NATIONAL QUALITY FORUM

Moderator: Cardiovascular Standing Committee
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OPERATOR: This is conference # 24007875.

Welcome to the conference. Please note today's call is being recorded, please standby.

Leslie Vicale: Good afternoon everyone. We'd like to thank you and welcome you to the call today. This is NQF my name is Leslie Vicale and I'm the Project Manager of the Cardiovascular Phase III Measure Endorsement Project. And today's call is regarding the related and competing measures – for the measures that have been reviewed for the Phase III project. I'm joined today by our Senior Director Melissa Marinelarena. I'm also joined on the phone with Karen Johnson, another one of our senior directors here and I'm also joined by Donna Herring, our Project Analyst.

So again I'd like to welcome the standing committee, the public as well as the measure developers that we do have on the line and I'm going to ahead and turn it over to our Senior Director, Melissa.

Melissa Marinelarena: Thank you Leslie. Thank you everybody for joining us. So you've had this call during Phase II and I'm sure during Phase I as well. So just a quick background, the current quality landscape that contains the calibration of measures as you know, I think I've had this discussion during the meetings including some that could be considered duplicate or overlapping. And we know that standardizing and aligning specifications including definitions for related measures can help alleviate this problem.

Multiple measures may address the same conceptual measure focus in the same target population. And when there is a sufficient amount of overlap between measures selecting one as best in class maybe appropriate.

You have probably seen this as well – this is a related versus competing measures and this is what we used to work through and to decide if measures are related or competing. And I will go through the whole thing but just note that competing measures are those address the same concepts for the measure of focus. For example the same target process condition even or outcome and the same target population. Related measures of those that address different concepts for the measure focus at the same target patient population or the same concepts for the measure focus in a different population. Either way the goal is to endorse the best measure and minimize confusing or conflicting information.

Leslie Vicale: Before we go any further know that folks have had an opportunity to go ahead and join the call, I just wanted to go ahead and take roll of the standing committee that have joined us today.

Tom Kottke, are you on the line?

Tom Kottke: Yes I'm on the line.

Leslie Vicale: Hi Tom.

Tom Kottke: Good afternoon.

Leslie Vicale: Carol Allred? I see that you are on the web platform. Linda Briggs? I see you've also joined the web platform. Leslie Cho? Joseph Cleveland? I also see you're on the web platform. Michael Crouch? Elizabeth DeLong? Ellen Hillegas? I see you're in the web platform. Judd Hollander? Tom James?

Tom James: Yes I'm here.

Leslie Vicale: Thanks Tom. Joel Marrs? Joel, I see you're on the web platform. All right, Gerard Martin? Kisti Mitchell?

Kristi Mitchell: I'm here.

Leslie Vicale: Thanks, Kisti. George Philippides?

George Philippides: I'm here.

Leslie Vicale: Thanks, George. Nick Ruggiero? Jason Spangler?

Jason Spangler: I'm here.

Leslie Vicale: Thanks, Jason. Henry Ting? And Mladen Vidovich?

OK, so before we go on and those of you who joined us on the web platform we appreciate that but if you could also join via phone because we will be having a discussion about the measures, that would be helpful and are there any other committee members that I haven't called that have joined or have joined since I called your name?

OK, I'll turn it back to Melissa. Thanks everyone.

Melissa Marinelarena: Thanks, Leslie.

Can I say something? So this is just a quick review of some considerations for assessing strengths and weaknesses of the measures, so when you are comparing measures or looking at two similar measures, you're going to evaluate them and be the criteria as you do when you're evaluating them for endorsement or re-endorsement.

The competing measures generally will be the same in terms of the evidence for the focus of measurement, but they are maybe differences in performance gap due to differences in measure construction. So this is when you begin to add importance the measure and report.

For scientific acceptability, we want to consider the specification, reliability testing and validity testing including the threats to validity that apply to the individual measure. And then you also want to compare the feasibility and usability and use of the measures. Right, thank you.

So, staff here at NQF take a look at the measures not only the measures that are under review in this phase but the entire cardiovascular portfolio. And so that is what we put together here and we determine that 02302473 and (0730) were similar and what we did was we don't have all of the specifications here but identified what is similar in the specifications or maybe what is different.

So, 0230 is a CMS measure and this is hospital 30-day all cost risk standardized quality rate following AMI hospitalization for patients 18 years and older. 2473 is hospital 30-day risk standardized acute myocardial infarction mortality. This is the E measure version of 0230, also a CMS measure. 0730 is acute M.I. mortality rate and this is AHRQ measure.

We provided the endorsement activity just so we can see where they stand, 0230 is the one that we are currently reviewing, 2473 was endorsed in CV1 so that was the first phase of this project and 0730 is also currently in review in this phase. They are all facility level measures, I mean then you could look at the different data sources there as well. And so, the numerators are similar except the CMS measures are 30 days following hospitalization and the AHRQ measure is an inpatient mortality rate.

So, some of the differences that I found and we can have this discussions were for the denominator for 0230 it includes patients 65 and over or patients 18 and over and in the specifications it says 65 and over because that is what Medicare publicly reports then they also have a set of specified for 18 and over. The 2473 is only specified for 65 and over, so we can – not sure why it's not 18 and over as the AHRQ one.

Some other differences were the exclusions and what I did was compare them side to side and the great out exclusions were the ones that seem to be aligned with each other and we did receive a response from – it was Yale, right? Yes, from Yale and they said that they had aligned with AHRQ as much as possible. So one of the exclusions AHRQ's (pregnancy) exclusion and then if there's somebody on the phone from Yale later maybe they can ask for this is that they said they had aligned and they were going to include that in CMS's measures but I couldn't find it in the exclusions in neither the claims measure or the e-measure.

The other thing that was different too is that the hospice exclusion is in 0230 but I couldn't find it in 2473 in the e-measure. Also the exclusion of – the first exclusion discharge the live on the day of admission or the following day who are not transferred to another acute care facility. And I think those were the main differences for these two, these three measures.

So if we go to the next slide, so this is just kind of a visual that I put together maybe some considerations for harmonization if 0230 and 2473 could also be 18 and for the ages. And for the exclusions if those could harmonize as well between 0230 and 2473 and they are both the same measure and I went and looked at the report for 2473 and this is the e-measure version of 0230 which you did recommend earlier this year and if not being used currently but they plan to transition to 2473, again it's an – it's a (inaudible) and so I think that is all I have. Those were the main differences for that one.

So if we go to the next slide. So this is part of some things that you should consider when you're having this best in class profession, so think about is one measure superior. In fact you're evaluating the measures, is it determined – it is determined that one measure is superior then you recommend the superior measure. If one measure is not superior, then you need to provide justification for endorsing multiple measures. If there is no justification for endorsing multiple measures, then the best measure is recommended. Again if there is justification for multiple measures then you assess harmonization of the measure. And when you assess harmonization you consider if the specifications are completely harmonized. If they're not are their specifications justified. If the differences and the specifications are not justified then you recommend the measure.

And then again always think about what would be the burden of having multiple measures. And then lastly we need you to provide us rationale for either recommending or nor not recommending the related or competing measures.

So that – With that I don't know if anybody has anything to say or anything to add to that?

Tom James: Is there a preference to the e-measure versus a non e-measure?

Melissa Marinelarena: The guidance – Our guidance says e-measures are considered superior, but then we have to go through and weigh everything, each criterion. Again the e-measure is brand new, it's not in use yet so, you know, you'd have to evaluate that but as we move towards e-measures that is supposed to be considered – that is supposed we considered superior.

Tom James: Thank you.

Melissa Marinelarena: So we'll just open it up for our a committee discussion right now. If you want to go ahead and talk a little bit further about e-measures. And I don't know if there were any discussions during when the e-measure was endorsed about the difference in the exclusions. I don't know if that has to do with the fact that one is an e-measure and the other one is a claims measure, if the half is exclusion, is a problem or not.

