

THE NATIONAL QUALITY FORUM

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PATIENT OUTCOMES STEERING COMMITTEE

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MEETING

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Monday, October 19, 2009

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The meeting convened at 9:00 a.m. in Salon D in the Marriott Metro Center, 775 12th Street, N.W., Washington, D.C., Joyce Dubow

and Lee A. Fleisher, Co-Chairs, presiding.

MEMBERS PRESENT:

JOYCE DUBOW, MUP, Co-Chair
LEE A. FLEISHER, MD, Co-Chair*
RUBEN AMARASINGHAM, MD, MBA
E. PATCHEN DELLINGER*

ANNE DEUTSCH, PhD, RN
BRIAN FILLIPO, MD, MMM, FACP
LINDA GERBIG, RN, MSPH*
EDWARD F. GIBBONS, MD
LINDA GROAH, RN, MSN, CNOR, FAAN
PATRICIA HAUGEN
DAVID HERMAN, MD*

DAVID S.P. HOPKINS, MS, PhD
DIANNE JEWELL, PT, DPT, PhD, CCS
DAVID A. JOHNSON, MD, FACP, FACG, FASGE*
IVER JUSTER, MD
BURKE KEALEY, MD, FHM
PAULINE McNULTY, PhD

MEMBERS PRESENT (Continued):

VANITA PINDOLIA, PharmD, BCPS*
BARBARA YAWN, MD, Msc, MPH, FAAFP

STAFF PRESENT:

HELEN BURSTIN
SARAH CALLAHAN
JENSEN CHIU
ALEXIS FORMAN

MELISSA MARINELARENA

EMMA NOCHOMOVITZ

KAREN PACE

REVA WINKLER

BONNIE ZELL

MEMBERS NOT PRESENT:

SHELDON GREENFIELD, MD

*Via Telephone

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

2 (9:01 a.m.)

3 CO-CHAIR DUBOW: Well, good
4 morning, everybody, and welcome. I'm Joyce
5 Dubow from AARP, and I'm co-chairing. Lee
6 Fleisher, the other Co-Chair, is on the line.

7 Lee, are you here?

8 CO-CHAIR FLEISHER: Yes. I am on
9 the line. I will intermittently mute so you
10 don't hear everything else going on here.

11 CO-CHAIR DUBOW: Okay. Lee is in
12 New Orleans at a competing meeting, but he's
13 going to try to be with us for whatever part
14 of the day he can.

15 So, Lee, whenever you want to say
16 something, just let us know.

17 CO-CHAIR FLEISHER: Thank you.

18 CO-CHAIR DUBOW: No. Wait a
19 minute. If you push the button on the
20 telephone, apparently that will signal us that
21 you want to talk.

22 CO-CHAIR FLEISHER: Got it. Thank

1 you.

2 CO-CHAIR DUBOW: Okay.

3 Technologies that I am not familiar with.

4 But, anyway, we have a fair number
5 of people who are expected to be on the call
6 today, as a matter of fact, today and
7 tomorrow, which is too bad because we have a
8 lot of nitty-gritty stuff. And it's hard to
9 do by telephone, but I hope everybody will be
10 able to participate, even on the telephone,
11 because this is an important opportunity for
12 us to have input into shaping the thinking on
13 the whole conceptual framework of the Outcomes
14 Steering Committee, the work of the Steering
15 Committee.

16 Reva has a full -- and Helen. We
17 are going to go around and introduce ourselves
18 in minute. You have seen the agenda. But I
19 think that today and tomorrow are really
20 important to all put us on the same page.

21 I am told that we all have
22 different levels of exposure and experience to

1 the ways and the why fores of the National
2 Quality Forum. And it's very, very useful for
3 us to understand what the role of the Steering
4 Committee is, the role of the various other
5 components that will have a role in what
6 happens with these measures. So it's a kind
7 of important nontechnical, I suppose, way of
8 just getting ourselves on the same page and
9 orienting ourselves.

10 So I think what we should do is to
11 start by introducing those who are here and
12 then we will see who is on the telephone.

13 DR. BURSTIN: Good morning. I am
14 Helen Burstin, the Senior Vice President for
15 Performance Measures at NQF.

16 MEMBER KEALEY: I am Burke Kealey.
17 I am a Hospitalist and a member of the Society
18 of Hospital Medicine Board of Directors, here
19 representing them.

20 MS. FORMAN: Could you please
21 disclose any interest when you introduce
22 yourself? Thank you.

1 MEMBER KEALEY: Sure. No outside
2 interests other than my primary employment
3 with HealthPartners Medical Group.

4 CO-CHAIR DUBOW: Also let us know
5 what part of the country, where you're from,
6 too.

7 MEMBER KEALEY: Minneapolis,
8 Minnesota.

9 MEMBER JUSTER: Iver Juster from
10 Active Health Management, New York, although
11 I live in San Francisco and oversee the area
12 involving outcomes and health informatics. I
13 am a family physician and medical
14 informaticist.

15 And both as a company and as a
16 wholly owned subsidiary of Aetna, we are
17 involved in clinical decision support and,
18 therefore, translating clinical practice
19 guidelines and performance measures into
20 clinical decision support.

21 We did have several measures,
22 clinical measures, last year in front of the

1 NQF. So is that disclosure? Thank you.

2 MEMBER YAWN: I am Barbara Yawn.

3 I am also a family physician. I do research
4 full-time now. My area of interest in
5 research is actually translational research
6 trying to figure out how we take all of those
7 guidelines somewhere, around 4,000 or 5,000 of
8 them, but one at a time or 2 or 3 at a time,
9 and translate them into things that can
10 actually be done in primary care practices.

11 I am the Director of Research at
12 the Olmstead Medical Center, which is in
13 Rochester, Minnesota. No, it is not part of
14 the Mayo Clinic in case anybody wants to ask
15 that. I am here, I think, representing the
16 American Academy -- they nominated me anyway
17 -- the American Academy of Family Physicians.

18 I don't know. How much do you
19 want? Do you want to know about research
20 grants? What do you want to know about?
21 Good. I don't think that I have any conflicts
22 except maybe some internal ones, and we won't

1 go there.

2 MEMBER DEUTSCH: Hi. My name is
3 Anne Deutsch. I am a clinical research
4 scientist at the Rehabilitation Institute of
5 Chicago and also a research professor at
6 Northwestern University. I am a registered
7 nurse by training, and I have a Ph.D. in
8 epidemiology.

9 In terms of conflict of interest,
10 probably just my employer; and, again, from
11 Chicago.

12 MEMBER JEWELL: Good morning. My
13 name is Dianne Jewell. I am a physical
14 therapist on the faculty in the Department of
15 Physical Therapy just down the road in
16 Richmond, Virginia at Virginia Commonwealth
17 University.

18 I have a varied background
19 pertinent to this exercise. Prior to joining
20 the faculty, I was Director of Quality
21 Management for a local rehabilitation hospital
22 system. So I got some experience there on

1 this topic. Currently, my research focus is
2 on outcomes and outcomes measurement in
3 physical therapy.

4 As far as I know I don't have any
5 conflicts of interest other than my present
6 employment. I am, however, on the Board of
7 Directors of the American Physical Therapy
8 Association.

9 MEMBER GROAH: Good morning. I am
10 Linda Groah, Executive Director of the
11 Association of Perioperative Registered
12 Nurses. I am a registered nurse, and I was
13 nominated by ANA. And I have no conflicts.

14 MEMBER AMARASINGHAM: My name is
15 Ruben Amarasingham. I am an internist and the
16 Associate Chief of Medicine at Parkland Health
17 and Hospital System and an Assistant Professor
18 of Medicine at the University of Texas
19 Southwestern Medical School, both in Dallas,
20 Texas.

21 And I believe I was nominated by
22 the National Association of Public Hospitals

1 to represent their viewpoint. My research
2 interest is in the outcomes research and
3 informatics, specifically in developing
4 electronic predictive models for improving
5 patient care.

6 And I have no conflicts of
7 interest.

8 MEMBER GIBBONS: Hi. My name is
9 Ted Gibbons from Seattle, Washington. I am an
10 Associate Professor of Medicine at the
11 University of Washington just recently, having
12 moved from the Virginia Mason Medical Center,
13 where I was Associate Chief of Medicine and
14 Chief of Cardiology and Endocrinology and have
15 recently come back to academics.

16 My interests have in the past been
17 towards bridging disciplines in terms of
18 quality assurance measures for high-risk
19 patient management, and I am currently at the
20 University of Washington, at Harbor View
21 Medical Center, for the safety of that
22 hospital, developing and expanding their heart

1 failure community management program.

2 I believe I have been sponsored by
3 the American College of Cardiology to be a
4 liaison to their quality assurance committees.

5 MEMBER McNULTY: Hi. My name is
6 Pauline McNulty. I work for Johnson and
7 Johnson in the pharmaceutical sector. I work
8 in a group that is focused on doing
9 healthiconics work. But specifically I myself
10 work in an area called patient-reported
11 outcomes, and I have led this group for the
12 last three years.

13 One of the big things that
14 happened a little over three years ago was
15 that the FDA published their draft guidance on
16 patient-reported outcomes if he wants to get
17 information in the label.

18 And so there are standards out
19 there with regard to what the FDA wants to see
20 around measures included in trials if you want
21 to put them into the labels. So that's where
22 a lot of my work has been focused these last

1 years.

2 In terms of conflicts of interest,
3 other than the fact that I work for the evil
4 pharmaceutical industry, I don't think I have
5 any.

6 (Laughter.)

7 MEMBER HOPKINS: Good morning. I
8 am David Hopkins. I am the Director of
9 Quality Measurement at Pacific Business Group
10 on Health in San Francisco.

11 For those of you who don't know my
12 organization, it's a coalition of about 50
13 large employers, mainly California-based. And
14 for the last 20 years, they have been striving
15 to moderate the costs of health care while
16 improving quality and access. And we are
17 still working towards those ends.

18 I don't have any conflicts to
19 report.

20 DR. WINKLER: Good morning. I am
21 Reva Winkler. I am a Project Consultant here
22 at NQF. I have actually been with NQF for

1 almost nine years now. So I have been able to
2 see the evolution of the organization from one
3 of its earliest stages onward.

4 I have had the opportunity to work
5 with some of you on previous projects and look
6 forward to working with all of you again on
7 this one.

8 MS. FORMAN: Hi. Good morning. I
9 am Alexis Forman, the Project Manager, for
10 this project -- well, one of the project
11 managers for this project.

12 And you have been receiving a lot
13 of e-mails from myself and Jensen. So I just
14 wanted to thank you for your patience and
15 thank you for coming.

16 CO-CHAIR DUBOW: Lee? Lee, are
17 you there?

18 CO-CHAIR FLEISHER: Yes, I am
19 here. I am back. Yes. My name is Lee
20 Fleisher. I am Professor and Chair of
21 Anesthesiology at the University of
22 Pennsylvania.

1 I have been doing work on
2 developing guidelines and looking at
3 performance measures with Jeff Spielberg from
4 a research perspective.

5 I was nominated by the American
6 Society of Anesthesiology and had the
7 privilege of previously working on the
8 steering committees related to perioperative
9 outcomes.

10 And my only potential conflict is
11 that I am a member, unpaid, of a facility, a
12 surgery center for the institute.

13 CO-CHAIR DUBOW: Okay. Thank you.

14 Are there any other members of
15 this Committee on the call that we know of?
16 Anybody out there?

17 THE OPERATOR: All the lines are
18 on mute right now. Would you like them
19 opened?

20 CO-CHAIR DUBOW: Please do.

21 THE OPERATOR: Okay. All lines
22 are now opened.

1 MEMBER FILLIPO: Hi. This is
2 Brian Fillipo. I am the Vice President for
3 Quality and Patient Safety for the Connecticut
4 Hospital Association.

5 My only conflict is my employer.

6 MEMBER JOHNSON: Hi. This is
7 David Johnson. I am a Professor of Medicine,
8 Chief of Gastroenterology, Eastern Virginia
9 Medical School, and past President of the
10 American College of Gastroenterology.

11 My only conflict is as disclosed.
12 I am on the Board of Trustees still for the
13 American College.

14 MEMBER GERBIG: This is Linda
15 Gerbig with Texas Health Resources. We are a
16 14-hospital not-for-profit system in north,
17 central, and west Texas.

18 And I have nothing to disclose.

19 CO-CHAIR DUBOW: Maybe more folks
20 will join us. We have some people from the
21 other coast. So maybe they will join us. The
22 speakers are designated for participating, I

1 mean, the members of the Committee? Okay. So
2 we do have a few people. You all have
3 received a copy of the roster. So I am not
4 going review it.

5 By the way, I have no conflict to
6 declare. My organization is a consumer
7 organization. We have about 40 million
8 members, half of whom are between 50 and 64.
9 The rest are over 65. So our interest spans
10 both the under 65 population and the Medicare
11 beneficiary population.

12 I think we should ask the staff to
13 identify themselves, please, because they are
14 going to be doing lots of work for us. So if
15 you could just let us know who you are,
16 please?

17 MS. NOCHOMOVITZ: Hi. My name is
18 Emma Nochomovitz, and I am a research analyst
19 at National Quality Forum.

20 MR. CHIU: Hello. I am Jensen
21 Chiu. You got a lot of e-mails from Alexis
22 and I. I am happy to work with you guys.

1 MS. CALLAHAN: Good morning. My
2 name is Sarah Callahan. I am the Senior
3 Director of Education at NQF.

4 MS. MARINELARENA: Good morning.
5 My name is Melissa Marinelarena. I am a
6 Project Manager, and I am actually working on
7 phase three of patient outcomes, which will be
8 in mental health and child health.

9 DR. ZELL: Good morning. I am
10 Bonnie Zell. I am Senior Director for
11 Population Health at NQF.

12 CO-CHAIR DUBOW: Thank you very
13 much.

14 Helen?

15 DR. BURSTIN: Again, welcome. For
16 those of you on the telephone, this is Helen
17 Burstin from NQF. Before Reva goes through
18 the lengthy full orientation to the big
19 picture, the project, you know, the rules and
20 all of that good stuff, I wanted to set the
21 stage a bit because this is an unusual and
22 exciting opportunity for NQF.

1 For many, many years, people like
2 David and Joyce and others have been saying,
3 "Let's process more outcomes. Let's process
4 more outcomes." And we clearly have heard
5 that.

6 Although, interestingly enough, we
7 actually, in the analysis that Alexis had
8 pulled together with staff have almost 200
9 outcome measures when you add them up in terms
10 of complication rates, they are still very
11 medically oriented with the exception of some
12 of the physical therapy measures.

13 So there is still a lot of work to
14 do on the outcome side. And we have this
15 opportunity to think about outcomes in the
16 broadest sense of the word, truly. Whatever
17 the case may be, functional status, anything
18 along those lines, we really decided it was a
19 great opportunity and wanted to take a chance
20 and be able to do both a generic view of
21 outcomes, ones that are not
22 condition-specific.

1 And our hope is there are a whole
2 lot of non-condition-specific measures that
3 can be brought to bear. When it's appropriate
4 and there are condition-specific ones, we will
5 certainly bring them in. And we have
6 structured this project a little differently
7 than we have our other projects.

