality reporting
8 programs, because that was something that we --
9 we were under the guise that that was the intent.

10 And we also had a question about
11 knowing if the IMPACT Act has really increased
12 the work load and the work flow for everyone from
13 CMS to NQF, if there was an opportunity for CMS
14 and NQF to coordinate activities to decrease the
15 burden of the MAP members. The one thing that we
16 heard from a lot of the MAP members last year was
17 that they were really appreciative that CMS was
18 open and transparent and that we were there in
19 person. And they were very appreciative of that,
20 but they said there is so much material here, I
21 don't even know what I'm looking at. There is so
22 much going on.

1 And Alan and I brought this up with
2 Michelle Geppi, but we thought maybe it would be
3 a great idea prior to the actual MAP meeting to
4 have a meeting, like a -- via telephone or
5 whatnot with the MAP members to walk them through
6 our measures so they'd know what the measures are
7 when we walk into the MAP and they're aware of
8 the concepts. And they don't have to tell us
9 what they think about the measures, but that they
10 just have an understanding of what the measures
11 are. We feel like that might save some time.

12 MEMBER PRATT: And we think that as
13 measure developers preparing their measures in
14 such a way that helps facilitate that kind of
15 understanding and discussion with the members of
16 the MAP and NQF that that is the kind of
17 predominant work that will help facilitate
18 everything maybe that flows from that point.

19 MEMBER McMULLEN: Yes, exactly.
20 Thanks, Mary. And then just to kind of wrap it
21 up, we, in bringing a point that Mary brought in
22 and this whole point about how can we coordinate

1 with NQF to be more efficient, the one thing that
2 has occurred in the last couple years was that
3 since we're on such a rigorous timeline in our
4 pre-rulemaking cycle, kind of going by when JIRA
5 is open, when JIRA is closed, when the MUC list
6 is open, when we can provide our measures, it's
7 proven to be pretty difficult for DCPAC, the
8 Division of Chronic and Post-Acute Care.

9 And as we all know, in 2014 we had
10 exercised an ad hoc Measure Applications
11 Partnership to review the first kind of wave of
12 the IMPACT Act measures. And this year we were
13 updating our MUC list up until the last moment of
14 the MAP. And in consequence of that, for the
15 Hospice Quality Reporting Program, but really for
16 some of our measures such as Medicare spending
17 through beneficiaries the MAP didn't have the
18 most accurate and detailed measure specifications
19 and that just kind of created some confusion.

20 And it's not a big deal because we
21 were able to speak and walk through them. But I
22 think it just opens up an opportunity for us to

1 talk through coordination and collaboration and
2 understanding that NQF is on a rigorous timeline.
3 So is CMS. We kind of feel like we have our
4 backs up against the wall. And we're working on
5 measures up until the last moment. So the life
6 cycle, well, it keeps going. It doesn't stop.
7 So just because a measure goes on the MUC list
8 doesn't mean we stop enhancing it and polishing
9 it, testing it.

10 And last but not least, we just wanted
11 to bring up the idea or maybe some discussion
12 around the public comment period at the Measure
13 Applications Partnership that occurred in 2015.
14 We really appreciate public comment. It's
15 actually one of my favorite things in the whole
16 process because I think it really highlights for
17 us some of the directions that we should be doing
18 as an agency in our measure development.

19 The public comment period was a bit
20 different this last year. It was just a bit
21 different. I think the words, a lobbyist effort,
22 was thrown out by multiple parties. And so I was

1 wondering, Sarah, if you guys at NQF had a
2 discussion about that and if that discussion
3 would be appropriate for today?

4 And so, I'll leave it to Mary to
5 close, but those are some of the main thoughts
6 that CMS is having. But we appreciated the
7 process last year.

8 MEMBER PRATT: So, hopefully this is
9 sort of a bird's eye view of some of the unique
10 aspects that we encountered on this very
11 successful year with the MAP and NQF. Just some
12 new challenges and really having a measure
13 development team that we work closely with that
14 is agile and knowledgeable and can work together
15 with CMS as well as NQF to meet the needs.
16 That's all we have.