Karen Johnson: So Melissa, this is Karen. It might be a little easier for the committee if they talk this very briefly about whether there is willingness to have all three of these measures go forward, so before we get into the differences between the measures and harmonizing, just make sure that everybody is comfortable with having two 30-day measures, one that's in e-measure, so kind of looking forward and trying to push the science a little bit there and then having the AHRQ measure which is the in patient mortality measure.

So if everybody is pretty comfortable with having the three of them, then we could kind of go systematically through a couple of those exclusions and, you know, the exclusions and maybe the age range, that sort of thing.

Melissa Marinelarena: OK.

Karen Johnson: So, committee members, is there anybody who is uncomfortable with having the three different mortality measures or are you comfortable with that? And if you're comfortable with this as soon as we're through that would help us write the report to say why you feel at this point in time it is appropriate to have multiple measures even though they are conceptually competing measures.

Ellen Hillegass: So this is Ellen and I have a little concern keeping all three because I think if we keep adding all these measures, I feel like we will have just way too many measures and I don't know if that's too cumbersome to sort through. So, I think I need practicality, guidance as to whether keeping three measures is really appropriate or is that going to weigh down and be too confusing for the individuals who are using these measures.

Tom James: Yes, this is Tom James and I agree completely and I think you get it also from the people who are looking at the measures is, whether it's the public or physicians in practice, you'll get different results. So we should be able – at one measure.

Karen Johnson: OK, maybe it would be good to talk about first, there's two measures that are 30-day measures and then one that's in-hospital measure. So, does it make sense to have like 30-day measure and an in-hospital mortality measure?

Ellen Hillegass: This is Ellen again, I – I'm sorry. This is Ellen and I would think that a 30-day and an in-hospital would be completely different. So, I wouldn't have a problem with those two.

Kristi Mitchell: I – This is Kristi and I agree with Ellen. I think those conceptually are different, 30-day post discharge is not the same as in-hospital mortality. And while I'm talking, because I have limited time here, is the issue regarding the e-measure versus a claims space measure and if the e-measures are supposed to be superior, there's going to be a period in time where we must be carrying both claims in e-measures until they're going to have evidence that the e-measures is actually looking, it's feasible. And we don't have that evidence for this 24/73 at this time, is that correct?

Female: I believe that one's correct.

Karen Johnson: And this is Karen, but let's make sure that we are all comfortable in this, the e-measure was recommended earlier by the committee. It's suitable for endorsement. So by that, I'm assuming that the committee feel comfortable that it didn't meet the evaluation criteria. So now, you know, the question that

we're asking you, you know, given that one of those measures have met the evaluation criteria, is there a reason to have both of those.

Tom James: I completely this isn't look well.

Tom Kottke: Tom Kottke here. Are we confident that all hospitals will actually implement the e-measure or is that an issue?

Karen Johnson: I think that might be a question for the developer. Is one of our Yale colleagues on the line?

(Susana Burnham): Hi it's (Susana Burnham) from the Yale team, can you hear me?

Karen Johnson: Yes. Thanks, (Susana).

(Susana Burnham): Great. So, the e-measure has gone through initial usability testing and the elements which is actually a hybrid measure, so the element in it which are electronically specified has been tested in one site with the – actually two sites with a plan to do an initial – an additional sites as well. So it's feasible in systems that have their EHRs up and running, but obviously it's not attached for implementation yet which is why the earlier speaker noted we're seeking to have sort of both measures endorsed one to start use of it and wants to continue use them in national programs as you have said.

Tom Kottke: So, it's Tom Kottke again, my understanding of the e-measure is that it's been tested in but one or two EHR systems and so I think it – I think at this time it would not be appropriate to delete the measure that is not the e-measure because I don't think that the e-measure really can be implemented in all hospitals. And so, I think for awhile we have to – we do have – we put two measures.

Karen Johnson: And (Susana) maybe you can clarify in your memo that you had suggested that after a certain point you are thinking of retiring the claims measure but not right now can you just elaborate on that for the committee in case they didn't see that in your memo?

(Susana Burnham): Yes, sure. And I will say this one I'm – I can't actually speak for CMS who are of course the group that will finally decide what happens so I can tell you what my understanding is and I don't know if someone from CMS is on the line. But my understanding is that the goal with e-measures in general like with the process measures, with the outcome measures it's a move to a point where the measures can be fully specified and be pulled out the EHR and the point where there is an ability to implement them on the national level that would face from the e-measure and phase out the claim space measure. I think that at a high level is CMS's plan.

Tom Kottke: So Tom Kottke again, so the – while in – I agree that having too many measures is both a so to speak that I would personally favor letting CMS phase out claims-based measure as they feel the e-measure is fully implementable and sort of taking the actual history of course rather than the more aggressive course.

Karen Johnson: So it sounds like I'm hearing that in terms of having a 10 patients versus a 30 days there's comfort in having both of those kinds of measures, you feel like they are doing different things. And then in having two 30-day measures, one claims-based, one e-measure, maybe a little bit of discomfort in having both because of potential confusion, but yet are realization that, you know, the e-measure will ramp up and be more feasible for more providers if time goes on.

I don't know that I'm hearing a lot of discomfort with having both of the 30-day mortality measures. So if there is some discomfort there, let's talk about that real quickly, otherwise we'll go on to talking about harmonization potential.

Tom James: This is Tom James, just to give a minority opinion, the – in the spirit of parsimony, it's a good NQF term, I think having two different 30-day or two different mortality measures one that's inpatient only and one that's a 30-day measure that as an internist I'm more interested in the longer term outcome for my patients. So the 30-day would be superior in my view and recognize that we do need to have this transition from paper measure to an e-measure. So I would favor not having the 0730.

Karen Johnson: OK, thank you, Tom. Anybody else?

Tom Kottke: I guess – Tom Kottke here, I guess I'd, you know, I've – of all the time if somebody, you know, in terms of Q.I. or somebody has problems with the 30-day mortality, the first thing you're going to do is look at it and, you know, track to with their inpatient mortality is and so I think that's probably reasonable to just look at 30-day.

Karen Johnson: I actually have a question for (Susanna). (Susanna) looking at the 30-day mortality, is it possible for you to stratify that so you could look at, you know, the 30-day but also be able to look at what was inpatient is that doable with your measures?

(Susanna Burnham): It's a good question. It's not something we've done before and the 30-day is there both for the ability to look at longer term outcomes but also to ensure that there's a standard period for follow-up. So there are uses where the inpatient measures were important, but the risk of an inpatient measure is that it can be biased by differences in length of stay, and so we've been hesitant to look just as a inpatient length of stay. I think it's a – there's not a logical issue that I have to think about, so if the committee feel strongly that we should try to create a stratified measure, I could go back and think with my team a little bit more about that.

Karen Johnson: Any thoughts from the committee?

And Leslie and Melissa, how are you doing the voting are you going to try to do a voting on the webinar today or you're going to send out surveys afterwards? I can think about – and we'll make sure there's participants.

Melissa Marinelarena: Thanks, Karen, yes. And for the purposes of our time constraints with the project, we were going to ask the committee to note any decision though the top function by raising their hands if and when we do this to a question about how to proceed with measures going forward.

Sheryl Davies: Hi, this is Sheryl Davies, I'm one of the measure developers for AHRQ here at Stanford University and I just want to note a few things regarding the inpatient measure that are going to be very important to just to understand.

The first thing is that, you know, they're developed using different data and, you know, when you use inpatient data some of the exclusions that you see for instance, you know, really arrive at the docs that we're using inpatient data. And therefore, you know, there maybe some difficult – difficulty we don't know this, like (Susanna) said we didn't, you know, no one actually looked at stratifying that CMS measure. But there maybe some difficulties, so we would urge you to consider, you know, the AHRQ measure and that you know we can certainly discuss, you know, with CMS, you know, that would be up to AHRQ as to whether or not they wanted to discuss with CMS stratified measure that would follow both inpatient and 30 days with the same population.