8 So we have, of course, a Steering
9 Committee of the folks here and some folks on
10 the phone. We are also going to have eight
11 technical panels -- and Reva will go over this
12 in more detail with you -- that are more
13 condition-specific.

14 The chair of each of the technical
15 panels will actually sit on the Steering
16 Committee with you, bring the voice of that
17 technical panel back to the table and go
18 through this.

19 And we will also probably not have
20 as many measures as we have had on some of our
21 other projects. We know that. Outcomes are
22 not as plentiful as many of the process

1 measures we are all used to seeing.

2 I think a really important part of
3 this project is actually having you help us
4 both set the scope, what are the most
5 important kinds of outcomes we should be going
6 for if you think about how to best use
7 outcomes to improve health care but also
8 helping us identify measures if they are out
9 there.

10 Our initial call for measures in
11 the first place was not very plentiful. I
12 think we are doing a lot of outreach now, and
13 some new measures are coming in.

14 But we often rely on the experts
15 around the table to say, "You know, those are
16 great measures" so and so has, and we will go
17 after it.

18 So we are going to both use you to
19 help us set scope, figure out what the right
20 approach to this is. I mean, for example,
21 there's been a lot of discussion about whether
22 NQF, just as an example, should endorse the

1 SF-12 as a functional status measure.

2 How would you use it? Would it be
3 a process measure? Did you do an SF-12? Is
4 it a delta of an SF-12, pre or
5 post-hospitalization?

6 There are very few examples of how
7 to use fundamental status in that way with the
8 exception of some of the physical therapy work
9 that certainly some of the folks around the
10 table know well.

11 So this is a very brave new world
12 for us to think about how to use outcomes in
13 a different kind of way. We are happy to take
14 some the traditional outcomes we have already
15 had. like many of the cardiovascular outcomes,
16 but I also just want you to think really
17 broadly here.

18 Our expectation is this will feed
19 into a process where, even if we don't get
20 those measures now, we want to be able to come
21 back out to the field, probably within about
22 a year or so, and say, "Okay. Of those key

1 gap areas that people identified as being the
2 outcomes we need, are you ready to bring them
3 in?"

4 The nice thing is many of you have
5 probably heard NQF now has a fair amount of
6 resources through dollars that we received
7 through the MEPA legislation, the Medicare
8 bill, so that NQF can now receive up to \$10
9 million per year for the next 4 years to do
10 the work that we do around priority setting,
11 measure endorsement. Increasingly a very
12 large piece is actually the translation of
13 what we do to health IT.

14 So it's not an accident of a
15 couple of informaticists or people with health
16 IT experience around this table. It's quite
17 intentional. So we think about really moving
18 the platform of measurement away from
19 Trump-based measures or pure admin. measures
20 to a blended measure, like our recently
21 clinically enriched administrative measures
22 project, all the way finally to getting

1 towards measures that are more clinically
2 based out of EHR.

3 So we have the resources to be
4 able to do these projects now. If we don't
5 get them all in this project, that's okay. I
6 think setting the scope, identifying the gaps
7 so that we can alert the field as to the
8 measures people really think are important is
9 still worth it.

10 So I don't want you to feel like
11 if you see the list of measures we received so
12 far and you go, "So what am I going to do over
13 the next 12 to 18 months?"; don't worry. We
14 will keep you plenty busy. And some of that
15 will be through your efforts to help us
16 identify what the right measures are but also
17 to help us think through what we should do
18 going forward.

19 Do you want to add anything,
20 Joyce?

21 CO-CHAIR DUBOW: No. I think
22 that's very helpful.

1 Can everybody first put your signs
2 up so that I could see your names until we get
3 -- just to put it on an angle.

4 I think that we are really about
5 to begin. So, Reva, let's start.

6 DR. WINKLER: Thanks. All right.
7 As Helen mentioned, a lot of you have
8 experience with NQF, but at various times in
9 our history, more recent and more remote, and
10 some of you, this is your first activity with
11 us particularly on a Steering Committee.

12 Over the last ten years -- and we
13 have just celebrated our tenth anniversary
14 last week. During our fall membership and
15 policy conference, we had our tenth
16 anniversary celebration.

17 A lot has happened in those ten
18 years. And NQF has grown to be a fairly large
19 organization. And the work that this
20 Committee does is not going to be done in a
21 silo but definitely within the context of
22 everything else that's going on.

1 So one of the most important
2 things I want to do for you this morning is
3 bring you into that larger picture of all of
4 the things that NQF is involved in, all of the
5 things that this work needs to consider and be
6 part of and then talk about how what you are
7 going to be doing influences or is influenced
8 by some of those other activities. So it's
9 not just all about us. All right?

10 Our goal for this meeting, this
11 two-day meeting, is really orienting you and
12 bringing you all into the current realm of
13 what NQF is doing and our current activities.
14 And I can tell you that that's a fairly
15 significant bit of work going on right now.

16 I want to talk to you about this
17 project in specific and the work plan you are
18 going to be steering as providing the guidance
19 for the overall work plan and helping NQF
20 staff do the work that this project needs to
21 do to reach our project goals. And we will
22 talk about those project goals.

1 We certainly need your help in
2 establishing the scope of this project, as
3 Helen alluded to. And that's going to be our
4 conversation this afternoon, is what are
5 outcome measures?

6 Do we all agree what they are?
7 Would you know one if you saw one? And while
8 that seems sort of a straightforward question,
9 the answer is far from straightforward. So I
10 hope that we can have some good discussion
11 about that.

12 And then we are going to, tomorrow
13 particularly, talk about the measure
14 evaluation process because that is a process
15 that has evolved over the years as we have
16 learned from many of the folks who have been
17 part of our Steering Committees, as we have
18 learned from the feedback from our very broad
19 audience out there about the measures that
20 ultimately get endorsed.

21 So this is sort of a constantly
22 evolving and maturing process. So even though

1 perhaps you have done this before, you haven't
2 done it this way before.

3 And so we need to be sure that you
4 are as familiar with how we want to do the
5 work going forward as you need to be in order
6 to do it.

7 Let's just talk about NQF. I
8 think most of the people here are familiar
9 with NQF. We are a private, nonprofit
10 organization.

11 Our membership has grown,
12 particularly recently. We are now over 400
13 member organizations. These represent the
14 wide spectrum of stakeholders.

15 All of the members are aligned
16 with eight stakeholder councils, including a
17 consumer council, a purchaser council, a
18 provider council, a professionals council, a
19 community and public health, supplier and
20 industry, quality measurement and research, so
21 the widest variety of membership possible.

22 And realize that they are your

1 audience. You are indeed working on their
2 behalf. And that is why around this table and
3 all of our Steering Committees, we really try
4 and meet the representation from that full
5 stakeholder spectrum. So realize that we are
6 bringing together people who see things
7 somewhat differently, and we do that very
8 intentionally.

9 The NQF structure at the top side
10 is led, of course, by our board of directors.
11 A subcommittee of the board of directors is
12 our Consensus Standards Approval Committee,
13 and we will talk more about their role in the
14 consensus process.

15 But just to let you know, both
16 David Hopkins and Joyce Dubow are members of
17 the Consensus Standards Approval Committee.
18 So they will be able to provide the feedback
19 from that particular perspective as well.

20 Also, we are going to talk a
21 little bit more about a very important part of
22 work that NQF does in partnership with a lot

1 of other organizations, and that's the
2 National Priorities Partnership.

3 And then we also work with the
4 leaders of our councils, meaning our members,
5 in our leadership network. So we really have
6 a large organization that has a lot of
7 different activities going on, a lot of
8 different groups, taking little bits and
9 pieces of all of this fairly large measure
10 development and measure endorsement enterprise
11 that we are engaged in.

12 If you are not familiar with our
13 new website, I would really like to point this
14 out to you. We are still at
15 www.qualityforum.org. And if you haven't
16 visited the site, I really strongly encourage
17 you to do so. This has been really completely
18 revamped this past summer. There is just a
19 lot of information about what's going on.

20 But not only visiting the site, I
21 strongly encourage everyone to enroll. And if
22 you notice over on the right-hand side, it

1 says, "Enroll now" in nice and green, where
2 you can see it.

3 Absolutely, anybody in the
4 universe or extraterrestrial should they
5 desire may enroll and become a member, you
6 know, to follow what's going on at NQF.

7 And the reason that it would be
8 useful for you to do so is you are able to
9 personalize the information on the NQF website
10 and create your own dashboard.

11 This project is something you can
12 put on that dashboard as well as anything else
13 on the activities that NQF is working on that
14 interests you.

15 So when you log in, that stuff
16 becomes front and center. And you don't have
17 to navigate your way around all the other
18 stuff that's on our very busy website. And
19 it's busy because we are busy.

20 The area that you are going to be
21 working in is under the tab called Measuring
22 Performance. You will find that is a

1 drop-down menu. And if you drop that down,
2 you will see Consensus Projects.

3 We are a consensus project. And
4 you will see the list of projects. And,
5 frankly, it is a long list of active projects
6 going on. And if you scroll down to Patient
7 Outcomes, phase one and two, that is us.
8 Okay? So that is the project that we will be
9 working on. But I really strongly recommend
10 that you explore the website and see what is
11 there.

12 Under News and Resources, there
13 are several things, our recent press releases,
14 but also our publications. A lot of the work
15 that you have done in the past with us ended
16 up as a published report. And that is
17 available there.

18 The Executive is summaries with
19 the measures, and the measure specifications
20 are available to anyone for download. Some of
21 the larger and full specifications, there is
22 a charge for. But the publications are under

1 News and Resources.

2 We have got a fair number of
3 events going on if you are interested in
4 those. And certainly if your organization or
5 you represent an organization or two or three,
6 as I can see from all of your bios, that are
7 not yet members of NQF, we can certainly
8 provide you all the information you need to
9 join NQF and become part of the party.

10 So I really would strongly
11 recommend that you explore the website and get
12 to know it but also use it as a tool. And we
13 will talk a little bit more later on how you
14 can use it as a tool.

15 The vast majority of the documents
16 and the information during this project will
17 be posted on that website under our Project
18 page including the transcripts of the meetings
19 and the recordings of our conference calls.

20 This slide sets the background
21 materials. And, in fact, should you wish it
22 on the project page, it can pretty much become

1 your filing cabinet for the project. So for
2 those of you who like to work that way, that
3 is one option.

4 NQF's mission, as every
5 organization has one, is to improve the
6 quality of American health care by setting
7 national priorities and goals for performance
8 measurement, endorsing national consensus
9 standards for measuring and public reporting
10 on performance, and promoting the attainment
11 of the national goals through education and
12 outreach programs. So we have a three-part
13 mission and the activities around NQF are
14 addressing one of those three parts.

15 In a bit, I will talk more about
16 the national priorities. But the part that we
17 are working on with this project is the second
18 one: endorsing national consensus standards
19 for measuring and public reporting on
20 performance.

21 As Sarah Callahan from our
22 Education Department introduced herself, she

1 oversees the work done on the third bullet.
2 So we do have a three-part mission, but, yet,
3 they are not independent. And they are all
4 interrelated in a variety of ways.

5 Our strategic goals. As, again,
6 all organizations have missions and goals.
7 NQF-endorsed standards, again, a trademarked
8 designation, will become the primary standards
9 used to measure the quality of health care in
10 the United States.

11 And over the nine years that I
12 have been associated with NQF, I certainly
13 have seen the growth and the utilization of
14 measures, the fact that folks come to us
15 looking for measures, wanting their measures
16 endorsed by us. I think we are doing a very
17 good job of reaching that goal.

18 NQF will be the principal body
19 that endorses national health care performance
20 measures, quality indicators, and our quality
21 of care standards. Through all of these
22 activities, we will increase the demand for

1 high-quality health care and will be
2 recognized as a major driving force for and a
3 facilitator for continuous quality improvement
4 of health care quality.

5 Certainly last week at our annual
6 policy conference, we had representatives from
7 the government as well as the private sector
8 talking about quality, talking about the
9 impact of the work that various members, NQF
10 membership, are actively involved in the
11 implications for a lot of the discussions
12 around health care reform and the fact that
13 NQF stays solidly, regardless of which version
14 of the formed discussion, the whole issue
15 around quality and the role NQF can play
16 pretty much stays the same, regardless of the
17 version. And that I think speaks to the role
18 that NQF has grown into over the last decade.

19 What we have seen over the last
20 decade is a growth of these measures. And, in
21 fact, if you go to that website, you can look
22 and do a search on NQF-endorsed measures.

1 And, as of this morning, we will find 537
2 measures in our current database.

3 And, just as a FYI, if you should
4 be so inclined, you actually connect for that
5 entire database of measures for whatever
6 purpose you may. The number of queries I have
7 had asking for that is fairly amazing.

8 There are a lot of reasons we have
9 done the work we have done and have endorsed
10 the measures that we have. There are a lot of
11 variety of needs of measures.

12 The entire performance measurement
13 world has grown. The demands have grown. But
14 certainly measures are needed for a lot of
15 various work in the striving for better
16 quality.

17 Certainly measures are needed for
18 reporting programs. They are needed for
19 incentive programs. They are needed for
20 providing information to the wide variety of
21 stakeholders out there.

22 So, particularly over the last

1 four to five years, we have certainly seen a
2 tremendous growth in the demand for more
3 measures endorsed by NQF.

4 And we have done any number of
5 projects. And some of you have been involved
6 in them to address important gaps in
7 performance measurement. We have done a lot
8 of work around measures at the individual
9 physician level. That has been a lot of the
10 work that I have done over the last five
11 years.

12 Joyce was with me as we did our
13 initial ambulatory care project, which was a
14 very large multi-year project addressing
15 clinical level measurement.

16 We have looked at
17 disparity-sensitive measures trying to deal
18 with the issue of disparities and how
19 measurement can be used to understand more
20 about disparities, how to help incentivize all
21 the various levels that exist to close some of
22 those disparities.

1 But first understanding them,
2 identifying, and providing that information,
3 we need the right tools. And we need the
4 methodology to help provide that information.

5 Measures of patient experience
6 with care are very, very important, certainly
7 very patient-centered and patient-focused
8 measurement of the quality of health care.
9 And NQF has endorsed ten or so measures of
10 patient experience with care in a variety of
11 settings. And so that is a very important gap
12 to be filled.

13 But then, again, we look at
14 cross-cutting areas. So much of measurement,
15 certainly in the early years, was focused
16 around specific conditions, certain diagnoses,
17 certain topics, very narrowly defined.

18 But for quality measurement to
19 have its broadest utility, identifying
20 measures that can be used across a larger
21 population of patients, cross-cutting without
22 being specific to any condition, but all

1 patients who appear in a certain setting,
2 encounters, have certain symptomatology,
3 whatever, without being so narrowly defined by
4 their diagnosis or condition, allows for more
5 robust measurement but also greater utility of
6 the information that is obtained for a whole
7 wide variety of the stakeholders. And that
8 really is one of our most important goals
9 here.