17 MS. SAMPSEL: Well, thanks, Mary and
18 Tara. We appreciate that feedback, and obviously
19 there are some take-aways that kind of NQF and
20 CMS can take back, but certainly exhibits the
21 point that there is a lot of collaboration that
22 goes on between CDP and MAP and understanding

1 each other's work and work flows, and they do
2 impact each other on extremely tight timelines.
3 But we're doing our best to do that, and that's
4 something that is obviously extended to any
5 measure developer, as Reva mentioned, with the
6 outreach on letting you know that programs are
7 coming up, et cetera. But it's always a back and
8 forth between organizations to get that ironed
9 out.

10 So with that -- and just, Tara and
11 Mary, I'm not sure if you're staying on, but we
12 have a group here at the NQF offices, all measure
13 developers, and then a number folks on the phone,
14 also all measure developers. So we had some
15 questions that we're again looking for your
16 feedback on. And these questions are -- and feel
17 free to notify us online if you have questions.

18 But some questions for developers
19 include how closely do you follow the annual MAP
20 pre-rulemaking activities? I would add on top of
21 that have you always been aware there are two
22 distinct NQF activities between endorsement and

1 MAPs? Have any of your experienced this
2 integration of CDP and MAP and how is it
3 affecting you? Or how could you perceive it to
4 be affecting you perhaps in the future?

5 And then you kind of heard some of the
6 issues and examples of things that happened
7 between NQF and CMS, between CDP and MAP. So do
8 you have any ideas for best strategies to include
9 developers and the flow of information?

10 As Tara mentioned, there are a lot of
11 times that measures are undergoing constant work.
12 And in this case I think with the hospice
13 measures the MAP met on a Monday and Tuesday and
14 we had received updated specs the Thursday or
15 Friday before. And those timelines might be off
16 a little bit. But again, that's an exchange of
17 information. So what strategies do you have to
18 kind of keep us updated so that we can update our
19 panels in house?

20 So we'll open that both to folks in
21 the room. And then if there's anybody online
22 that has questions, Jean-Luc's monitoring as

1 well.

2 MEMBER DOMI: Hi, this is Marsida,
3 AHCA. Thank you very much for the overview with
4 regards to the MAP-CDP integration. It has been
5 really informative and wonderful to hear this
6 type of work.

7 I just had a really quick question.
8 I'm not sure if you know, with regards to the
9 JIRA the form encompasses numerator, denominator
10 and so on and so forth. It's not as extensive as
11 an actual NQF application. However, I was
12 wondering are there any talks with regards to --
13 since we're in the theme of integration, are
14 there any talks with regards to getting the two
15 systems to integrate together so that you, I
16 don't know, can click something and it
17 automatically populates something? I know I'm
18 wishful thinking, but just a question.

19 DR. WINKLER: I'll wish along with
20 you. At this point when you're talking about the
21 hardware infrastructure not -- I mean, we talk
22 about it, but the likelihood of anything in the

1 near terms doesn't seem real high.

2 But one thing that does happen is we
3 have met and talked with CMS during -- multiple
4 times over the last couple of years in terms of
5 the information that is included, the fields that
6 they use in JIRA. And so, what would be
7 particularly more useful for the MAP, the kinds
8 of information they're looking for?

9 Our biggest struggle actually when we
10 get the MUC list, which is generated from the
11 data submitted through JIRA, is so much of the
12 data is not there. I mean, there are very few
13 fields that are required and there are a whole
14 bunch of fields that we'd sure like to see. And
15 what the MAP gets is a bunch of blank fields. So
16 there's very little information.

17 So I realize that it -- because
18 they're not required, they're not required. But
19 realize that the more information, the better it
20 helps the measure, because then there just isn't
21 a lot of unknowns where people fill in the blank
22 in the way that suits them. The more you can

1 provide that information that's requested, it's
2 really much more helpful for the MAP to go beyond
3 the simple required fields.

4 But we do have conversations back and
5 forth with the folks that are managing the JIRA
6 as well as in terms of trying to keep them
7 somewhat aligned so that at least the way we ask
8 the same question can be similar. And I think we
9 can continue to have those conversations, but at
10 this point -- not next week.