You're looking and it's really important to know that hospitals that – the hospitals themselves when they want to look at their own measure aren't able to use 30-day mortality measures and other groups for instance they don't have access to the mortality information may not be able to use 30-day mortality especially for all pairs. And especially for uninsured, I think as our Yale colleagues seemed have outlined in their memo, you know, for uninsured population this is also an issue.

So, you know, there are other differences between these measures besides the fact that, you know, the outcome itself is not, you know, perfectly correlated, they're not the same outcome, but also that there are some feasibility differences and that it's really why AHRQ has maintained it inpatient. You know mortality measure even though, you know, we acknowledge, you know, some of the draw backs of an inpatient measure as (Susanna) has presented already, you know, mentioned about differences and follow-up types.

Leslie Vicale: Are there any more comments?

Karen Johnson: So typically what we would do is actually have the vote to see if there's a superior measure or not, and then that would tell us how much we need to talk about harmonization. It's a little harder since we're looking at three different measures. And so, it might be – it's reasonable to talk a little bit about potential for harmonization, but I'll leave that to the project team actually.

Melissa and Leslie do you have a preference in how you want to do this because it is a little confusing.

Melissa Marinelarena: I think we agree with you, Karen and it doesn't sound like the committee – the majority of the committee wants to vote down any of the measures. Does anybody disagree?

Leslie Vicale: OK, hearing nothing we will go ahead and proceed.

Karen Johnson: So can you just clarify are you – you're not going to ask for a formal vote for and – choosing recommendation for endorsement as we make sure everybody is very clearly about it because you're doing that.

Melissa Marinelarena: Right, but didn't we want to have a conversation about harmonization?

Karen Johnson: Well, this is where it gets a little confusing. If there was an appetite to say that – and for example you didn't want to move the AHRQ measure forward, if that were the case then there wouldn't be much use in talking about harmonization between the CMS measures and the AHRQ measure. So that's what we're trying to weigh here.

Melissa Marinelarena: Do we have quorum on the phone?

Female: We don't have quorum?

Female: No, we do not.

Melissa Marinelarena: OK, well we just – can't vote if we don't have a quorum and we'll move on.

Karen Johnson: So we're not going to have a vote because we do not have …

Melissa Marinelarena: Correct.

Karen Johnson: So what we are going to have to do, let's go ahead and have the harmonization question anyway, Melissa pointed out at least a couple of different things and either between the AHRQ measure and the CMS measures or between the two

CMS measures and I believe that the main ones were on the exclusions for hospice and Melissa help me and the …

Melissa Marinelarena: Yes.

Karen Johnson: … age and I think we had a question for CMS about whether they're going to – did all pair or not, we have this a little confused on that one.

Melissa Marinelarena: Right. And the pregnancy-related admissions.

Karen Johnson: Maybe we can talk about that and see from that if the committee has any – after we hear from the developers maybe on those things if the committee has any suggestions for harmonization knowing that depending on the results of the voting which we can't do until after the call because there's no quorum, we'll have to see how everything works out.

Melissa Marinelarena: OK.

Tom Kottke: So, Tom Kottke here, and 730 is the pregnancy-related admission is that part of that standard long list of exclusions or?

Melissa Marinelarena: So that is part of – that is an excluded in 730, the moment that we received from Yale, I believe they said that they were going to harmonize with 730 and include pregnancy and their measure but it's not in there now, so I don't know if the developer can respond to that?

(Susana Burnham): Yes, this is (Susana Burnham), so for 0230 we tested that so that it can be used as an all-pair measure for consistency and all-pair it's not in use at this point and I think the recommendation was that we consider changing the specifications for the all-pair version to exclude pregnancy which we can do.

For the other measure, 2473 at this time it's only been tested in the over 55 population, there is an intention to bring it back to NQF once it's been tested in an all-pair population and then we could, you know, exclude the pregnancy-related AMIs in that measure at that time.

Melissa Marinelarena: Thank you. What about – Are you planning on including the hospice exclusion in 2473?

(Susana Burnham): Yes. So, I was just pulling this, I'll confirm it again, because I think it is – I thought it was in 2473, so I was just trying to – just looking at our definition. There is some background noise, I'm not sure where that's coming from, are you hearing it as well? No, no it's fine.

Melissa Marinelarena: If you're not speaking, please just make sure that you're line is muted. Thanks everybody.

(Susana Burnham): Yes, so my – just confirming one more time. And so I am – I'm sorry, I am remembering now. The reason of hospice inclusion isn't in there, it has to do with the EHR data and just insuring that we can exclude patients with hospice, that are hospice in the exact same way as we do in the claims-based measures. So that is the intention once it's possible with the data.

Melissa Marinelarena: OK, thank you.

Karen Johnson: And (Susana) if you have any flavor about your timelines when you might be able to take a look at the e-measure and the pregnancy and hospice exclusions.

(Susana Burnham): So I think that the all-pair testing we hope to do in the next year so that when this measure came back to NQF, I don't have my – I don't remember exactly when you have the next annual update on this measure but the hope would be to bring it back with that at that point and that will handle the pregnancy piece as well. I'm not sure about the hospice.

Karen Johnson: OK. And I think those – Melissa, those were the main points where there were differences, correct?

Melissa Marinelarena: Yes, those for the main differences.

Karen Johnson: OK. But it sounds like the harmonization plans are in place maybe more on definitive for the claims-based measure at this point. But does the committee have any discussion point from this? Does this sound reasonable to you?

Melissa Marinelarena: Yes.

Karen Johnson: In terms of – OK.

Melissa Marinelarena: OK?

Karen Johnson: Yes. I don't know that we need anymore discussion unless committee members have anything else that they would like to say in regards to these three measures.

Leslie Vicale: OK, hearing nothing, I think we'll move on to the next set of measure.

Melissa Marinelarena: OK, the next set of measures that we identified is 0067 and 0068. 0067 is chronic stable coronary artery disease, anti-platelet therapy, and ACC measure. And 0068 ischemic vascular disease, use of aspirin or other anti-platelet and this is an NCQA measure, both of them are currently under review in this phase. They are both clinician level measures and you can see one is a registry measure the other one is either claims or electronic clinical data.

The measure focus for 67 is patients with CAD who are prescribed aspirin or Clavix and the patients for 68 is patients with AMI, CABG, PCI, or a diagnosis of IVD who have that communication of routine use of aspirin or another anti-platelet. And you could look at the – you could see the numerator here which I'm not going to go through because I think I outlined the differences.

On the next slides – so we have the denominator, so 67 is patients aged 18 years and older with the diagnosis of coronary artery disease, seen within a 12-month period and the denominator for 68 is patients 18 years or older by the end of the measurement year, discharged from an inpatient setting, again with an AMI, CABG, or PCI during the 12 months period prior to the measurement year or who have a diagnosis of IBD during the measurement year and the year prior to the measurement year.

The exclusion for 67 are these general exclusions of documentation of a medical reasons for not prescribing offering Clavix, a documentation of a patient reason or a system reason and for 68 its patients who had documentation of use of an anti-coagulant medication during the measurement year. So when we took a look at these two measures it appears that 68

includes a broader population of patients with a cardiovascular disease. Look at the code for 67 and those codes of 67 are actually part of 68.

So the question is do we need both of these measures? And again these were just reviewed a few weeks ago with – we discussed at our meeting, so I don't know if anybody want to – have anything to say about this?

Tom James: This is Tom James, in more than 1 percent of the splitter, the 0068 is as far as I'm concerned a superior measure because it is inclusive of a lot of different types of vascular disease. Besides it's that situation that there's a number of different organizations for these groups and health plans that are all being measured on this currently.

Tom Kottke: And Tom Kottke here, and I think what ACC would probably say as they miss something differently if they're only, mine is that they – their register can pick IVD because it's a coronary registered, but I think that they can still use 68 with their register recognizing that they don't pick up the ischemic cardiovascular disease other than coronary disease message. If they're on the line it would be interesting to hear from them.