10 So one of the key issues of this
11 monster portfolio that we manage is how many
12 measures do we need; where are the right kinds
13 of measures; are there too many, too few. and
14 if we ask everybody in the NQF membership, I
15 can tell you we will get a whole wide spectrum
16 of answers. And that happens to us regularly.

17 But from a perspective of watching
18 over this past decade, what I can tell you is
19 there is an evolution going on. It is not a
20 static number. As we go through the measures,
21 the measures that we looked at five years ago
22 were great for their time, but we can do

1 better.

2 And so measures will be
3 superseded. They will be replaced. They will
4 be revised. They will be updated. And so I
5 think it's less a matter of the actual right
6 number but, rather, the right measures.

7 And so part of our process is
8 trying to be sure that we are constantly
9 updating, revising, and putting into the
10 portfolio the measures that are of the
11 greatest usefulness for the wide variety of
12 needs out there.

13 And I think this is why this
14 project is particularly salient. The need for
15 outcomes and the desire for outcomes among a
16 large number of the stakeholders is quite
17 strong and urgent.

18 Outcomes for a lot of people are
19 easier to understand from a consumer patient
20 perspective, you know, why did I encounter the
21 health care delivery system? Why did I go
22 there? What were my hopes and expectations?

1 What were the problems I wanted to be solved?

2 And at the end of the day, they
3 care about what happened. What happened? And
4 so we are in the what happened business and
5 trying to provide greater information around
6 that.

7 We do have a certain amount of
8 changes associated with both measurement in
9 general but outcomes measurement in specific.
10 And that is the availability of data. That is
11 often a weight-limiting or structural factor
12 that we would have to deal with and then, of
13 course, this certain over-arching issue of
14 translation and transitioning to electronic
15 health records.

16 And so some of the work that NQF
17 is working on right now is trying to
18 facilitate that. And we will talk a little
19 bit more about how that is going. And Helen
20 can fill in some of the blanks.

21 Slide number 8 is "Describe some
22 of the thinking that has gone on in terms of

1 the evolution around quality measurement that
2 NQF is attempting to address" in the way we
3 structure our projects and in the way we are
4 evaluating measures and in a lot of the
5 feedback we get from our members, from our
6 CSAC committee, from the board of directors,
7 from all the folks who like to talk back at
8 us.

9 One is driving towards higher
10 performance. Measuring performance is one
11 thing, but how do we keep pushing for better?
12 Sometimes measures run their course and are no
13 longer particularly useful at driving further
14 performance.

15 So looking at measures with the
16 perspective of their ability to drive that
17 performance, perhaps it will only be in the
18 short term, but what is the leverage that they
19 will bring to bear? So we're looking for the
20 measures that will do the biggest bang for the
21 buck, if you will.

22 We certainly are looking at

1 shifting towards a focus on composite
2 measures. Composite measures bring together
3 a lot of information. It is easier in some
4 respects for certain audiences to understand.
5 It also gives us a much more comprehensive
6 picture of a particular aspect of health care.

7 So composite measures are
8 something that we hear a great deal of demand
9 for. And so to the degree that we have
10 composite measures and we will have composite
11 measures to evaluate in this project, they are
12 an important aspect. Composite measures bring
13 their own set of challenges with them.

14 We actually have a somewhat
15 different additional set of measure evaluation
16 criteria for composite measures. So those
17 characteristics that are unique to composite
18 measures have to be considered as well. The
19 composite measures are an important factor of
20 quality measurement as we go forward.

21 Again, disparities. The ability
22 to measure disparities and not have them

1 buried within the results of measurement is an
2 important quality of the measures if we are
3 ever going to be able to tackle disparities.
4 If we cannot tease out the information about
5 what disparities exist, we won't be able to
6 create actions to deal with them.

7 So measurement in its best form
8 when disparities are an issue will have the
9 characteristics and abilities to identify
10 those disparities, provide information about
11 them. And hopefully that will stimulate the
12 ability to find appropriate responses to those
13 disparities. So disparities measurement is
14 clearly an important aspect of everything we
15 do.

16 Harmonizing measures across sites
17 and providers, this is probably the biggest
18 challenge and one of the issues that probably
19 prompts the fact that we have got 500 measures
20 in our database.

21 Measures for the most part in the
22 past have been developed for the purpose of

1 whatever the measure developer had in mind,
2 whatever their individual goals were. Usually
3 they were focused on a particular setting of
4 care: measurement within a hospital,
5 measurement within a nursing home, measurement
6 within a doctor's office, the ambulatory care
7 setting.

8 A lot of that is driven by data
9 source, absolutely. However, when we start
10 looking at a big picture and think of it from
11 the patient's perspective, many patients,
12 particularly those with chronic disease, may
13 have an episode in the hospital, at which we
14 do all the right things and measure it to get
15 a hospital measurement.

16 But that person may end up either
17 in a rehabilitation facility or long-term care
18 facility, post-acute care facility. And the
19 condition of the patient hasn't changed a
20 whole lot. Yet, the measures that are often
21 done there are done differently, same patient,
22 same condition, different measures. This is

1 not making a lot of sense out there.

2 And so as patients move through
3 the various settings with the same conditions,
4 the idea that the measurement should also have
5 the similarity to support following that
6 patient through their entire episode of care,
7 regardless of whether they are in a nursing
8 home, in a hospital, or at home.

9 So harmonizing measures -- and
10 sometimes it's as simple as what is included
11 and what is excluded, which patients are
12 captured and which ones are not, how you
13 define a certain element of it. It is sort of
14 chaotic and at the end of the day crazy to
15 measure it slightly differently in all of
16 these settings.

17 So harmonization is an extremely
18 challenging aspect of what we try and do. But
19 certainly we would like to have all of these
20 various measurement efforts come together so
21 that when we are measuring the same condition
22 and the same aspect of care for the same

1 patient, regardless of where they are, the
2 measurements can follow them along and be
3 useful. And we can get a more comprehensive
4 view of the entire patient experience through
5 that episode of care.

6 So harmonization has some very
7 nitty-gritty technical aspects of it, but it
8 has a conceptual basis that says we are just
9 trying to understand what happens to real
10 patients.

11 So harmonization is something we
12 will talk about. And we will actually be
13 looking at other existing endorsed measures to
14 say "Okay. They sort of measured the same
15 concept this way." This new measure looks at
16 it slightly differently. Why are they
17 different? Should they be different? How can
18 we make them more of the same? So
19 harmonization is important.

20 Promote share accountability and
21 measurement across the patient-focused
22 episodes of care. Now we are really starting

1 to get kind of located. The shared
2 accountability in measured-across episodes, we
3 are starting to talk about how do we look at
4 measures where the patient might be in two
5 different settings.

6 Certainly for folks who have
7 looked at the siloed measurement of hospital
8 measurement or nursing home measurement or
9 outpatient measurement, it's like, "I'm not
10 responsible for what happened over there."
11 That is the sort of barriers and silos we need
12 to break down in our measurement.

13 Certainly I have observed a
14 greater willingness over the years of people
15 to start talking about that, though it is
16 difficult. Again, we have some of the issues
17 around data systems.

18 Now, we only collect our data this
19 way. And we only collect our data that way.
20 And then how do we bring the two data systems
21 together? You know, difficult and
22 challenging, but at the end of the day,

1 something we simply must tackle.

2 We are going to talk a little bit

3 about the patient-focused episodes of care.

4 This is some work that has been done at NQF

5 trying to understand what an episode of care

6 might be. And we have had work done in some

7 of the topic areas that we are going to

8 discuss, particularly around AMI and coronary

9 artery disease and diabetes and cancer. And

10 we are going to use some of that work to help

11 us do some of our work.

12 Clearly that shared accountability

13 is going to be embedded in outcome measures

14 because ultimately the outcome of patient care

15 will have contributions for all of the various

16 factors. And so outcome measures you can see

17 are becoming sort of a very integrated way of

18 observing a lot of different aspects of health

19 care.

20 Certainly another area of desire

21 for measures is appropriateness measures.

22 Should you be doing whatever was done? Should

1 you be doing it this way or that way?

2 So appropriateness, difficult,
3 still in its infancy, but certainly we are
4 starting to see people addressing that and
5 developing measures coming in; and then cost
6 or resource issue measures, coupled with the
7 quality measures, to address something people
8 generally call efficiency.

9 And so the kinds of work that we
10 are doing around the outcome is addressing the
11 quality side of that, that ultimately cost and
12 resource measures can be coupled with to help
13 address this whole desire, highly desirable
14 and urgent need for measures of efficiency.

15 So this is sort of the large
16 picture and the issues that NQF as a whole is
17 addressing through a wide variety of
18 activities and projects. But, as you can see,
19 this project definitely feeds into multiple.

20 As I mentioned our quality and
21 disparities, this is going to become pertinent
22 to this particular group as we look at the

1 risk adjustment around outcome measures.

2 One of the challenging aspects
3 about outcome measurement, of course, is the
4 need for risk adjustment. And how you handle
5 the various aspects that could relate to
6 disparities within that risk adjustment is an
7 important one.

8 NQF has had prior discussions
9 around this, how to address those patient
10 factors and whether they get sort of zeroed
11 out in the risk adjustment methodology or
12 whether they need to be allowed to remain to
13 identify the disparities so that they become
14 actionable.

15 And these would be some of the
16 issues that our measure evaluation criteria do
17 address. And we will talk about this further.
18 But it is an important aspect.

19 Clearly our preference is that
20 measures that are disparity-sensitive, rather
21 than being more risk-adjusted with a
22 regression analysis, as is often done, are

1 stratified so that you can identify them and
2 pull them out and put them front and center,
3 where they can be dealt with.

4 I had mentioned the episode
5 framework. This is the bubble diagram. I
6 don't know how many of you have seen this, but
7 it is amazing the talks I go to from other
8 organizations that use our bubble diagram. So
9 it is making its way out there.

10 This was work that was done under
11 the leadership of Karen Adams and her staff.
12 This is an attempt to try and define these
13 episodes. I mean, what happens? How do you
14 put a box around chronic conditions or even
15 acute conditions such that if you were to try
16 and look at resource use or costs associated
17 with that care, where is the beginning and
18 where is the end?

19 So these episode frameworks have
20 become very useful to understanding the
21 various patient experiences, if you will. And
22 you can see that in this particular framework,

1 we start with a population at risk, which, of
2 course, is everybody, and primary prevention.
3 Those are important aspects.

4 Secondary prevention for those who
5 don't have an AMI but may have angina or other
6 signs of coronary artery disease, those
7 unfortunate folks in that larger group who go
8 on to have an acute MI go through an acute
9 phase, a post-acute rehab phase, and then into
10 the need for secondary prevention assuming
11 they survived the acute phase.

12 There are potential outcomes at
13 all stages along that trajectory, and you can
14 see some of them described in the blue boxes
15 on the right. You can see that it is a
16 relatively complex experience and instead of
17 looking at it as silos of the hospital
18 experience or the post-acute or the rehab or
19 the home or whatever, trying to look at it
20 from the patient's perspective of the
21 episodes. And this is the kind of approach
22 that we need to take to look at where we have

1 our outcome measures but where we need our
2 outcome measures that don't yet exist. And so
3 this kind of framework is something I would
4 like to build on and use throughout this
5 project.

6 Now, the first bullet of NQF's
7 mission, the first prong, if you will, is
8 addressing the national goals and priorities.
9 And there is a need for national priorities
10 and goals because, frankly, health care is
11 huge.

12 Without priorities, there is a lot
13 of independent work, but without pulling
14 everyone together and building on each other's
15 work, the steps will be small. And the
16 progress will be relatively slow.

17 So, focusing in on high leverage
18 areas aligning the activities of all sorts of
19 folks in the quality measurement enterprise,
20 we accelerate the actual improvements that we
21 all are working towards attaining. So the
22 need for the national priorities and goals is

1 very critical.

2 As a result, the National
3 Priorities Partnership was formed. Is it now
4 three years ago, two years ago? Two to three
5 years ago. That's rounding.

6 This is an organization of 32
7 leadership organizations within the health
8 care measurement world. They came together as
9 a partnership.

10 NQF was sort of the convening
11 authority and one of the partners, but it is
12 indeed a partnership of this multi-stakeholder
13 group of organizations to establish national
14 priorities and goals for performance
15 measurement and public reporting. Okay?
16 Getting everybody to agree on what the most
17 important focus, the most important priorities
18 helps us all work together.

19 This group over the last two
20 years, three years has worked to select some
21 national priorities and goals associated with
22 them that all of the partner organizations

1 have agreed to work together to try and push
2 things farther and faster.

3 And they selected those national
4 priorities through sort of finding where the
5 high impact would be. By looking at the areas
6 around effectiveness, adverse outcomes,
7 disparities, and wasteful resource use, they
8 found what the high impact areas were.

9 So as a result of the work of the
10 national priorities partners, -- we are on
11 slide 14 for those of you on the phone -- six
12 priorities were identified. And each of those
13 priority areas had some goals around it.

14 Not all of the work of any NQF
15 project is directed at all of these goals, but
16 some of the work within this project can
17 address some of these goals. And when we can,
18 it will be important for us to know and for us
19 to really consider because it will have an
20 impact on some of this larger work that is
21 going on.

22 So what were the priorities and

1 the specific goals? The first priority is
2 ensuring that patients receive
3 well-coordinated care across all providers,
4 settings, and levels of care. Big priority.

5 The actual goals around it,
6 certainly we would like sort of the bigger
7 picture, but the goals around that are
8 medication reconciliation, preventable
9 hospital readmissions, and preventable ED
10 visits. And some of those are the kinds of
11 measures we will see or might see within this
12 project. And so this is important to just
13 realize that this would be a high priority
14 area.

15 The second one is improve the
16 health of the population around preventive
17 services, healthy lifestyle behaviors, and
18 ultimately develop a population health index.

19 And our colleague, Bonnie Zell,
20 who is in the audience, has recently joined
21 NQF to provide the leadership in this area.
22 It is a tough one. It is a relatively new

1 area for NQF but certainly a very important
2 one.

3 The next priority area is to
4 improve the safety and reliability of our
5 health care system. Sort of one of the
6 springboards of the NQF ten years ago was the
7 IOM's report on "To Err is Human." Some of
8 our very first work was around patient safety
9 in terms of the serious reportable events and
10 safe practices.

11 There is still a lot of work to be
12 done around safety. And the goals in that
13 area are hospital-level mortality, serious
14 adverse events that can occur to a patient
15 anywhere in the health care system, and
16 certainly the total of health care-associated
17 infections as a serious complication of care.
18 So those are the goals in the first three
19 areas.

20 The next three priority areas are
21 -- the first one is engaging patients and
22 families in managing health and making

1 decisions about care. This is around informed
2 decision-making, patient experience with care,
3 and patient self-management.

4 We have done certainly a lot of
5 work on measures of patient experience with
6 care, but some of the others, the informed
7 decision-making and patient self-management,
8 these are toughies. These are not easy but
9 important, nonetheless. And the challenge is
10 there to all of us to figure out, how do we
11 measure this important aspect of care?