11 Questions from anybody else?

12 MEMBER DORSEY: So I had two
13 questions. One was that we're -- maybe this is
14 more of a comment, but we're always racing
15 against the clock because there's such a long
16 period of lag between the conclusion of measure
17 development and success of implementation. And
18 so, we're often really pushing to get things on
19 the MUC and before the MAP so that the clock to
20 implementation can start ticking. And because of
21 that I think -- and we also sort of -- we like to
22 provide a complete specification report for the

1 MAP. And because of that I think we are often
2 pushing right up to the limit of the MAP meeting
3 in terms of getting information.

4 And so, I mean, I'm saying that to say
5 I think we are interested in how to streamline
6 that and create efficiencies given the time
7 constraints and are open to conversations about
8 how best to present information to the MAP and
9 what information is critical and what might be
10 more than they need. So I wanted to say that.

11 And then the other is just I'm curious
12 about how you all are thinking about how -- sort
13 of formally including information about the MAP
14 recommendations into the committee's
15 deliberations. Like what kind of conversation or
16 addition to the conversation are you anticipating
17 from that? I'm trying to sort of get my head
18 around how that goes.

19 DR. WINKLER: Right. I mean, we're
20 still just seeing the first couple as we've
21 started really doing this this spring. It's
22 under use and usability. We've kind of created a

1 category of feedback loops. And it won't be
2 exclusively the MAP. It's just right now that's
3 our best source. We're looking to try and create
4 whatever feedback loops we possibly can to get
5 information from the field on how it's going,
6 because that's really the fundamental question
7 under use and usability. Is it being used?
8 How's it going? What are the problems or -- and
9 successes?

10 And so, like I say, right now your
11 most ready source of feedback that we can easily
12 get to is the MAP. And so we're including it in
13 that. And I think that it's just one more bit of
14 information. And I think it becomes a lot more
15 -- it probably has a lot more import for measures
16 that have been around awhile, maintenance
17 measures, because it's like what's the experience
18 with the measure? It's been recommended and it
19 is in use in this program. And there's just more
20 to talk about to raise that, where before we were
21 just silent. The MAP didn't exist and nobody had
22 any feedback and we just didn't go there.

1 And so, I think it adds something.
2 And I think we're still evolving what we're able
3 to say. And I think that the more information
4 the MAP has to work with, the more they're able
5 to say. But the limited amount of information on
6 the measures at this point that often comes
7 through JIRA onto the MUC list is so limited,
8 they start speculating all over the board.

9 MEMBER DORSEY: Right.

10 DR. WINKLER: And it's hard to
11 translate that into something concrete that you
12 really want a committee to pay attention to.

13 So again, the more information there
14 is -- and I know last year -- it's a very, very
15 short time frame from when the MUC list becomes
16 available and before we take to committee and --
17 or the workgroup. And, but I know last year I
18 tried to contact many of the measure developers
19 just -- you know, is there anything more? Is
20 there anything more you want to tell us? Because
21 I know that the submission deadline for that
22 information was back in July, and things change

1 in four or five months. And so, if there's some
2 kind of update, we're happy to collect that
3 information and to be able to provide it to the
4 MAP. It's just we're running on such a short
5 time frame.

6 So perhaps just be aware. If you know
7 you've got a measure that could be coming up on
8 the MUC list, we're probably going to try and get
9 in touch with you and see if we can find out if
10 there's anything new in your world. Particularly
11 if you're saying the measure is being tested,
12 it's like, well, perhaps you finished in the
13 intervening time frame. We don't know that. So
14 again, it's all about information flowing as
15 readily back and forth.

16 MEMBER DORSEY: So, because my brain
17 always goes to the worst case scenario, I'm just
18 thinking about -- there may be an instance in
19 which a measure is recommended for use in a
20 program and the MAP declines to support that
21 recommended use. And so, I would think that in
22 those cases it would be important to give

1 instructions to committees about how they're
2 supposed to think about that in terms of their --
3 whether to make a decision to endorse.

4 DR. WINKLER: I would agree with you
5 because it's -- that's what I'm saying. When you
6 have very superficial conversations with minimal
7 information, it's really hard to understand that
8 and then be able to transfer that information.
9 So the more we're able to have data-driven,
10 information-driven conversations that can readily
11 transfer, I feel much more comfortable saying,
12 well, the MAP said this. Well, to tell the
13 committee the MAP didn't like it. Why? I don't
14 know, they just didn't like it. I mean, what do
15 you do with that?