(Paul Heinrich): This is (Paul Heinrich) from (ACCHA) and right, the registry is for ischemic heart diseased or coronary artery disease, so – but we also think that the medications, while aspirin would be recommended the long list of medications, it's not as clear for other vascular diseases particularly the use of Ticagrelor for artery disease. So that's why we – That's why which I think limited because one we have the way to collect the data and two the Diopines are most directly in sync with ischemic heart disease.

(Penelope Felis): And this is (Penelope Felis), the one thing that I would also add is that, this measure is currently used in the PQRS recording system not just as one of the measures but within the larger 250 plus, but its also currently used by other registries that are participating and qualify clinical data registry submission for PQRS product. So, you know, there is a broad use of this measure above and beyond, you know, the use of it by PCCP clinical registry.

Melissa Marinelarena: So again these are, you know, the things that we needed to think about when we're comparing the two measures. One superior we had a couple of

different opinions, we have justification for endorsing this multiple measures if we're going to keep them. Are specifications harmonized, is there a difference in specification and, you know, is there a burden of having all full measures. Does anybody else have anything to add?

Leslie Vicale: So would the committee like to go ahead and make a decision about on whether if they would like to choose one measure over the other?

Female: Leslie do you have quorum on the call right now?

Leslie Vicale: No, we don't but to have a discussion about – could we have a little bit more discussion about these measures perhaps?

Tom Kottke: Tom Kottke here, you know, this is sort of a returning theme where one measure may be superior and one component and the other is more superior or let's say more particular than the other like the ACC measure with the number of drugs that you – and the point is well taken that if you – that the evidence for certain and in spite of medications for ischemic vascular disease that is not coronary disease, its less well-established.

And then there's the question of disrupting systems that are – been underway and we know that change in the measure for a system that's already underway, well in fact be disruptive whereas that the competing measures that serve as compete but don't absolutely compete and its kind of hypothetical that the burden is increased. I guess that's our – that's sort of a comment I said well maybe we keep them both because they're not quite competed.

Female: So that was my comment, was really what was the evidence that this is in fact burdensome, the populations are independently using the measures. Do we have type of data?

Melissa Marinelarena: They weren't picked out based on evidence that they were burdensome. We use the algorithm on measure focus and then determined if they're related or competing.

Tom Kottke: So I'm wondering, you know, maybe the– I'm aware of this whole issue of too many measures, or the potential for too many measures and focusing on to

make sure that the measures measure important things, this obviously both of these measures measure very important things because they use a plan – it place the data after inpatients with vascular disease, it has a very important impact on outcomes. But, I mean maybe the benefit of limiting measures lies somewhere else and that's to make sure there that we don't get measures in about things that are trivial or where performance is already good, those kind of things.

Female: And I kind of agree with Tom. I'm not sure whether this is burdensome or not. I think it would be the user that would be telling us it's burdensome and that I'm hearing we don't have any statistics or any data to tell us that they are burdensome. My tendency is to try and downsize if they look too similar but maybe they're being used differently and they would be a benefit. So, I guess making a decision whether they're burdensome is not something that I'm able to make.

Tom Kottke: You know, it would be very interesting if NQF could, you know, sort of pull or, you know, put out a request of like where are the specific problems other than this general, let me call the general line about too many measures. Others places where people say look I'm, you know, on Mondays I measure 67 and on Tuesdays I have to measure 68 then that, you know, that kind of thing where there's actual end-user experience was being burdened with very similar measures when assessed by two different organizations and to demonstrate that this is really a problem.

Melissa Marinelarena: Yes, and I think going forward with our new maintenance process we might be able to get more of that because then we're going to focus more on as long as the evidence hasn't changed in the testing of the change from the previous maintenance cycle, we're going to focus on use in usability because a lot of the times the measure developers don't have access to like the implementation information. I mean, we went through that at the meeting just a few weeks ago, so I think we are going to focus more on that and especially on measure, you know, on measures that are – have been in use. So where at that doesn't apply to these measures right now.

But with related in competing measures, burden is not one of the criteria when we are pulling the measures, and again looking at measures that have a similar measure focus or populated and in that time we determined them. You can decide and say, no these are perfectly fine, you know, if they don't measure the same thing and it all has to be based on evidence. If you say the evidence is – shows that these are different conditions and its different medication and they're completely different or they're similar enough, but it's sufficient if you justify it by that then its fine.

And just so you know, these conversations have been going on for a really long time, (Reva) who you all know I'm sure, looked at these same measures back in 2011 which is before this standing committee and have this exact thing discussion with these to measures of some of the other ones that we're looking at right now. So its – We've been through this before, it's – but, you know, you don't have to decide between the two of them if you say they're different and you tell us that and the evidence supports it, then its fine.

Tom Kottke: Well then I would say, I mean, I have two comments. One, maybe the fact that we keep revisiting this without any resolution suggests that we're looking at the problem with a wrong light, but then regarding these two measures I would say that they're different enough with the IVD in there and they class it with drugs that we let them both go forward.

Leslie Vicale: Do we have any other committee members who would like to comment on that, who agree or disagree?

Well, what we can do because we don't have quorum on the call is if the committee would like to make some sort of decision between the measures we can offer that as an option during the post-comment call when you will have to have everyone on the call that time and we will have the ability to make some voting decision. So, although that committee could decide to keep both measures and not have to have any vote.

So can I hear some thoughts on whether you'd like to revisit decision during the post-comment call?

Karen Johnson: And Leslie this is Karen I'm sorry to keep harping on this but I am actually confused about what you're doing on voting. I had thought that you were going to ask the committee to make their votes after this call in a survey environment.

Leslie Vicale: I'm sorry, Karen, no – yes, we don't actually have the opportunity to do that at this point and that's why if there are any voting requirements that folks like to do that we'll have to go ahead and visit that during the post-comment call because we don't have quorum on this call.

Karen Johnson: Well, I know you don't have quorum on this call but you could get quorum after in a vote, so I'm still a little bit at lost as to why you're not asking for votes before you go after comment.

Leslie Vicale: Yes, we're scheduled to go out for comments with the full draft report in roughly a week or so. We don't have the opportunity to incorporate any surveys after this call right now.

Karen Johnson: OK, so let's clarify then, what we're asking the committee to do today is basically have these discussions and we will try to write up their – in the pros and cons, the minority, majority points if there are any, and try to invite I think to Tom's point particularly about use. See if we can get some comments specifically on those issues and then it will have to be revisited on the post-comment call. So there will actually be a formal vote on related in competing at the post-comment side, OK.

Tom Kottke: In our – And maybe I suggest we run it up with, you know, after (who chain), this is a question about should, I mean should we be asking, I mean one of the criteria is as you said whether a similar criteria are actually burdensome to somebody out there because the one creating these measures obviously is not alert. I mean, it's a lot of work, a lot of thought. There is serious spot goes in that result tremendous amount of debate and sort of mental – I mean, I know that the ACC puts a lot of work and CMS puts a lot of work and Yale puts a lot of work in them and then to have the committee just sort of flip and switch, arbitrarily it seems to be a bit rude and I think that NQF ought to consider

actual burden not theoretical burden as one of the criteria for assessing whether a measure is competing.

Females: And yes we would love to do that and I think as Melissa has mentioned, going forward we're going to try to concentrate more on these kinds of questions in the maintenance review that as, you know, that have quandary there's this kind of two things, one quandary is that the folks who developed the measures may not be the ones who are implementing, they may not know about the burden. And …

Tom Kottke: Right, but …

Females: … supposedly, you know, we've had little success on what we are working on in and trying to think of ways to improve but we have is relatively little success in getting feedback in a systematic and comprehensive way from the user community. So we agree that's what we need but we just haven't been successful in getting that to tell you the truth.

Tom Kottke: Well – Or maybe if they aren't responding they don't care. Maybe if they aren't responding it's not a problem.