12 The next priority area is to
13 guarantee appropriate and compassionate care
14 for patients with life-limiting illnesses,
15 relief of physical symptoms, meeting
16 psychosocial and spiritual needs. These are
17 potentially the kinds of outcomes for this
18 population on something that we perhaps want
19 to explore and hope that perhaps maybe there
20 are some measures out there, perhaps not,
21 communication regarding treatment options and
22 prognoses and access to palliative and

1 hospital services. So certainly this is a
2 topic area where there is a potential for some
3 of our outcomes work to address.

4 And then the last one is
5 eliminating waste by ensuring the delivery of
6 appropriate care. Whether we will get into
7 this realm in our outcomes remains to be seen.
8 It is possible. It seems to pervade pretty
9 much all of the measurement area we do.

10 So these are the national
11 priorities and goals. I am just going to stop
12 for a second, see if anybody has any questions
13 or comments. This is an important aspect of
14 the work that NQF does.

15 While all of our projects aren't
16 directed exactly to that, certainly it is
17 important to understand that context. And it
18 is important to understand that some of the
19 work we do might very well feed into it.

20 So if anybody has any questions?

21 Yes, Barbara?

22 MEMBER YAWN: Just one comment

1 about the life-limiting illnesses. Almost all
2 chronic diseases are life-limiting illnesses.
3 And so I think it is really important we don't
4 focus on only that last six months, that you
5 have to think about this as part of all
6 chronic disease.

7 DR. BURSTIN: And, in fact, those
8 words are chosen very carefully to not be just
9 patients at end of life organizing for a lot
10 of patients. Life-limiting can go on for a
11 long time.

12 DR. WINKLER: We all have a
13 life-limiting illness.

14 (Laughter.)

15 CO-CHAIR DUBOW: Does anybody on
16 the phone have any questions or comments?

17 MEMBER AMARASINGHAM: I have a
18 question. I am aware of a lot of different
19 groups that seem to be trying to create
20 measures. I am just curious how it all
21 integrates together.

22 For example, I know that there was

1 recently a panel convened by the Center for
2 Medicaid and Medicare Services to develop care
3 transition measures about hospital
4 readmissions. How does that fare with this?

5 I know NCQA is developing
6 measures. Which measures achieve primacy? I
7 mean, is it ultimately going to be the ones
8 that CMS picks? And then finally those will
9 be adopted by all ventures? So I am curious
10 how we are integrating these efforts.

11 DR. WINKLER: Do you want to?

12 DR. BURSTIN: In general, NQF
13 doesn't develop any measures. So all of the
14 measures you have mentioned will come to NQF
15 for review. And it will be up to committees
16 like this to, in fact, go through the four
17 evaluation criteria and pick what is best in
18 class.

19 The core transitions measures will
20 come to us in the spring, for example. We
21 routinely get NCQA measures submitted as well.
22 So it is really just an opportunity for the

1 process to work through the multi-stakeholder
2 consensus process to figure out which of those
3 measures are up to snuff. CMS measures don't
4 particularly get higher priority. They just
5 are evaluated like anyone else's measures.

6 MEMBER AMARASINGHAM: So is NQF
7 considered the final stopping place for any
8 measure before it gets into the wide public
9 use?

10 DR. BURSTIN: Yes. There is
11 actually --

12 DR. WINKLER: I didn't.

13 DR. BURSTIN: One of the basic
14 premises at NQF is something called the
15 National Technology Transfer and Advancement
16 Act, which is an act as well as an OMB
17 circular letter, companies that make NQF a
18 standard-setting organization.

19 So for those you know, HIT, HITSP,
20 things like that, we are very similar. We are
21 the quality standard-setting organization. So
22 when the federal government needs to use

1 quality standards, they need to look to
2 NQF-endorsed standards first. If they are not
3 available, they could use others. But it is
4 a very important reason why NQF-endorsed
5 standards have a different cachet in the
6 marketplace in terms of use by both public and
7 increasingly private purchasers as well.

8 CO-CHAIR DUBOW: Although I think,
9 to your point, it is true that there are those
10 who use measures that haven't been endorsed by
11 NQF. As an advocacy position, for example, we
12 encourage, strongly encourage, our members to
13 look to be sure that the measure is endorsed
14 so that they know that it is a valid, reliable
15 measure. That is not necessarily the case
16 with some of the other stuff that is out there
17 that is used.

18 So what those of us who are
19 participating in NQF want to accomplish is for
20 NQF to be the locus of measurement and for the
21 measures that are endorsed to be the ones used
22 for public reporting particularly.

1 DR. WINKLER: In addition, I will
2 tell you that NQF is usually a fairly
3 significant participant in a lot of those
4 conversations. And we have very strongly
5 relationships with many of the measure
6 developers. We work all the time with CMS and
7 their measure development organizations as
8 well as NCQA and a lot of the others.

9 So we tend to work collaboratively
10 to the degree possible. We keep an eye on
11 their measure development agenda and progress
12 and with an eye towards our projects in
13 determining how they will all come together.
14 So there is an awful lot of communication
15 among all of us on an ongoing basis.

16 MEMBER GIBBONS: One other point.
17 Reva alluded to this at the very beginning of
18 her remarks. And that was how the measurement
19 enterprise is recognized in all of the health
20 care reform proposals.

21 I think it is noteworthy that NQF
22 is either implicitly or explicitly

1 acknowledged in all of them. The NQF process
2 and the NQF as an entity, that is recognized
3 now in statute, is integrated into this
4 measurement enterprise.

5 So that we are likely to see the
6 codification of the process in a more formal
7 way than has been up until now through the
8 health care reform legislation.

9 DR. BURSTIN: That is an excellent
10 point.

11 MEMBER JUSTER: One of the things
12 that occurs to me in speaking to smaller
13 hospitals and smaller health care
14 organizations is there is a bit of a tension
15 between the sense to need to comply and the
16 need to involve towards more durable quality
17 measures.

18 And I was just wondering if there
19 was a map -- and you will maybe get into this
20 -- a map about how you proceed from process
21 measures to outcome measures.

22 So, for instance, some of the

1 process measures, some of the basic process
2 measures for cardiovascular outcomes are
3 evidence-based. And they are all quite good.
4 But some of them aren't really measured in
5 terms of the quality of that particular
6 process measure.

7 Probably the best example is the
8 teaching components of heart failure
9 discharging, where the six components of
10 patient self-management and in follow-up are
11 taught, but the quality of the teaching isn't
12 necessarily uniform or even high quality.

13 So that the top bullet there,
14 "Engaging patients and families in managing
15 health and decisions about care," one of the
16 outcome measures that I think would be useful
17 from a process measure is actually somehow to
18 get a handle on whether or not there is
19 effective teaching.

20 And I don't know if that is one of
21 the goals, but it would seem that the fatigue
22 of compliance would have to be building on a

1 process measure to actually achieve an
2 outcome.

3 DR. BURSTIN: It is an excellent
4 point, actually. And, just so you know, for
5 example, speaking of similar process measures,
6 there was a series of condition-specific
7 smoking measures in hospitals that were
8 NQF-endorsed that had essentially become a
9 check box. We all knew they had become a
10 check box. They have now been retired by NQF
11 as being no longer endorsed.

12 So that is the kind of thing. We
13 don't need measures, truly, that are not
14 meaningful. And so I think your ideas to
15 think about some of the things we may think of
16 as more process measures now that could become
17 a more meaningful outcome, like effectiveness
18 of teaching or how would you even kind of get
19 at that concept, would be exactly what we are
20 hoping to get in this project.

21 Do we have a map? Not
22 necessarily. We will show you some ideas of

1 the concepts we consider under outcomes, but
2 it is part of the reason you are here, to hold
3 this thing through that, how we get there.

4 MEMBER JUSTER: Well, knowledge is
5 itself an outcome. It is a little bit hard to
6 measure because then you have to standardize
7 it. But it bridges process and outcome.

8 Was the patient taught something?
9 And then in my practice, if the patient nodded
10 their head after I said, "Do you understand
11 this?" that was almost a certain marker that
12 they didn't.

13 (Laughter.)

14 MEMBER JUSTER: But, actually,
15 asking the patients a multiple choice question
16 or something like that would be more like an
17 outcome. But that gets to be very difficult.
18 It is much easier to check off, "I talked to
19 this person about the possible side effects of
20 their ACE inhibitor" or whatever.

21 I have also a question. What is
22 the NQF's process for reevaluating measures

1 when the guideline itself changed?

2 DR. WINKLER: NQF actually has a
3 formal measurement in its process. All
4 measures that are endorsed are reevaluate
5 every three years. However, we do have the
6 ability, if you will, to do an ad hoc review
7 if, in fact, science changes.

8 We have seen science change rather
9 dramatically and quickly such that the need to
10 act on an ad hoc basis is important. However,
11 one of the issues that we address in terms of
12 the every-three-year maintenance review is, is
13 the science still there? Is it still solid?
14 And that is an important one of the measure
15 evaluation criteria. So that is part of the
16 updating.

17 So we have sort of two arms,
18 either if it is truly urgent and something
19 drastically changed that we can act
20 immediately; whereas, otherwise it becomes
21 part of the routine update.

22 MEMBER HOPKINS: Yes. I just

1 wanted to thank you for making that
2 observation about teaching or often we see
3 measures of counseling of patients. And the
4 measures that we have today are usually as
5 seen through the provider of the counseling's
6 eyes, not the patient's eyes.

7 So it kind of takes us into the
8 domain of patient-reported outcomes, which is
9 multidimensional, but I hope that we will have
10 some discussion about what could fit under
11 that bucket of patient-reported outcomes
12 before we are done here.

13 DR. WINKLER: Any other questions
14 or comments? Lee? Brian? Anybody on the
15 phone?

16 CO-CHAIR FLEISHER: No.

17 DR. WINKLER: All right. Just
18 because it is a topic, just to follow on on
19 the last bullet, areas of potential overuse
20 that are coming up are around medications,
21 laboratory testing, diagnostic procedures,
22 consultations, hospitalization, needy visits.

1 So all of these things are potentially -- and
2 I see the potential for some outcome measures
3 among some of these issues.

4 Again, another website for you to
5 explore, and that is the website of the
6 National Priorities Partnership. As I
7 mentioned, it is a partnership. NQF is one of
8 the partners. So it is not NQF alone.

9 So it has its own website, and
10 it's at nationalprioritiespartnership.org.
11 And, again, there is a lot of information
12 there to talk about what the priorities
13 partners are doing, when they are meeting,
14 some of the action that they are beginning to
15 take in their action agenda coming up.

16 Don Berwick and Peggy O'Kane are
17 the chairs for the National Priorities
18 Partnership. So this is another website that
19 you may want to explore to kind of see that
20 bigger picture and all of the work around
21 those priorities and goals and what is
22 happening there. So that is a resource for

1 you.

2 And because all of this work does
3 ultimately come together, the crosswalk
4 between the bubble diagram I showed you
5 earlier and where do the priorities fit in?

6 And you can see we just keep
7 trying to make things all fit together, it
8 gets more and more complicated. The diagrams
9 get more complicated. But we do have to be
10 aware of all of this and integrate all of our
11 efforts so that we are doing so within the
12 context of all of the other work that is
13 ongoing.

14 So a messy slide, absolutely, but
15 potentially a very useful one as we start
16 looking at what our outcomes around any of
17 these conditions. And using this work I think
18 will be particularly helpful.

19 DR. BURSTIN: One thing, this does
20 really sort of become our two-dimensional
21 framework. So we think about what the
22 portfolio should look like in the next three

1 to five years. So our hope is we will
2 certainly fill out those national priorities
3 and goals here, which we see as cross-cutting.

4 It is regardless of the condition.
5 Those are all going to be important. You
6 might respecify overuse slightly differently
7 depending on the condition, but you would
8 still want to ensure those are all
9 cross-cutting concepts.

10 We also want to increasingly move
11 towards having those measures that worked
12 across those patient-focused episodes over
13 time, which are often more condition-based.

14 That is kind of our view of where
15 we hope the portfolio goes. And I suspect
16 that over the next few years as well many of
17 our current process measures will probably not
18 make it through measure maintenance.

19 They are not being used. They
20 have not shown their ability to improve care
21 or they are not being publicly reported as an
22 example.

1 So I think some of those measures
2 will begin to fall away. And hopefully we
3 will get to a portfolio of measures that seems
4 more relevant, which is good bidding on this
5 two-dimensional framework.

6 MEMBER YAWN: Do you see underuse
7 as part of multiple areas here? Because every
8 area is specific, and that is important that
9 it is specifically addressed because it gets
10 ignored too often. But you see underuse as
11 really part of every single one of those?

12 DR. BURSTIN: And we have so many
13 effectiveness measures, which essentially get
14 at underuse. But what is not represented on
15 this slide and should be is it is also all --
16 again, it is that backdrop as well as
17 disparities assessment, where underuse becomes
18 so much more important.

19 CO-CHAIR DUBOW: Dianne?

20 MEMBER JEWELL: I am curious about
21 the care coordination box, that it is focused
22 specifically on post-acute care, as opposed to

1 translating across all the way to acute care.

2 So if you could speak to that a little bit?

3 DR. BURSTIN: I did the slide. It
4 is truly my limitations in PowerPoint.

5 (Laughter.)

6 DR. BURSTIN: It is more
7 meaningful, but thank you. You are the second
8 person over the last couple of days who has
9 brought that up.

10 I am not exactly sure. I guess I
11 just need to continue to extend my arrow in
12 all directions.

13 MEMBER JEWELL: Well, I mean,
14 given the conversation --

15 DR. BURSTIN: Yes?

16 MEMBER JEWELL: -- at CMS about
17 bundling and looking at it as a post-acute
18 activity, if you will, I actually wondered if
19 it was purposeful, sort of jibbing with that
20 particular conversation, but certainly from a
21 philosophical and practical perspective, a
22 larger box could be better.

1 MEMBER HOPKINS: Helen, as long as
2 we are picking on your picture, I am reminded
3 that Brent James has been saying for a long
4 time that cost is an outcome. I wish all --
5 focus on the part at the end there: cost.

6 DR. BURSTIN: Actually, I think I
7 just have too many slides, in addition to not
8 being -- there is one that goes above where it
9 says, "Episode begins," "Episode ends." It
10 also says, "Cost and Resource Use." I think,
11 for some reason, I didn't include it because
12 it wasn't one of the six just on the specific
13 NPP slide. But it is our vision.

14 He got them from me. All come to
15 me. It is my fault. I am the slide funnel at
16 NQF.

17 MEMBER YAWN: A measure from
18 willingness to accept responsibility. It is
19 a very important aspect and attribute.

20 CO-CHAIR DUBOW: And then we will
21 go to PowerPoint presentation.

22 DR. WINKLER: Let's talk about the

1 health IT landscape. This is such a pervasive
2 issue for us and certainly from quality
3 measurement going forward and how we are going
4 to do this. I am going to rely a lot on Helen
5 to jump in and add to this.

6 Certainly health IT is an
7 important aspect of what is going on. There
8 is a certain stimulus for accelerating ongoing
9 efforts of defining how health information
10 technology can evolve to support performance
11 measurement.

12 Certainly there is a lot of talk
13 around the stimulus funds that are available
14 for adoption of electronic health records and
15 the whole definition around meaningful use of
16 electronic health records.