16 So they were concerned that the
17 denominator didn't include this population, blah,
18 blah, blah. I mean, the details become -- makes
19 it much more valuable information exchange.

20 Anything else from anybody? Kyle?

21 MEMBER CAMPBELL: I just wanted to
22 follow up on what you were saying, because we

1 follow the MAP very closely. So I think that
2 that issue of the lack of information fostering
3 dialogue that isn't necessarily valid in relation
4 to the measure is an important point. And I
5 don't know what your thoughts are about fostering
6 more dialogue with the measure developers per se
7 to -- I know there's limited amount of time, and
8 that's another thing. Like I feel like the MAP
9 gets into areas where the CDP really should be
10 focused.

11 And so, what are the different
12 criteria sort of between the MAP and the CDP?
13 And if they're evaluating things with the absence
14 of information, it's really hard to make that --

15 DR. WINKLER: Yes, the Coordinating
16 Committee and the MAP will be the first ones to
17 agree with you on that.

18 MEMBER CAMPBELL: Yes.

19 DR. WINKLER: Which is why they have
20 a preference for measures that have been through
21 NQF simply for the information that's available.
22 And so, we struggle with it. Like I say, I think

1 it's reasonable for us, given the limitations on
2 time, that if it's at all possible to get -- to
3 interact with the developers before we take it to
4 the workgroup to do that.

5 Again, as I say, it's always over
6 Thanksgiving. We usually get the MUC sent to us
7 on Wednesday afternoon before Thanksgiving.
8 Again, as I said, those of us at NQF, it's not
9 holiday says, it's MAP season. And so, it's that
10 time frame thing that just makes it really hard.

11 So, yes, I'm more than happy to send
12 you an email, but I'm not at all surprised if you
13 don't answer it over Thanksgiving. So that
14 becomes some of the limitations of just using
15 that particular time frame. So I think we're
16 happy to try to do it, but realizing we're both
17 limited on each side of the fence.

18 Yes, I think that's the thing
19 everybody feels a little -- I wish I had a little
20 more to work with on the MAP side.

21 Anything else from anybody?

22 (No audible response.)

1 DR. WINKLER: Okay. Thanks. Anybody
2 on the phone? Operator? Yo-ho.

3 OPERATOR: Okay. To ask a question,
4 please press star then the number one.

5 (Pause.)

6 OPERATOR: And there are no questions
7 at this time.

8 DR. WINKLER: Thank you. Ms. Wunmi?

9 MS. ISIJOLA: Okay. And thank you to
10 your CMS colleagues for just joining us. I think
11 the input that they provided was helpful for you
12 as well, but it also helps us to think about ways
13 that we can more closely align our work with the
14 CDP and MAP work.

15 So with that being said, I think this
16 is the end of the rodeo. And also hopefully you
17 filled out your cards. We'll definitely take
18 that into consideration, as always. We have
19 plenty of opportunities for you to engage with
20 us, whether it's via email from our maintenance
21 inbox, measuremaintenance@qualityforum.org,
22 whether it's contacting project staff on specific

1 project areas, but also we have our submitting
2 standards page, which has all of our resources.
3 If you have any question about anything regarding
4 our measure maintenance work, we encourage you to
5 utilize that.

6 As we mentioned over the past two
7 days, there's a lot of new revisions and upgrades
8 to some of our policies and processes. We'll
9 definitely be informing you of that during our
10 various channels on our web site, through emails.
11 Also following this meeting, again we'll
12 definitely send out the recording as well as the
13 slides.

14 But I'll stop one more time to see if
15 there are any questions about anything that we've
16 discussed, any final thoughts and comments, what
17 you felt about this workshop over the past two
18 days. Was this helpful? Informational? I see
19 nods. Anyone on the phone, any comments?

20 Okay. Well, thank you again everyone
21 for participating and sticking with us for the
22 past two days. Happy Cinco de Mayo and enjoy

1 your weekend.

2 Meeting's adjourned. Thanks.

3 (Whereupon, the above-entitled matter
4 went off the record at 1:06 p.m.)

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