Females: So that's one viewpoint, they very well be.

Tom Kottke: Yes, I mean I don't complain about the weather in Miami this have done little in the effort.

Joe Cleveland: This is Joe Cleveland, I felt like finally got my phone unmuted, but I just want to endorse completely with I guess Tom has said not to use that word, but I think that it's kind of hard for us to sit and kind of – I don't want to say isolation, but obviously we vet these measures for the criteria that are here and we don't, you know, willy-nilly endorse them, developers don't either, but I guess knowing kind of what happens to them again, I think is incredibly important and whether there is fatigue of these measures being present and I think we – we'd be able to give a more sanguine viewpoint if we knew those things were present. So that's my two cents.

Melissa Marinelarena: Yes, thanks, Joe. So those are all really good points and thanks for NQF to continue considering as we were applying our measure evaluation criteria and endorsement process and we definitely noted those on the call today. Are there any other thoughts before we continue along?

OK, great.

So the next two that we are briefly going to look at is 0081 and 0066 and I say briefly because 0081 is currently under review in CV3 and this is AMA and PCPI's heart failure measure and this is an ACE or ARB therapy for LVSDs and 0066 is ACC's CAD and this is ACE or ARB therapy for diabetes or LVEF. And we – This is scheduled to be reviewed in the next phase mid next year in CV4. So if you could look at the level of analysis which is the same, the data sources for 81, this is the one that has the claims and registry version and then the e-measure version that we – and we reviewed both of them in this phase. And then ACC's measure is the registry measure.

So the measure focus for 81 is heart failure patients who were prescribed ACE or ARB therapy. ACC's measure is patients with CAD and diabetes or patients with CAD and heart failure who were prescribe ACE or ARB therapy. The numerator for 81 is patients who are prescribed ACE – an ACE or ARB either within a 12-month period when seen in the outpatient setting or at hospital discharge versus 66 who are patients who were prescribed an ACE or ARB therapy. As the denominator for 81 is patients 18 and older with a diagnosis of heart failure with a current or prior LVEF less than 40. And 66 is all patients 18 and older with coronary artery disease that is seen within a 12-month period who also have diabetes or a current or prior LVEF.

The exclusions appear to be the same, their documentation of a medical reason for not prescribing the medication, documentation of a patient reason or documentation of the system reason and like I said those appear to be the same.

The reason we are not going to have this discussion that we've been having is because 0066 has not been reviewed by this committee, the other measures that are not in this phase right now have been reviewed by you in either Phase

I or Phase II but 66 has not, so we're going to hold off on it for now until we look at it in CV4 and then we'll have the related and competing conversation and we'll bring the two back to look at them side by side.

Tom Kottke: Tom Kottke here, I'd like to make – just make a comment, I mean these two measures look nearly identical except with the diabetes in the ACC measure.

Male: Yes.

Female: Yes.

Tom Kottke: This is one where I think if they put the diabetes on I mean, unless there, you know, there's some sort of pride in owning the measure and which, you know, the maintenance of it that worked, you know, I could imagine having pride in getting rid of it. You know, these two are nearly identical, except for that diabetes and this a, you know, sort of a reoccurring theme and all of this apparently continue measure and from that can we discuss it or we won't discuss it?

Leslie Vicale: Right. And so the reason that we're not going to have the discussion right now about – because, you know, if you were to say these are nearly identical, we have to pick one, one of them would potentially lose endorsement and because 66 hasn't been reviewed in awhile, it needs to go through, you know, it needs to go through the process. So, its on the list you'll be seeing it soon, we will all be back together soon and then we will be able to have this discussion but you'll know upfront that, you know, it is competing with 81 and then we can have that conversation in the next phase. Is – Does that make sense to everybody?

Tom Kottke: Yes.

Leslie Vicale: Does anybody else have any questions, comments, anything from the developers?

(Sam Turney): So, this is (Sam Turney) with the AMA PCPI, I just – if I could make two quick comments and I appreciate that you're not going to have a protected discussion of this at this time for the reasons you described. But I just want to

point out first of all that the two measures that are under review were developed through projects with the ACC, AHA and AMA PCPI both measures, they were developed through separate workgroups, one dealing with CAD and one dealing with heart failure.

So, I just wanted to clarify that point because I know you only with just two did not necessarily all of those who were involved in the development process. And the other thing I just wanted to also point out, I know that maybe on appearance they look similar because of the same measure concept, they do actually address different target populations with the 0081 addressing heart failure from the other one addressing CAD. So I just wanted to point that out but again I realize you're not going to have that discussion at this point.

Tom Kottke: But the real commonality is an objection for action less than 40 percent for some reason.

Leslie Vicale: Are there any other comments regarding this brief discussion?

OK, we'll go ahead and we'll move on to the next set of measure.

Melissa Marinelarena: OK, the next ones are 0083 and 2438 and again 0083 was just evaluated in this space and this is another one of AMA PCPI's measure and this is heart failure and this is beta-blocker therapy for LVSD. And 2438 is beta-blocker therapy and it lists the three beta-blockers for LVSD prescribed at discharged and this is a joint commissions measure and this was endorsed in Phase II we just finished in June of this year.

The main difference with these two measures and it's from what I could tell is probably the only difference is 0083 is a clinician level measure and 2438 is a facility level measure. The data sources you can see there – so the measure focus for 83 is patients with heart failure who were prescribed beta-blocker therapy. And the measure focus for 2438 is patients with heart failure who were prescribed beta-blocker at discharge.

The numerator 483 patients who were prescribed beta-blocker therapy either within a 12-month period when seen in the outpatient setting or out a hospital

setting, they list the three medications and then if you remember they also define outpatient and discharge as well. And for 2438 the numerator is patients who were prescribed the three beta-blockers for LVSD at hospital discharge.

The denominator is outpatient aged 18 years and older with the diagnosis of heart failure with a current or prior IVF less than 40 and then they described LVAF how you find that in documentation, for 2438 heart failure patients with current or prior documentation of left ventricular ejection fraction of less than 40.

The exclusion for 83 or the three general exclusions that we are used to seeing the documentation of a medical reason for not prescribing the medication, documentation of the patient reason, and documentation of the system reason. 2438 has these various specific exclusions including an LVAD or heart transplant, a patient less than 18 years of age, patients who have had a length of figure at 120 days come for measures only, patients enrolled in a clinical trial, patients who are discharged from another hospital, AMA, patients who expired, patients discharged to home for hospice, patients discharged to a healthcare facility for hospice care, and patients with the documented reason for no beta-blockers at discharge.

So, for these is the biggest question I think we had – we were contacted about this as well.

Female: No.

Melissa Marinelarena: No. No, I read in this we had it in the submission the difference in the exclusions were 2438 where they were larger because it's a hospital-based measures so the exclusion are specific to hospital. So, the only question is do you need one for clinicians and do you need an identical measure for facilities, that's the only thing here and my question whether is it possible can you get the same measures – I think it's the same question that Karen asked awhile ago, can one of these measures give you provider's level performance and kind of be rolled up to a facility level.

Tom James: Hello this is Tom James. It really sounds like a good measure for harmonization. You could be on either by – at a facility level or at a clinician level.

Melissa Marinelarena: Is there anyone else care to elaborate (this well)?

Tom Kottke: I would think – yes, I would agree with Tom, I think they get together and maybe this is sort of a slipped in suggestion but put them both in a room and say – and we'll say come up with just one they'll be consoled with anything.

Tom James: Yes, and then …

Tom Kottke: You know, there's

Tom James: There's greater opportunity for the collaboration and getting to the same result.

Tom Kottke: Yes.

Tom James: Everybody have the same measure.

Tom Kottke: Yes. And I think that they should be able to – but creating some sort of urgency they actually collaborate is the trick. But these two they ought to be able to come up with a measure that doesn't violate anybody's sense of morality.