17 One of the proposed sort of goals
18 around meaningful use sort of in the later
19 years is that the appropriate use of
20 electronic health records will improve patient
21 outcomes.

22 So things are still in draft, but

1 I heard that phrase a lot going around. So
2 realize that what we are doing here is
3 certainly going to be an important part of
4 that whole concept.

5 Did somebody on the phone want to
6 say something?

7 MEMBER PINDOLIA: This is Vanita
8 Pindolia with Henry Ford Health System.

9 DR. WINKLER: Hi, Vanita. How are
10 you?

11 MEMBER PINDOLIA: And how are you?

12 DR. WINKLER: Good. Thank you for
13 joining us.

14 MEMBER PINDOLIA: I have a
15 comment. I was looking at the outcome
16 measures that are listed, and one comment that
17 I had -- I will just note for the group I am
18 a pharmacist. And my role is to develop and
19 implement a different medication management
20 plan that will improve the care for our
21 patients.

22 And our goal is to really get

1 these patients to be more self-sufficient. So
2 we ask for their health care goals and
3 integrate it with the evidence-based medicine
4 and talk to physicians and develop new plans
5 and then launch those basically for the
6 physicians and then follow up.

7 So we have had success with that
8 in our seniors. And then we have also started
9 doing that for integrating into patients that
10 are like the whole models also, but we are
11 also now looking at employers who are sort of
12 coming to us wanting to have these programs
13 for them.

14 These are younger individuals than
15 are typical. And they don't always have your
16 typical chronic diseases. One of the measures
17 that we are really looking into -- and I don't
18 really see it listed in the type of outcomes.
19 Is absenteeism and presenteeism something that
20 is going to be considered by this Committee?

21 Did I get cut off?

22 CO-CHAIR DUBOW: Vanita, we are

1 having a little trouble hearing. I heard
2 outcomes that were not necessarily related to
3 chronic diseases for the younger population.

4 Did I get --

5 MEMBER PINDOLIA: It's not really
6 chronic diseases, but there are a number of
7 projects that are looking at absenteeism and
8 presenteeism. So it could be you think a lot
9 of appointments and things like that. So they
10 have migraines. They have low back. So they
11 don't have the full-blown chronic disease, but
12 we know it is compounding and it is going to
13 amount to something big.

14 And so if we go and try to improve
15 that, the typical chronic disease measure,
16 outcome measures, can't be applied some clinic
17 groups are really looking into, but we know
18 that we are improving their care.

19 So absenteeism and presenteeism
20 are very important. Are those two measures
21 something that would be discussed in this
22 Committee?

1 DR. WINKLER: Vanita, I am hoping
2 you are going to be able to be with us this
3 afternoon because the discussion after lunch
4 is exactly focused around what are outcome
5 measures. And these certainly would be
6 something to be discussed and potentially
7 added to the desirable types of outcome
8 measures.

9 So if you are able to be with us,
10 we will discuss it further. If you are not
11 able to be with us this afternoon, we have got
12 notes. And we will keep it on the list.
13 Okay?

14 MEMBER PINDOLIA: I am going to
15 call in. I can call in between.

16 DR. WINKLER: Okay. Thank you
17 very much. I am glad you are with us this
18 morning.

19 CO-CHAIR DUBOW: You know, if
20 anybody is speaking to us from a speaker
21 phone, please try not to do that. We are
22 having trouble hearing you. And if you are

1 not using your speaker phone, it might be
2 easier. So we would appreciate that for those
3 of you who are on the phone. Thanks.

4 DR. WINKLER: Any other comments
5 from anybody else who is on the phone?

6 Anybody else want to say anything up there?

7 You are speaking to us from the ceiling.

8 (No response.)

9 DR. WINKLER: Okay. So we are now
10 on slide 19 and talking about health
11 information technology and its impact on all
12 of this. And certainly the hope is that the
13 stimulus will cause a great deal more adoption
14 and use of health information technology.

15 Conversely, in order for that to
16 actually work to connect the dots, if you
17 will, a lot of other work needs to be done
18 along standard setting, along the
19 interoperability, but in terms of performance
20 measurement specifically, there are issues
21 around, is the data being captured within the
22 record, the kind of data that we need, that

1 will allow a very straightforward, you know,
2 single keystroke calculation of the quality
3 measures? And I think we have still got a bit
4 of ways to go on that.

5 One of our issues now is around
6 the various data sources that are out there.
7 And certainly the project that Alexis and I
8 are just winding up is on clinically enriched
9 or administrative data. And that is pulling
10 together various data sources based on
11 traditional administrative claims data, either
12 one or two streams from, say, pharmacy or
13 medical visits or labs or something.

14 And then perhaps add in clinical
15 information, electronic clinical information,
16 such as lab values or information from PHRs or
17 EHRs.

18 Feasibility of that is limited at
19 this point in time, though there are certainly
20 leaders out there who are doing it and showing
21 how it can be done. And so this combined
22 effort of how to pull these streams of data

1 together, there are organizations who are very
2 forward-thinking and are beginning to do it
3 and figure it out and will sort of provide the
4 guidance for others.

5 But it is no simple thing. And
6 outcomes measures is so dependent on a lot of
7 fairly detailed and clinical data to do it
8 right. And so it is one of the biggest
9 challenges we have certainly around outcomes
10 measurement but also the need for better data.

11 MEMBER HOPKINS: So, Reva, --

12 DR. WINKLER: Yes?

13 MEMBER HOPKINS: -- since this is
14 Outcomes Steering Committee, I think we need
15 to add another stream of input data and its
16 patients, not recognized heretofore in the
17 diagram.

18 DR. BURSTIN: It is an RWJF slide.
19 So I can't change it. I will have to figure
20 out how. Yes. But it is a great idea. And
21 I sort of assumed some of that would come
22 through registries. I was thinking of that

1 not just clinical-based but patient-offered
2 data into registries as well.

3 MEMBER YAWN: And I think it
4 should be patients and families depending on
5 the age of the patient and their intellectual
6 abilities perhaps.

7 CO-CHAIR DUBOW: It is an Aligning
8 Forces slide. We will have to let them known.

9 MEMBER YAWN: Well, kids can't
10 always report.

11 CO-CHAIR DUBOW: Right. Well,
12 they are actually very aware. The
13 patient-centeredness is clearly considered by
14 them as patients and families. So it is --

15 MEMBER JUSTER: And, in fact, a
16 lot of times the achievement of a good outcome
17 is dependent on people around the patient; for
18 example, the family eating better, let's say.

19 DR. WINKLER: Some of the work
20 that NQF is doing in the IT space to help
21 support quality measurement is around
22 developing the Quality Data Set, the QDS.

1 This is identifying the data types and the
2 data elements for each quality measure, such
3 that it could then be put into an electronic
4 health record kind of data set, if you will.

5 So there have been several
6 activities on NQF in trying to support that.
7 And Helen is more versed in this than I am.
8 So I will ask her to kind of jump in at any
9 point.

10 Of the 500 measures we have
11 endorsed over the last few years, our
12 department has spent time looking at each of
13 them and identifying the various quality, the
14 data elements among each of those, and trying
15 to create this QDS, Quality Data Set, which is
16 a set, large set, of data elements that are
17 needed to create the quality measures.

18 And those data elements need to be
19 embedded in your data systems: EHR, PHR,
20 whatever. And so identifying them is a huge
21 step forward.

22 And it is going to be a growing

1 set because as we get into better measures or
2 different measures or some of the areas we
3 have never gone before, we are going to have
4 new data elements.

5 So this is something that we are
6 working on. And, in fact, the whole IT group
7 is also looking at not only the data element
8 but where are they going to get that
9 information? So if you have got EHR and it
10 has got a slot for the data, where is it going
11 to get that data?

12 Sometimes it comes from, say,
13 office equipment. Sometimes it comes from a
14 patient as a historical element. Sometimes it
15 comes from a lab value. Sometimes it comes
16 from wherever?

17 But they are mapping all of these
18 things out to try and help understand what it
19 is going to take for an EHR to create quality
20 measures.

21 And one of the things that they
22 are doing is they have taken -- and I don't

1 even know -- some -- I don't even know the
2 number; it seems to change -- of our quality
3 measures as a prototype to try and map them
4 all completely in how they would get embedded
5 in EHR.

6 So this work is not simple, and it
7 is ongoing. Certainly it is an urgent need
8 for it as it is one thing to incentivize
9 everybody to go out and buy an EHR, but if it
10 won't do what we want it to do, we haven't
11 really accomplished anything, so trying to be
12 sure it has the capability of doing the
13 quality measurement performance work that we
14 need it to do.

15 Sort of part and parcel with that
16 is sort of a secondary thing that is going on
17 is if you know what you need at the back end,
18 ask for it at the front end.

19 And so the measure authoring tool
20 is something that we are beginning to talk
21 about and develop; whereas, if you want to do
22 a measure on diabetes, that is your

1 population, you put diabetes, and it tells you
2 all of the stuff, all of the data types, the
3 codes you might need, the sources of the data
4 you might need, because, again, this is sort
5 of part of the idea of harmonization. And it
6 shouldn't be different for different folks in
7 different measures.

8 And so you can create the measure,
9 but behind it will be all of the standardized
10 data types and data elements to do that so
11 that it will work in the electronic
12 environment. And that will naturally
13 harmonize the measures.

14 So it is an interesting concept
15 going forward. Helen, did you want to say
16 more about it?

17 DR. BURSTIN: The only thing I
18 will add is that the QDS is intended to be a
19 live data set that gets added to a retirement.
20 So it is not an accident, but the current
21 Quality Data Set, although the data types have
22 all been laid out in a very broad way, is very

1 oriented to our current set of measures.

2 So I think we fully expect and
3 hope this group will help think through as you
4 think about a broader set of outcome measures
5 what needs to get added in terms of data
6 types, patient sources, things like that, to
7 a quality data set that as you're building the
8 EHR, hopefully tethered to PHR of the future
9 the next three to five years, what are those
10 key data elements and data types you would
11 want to capture to get at patient-reported
12 outcomes or other kinds of outcomes and things
13 that we wouldn't have captured just by
14 reviewing 500 of our measures and bringing it
15 down to data-type level. It is still going to
16 be different than I think getting to a
17 different kind of measure that we had to have
18 in our data set.

19 MEMBER YAWN: I would hope in the
20 near future NQF would never endorse a measure
21 until it has been through that step. And then
22 I would suggest, then, there is another

1 measure in that, how many people could
2 realistically need it now, could realistically
3 collect that data.

4 That doesn't mean you don't
5 endorse it, but just that then becomes a
6 measure within itself of okay. Over time are
7 we getting more people to be able to collect
8 this data?

9 So I think, really, NQF three
10 years from now should just not endorse a
11 measure if it has this second set of how do
12 you collect it. That is the translational
13 researcher in me coming out, but I just think
14 it is crucial.

15 We are actually going to talk
16 about that with the board of directors in
17 December, but I suspect it is a whole lot less
18 than three years. Probably one to two years
19 will require these specifications on all
20 measures.

21 Again, the other point about, you
22 know, what portion of people can do it yet is

1 a tough one. The meaningful use criteria
2 specifically are at for 2011. So that is a
3 fairly simple set of measures that is being
4 retooled right now that hopefully most people
5 should be able to do.

6 As we get to 2013 and 2015, the
7 bar for meaningful use gets higher and higher,
8 includes from interoperability like ability to
9 transmit data between places, ability to pull
10 in public health registry information.

11 So I think the bar will continue
12 to be raised as we bring in some of those
13 additional measures, but we fully expect for
14 the next several years it is just going to be
15 a strange time. We are going to have
16 e-specifications, probably clinically enriched
17 administrative measure specifications, and a
18 few measures where they still require
19 Trump-based specifications, but the
20 Trump-based ones are getting fewer and fewer
21 and far between, which is a good thing to see.

22 MEMBER PINDOLIA: This is Vanita

1 again. I have a comment.

2 DR. WINKLER: Go ahead, Vanita.

3 MEMBER PINDOLIA: I have a

4 comment. I was also on the NQF Medication

5 Management Steering Committee. Just looking

6 from a year ago, measures that we approved and

7 CMS had a bunch related to like medication

8 possession ratio to see if people are

9 adhering, if they are taking things that they

10 shouldn't, et cetera, and I just wanted you to

11 understand the platform for medication has

12 changed so much in that one year that that

13 measure is not as useful anymore.

14 And that is something that I think

15 NQF needs to look at. And once you endorse

16 something, you need to see if that measure is

17 something that can continue. And the reason

18 is for seniors with all these \$4 generic

19 programs and free antibiotics and everything,

20 they are not showing their insurance cards.

21 And so at least 65 to 70 percent

22 of our patients in our program are unclaimed

1 medication possession ratio showing that they
2 are under-utilizing their medications. You
3 call them. They are taking all of their meds.

4 And so now medication adherence is
5 not as easy to measure as it used to be. So
6 that was just something that I think that we
7 need to be aware of that what we approved made
8 sense that intends to be reevaluated probably
9 even more frequently than every three years.

10 DR. BURSTIN: And this is Helen.
11 The way we do it is every three years is the
12 absolute requirement. But then any time there
13 is a change in evidence or anybody, any person
14 of any kind, any member, NQF developer, can
15 bring back to us and say, "This measure needs
16 to change."

17 I mean, the classic example over
18 the last couple of years was the antibiotics
19 for pneumonia measure, you know, antibiotics
20 within four hours. It was very clear there
21 were unintended consequences out there of that
22 measure.

1 We subsequently convened a small
2 group, worked with the measure developer,
3 brought in the revised specifications, which
4 increased it from four to six hours but also
5 required a presumptive diagnosis of pneumonia,
6 so a pretty important step.

7 So we are ready and able to do
8 that at any time. Part of it is we need a
9 more effective feedback loop, people like you
10 who say, "Hey, this no longer works" or "That
11 percentage of patient getting generic drugs,
12 for example, through target is not being
13 captured on claims data, we really need to
14 rethink this."

15 So that is the kind of thing we
16 really rely on and need a more vigorous
17 feedback loop from the public on.

18 MEMBER PINDOLIA: Okay. Thank
19 you.

20 DR. WINKLER: Any other questions?
21 I think that is it for this section for me,
22 Joyce.

1 CO-CHAIR DUBOW: Okay. Is there
2 any? Dianne?

3 MEMBER JEWELL: Actually, Helen
4 addressed it, this issue of how logistics and
5 practicalities, the science aside, might
6 change what the measure usefulness is and how
7 do you identify the trigger.

8 So you had already alluded to the
9 need and the challenge of doing just that. So
10 that was all.

11 CO-CHAIR DUBOW: Feedback loop is
12 something we have talked about. And it really
13 is important to understand the experience with
14 the measures and whether there are any
15 particular -- I mean, this point that Vanita
16 just mentioned is obviously what is happening
17 here and now. And it is worth thinking about
18 how you collect those data that are otherwise
19 lost. So it is an important point.

20 We are 15 minutes ahead. Well, if
21 there aren't any other questions, perhaps this
22 is a good time to take a break. We have 15

1 minutes scheduled. Please come back at 10:45,
2 and we will continue.