(Anne Watt): Excuse me, this is (Anne Watt), I'm from the Joint Commission and thank you we appreciate that thought very well. And I think I would like to point out to you that we have a long history of collaborating with the folks from AMA PCPI and we will certainly do so with these measures as well, but I think that to expect that we will come out with a single measure isn't realistic. I think you need to consider the programs and the purposes for which measures are developed.

We agreed that these measures are related measures and as such they should be harmonized, but one also needs to consider the data collection system, the databases that all of this information goes into and also the reporting structures and that's the part that we can duplicate because AMA PCPI does

things differently down in the Join Commission because they have different needs for the information.

So I'm speaking for the Join Commission, we're very happy to harmonize on the specifications, but I think that there were still be two distinct measures because of these two distinct levels – not levels of care, the levels of analysis that need to take place.

(Karen Davidson): Hi, this is (Karen Davidson) from the PCPI, we agreement with what (Anne) just said and we would also like to point out that our measure is at the outpatient level as well as hospital discharge and that clinician level measures and facility of the measures will always – will harmonize as much as possible but you'll always have different specification needs.

Tom Kottke: Yes, Tom Kottke, let me, you know, maybe the real problem is where a clinician is tasked to do two different things, you know, measures that ask the clinician to do two different things for the same problem, right. In one case, you know, they're told to definitely gives them in other case it go – whatever you do, don't give us that thing. And if measures are very similar maybe, you know, the burden isn't collecting the data and here I mean, it's very clear, one for hospital and one is not. And then maybe they aren't competing at all but, you know, the real problem are not what we're seeing in other cases since where commissions are explicitly instructed to practice in two different manners. And that's what we really want to avoid.

Leslie Vicale: Is anyone else care to comment on this?

Melissa Marinelarena: I have a question – oh, go ahead.

Tom James: I just – I agree with Tom the whole way.

Leslie Vicale: OK.

Melissa Marinelarena: Hi, this is Melissa. I just have a question for when looking at the medication prescribed at discharge, how does the clinician get access to that? Is it something that the patient brings to the clinician or do they have access to the hospital discharged medications?

Tom Kottke: It depends. There – It may be like in a system like (Aries) we have access to the data from the medical record but a station comes in from another system we may have to depend on either A, the patient bringing the information with us or us getting permission to contact the hospital where they're hospitalized and get the information. We may have no access to the information if the patient can't remember where they are hospitalized and doesn't have a discharge summary with them. So it's very variable and that's one problem with healthcare in United States.

Leslie Vicale: Are there any other thoughts from any of the other committee members?

Male: I have one other side is that, you know, and this was brought up by the measure developers is that these measures can look very similar on the surface but when you dig in to the specifications and how the data are collected and that's where real differences can be present that don't show up on a couple of PowerPoints.

Ellen Hillegass: So this is Ellen. In the future, is there any way that we could in their application also ask for some the technical detail such as if the committee decides that this should be harmonized or if the committee decides that this is duplicate. Do you see any concerns with merging measures or something and maybe they could therefore discuss these kinds of issues. I'm sitting here with some content expertise but I have none of this technical expertise to make this kind of decisions that they could be harmonized or they could be collected individually or combined in anyway.

So, I think we're all sitting here thinking that just like what Tom just said that we – there maybe a lot of differences that we just have no clue and if we reject it and try and combine it, it may not be possible to do this except as a combined, you know, measure versus a separate measure.

Leslie Vicale: Karen, do you have any thoughts on that?

Karen Johnson: Actually there is a section in the submission form where developers explain, you know, what measures maybe related or competing to their measures and

why they think, you know, the way that they did things is the way that needs to be done. So there probably is something there.

And in addition we do ask developers or at least we try to earlier on to give us a letter or give us some information about, you know, any harmonization efforts that I have tried to do in the past. I think your point is well-taken. Anyway we are not actually asking you to select best in class from these two because one is a facility level and one is clinician level. So, you know, right now we're kind of at the point of saying, you know, right we do things that, you know, at least for now having two measures is going to be needed.

I think it would be nice if maybe (Ann) and the folks, (Sam) or other fixed room, AMA PCPI, maybe could address specifically some of these reasons why you couldn't easily combine into one measure. On the face of it, it looks like you could, now, you know, clearly there are some differences and exclusions and, et cetera. And I think that is the key question, you know, why isn't it possible to have one.

So, like my question has always been would you follow clinicians and since the PCPI measure is an outpatient measure as well as a discharge measure, I would imagine that you would be missing clinician if you try to grab all the clinicians just from the hospital side, so that would be one reason that at least right now that you couldn't have just one measure but there may be others.

Leslie Vicale: OK. So it sounds like the measure developers can certainly take the discussion into consideration as they refine their measures in the future. And for the purposes of this discussion we'll go ahead and we'll continue on.

Melissa Marinelarena: OK. So the next ones that we're going to look at is 0669 and 0670, 669 is cardiac imaging for pre-op risk assessment for non-cardiac low-risk surgery. This is CMS's measure and 670 is cardiac stress imaging not meeting appropriate use criteria pre-op EVAL in low-risk surgery patients and this is ACC's measure. 669 is currently under review in CV3, so this is something that we looked at a few weeks ago and 670 was recommended in Phase II and just recently endorsed in June of this year.

You can see the level of analysis for 669 is facility level measure and 670 is facility and clinician or groups. The data sources for 669 are claims and for 670 is clinical electronic, clinical data or EHR registry. So the measure focus for 669 is patients who receive a stress echo, a Single-Photon Emission Computed Tomography myocardial perfusion imaging or a stress magnetic resonance imaging study 30 days prior to undergoing non-cardiac low-risk surgery. The focus for 670 is patients who receive a stress Single-photon Emission Computed Tomography myocardial perfusion imaging, a stress echo or a CPA or cardiac MRI.

The numerator for 669 is the number of stress echo, SPECT MPI and stress MRI study performed in a hospital outpatient department within 30 days of an ambulatory, non-cardiac low-risk surgery performed at any vocation. As for 670 it is the number of stress SPECT MPI stress echo, CPA or CMR performed to patients undergoing low-risk surgery as a part of the pre-op evaluation.

OK, the denominator for 669 is the number – again the number of this study is performed in a hospital outpatient department on Medicare beneficiaries within a 12-month time window and 670 is looking at the number of the studies performed. There are exclusions for 669 and they exclude patients with at least three of the following categories. They're excluding diabetes, renal insufficiency, stroke, PIA, heart failure or ischemic heart disease and 670 has no exclusions.

So we received a letter from – thank you.

So, the difference is here between 669 to 670 was one is a patient A, so 669 is for Medicare beneficiaries. I think it says no age – no age restriction, whereas 670 is 18 and above. The question was denominator – there is a difference in denominator and that's just the study that are in the denominator and 670 or 669 does not include the CTA and the cardiac MRI. And so the question would be why, and then why 670 doesn't have the exclusions that 669 does. Now in the correspondence that we received they did say – the developer did say that they had harmonized all of the low-risk surgeries, the two developers

have harmonized that so we didn't tossed all of that, it's a long list of surgeries, so I didn't go through all of that.

So, again, you know just a question that we want to consider, I don't know if anybody has any comments about the different studies why one is in this measure and not in the other. And any comments about the exclusions or just about the two measures in general.

Tom Kottke: You know, Tom Kottke here, this – it's very clear that both of these measures have exactly the same in count. And the intent is to reduce unnecessary testing and to the extent that ACC and CMS can get together and sing exactly the same song in exactly the same key, will make both of them more powerful. And the argument more powerful, that said we agree on this and I think they could go back and agree on everything and harmonize this thing and come up with one measure that's inappropriate test and its inappropriate and it's just the manner of them, you know, everybody giving a little bit, compromising telling me that for it, because it's same population, same test, same intent.

Leslie Vicale: Thanks, Tom.

Melissa Marinelarena: Thanks, Tom. Any members have some thoughts on that?

Joe Cleveland: This is Joe Cleveland, well I say I agree wholeheartedly with Tom. I think aside if I remember the letter correctly, so many trying to make a bit of an argument about well these are different tests, they're really not. With Tom's point is salient whether you're using, you know, SPECT or M.R. or whatever. Any appropriate tests is inappropriate intent to the measure is to discourage inappropriate use of measures and that patient populations are not intended for. So, I would agree that probably between the two measure developers that harmonization could be achieved and that would be beneficial.

Leslie Vicale: Thanks Joe. Will the measure developers like to respond to any of those comments?

(Joe Allen): This is (Joe Allen) from ACC and we did have extensive conversation with CMS as they developed this measure and we developed ours. We do

understand that they are very similar. The populations are different, Medicare versus a wider adult population as well that the source of data is very different, ours is a perspective data collection primarily using either decisions support or a registry that provides clinical detail while the CMS measure is a broader measure in some ways and that it uses claims data but it's only on the Medicare population and has some limitations about what they can look at related to other clinical reasons for testing.

And so we have seen facilities, use the data differently and our targeted at different facilities. The CMS measure has been used for hospital reporting while ours has been generally used for outpatient imaging labs that occasionally are hospital-based but many of them are out in the community. So, we have harmonize to a large extent but they are very different in their data sources as well as their target populations at this point.

(Crosstalk)

(Tom Kottke): Will that make a difference for the measure? I mean, and this is going to come up every time of, gee we're different, you know, in something either, you know. Pink shirt or blue shirt or something, but I would think – I would, you know, people over 65 are members of the set of people who are 80 and older, so that argument is off the table. Where you have your predominant data collection, I mean, I don't think that makes any difference I mean I still think that this could come up as a single measure and that ACC and PCPI and CMS can work that out.

(Coleen McKiernan): This is (Coleen McKiernan) from the (LOEN) group to echo (Joe's) point, while we appreciate that many of the clinical aspects of the measures are very similar, technically it would be extremely challenging or wholly invisible to align the measures for the reasons that Joe outlined. We do look retrospectively as for instances in claims data, so because our measure is a claims data, we just obtained different information than that which is obtained for the ACC measure which uses EHR registered data. I do think that we are willing to continue discussions about the clinical aspects of the measures and areas in which the measures to be more closely aligned. But from the technical standpoint, I would say it is merely impossible to wholly align these

measures just because of the problematic committees and the way the data are collected and this uses of the data that's more usability challenged.

Tom James: This is Tom James, one of the issues stepping back has to do with the proliferation of measures and how does the consumer, how does a primary care physician, how does the health plan or any other group trying to look at quality and differences and if there's too many measures, it become something which is totally confusing. So, I would really urge some form of consolidation and collaboration here to come up with – or I'll make a new decision, one measure is what would endorse.

(Joe Allen): This is (Joe Allen) again from ACC and listening to the conversation, I'm reminded of something that's coming up in 2017 or '18 which is CMS does have a mandate to prospectively collect this data through decision support mechanisms under a new mandate which will provide them a data source for this information that is more aligned with the ACC phase measure data source and so what I would say is, you know, the statement is correct right now, one views for public reporting for a very specific population which is Medicare and for hospitals only.

Going forward, hospitals who have a huge incentive to install decision support that would report the same data for the Medicare population as well as the broader population in the next year to two we could align these measures because they'll have the same data source is their requirement to do so now giving the limitations that CMS does not have access to the same data that we do to register these.

Male: Yes, this …

(Joe Allen): Or could we work over the next year to align.

(Dr. Bergman): Yes, I would – this is Dr. (Bergman) from (LOEN) group as well and I would like to emphasize the issue we have is for CMS it would be – and I understand the goal of harmonizing, I think it's a very well thought goal. I think that challenge is CMS wouldn't – it would be impossible to collect the data so that part at this point in the future might be feasible with patient support systems as they get involved or EHRs, they would not be able to – or the burden would

be so expensive on hospitals and it would be infeasible to put into practice in – under the hospital program. So the claims-based process allows them to have no burden on the collection which is a key requirement, easily collectible information and that's how they can report in the public in – for the goal that they have which is hospital follow up reporting and allowing patients to look at that information.

And that's why I think I agree that in the future, maybe in two years and we can have a discussion on easier ways to harmonize and I think we all want to harmonize down the road this, but at this point by not having both measures we would not allow the whole population to really get access or try to reduce the overuse of the imaging that is currently occurring.

Tom Kottke: So, Tom Kottke here, so this is very interesting because the – what the decision rest on is not the criteria for like the population or, you know, like this is inappropriate use of testing but for example if we said, we're not going to endorse 669, Medicare CMS would be left without a nationally-endorsed measure that they could use if I understand the argument correctly. Let's – We don't want to do that and so that in fact the decisions around whether or not measures are harmonized is around – harmonization around frequently around data collection and data source is not I mean it's not adequate to just line up numerator, denominator that kind of stuff there's this much, much more nuance than one would – it would appear on the surface.

(Crosstalk)

Karen Johnson: Sure, and I have a couple of questions so that I can understand the measures better but I realize that the ACC measure is a registry measure and it sounds like you're saying that that is mostly use by outpatient departments. Is that registry not used typically by hospitals?

(Dr. Bergman): It can be used by hospitals, but it is a smaller select group of hospitals unlike the Medicare measure. The way we've looked at and the way we've worked to use both measure is CMS is a broad based measure, but it's like population using a very specific data source that has some limitations, but it gives you a sense of are you a huge outlier or not and it's based and then specific hospitals

and outpatients departments have used our registry and perspective decision support to then further explore here because they want to improve specifically and use it quality improvement or if they note in the CMS measure they're an outlier so we use our perspective decision support to change that behavior so in many ways they complement each other, but I know on the surface it may seem they overlap.

Karen Johnson: Yes, I guess I'm trying to – and if hospitals could use the ACC registry and report it that way, that's all I'm asking on that one.

(Dr. Bergman): They can and – there is the same as mandate to be use something similar to either the ACC registry or an equivalent by 2017 and then CMS will have access to that data, but they don't have funding to do that until at least 2017.

Karen Johnson: OK, so they could do it but a lot of them are not doing it now. Am I saying that correctly?

(Dr. Bergman): Correct, we have only specific states that are doing it because of state-based mandates.

Karen Johnson: OK, and then I had one other question. I am definitely not a clinician, but as I was leading the deferent types of tests that are being assessed, it looks like they were a little deferent, is there a – is it just the way that there are – the wording and they're actually the same four or five tests that are being counted or is there a deference in the ones they are being counted?

(Dr. Bergman): They're not telling is that the CMS measure just doesn't include CTA, but the rest of the wording is – would include the same test.

(Coleen McKiernan): Yes, this is (Coleen McKiernan) from (LOEN), I can confirm that. We do not have this CCTA include in our measure, but it's something that we could bring back to our technical expert panel and talk with CMS to consider for inclusions that are aligned measures, but that current – at the time they – it did not include CCTA.

Karen Johnson: OK, but there is evidence that that would be a place where there could be overuse. I guess what I'm asking if this would be a committee thing, would

the committee recommend that CMS go back and at least harmonize on the actual tests that are being looked at.

Male: Yes, yes at CTA.

Melissa Marinelarena: What about CMRI?

(Off-mike)

Male: Yes. Let me – can you hear me? There is no evidence that pre-operative testing for low-risk surgery by any means does anything helpful.

(Dr. Bergman): Right and CMR has in both measure is one it's called CMR and the other is called stress M.R. but they both cover the same test.

Karen Johnson: OK. But I wasn't sure if they – if I was not understanding the wording.

(Dr. Bergman): And then that's in the detailed specifications for that code they are the same it's just that English version that's here doesn't – might appear deferent.

Karen Johnson: OK, all right. And then that 30-day timeframe in the CMS measure is more because it say a retrospective look as opposed to a prospective look, am I characterizing that correctly?