3 Thank you very much. That was a
4 very complete overview. Okay. And those of
5 you on the phone, we will see you in 15
6 minutes.

7 (Whereupon, the above-entitled
8 matter went off the record at 10:31 a.m. and
9 resumed at 10:50 a.m.)

10 CO-CHAIR DUBOW: For those of you
11 who are on the phone, we are about to start
12 again. And we are at the part of the agenda
13 to talk about the role of the Steering
14 Committee. And Reva is on again.

15 DR. WINKLER: We have talked so
16 far more in generalities about NQF, but now we
17 are going to talk very specifically about this
18 project and the work that we are asking you to
19 help us out with.

20 This project, focused on outcomes,
21 is funded as part of our large contract from
22 the Department of Health and Human Services.

1 Their interest in outcomes is focusing on the
2 top 20 Medicare conditions. So you will see
3 that bias to the list.

4 However, as part of the project,
5 they were open to us adding a few other
6 subjects. So we did add in to the top 20
7 Medicare conditions things like child health,
8 which is not going to be the part that you are
9 working on, but it is part of the larger
10 project.

11 Also, a couple of other
12 conditions, specifically asthma and pneumonia,
13 were added in, again big topic areas. Somehow
14 it didn't hit their top 20. So that is how
15 those conditions in this project that we are
16 going to talk about came to be.

17 So, you know, we do know that
18 there is a wide variation in the availability
19 of existing outcome measures among those
20 conditions.

21 There are a large number of
22 measures, outcome measures, around

1 cardiovascular conditions, specifically VCAD
2 AMI heart failure group.

3 Yes, so in some of the other topic
4 areas. And so this is why this project is
5 going to have sort of a two-pronged focus. We
6 will be looking at NQF's current set of
7 measures with the eye to expanding them or
8 improving them or whatever with existing
9 measures.

10 As with all projects, one of the
11 things for NQF is that we don't develop
12 measures. We need to look at existing
13 measures developed by somebody else. So that
14 puts a certain inherent limit if they have yet
15 to be developed, we can't do much with them at
16 this point in time.

17 So I have already heard comments
18 from some of you in terms of the spreadsheet
19 that we prepared in terms of our current
20 portfolio of outcome measures. You don't all
21 agree what got in and out. Fine. That is the
22 after-lunch conversation. We will get there.

1 I very deliberately cast it large for you to
2 react to.

3 So realize, though, that this
4 isn't the first foray into outcome measures
5 that NQF has done, but it is certainly one of
6 the first around such a large approach to
7 outcomes.

8 We have just wrapped up a project
9 on hospital outcomes measurement. And my
10 colleague, Karen Pace, who is not only a
11 methodologist in her own right, she handled
12 that at times difficult project. And so her
13 expertise will bring her in to kind of help
14 deal with some of the issues for us around
15 evaluating outcome measures and some of the
16 lessons learned from prior work.

17 Now, because this is a large
18 number of conditions, the work was broken down
19 into phases. And you guys are phase one and
20 two. All right? In phase one, the topics we
21 are looking at are cost-cutting measures. And
22 then we have got measures in the respiratory

1 realm of asthma and COPD; cardiovascular, a
2 goodly number of topics, CADMI, heart failure,
3 A-Fib, stroke, and TIAs. And then metabolic
4 wraps up diabetes and chronic kidney disease.

5 From the Steering Committee's
6 perspective, the phase one and two are
7 probably not a meaningful term. It is how we
8 are scheduling, actually, the TAPs to meet.

9 There will be a technical advisory
10 panel for each of these areas except for
11 cross-cutting. So there is one for
12 respiratory. There is one for cardiovascular
13 and metabolic. And they will be meeting with
14 their committee to do the preliminary review.
15 And we are going to talk about the relative
16 roles.

17 Phase two, the topic areas are
18 bone and joint looking at the rheumatoid and
19 osteoarthritis, osteoporosis, and then hip and
20 pelvic fractures. There is a cancer area
21 looking at five types of cancer. These are
22 prominent cancers in the Medicare population.

1 An area we have not done a lot of
2 work in before is GI and biliary, looking at
3 cholecystitis, GERD, and ulcer disease, so a
4 wide variety of topics.

5 In infectious disease, the focus
6 is urinary tract infection and pneumonia and
7 eye care, glaucoma, and cataract. However,
8 when we have done the call for measures, we
9 have left it open for other conditions that
10 fall into these topic areas to come into the
11 project. But those are the actual focus
12 conditions that are identified particularly by
13 HHS.

14 Barbara, you have a question?

15 MEMBER YAWN: There are obviously
16 overlaps between some of these. For example,
17 you said respiratory. That is fine,
18 pulmonary, whatever. Obviously pneumonia and
19 lung cancer are important across those. So
20 will there be the opportunity to cross-talk
21 among those or will that be coming back to
22 this group to do that?

1 DR. WINKLER: I think once we take
2 a look at the measures themselves because
3 right now this is just a list of conditions.
4 We don't even know if we have any measures.
5 So I think this will be an important thing for
6 the TAP chairs and the TAPs and staff to
7 coordinate to see if it is important.

8 In some measures, it might be
9 useful for two different TAPs to take a look
10 at for the various levels of input. So we
11 will have to see how that works depending on
12 the measures we actually get.

13 It is a little bit easier to make
14 those decisions when we actually have the
15 measures in hand, rather than in a more
16 theoretical realm.

17 But I agree with you. When we
18 were planning it, it was like should it go in
19 this category? Should it go in that one? And
20 how do we break the work down?

21 And, admittedly, these are
22 somewhat arbitrary breakdowns.

1 CO-CHAIR DUBOW: Ted?

2 MEMBER GIBBONS: One of the
3 questions I had, particularly in reviewing
4 some of the measures that have been proposed,
5 is, is there a prioritization of whether these
6 apply to inpatients versus outpatients?
7 Because the ability to acquire information in
8 outpatients is so much more difficult across
9 the board.

10 DR. WINKLER: Actually, there is
11 no priority. Acknowledging the issues that
12 you raised around data, I think it is
13 well-acknowledged by everyone.

14 The fact is that if this were the
15 perfect project, there are no limits on
16 setting or those specifics. We really do want
17 to take as broad a view as possible. So if in
18 any way it was possible to have a measure, an
19 outcome measure, that captured information
20 from the patient who went into the hospital,
21 into post-acute care rehab, and then went to
22 home health care, and then went home, you

1 know, that would be the perfect world, if at
2 all possible. And I think we all know the
3 challenges around data collection certainly
4 limit that at this point in time.

5 So this is not focused exclusively
6 on hospitals. It is not focused exclusively
7 on any particular setting of care. However,
8 I think realistically when you look at the
9 likely measures that we are going to get, they
10 will tend to be focused on a specific setting
11 of care because they are designed around a
12 certain type of data. And those are going to
13 be the limitations.

14 Hopefully perhaps one of the
15 conceptual pieces that you all can work on is,
16 how do we break through that? Where do we go
17 next? How do we look at it from the patients'
18 perspective unless these unnatural divisions
19 that have been established because of things
20 like data systems and the sense of settings
21 being sort of siloed.

22 But those will be limitations of

1 the project, admittedly. You know, I doubt we
2 are going to be able to fix that problem in
3 the next couple of months.

4 But certainly any suggestions and
5 things you can offer in the way of
6 recommendations will be very useful.

7 MEMBER YAWN: Are there any age
8 limitations? I mean, obviously child health
9 must have some upper limit, but, like asthma,
10 for example, will that be cross-cutting from
11 basically birth to death?

12 DR. WINKLER: Yes. In general, I
13 think that we will want to take the widest
14 scope. Asthma being a childhood, prominent
15 childhood, condition, certainly you wouldn't
16 want to do just adult asthma. So it will
17 include all of them.

18 Also, as we will mention in phase
19 three, we actually have another group looking
20 at child health. So we will be bringing the
21 two.

22 This is where being the staff

1 person gets to be interesting as we try and
2 make sure everybody who needs to look at
3 something has the opportunity for their input
4 because there are multiple ways of slicing and
5 dicing it, if you will.

6 CO-CHAIR DUBOW: Dianne?

7 MEMBER JEWELL: So in our
8 conversation prior to the break, we talked
9 about the need for more vigorous feedback
10 loops, I think, for members. And, similarly,
11 were talked about this issue of data and
12 electronic health records versus not.

13 I guess my question is, where in
14 the process or how in the process do we
15 transfer some of the burden to the creators of
16 the measures to respond to some of these
17 questions that we have?

18 In other words, to what extent do
19 we say we foresee that these are obstacles or
20 challenges to make these cross-cutting or for
21 settings for populations and really ask them
22 as part of the process?

1 And perhaps that is already
2 embedded in the author creation forms and I
3 just haven't seen a more recent one. But I
4 think to some degree, that is where the
5 partnership would have to come.

6 DR. WINKLER: You are scheduled to
7 have this meeting and then another one in the
8 spring. They are going to be very, very
9 different meetings.

10 In the spring, you will actually
11 be asked to finally evaluate all of the
12 measures when we talk about the criteria. The
13 measure developers will be present. They will
14 be here to engage in that dialogue.

15 The measure developers will also
16 be available to the technical advisory panels
17 to respond to questions because so much of the
18 information that you are going to be working
19 on comes from them. Questions are just
20 normal.

21 And having them intimately
22 involved in the discussion around their

1 measures so that you can ask these questions,
2 you can provide that direct feedback, is a
3 very important part of these projects.

4 And we have seen evolution of
5 measures as a result of the discussion that
6 occurs between the technical panels, the
7 Steering Committee panels, the Steering
8 Committee, and the measure developers.

9 So they will definitely be an
10 important part of the conversation going
11 forward. So you will be able to tell them
12 anything you want.

13 MEMBER HOPKINS: Can I press you a
14 little bit on the question of age ranges
15 attached to these measures? So often in the
16 past, measures that have been proposed by CMS
17 have a built-in lower age limit of 65 just
18 because of who the payer is. Are we going to
19 be able to avoid that here?

20 DR. WINKLER: David, I think you
21 are going to have to look at each measure
22 individually, but I can tell you from previous

1 experience, such as in our most recent
2 medication management, measures came in in
3 that way, but they did not end up endorsed by
4 NQF that way.

5 During the course of the project,
6 the dialogue, "Hey, guys, why?" "There's no
7 reason." "You know, let's make it as big as
8 possible." And a lot of age ranges were
9 changed.

10 So that is certainly something
11 that is on the table for you all and the
12 technical panels to ask the question, what is
13 the appropriate age range?

14 Maybe there is a cutoff. What is
15 it? And agree. Here is where harmonization
16 of measures becomes very important as well.
17 You know, if the measure in the outpatient
18 setting cuts off at 65 and the measure in the
19 hospital cuts off at 40, I mean, this makes no
20 sense. So this is another element of
21 harmonization.

22 And this would be part of your

1 evaluation. So age should be what is
2 appropriate for patient in assessing quality.

3 MEMBER AMARASINGHAM: May I ask a
4 question? In those cases where the age range
5 was changed, was the measure methodology
6 changed as well before the age coefficient?

7 DR. WINKLER: I don't believe
8 there were outcome measures such that that to
9 that degree was necessary to start changing
10 coefficients, but what they did was look at
11 the data to see if it was appropriate.

12 That is the dialogue. You know,
13 it depends on the type of measure, how much
14 work needs to be done to evaluate whether
15 changing it is appropriate or having an
16 explanation of why they established the ages
17 that they established.

18 There may be just greater
19 understanding of that. But that is the
20 dialogue that we encourage you to have and
21 want you to have with the developers so that
22 we end up in the best place possible.

1 MEMBER HOPKINS: So that question
2 does raise an interesting challenge. I see
3 exactly what you are saying.

4 So often the measure is created
5 for over 65 and because it is an outcome and
6 has risk adjustment built in and the model for
7 risk adjustment is measured using over 65,
8 somebody has got to go and redo that in order
9 to --

10 DR. BURSTIN: This actually came
11 up during a hospital outcomes and efficiency
12 project that we just completed.

13 There was a measure we already had
14 endorsed on readmission for CHF for patients
15 65 and over. A competing measure came in, CHF
16 readmission patients under 65.

17 And the logic was, well, does that
18 really make sense? Do we really need two
19 separate risk models? It was exactly that
20 kind of issue.

21 What was ultimately decided was
22 the measure under 65 had some sort of

1 methodologic issues with is, including within
2 the risk model factors that were actually
3 probably not appropriate for risk adjustment,
4 like discharge to a nursing home.

5 One of the key features of risk
6 adjustment is it should happen as fairly close
7 to admission as possible. So discharge for
8 nursing home, while it improved their model
9 specificity beautifully, it wasn't
10 appropriate.

11 So that measure was rejected. But
12 then what actually wound up happening is CMS
13 is now working with their measure developers
14 to say, "Well, is there anything else that
15 needs to happen to that model to make it all
16 age?"

17 So that is the kind of work we are
18 trying to push around this harmonization
19 front. But you are absolutely right. It
20 comes up a lot on the process measure side.

21 It was fairly easy for Reva's last
22 committee to say, "COPD less than age 40?"

1 That makes no sense. Please all harmonize
2 your age groups. COPD should be the right
3 age" -- that was the 40 or 45 -- "as the lower
4 limit," period, because otherwise you will
5 just get so confused with asthma.

6 Those are easier to change when
7 there is a risk model involved or there would
8 be a much more elaborate dialogue analysis on
9 the part of the developer.

10 MEMBER AMARASINGHAM: This is a
11 really important question, I think very
12 important question, is the CMS heart failure
13 rate emission measure developed at Yale by Dr.
14 Krumholz and colleagues at Harvard. That was
15 derived and validated on purely Medicare data
16 sets. So how would you derive and validate it
17 on the lower than 65 age group?

18 DR. BURSTIN: They are going to do
19 it off of private data sets, private plan data
20 sets.

21 MEMBER AMARASINGHAM: And they
22 look at the 30-day --

1 DR. BURSTIN: Yes.

2 MEMBER AMARASINGHAM: --

3 readmission rate to any hospital?

4 DR. BURSTIN: They are going to.

5 That is exactly what this other measure

6 developer had done. So they are now trying to

7 work together to think that through.

8 MEMBER AMARASINGHAM: And that is

9 great. These are the kinds of questions that

10 need to be discussed.

11 CO-CHAIR DUBOW: Dianne, did you

12 have another question?

13 MEMBER JEWELL: Well, and I am

14 realizing, Reva, when you were talking about

15 the dialogue between individual panels and

16 measure developers that there are things --

17 and this is a great example of it -- where the

18 specific conversation on specific measures is

19 really going to be that give and take.

20 I am realizing that I think my

21 question was about whether, regardless of who

22 the developers are and what the measures are,

1 maybe this group has a way of identifying sets
2 of questions that really are sort of
3 preemptive.

4 In other words, they come to the
5 table with these questions already answered.
6 They don't wait until we think of them related
7 to things like, how would you propose to
8 harmonize this across age groups if it hasn't
9 already?