(Dr. Bergman): Correct.

(Coleen McKiernan): This is (Coleen McKiernan) from (LOEN), yes, that's correct. One other benefits of using the retrospective claims data is that where we can look for this surgery in any location and so we're not restricted to explicitly at this facility, so the imagings, is performed at a facility included in the hospital outpatient reporting program and then the surgery can occur in any location.

Karen Johnson: OK, sorry those were burning questions I had to ask, but does the committee – anybody on the committee have other questions or clarifications that they would like to make?

I think we're hearing that we would really like to see one measure that does what both of these measure doing and realizing that may be a little difficult to do it, but it might be possible to do it.

Male: Yes and I would also I mean congratulate both proposers and their intent to develop a single measure over the next couple of years and that's what I'm happy with that – happy to hear.

Karen Johnson: And we can certainly write that up in our report, sot that you know, three or four years down the road when were having this conversation again may be we don't need to have this conversation again.

Leslie Vicale: Yes, that's a good point, Karen, and we're capturing the notes here and we will be sure to capture that the report.

Male: Or at least you only have one conversation.

Leslie Vicale: Right.

Karen Johnson: Right, we can have one – that would be fun. And we'll ensure that we continue to work with that the ACC to align one possible both clinically and technically.

Tom Kottke: And I just want to clarify, I mean that was intend, we had some very good conversation, I think we – also this road block that we can't solve that problem because the data have – the data source I know it kind of sounds well, we shouldn't only focus on the data, but that would makes it – it's one of the feasibility aspects of this for CMS they couldn't and I'm having a we couldn't report it which what creates challenges, but I think the goal is to continue to try to get to eventually in a one measure that we can both work on and NQF (what's have) in place.

Male: Great.

Leslie Vicale: OK, Great. Thank you. So we do have one last set of measures that we want to do again briefly go over, so allow Melissa to do so.

Melissa Marinelarena: OK, so the last set that we're going to briefly look at is 0076 and 2763 and 2763 is Ischemic Vascular Disease Care, this is an all or none outcome measure outcome measure of (small) control and this is under review right now and this is with confidence measure I mean we looked at this a few weeks ago and 0076 is Optimal Vascular Care and this is Minnesota's measure and this is going to be review, so currently endorsed and it's going to be reviewed in phase four next year, the level of analysis you see is the same, that data source is pretty much the same claims, EHR and registry for 2763 and for 76 is electronic clinical data in EHR and medical records.

So the measure focus for 2763 is patients 18 to 75 years of age with IVD who have documentation of daily aspirin or other anti platelets unless contraindicated, blood pressure, control tobacco free status and statin use, so those where the four components in this measure.

For 76, it's again patients 18 to 75 years of age with IVD with optimally managed modifiable risk factors and they are blood pressure, tobacco free status and daily aspirin use.

The numerator again for 2763 is the most recent blood pressure of measurement less than 140 over 90 and because it's an all or none most recent tobacco status is tobacco free and the discussion if you recall was it's not just smoking sensation, it is documentation of tobacco free. Daily aspirin or another anti platelet unless it's contraindicated and statin use.

For 0076, it's again patient 18 to 75 with IVD who meet all of the – they have to have pressure less than 140 tobacco free status and daily aspirin unless it’s contraindicated.

So the two – they're similar which is the numerator, the only thing that's different is the 0076 does not have the statin component and the reason we're not going to discuss this. We got to the next slide – what do I have on the next slide. Some more differences, so exclusions for 2763, there are no exclusions; and for 76, the exclusions include patient who has died, patients in hospice and patient who were permanent nursing home residents during the measurement period or patient who were coded with IVD in (error).

2763 is not risk adjusted and 76 is risk adjusted based on insurance product and age (band). So we just wanted to show this to you because again 76 has not been reviewed by this committee and the status component, we have confirmed to the Minnesota, they are going to be including the statin component again, so they're going to be putting it back in, so this will be a complete in measures, so when they submit it with the – into CV4, we are going to be – you're going to be evaluating 76, so NQF staff is recommending because 2763 is under review right now, we are recognizing is that we defer having a discussion and making any recommendations on endorsement for 2763.

Male: I would second that recommendation. You know because the PCSK9 inhibitors, probably LDL level is going to creep back into the measure and then with the SPRINT trial, blood pressures are going to change.

Melissa Marinelarena: Right.

Male: They come down to 140 or 120 over 80, you know, so I don't think there's any point in lengthy discussion about either of these measures.

Melissa Marinelarena: Yes and also we were talking, Leslie and I were talking, we're hoping by CV4 with the committee and then, you know, some – with us by then we will have – you will had evaluated probably most of the portfolios, so we'll have a good handle on all the measures and then we can, you know, really take a look at them and, you know, be able to look at hopefully the guidelines will be out by then, but, you know, we'll have a good sort of overview of the measure that.

So yes, does anybody else have any questions, issues, comments, is anybody from Wisconsin or Minnesota on the line that would like to say something?

(Mary): This is (Mary) form Wisconsin, can you guys hear me?

Leslie Vicale: Yes.

Male: Yes.

(Mary): OK and I really – I didn't really have anything to add, I completely understand your recommendation, just wanted to say that that makes sense to us.

Male: It's great.

Leslie Vicale: So we just want to confirm that we will go ahead and defer the recommendation for 2763 until we can have the complete discussion when 0076 is up for maintenance and phase four project which will happen in the middle of next year and we're looking at July next year.

So we will go ahead and make sure we note that in our report. Are there any other comments from the committee?

Male: Other than being shocked that you got through this thing in less than two hours, I would not have believed it.

(Crosstalk)

Leslie Vicale: … with our time management. We're going to get really good by next year. All right.

Male: After then, there's no quorum.

Male: Yes, right. It helps when you only have four people on the phone.

Leslie Vicale: Well, don't worry, for the post-comment call, we will make sure that you are all on the phone and all present and ready to vote.

OK, so with that, I just wanted to go ahead and review the project next steps for the cardiovascular phase three project and as you can see here we've actually move the timeline, just a bit. Our draft report, we won't actually have post-comment, public comments like we had originally intended by the end of next week on the 16th, we're looking at the 23rd of October now and have that public comment open through November 22nd.

And as you can tell having this conversation as lead as we did – we want to make sure that we capture all of your thoughts, your recommendations and

information in that draft report as complete as it can be so that folks can go ahead and make those comments.

Once we've receive all those comments, we will go ahead and we'll collect all the themes from the comment and provide that form the committee and have our post comment (then) community call to review the comments on December 7th from 1:00 to 2:00 p.m. and the draft report will be posted for the member vote from December 18th through January 3rd.

And now as you can see here we have the date listed for CSAC review and approval as well as review by the executive committee of the board of directors that would be January 6th through 26 for the CSAC and then followed by the board review, January 27th through February 5th and I just wanted to note that those are timeframes right now and we will be able to confirm with you in the future once those dates for CSAC and the board have been finalized and as you can see here, our appeals will be open for February to March 9th. That's just a brief overview.

So at this time, I like to go ahead and ask the operator to open the call up for any public comment. Operator?

Operator: Certainly. As a reminder, if you would like to make a public comment please press start one.

And there are currently no public comment.

Karen Johnson: Thank you, and we would like to know if we didn't receive any public comments through the chat function in our web platform either.

Leslie Vicale: Well, at this point, we'd like to thank everyone for joining us today, we specially like to thank the standing committee members as well as our measure developer and the public for joining us, if anyone has any questions or anything that they like to contact NQF staff, please feel free to do so at anytime, again my name is Leslie Vicale and I'm the project manager.

So we look forward to speaking with the committee during our next call the post-comment call in December 7th, so we hope you all have a wonderful weekend and thanks again for joining us.

Male: Enjoy. Thanks, (inaudible).

Female: Thank you everybody.

Male: Thank you.

Female: Thanks.

Female: Bye-bye.

Male: Bye.

Female: Thank you.

END