10 How would you propose to embed the
11 data elements in the EHR or the kinds of sort
12 of big picture things that we had talked about
13 earlier? I think that was more of a --

14 DR. WINKLER: Okay. Some of that
15 I think, particularly the EHR part, some of
16 that is already embedded in the measure
17 information that we have asked, I mean, a year
18 ago -- and I was going to go into this a
19 little bit more later -- was revised to ask
20 these questions fairly specifically. Some
21 measure developers respond to them better than
22 others and more detail than others. And you

1 will have that information.

2 But I think to the degree that
3 this group identifies sort of over-arching
4 questions that all measure developers could
5 and should respond to, we have two things.
6 One, let us know. And we will get that
7 information out to them for them to respond
8 currently. But it becomes information that
9 perhaps should be embedded in our measure
10 submission information to ask.

11 So both of those, I see the
12 potential for both of those, going forward.
13 So if there are things that you want to ask of
14 them, then, by all means, let us know. And we
15 will get that information and get those
16 questions out to them.

17 We certainly have time to do that
18 and to give them an opportunity to respond and
19 provide you the information you are looking
20 for.

21 MEMBER JEWELL: Well, certainly
22 the thought that came to mind relative to the

1 example that Vanita gave earlier about the
2 generic drug purchases and the loss of data,
3 one approach would be to ask measure
4 developers to regularly report on their own
5 environmental scan of the performance of the
6 measure, which may not be the science piece or
7 it could be.

8 DR. WINKLER: Right.

9 MEMBER JEWELL: So, again, just
10 sort of trying to think.

11 DR. WINKLER: Yes. I know that
12 one of the questions on our measure
13 maintenance that we ask them is, how is the
14 measure being used? And what issues have come
15 about as it has been in use because currently
16 measures that aren't being used, there is
17 usually a reason. And so figuring out what
18 that is is an important aspect of measure
19 updating.

20 DR. BURSTIN: I will just add that
21 on our measure specification form, we actually
22 ask the measure author to identify if there

1 are competing measures. If there are
2 harmonization issues, do you have a plan? Can
3 this be done with any EHR? Again, it is from
4 their orientation. So they may not always
5 have the full view, which is why we try to
6 call in the technical experts.

7 But we specifically say, is there
8 a competing guideline, for example? Why did
9 you select this one? Those are the kinds of
10 issues that methodologically are really
11 important to address.

12 But the committees will often
13 identify those. And we will go back to the
14 measure developers for them to respond as
15 well.

16 MEMBER KEALEY: Are we able to see
17 the submission forms on the website and review
18 all of that?

19 DR. WINKLER: Later on it is going
20 to be one of our major discussion points. We
21 are going to go through what you are going to
22 see. And yes, you get everything. It is just

1 we reformat it for you.

2 So just the overall structure of
3 this project, phase three is not an area that
4 you all will be involved in, but just realize
5 that it is part of the bigger project. And
6 this is addressing the areas of mental health
7 and child health and somewhat different types
8 and requiring different sort of expertise so
9 that they have separate steering committees
10 going forward. But they will be working along
11 the same time frame that you all will be
12 working.

13 Okay. We gave you the sortable
14 spreadsheet. Okay. These are the endorsed
15 outcome measures as Reva thinks. Of the 537,
16 I came up with 139. I will tell you how I did
17 it.

18 What I did is I went through. I
19 downloaded the current spreadsheet from the
20 database, 537 measures. Yippee. Then I went
21 through and, using my own judgment -- and we
22 will discuss how good that might have been --

1 assigned structure process outcome
2 characteristic to each of them. And then I
3 pulled out the outcomes, and I cast it large
4 intentionally. I may have captured things
5 that don't belong there, but I don't think I
6 missed anything that should.

7 Then I added a column for
8 conditions along the conditions we have. All
9 right? And then I added the type of measure
10 based on the table that was in your background
11 briefing materials and that we will talk about
12 after lunch.

13 So that is what I did. And
14 realize that there is a second sheet. We have
15 got four measures, four outcome measures, in
16 the pipeline. And that means they aren't
17 endorsed yet but expected very soon.

18 Three of them are eye outcome
19 measures that should be endorsed probably by
20 the end of November and one for diabetes that
21 should be a similar time frame. So they are
22 almost to the end of the consensus process.

1 So we expect them to join that. I can't
2 technically call them endorsed because they
3 aren't yet but likely to be soon.

4 What I want to do is after we have
5 this conversation this afternoon about what is
6 an outcome measure, what should be included
7 and what is not, I am going to redo this based
8 on your input.

9 So this was an attempt to show you
10 where we want to go. And then this will be
11 the foundation of the measures we have, the
12 goal to add to them. It will help in
13 understanding where the gaps are. Okay? So
14 that is what that is all about.

15 What are the goals of this
16 project? There are two main goals, but I
17 wouldn't say one is more important than the
18 other. So we have to keep in mind most of our
19 consensus development projects, the whole goal
20 is to endorse measures.

21 And yes, that is one of them here,
22 to identify, evaluate, and endorse additional

1 measures suitable for public reporting and
2 quality improvement that specifically
3 addressed outcomes of health care, including
4 cross-cutting; in other words, not
5 condition-specific, things that we cross over
6 larger populations, as well as specific
7 outcomes for 20 or more common conditions. So
8 yes, we are here to endorse measures to the
9 degree we can identify them and that they pass
10 muster.

11 The second one, however, I think
12 is equally important. And this is to identify
13 the gaps in the existing outcome measures and
14 recommend potential outcome measures to fill
15 those gaps. That is easy to say, and it may
16 seem as a sort of a straightforward to-do and
17 not take a lot of time, but, frankly,
18 understanding the perspectives and
19 understanding the thinking around what is an
20 outcome, which we are going to talk later
21 about, from all the different perspectives and
22 then thinking about how we can use that as a

1 framework -- and I use that word sort of
2 loosely -- to do a gaps analysis and ask the
3 questions, what are the kinds of measures that
4 are desirable but we don't get have. And for
5 this particular project, we want to get fairly
6 granular.

7 So we look at some of the topics.
8 And I am going to pick eye care. In eye care,
9 we want some outcome measures. What would be
10 measures of function? Would it be appropriate
11 to have measures of function? Would it be
12 appropriate to have measures of symptom relief
13 or symptom change? Would it be appropriate to
14 have measures of mortality? Would it be
15 appropriate to have measures of complications?

16 Looking at them very specifically
17 in the various conditions, in a granular
18 level, to say, "Yes, we really would like to
19 have measures of function so that
20 post-cataract surgery functioning, either
21 related to ADLs or the ability to do things
22 you didn't use to be able to do now that you

1 can see," whatever, but be it fairly granular,
2 as opposed to just saying, "Hey, we just need
3 more outcome measures for all of these
4 topics." So we do want to have some thinking
5 done in that?

6 Particularly in the cross-cutting
7 area, there is no TAP for cross-cutting. So
8 the Steering Committee's role will be to
9 primarily evaluate those measures and to do
10 the gaps assessment.

11 So when you start thinking about
12 cross-cutting outcome measures for all
13 patients or large populations of patients
14 across settings of care, this becomes an
15 interesting question. And we need to work
16 with you to find out exactly the best approach
17 to figure out how we are going to do that gaps
18 analysis.

19 What are the domains? What are
20 the characteristics we want to think about so
21 that we can look at it and say, "Do we have a
22 measure?" No, we don't, but we want a measure

1 and we need a measure.

2 That I think will be a creative
3 and challenging and in my view one of the fun
4 parts of this project, but certainly it will
5 require some thinking on all of our parts.

6 And so one of the best parts of my
7 job is meeting all of you and tapping into
8 your good brains. And so I fully plan on
9 doing that.

10 MEMBER YAWN: Reva, would you
11 consider -- this is really micromanaging, and
12 I apologize, but would you consider making it
13 three outcome goals because I think this
14 cross-cutting is so crucial that I don't want
15 to lose it.

16 When I to go back to my TAP, I
17 want to make darn sure they are thinking this,
18 too. I am afraid I may have a whole bunch of
19 people that are really tuned into respiratory
20 disease and might not think about this.

21 So I just think it is so, so
22 important.

1 DR. WINKLER: Okay. Very fair.

2 MEMBER JUSTER: Would it help to
3 have in our definition of what constitutes
4 cross-cutting? So some of what you have
5 talked about in harmonization is cross-cutting
6 because it is cross-cutting where I move from
7 one place or kind of to another. Sometimes it
8 is cross-cutting because it doesn't have
9 something to do with the specific disease,
10 like my quality of life or presenteeism.

11 Sometimes it is cross-cutting
12 because of the 20 denominators I belong to,
13 what percent of them am I in the numerator;
14 that is, it is a bunch of siloed outcomes
15 relating to me, but they all relate to me. So
16 it is cross-cutting in that way.

17 Do we have a formal definition for
18 cross-cutting?

19 DR. WINKLER: No. And I think
20 that since you brought it up, this is what
21 this group is here to do, is to help us. It
22 sounds like we need a definition. So I think

1 we need to create a definition.

2 And I would open it to the rest of
3 you to kind of weigh in on what Iver has said.
4 How would you like us to define cross-cutting?
5 We have generally thought about it not being
6 associated with any specific diagnosis or
7 condition. However, we are certainly open to
8 any other way you want to look at it and
9 define it.

10 DR. BURSTIN: And across settings
11 of care as well.

12 MEMBER YAWN: Right. As I was
13 thinking about it, I was thinking about things
14 that affect outcomes that should be measured
15 across every single condition that we are
16 doing.

17 For example, what are the major
18 comorbidities? And are they being addressed.
19 Is adherence being addressed and measured and
20 certainly the knowledge in terms of, how do we
21 know about it from patients' actions?

22 So I thought of cross-cutting in a

1 different way. I thought of it as something
2 that every one of the TAPs or whoever they are
3 should address these kinds of issues. And
4 that may not be what other people are thinking
5 of through cross-cutting.

6 I mean, I agree the age and the
7 different settings is very cross-cutting.

8 DR. BURSTIN: I would actually
9 propose I think there is a set of principles
10 for outcome measurement, which is I think
11 what you were getting at; whereas, I think we
12 are trying to also, which I think is critical
13 and will be very useful for this group to come
14 up with a set of principles. If you are going
15 to look at outcomes, in addition to what is
16 already in our evaluation criteria, what other
17 concepts would you want them to really think
18 about?

19 And part of the reason for putting
20 all of the TAP chairs on the Steering
21 Committee is to try to get that degree of
22 consistency across the conditions.

1 But I also think this
2 cross-cutting issue of what are the kinds of
3 outcomes you could use across conditions and
4 sites of care would be really important as
5 well.

6 MEMBER GIBBONS: I agree with
7 Barbara as well. I think there have to be
8 some principles of cross-cutting that aren't
9 specific to -- I mean, we're saying that it is
10 not specific to a condition, but if I am in
11 the cardiovascular TAP, then I think we need
12 to communicate to them that it is not just
13 something seems cross-cutting within a
14 cardiovascular setting, such as the Minnesota
15 vascular ischemic disease measure, where they
16 are looking at four different measures and
17 sort of bundling the way that IHI wants to
18 bundle chronic conditions but, rather, some of
19 the principles that would apply to patient
20 care and patient-focused outcomes and the
21 practical aspects of managing chronic care are
22 not specific to the disease itself. So I

1 think that is a really important point.

2 MEMBER McNULTY: Yes, just kind of
3 from the patient-reported outcomes
4 perspective. The way I always think of this
5 -- this is quite narrow -- is I would think of
6 cross-cutting as something like a generic
7 measure, an SF measure, something like that.

8 But then when you start talking
9 about specific patient-reported outcome
10 measures, it is going to be focusing on the
11 specific disease that you are dealing with.

12 And the beauty of a cross-cutting
13 measure is that for something like an SF
14 measure, you have normative data and you are
15 going to be able to do comparisons. When you
16 get down to the level of having specific
17 measures, you have less ability to do those
18 kinds of comparisons.

19 So in many instances, in the work
20 that I do, we need to have both in there so
21 that we can do what we need to do in terms of
22 comparisons, but we also have specific data

1 that is focused on the particular patient
2 population and whose disease we --

3 CO-CHAIR DUBOW: Excuse me? Is
4 there somebody on the phone --

5 CO-CHAIR FLEISHER: Yes.

6 CO-CHAIR DUBOW: -- who wants to
7 make a comment?

8 CO-CHAIR FLEISHER: Yes. Hi. It
9 is Lee. I just got back on the call. One of
10 my questions as I am hearing about the SF-12
11 is what about risk-adjusted methodology?
12 Because if you are talking about outcomes, is
13 it within our scope to also talk about the
14 appropriate methodology endorsing some
15 methodology or approach?

16 I don't know if that has been
17 discussed. Is that going to be in a TAP or
18 how would that actually be evaluated?

19 DR. WINKLER: Okay. Lee, this is
20 Reva. Risk adjustment methodology is
21 definitely a very important measure evaluation
22 criteria that will be addressed.

1 Initially the TAPs will give you
2 some input, but ultimately it will be the
3 Steering Committee's ultimate decision on
4 evaluating it how that evaluates out.

5 Each of the measures comes with
6 its own risk adjustment methodology or not,
7 but it comes with whatever it comes. And we
8 will be evaluating whatever it is. So it is
9 absolutely one of the most important aspects
10 of evaluating outcome measures.

11 MEMBER YAWN: Can I give a
12 specific example of the kinds of cross-cutting
13 I was thinking about with comorbidities, for
14 example?

15 Let's take COPD. Most people with
16 COPD have smoked 20 or more years. Guess what
17 they have besides COPD. They have
18 cardiovascular disease, almost all of them.
19 Up to 60 percent of them also have depression.

20 Now, if I am measuring outcomes
21 and no one has bothered to look at their
22 cardiovascular disease or their depression, I

1 don't expect them to get a lot better. So
2 that is what I was trying to say with
3 cross-cutting.

4 For example, pneumonia, somebody
5 looks at outcomes of pneumonia. And if this
6 person has had three pneumonias and nobody
7 bothers to think that they might have COPD and
8 that is the reason and that is what needs to
9 be treated, that is a problem.

10 So I am trying to think in my
11 mind, how do we do things that are outcome
12 measures? And that is not exactly risk
13 adjustment because if nobody has bothered to
14 think of the diagnosis, then they aren't
15 called that. And you can't do it in risk
16 adjustment. So how do we deal with, has that
17 even been considered? Because I think that is
18 crucial to people's outcomes.

19 And I don't know how to do it, but
20 I think we need to wrestle with it a little.

21 MEMBER AMARASINGHAM: I would like
22 to add a point to that. I think that is

1 really important to question and debate. I
2 think one of the things we have to determine
3 is, are we specifically talking about process
4 measures versus outcome measures?

5 In things like regimented
6 adherence, whether or not something was
7 considered and done I would say is more of a
8 process measure and outcome measure is
9 specific. What exactly occurs to this
10 patient, including, for example, their
11 knowledge base on the certain subject?

12 With respect to cross-cutting
13 measure, the question would be, do we want
14 something like cross-cutting measures would be
15 specifically outcome measures, but the
16 capability or the measures from which we could
17 draw would be purposely broad?

18 For example, there could be things
19 like knowledge. You know, in our hospital
20 system, one of the outcome measures that we
21 use to generate our own public support is
22 measures like for parents that are sick, how

1 often do the children actually miss school?

2 I am not proposing that that is an actual
3 measure, but that is a true outcome measure
4 that you can judge a health system by.

5 So that would be a very broad
6 outcome measure, but it is not a process
7 measure. And I think we have to be very
8 careful about what we are describing, what we
9 are planning to use, and whether or not we
10 want to specifically focus on outcome measures
11 because that is where the process measures
12 have been criticized because of some of the
13 problems with whether or not it is related to
14 specific outcomes that make a difference for
15 a population.

16 MEMBER JUSTER: So I am hearing
17 kind of two things here. One is ultimately
18 patient-centered, and another one is
19 ultimately system-centered. In the
20 patient-centered side, there is this construct
21 that seems to be gaining some popularity
22 called patient activation, basically do I have

1 the knowledge, skill, and confidence to do
2 something?

3 Now, of course, that seems to
4 predict whether I will do it; that is, engage
5 in a healthy behavior, but I may not be able
6 to measure that because somebody has to give
7 answers to a quiz basically to tell me whether
8 they are activated, but I can look in their
9 data and get a clue.

10 For example, if they seem to have
11 a high medication compliance, they are getting
12 their retinal exams, nephropathy screening,
13 whatever -- it goes back to how many
14 denominators, how many numerators things --
15 sometimes these process measures might --
16 somebody will have to do their research on
17 this, but sometimes the process measures
18 actually forecast whether a person is in a
19 good place to achieve the outcomes they need
20 to achieve in the future.

21 MEMBER JOHNSON: This is Dave
22 Johnson. It is kind of hard to raise my hand.

1 Can you all hear me?

2 CO-CHAIR DUBOW: Yes. Is that
3 Jonathan?

4 MEMBER JOHNSON: I'm sorry? One
5 of the things --

6 CO-CHAIR DUBOW: David Johnson?

7 MEMBER JOHNSON: -- that I think
8 that is helpful is process measures may be all
9 we have. if we identify a bridge to an outcome
10 measure, process measures sometimes are
11 helpful to gain something that we can gap a
12 care issue until we have appropriate outcome
13 measures.

14 The outcome measures obviously may
15 take longer to develop. There may be
16 validation issues for the ultimate outcome.
17 There may be time sequences that really
18 preclude a rapid outcome assessment. And the
19 process measure may be all we have to bridge
20 better care until we can get appropriate
21 outcomes. So I think it is a combination of
22 both.

1 Let me give you an example. In my
2 specialty, in gastroenterology, I believe we
3 need some type of measure to look at
4 colonoscopy and polyp detection that is
5 adenomatous. We don't really have a good way
6 of assessing the polyp removal outcome, and we
7 are really trying to prevent colon cancer.

8 That may take five or ten years
9 until we can really assess adequately if we
10 had a meaningful benefit from the patient
11 getting a colonoscopy and the polypectomy.

12 So what we have developed in our
13 specialty is certain benchmarks for
14 documenting that you have a reasonable good
15 exam and that we monitor things, like
16 withdrawal times and things that you all have
17 been seeing in the press.

18 But that is really a process
19 measure. And then it is a process measure to
20 an adenoma detection rate, which is another
21 little easier-to-measure, but those are really
22 still intermediate measures for saying that

1 this is supposed to be prevention of colon
2 cancer and improved colorectal mortality
3 reduction.

4 So I think these measures
5 sometimes, these process measures, although
6 they had some criticism, are very helpful in
7 some circumstances as a bridge until we can
8 really define adequate outcome measures.

9 CO-CHAIR DUBOW: This is Joyce. I
10 am going to take off my Chair's hat for a
11 minute. I want to respond to that comment and
12 also Iver's comment.

13 I think about these measures and
14 the outcome measures and think about public
15 reporting and what the public is going to see.
16 And activation is an example. I mean, you
17 know, activation, Judy Heber has a validated
18 scale that is down to 13 items, I think. It
19 is short.

20 I, frankly, am not interested in
21 seeing a public report of measure on patient
22 activation. I think that is a tool that a

1 health system and organized practice and
2 organized delivery system ought to be using in
3 order to effect better outcomes. That is what
4 I want to see. I want to see the result of
5 the use of that tool.

6 Any practice, any delivery system
7 that is interested in improving outcomes ought
8 to be measuring activation. They ought to be
9 measuring health literacy. They ought to be
10 measuring decision skills. They ought to be
11 measuring patient preferences. But these are
12 tools to achieve outcomes.

13 And, you know, we have lots of
14 process measures in the mix. And I, frankly,
15 think that we ought to think seriously about
16 whether we ought to be adding to them or
17 whether we ought to be expecting these tools
18 to be used to achieve the outcomes that we are
19 seeking. So I throw that out as an area for
20 discussion.

21 MEMBER YAWN: I think you are
22 about five to ten years ahead of where the

1 world of health care may be right now.

2 CO-CHAIR DUBOW: I have a sense of
3 urgency about this.

4 MEMBER YAWN: I understand that.

5 And I have a sense of urgency --

6 (Laughter.)

7 MEMBER YAWN: Well, that is why I
8 am hoping it is that far out because I don't
9 want to be around for all of it either. But
10 I would like my colleagues to be able to
11 continue providing health care. And I can't
12 see them being able to do all of those things
13 in the system they have right now with all of
14 the other things. But I would like to help
15 drive them in that way. And sometimes it is
16 a matter of translation.

17 And translation, I know people
18 think it is just whatever. I think it is
19 still a science or it is a science, becoming
20 one. I think we need to think about how do we
21 leverage these outcome measures to encourage
22 not seven new things you want me measure on

1 every patient, please, but something.

2 Maybe we measure adherence as an
3 outcome. And we could think how adherence is.
4 And then say, "Okay. Now you have to figure
5 out why you didn't achieve it here as well"
6 because you didn't teach the patient whatever
7 they needed to know. You didn't activate
8 them. You didn't know what their health
9 literacy was. There may be six or seven
10 things.

11 I would like to get at the
12 adherence and then work backwards. And that
13 may be what you are suggesting, too, but just
14 not all of it tomorrow, please.

15 CO-CHAIR DUBOW: I am okay with
16 intermediate outcomes, you know, the processes
17 that have a known relationship to outcome, but
18 I really have some concern about giving
19 credit, if you will, in a measure that could
20 potentially be used for pain or something else
21 for using -- I think it depends what kind of
22 tool it is. There are some things that

1 address integral practice that practices need
2 to do.

3 They need to know their patients
4 well enough in order to be able to achieve the
5 outcomes that we seek. And I think that we
6 need to push on this. And that is my
7 interest.

8 MEMBER JUSTER: I think that
9 increasing patient activation is an outcome,
10 but it is the outcome of a system of error.
11 And I would not myself propose activation as
12 an outcome metric.

13 For one thing, I don't think we
14 would want to say, "Well, you have to use this
15 instrument." And it, as far as I can see, is
16 actually still in development in some sense.

17 But I think for systems, maybe we
18 are more at the process stage and for people,
19 we are more at the outcome stage.

20 DR. BURSTIN: I am just going to
21 add in that I think that this is a great
22 conversation, exactly what we were hoping you

1 guys would engage in. We as we ultimately
2 think about it know we are going to need
3 measurement sets.

4 And so I think that it is very
5 logical that as you think about these
6 patient-focused episodes over time and the
7 patients with the multiple comorbidities, of
8 course, there are going to be outcomes.

9 Of course, there will be linked
10 process measures that are particularly
11 important, like the one David just mentioned
12 about the colonoscopy process that we know are
13 associated with better detection.

14 It doesn't take a big leap to say,
15 therefore, you would then have a potentially
16 earlier detection of colon cancer. I don't
17 think we require that as the evidence for
18 this, pretty clear indication.

19 But you are also going to want
20 some patient adherence measures. You are
21 going to want some patient experience of care
22 measures. Those are very reasonable

1 measurements, that package of where I think we
2 want to go.

3 What we are trying to do, in this
4 project at least, is stick to the outcomes.
5 What I would really like the TAPs to do in
6 this group as well is, in addition to all of
7 the outcome measures we have shared, as they
8 go through all the condition-specific work, we
9 are also going to share all of the process
10 measures we have got. I mean, some of them
11 may be distal enough that they are pretty
12 linked to an intermediate outcome.

13 I am intrigued by what David just
14 mentioned about the colonoscopy withdrawal
15 times. To me that is a clear process measure
16 we probably need, but the polyp detection rate
17 that he mentioned to me sounds like an
18 intermediate outcome measure. I think that
19 would be a great thing to bring in because I
20 think we can't always just have the very, very
21 distal outcomes. The intermediate process
22 ones can be really useful on that path.

1 MEMBER KEALEY: So where does the
2 synthesis occur, then, between the process and
3 the outcomes? If it is not really here, where
4 does it hit the road in the real world?

5 DR. BURSTIN: I actually think it
6 is going to increasingly be here, but I think
7 it is a little bit of an artificial separation
8 in that we try to do the outcomes project
9 because we had so few of them that it seemed
10 logical, but I do think that increasingly
11 knitting together is going to happen at groups
12 like this.

13 We really will very much see your
14 role as these all come back to you as the
15 final multi-stakeholder Steering Committee in
16 the spring to say, "That really sounds like a
17 process measure, but, boy, that is a really
18 important measure you would want to use with
19 these kinds of outcomes."

20 And I suspect that, going forward,
21 this is an even bigger issue for us as we
22 begin to do cost and resource measures across

1 conditions that will begin in a few months.
2 Knitting together the cost and resource
3 measures with the outcomes is going to be the
4 next step that we plan to do probably
5 beginning this winter.

6 But, you know, your early thinking
7 about the best way to construct these sets
8 would be really valuable.

9 MEMBER JOHNSON: This is Dave
10 Johnson again. Just one comment about where
11 they may be helpful as process measures. If
12 you have defined gaps where you don't have an
13 easy ability to register an outcome, these
14 process measures are helpful as they are
15 educational because it makes the practitioner
16 start thinking.

17 Each time it holds them
18 accountable to standards and re-edifies what
19 the standards are every time they see a
20 patient. And it is easy to just -- if you are
21 trying to steer the ship, you are slowly
22 getting them into a standardization of

1 practice thought along with whatever that is
2 driving to whatever the ultimate outcome you
3 are trying to get to.

4 But I think the process measures
5 are sometimes very educational for changing
6 behavior and, again, have to obviously be
7 well-selected and appropriate.

8 And nobody wants more things to
9 do, but I think that is where I view some of
10 these where we can get to improved care
11 quicker, rather than waiting for delay in
12 outcome assessment.

13 CO-CHAIR DUBOW: There are nodding
14 heads around the table. Pauline?

15 MEMBER McNULTY: Yes. I have a
16 question. It is probably based on my naivete,
17 but I have heard the term "patient activation"
18 being used here, and I really don't understand
19 what that is.

20 And then I have another question,
21 which is you talk about patient adherence and
22 adherence to what from the narrow perspective

1 that I come from, pharmaceutical trials, when
2 we talk about adherence, we are talking about
3 adherence to a drug treatment regimen. So I
4 would just like to hear more about what you
5 are talking about when you talk about patient
6 adherence.

7 MEMBER YAWN: Can I answer the
8 adherence and then you? First, there have
9 been a lot of them. When I think of patient
10 adherence, I think of it extremely broadly,
11 all of the things that I hope I have helped
12 the patient understand.

13 I will go to COPD because that is
14 the TAP. I could do others, but I will do
15 that one quickly. I think that they need to
16 adhere to smoking cessation. They need to,
17 yes, take medications if we have done that,
18 other lifestyle changes, like increasing
19 physical activity, trying to increase that,
20 being able to recognize an exacerbation early
21 and get in before they end up in the hospital
22 with it; if we have screened for depression

1 and they have it, helping them take care of
2 their comorbid conditions.

3 All of those I think have to do
4 with patient adherence to a very broad
5 management strategy, of which they are a very
6 crucial part. And so drugs are a very small
7 part, I think, for most conditions.

8 CO-CHAIR DUBOW: I think that is a
9 very broad definition. When you talk about
10 recognizing symptoms, I see that as parts of
11 self-management. Somebody would likely say
12 that it is an activated patient who is
13 engaged.

14 I mean, I think that is a really
15 broad definition of adherence. I mean, you
16 know, we are free to define anything we care
17 to, but I wonder whether those people who are
18 really working in the adherence area see that
19 as such a broad spectrum.

20 MEMBER YAWN: Most of the ones I
21 work with --

22 CO-CHAIR DUBOW: Do.

1 MEMBER YAWN: -- do see it that
2 way. I intentionally chose some things like
3 adhering to symptoms early because that really
4 impacts outcomes in COPD, symptom recognition
5 early.

6 CO-CHAIR DUBOW: This is an issue
7 of semantics. I mean, I have no disagreement
8 with the importance of that. I think it is a
9 label more than anything else. And I don't
10 think that is particularly important.

11 When I use activation, I am really
12 thinking about the components of the
13 instrument that Judy Heber developed, which
14 looks at a patient's knowledge, confidence,
15 ability to understand it is a range. She has
16 got several domains in there that all speak to
17 how a patient manages, engages, and feels
18 confident in being able to manage her own
19 care.

20 I can send you a link or whatever,
21 but I use it in her context. I don't know if
22 you are using it differently.

1 MEMBER JUSTER: Well, we are just
2 exploring it because another one of our -- in
3 a clinical decision support arena -- and also
4 I do a lot of work with the DMAA. I think
5 they've got it down to ten questions now for
6 most populations.

7 Well, asking people ten more
8 questions on top of everything else probably
9 means you are not going to ask them something
10 else because pretty soon they are just going
11 to get tired of being around and being asked
12 questions.

13 And so it would be nice if they
14 could -- it is a bit like the SF. Everybody
15 wants the SF-1. How are you doing? But it is
16 not granular enough.

17 MEMBER YAWN: We have used that
18 for years.

19 MEMBER JUSTER: Yes. Well, I
20 think we all do. Yes. And I guess we all ask
21 that when we --

22 MEMBER YAWN: We do.

1 MEMBER JUSTER: It is not a very
2 good forecaster. Yes. But that is certainly
3 criteria that is usable. The SF-12 and the
4 patient activation ten, presenteeism, I have
5 seen some instruments down to five. But the
6 classic one at WLQ is eight or nine questions.

7 And these are all called the short
8 form of some other thing that used to be
9 longer. And so when we start getting
10 cross-cutting and we think about me and my
11 heart attack and how I am going to be treated
12 for the next 40 years and move among all of
13 these sites, that is a lot of information
14 gathering.

15 How can we leverage and get
16 efficiencies, especially when we are in an
17 HIE, health information exchange, rich
18 environment with medical homes all over the
19 place? How are we going to make it look like
20 we are doing this and this is going to make
21 everybody's life better, rather than more data
22 collection?

1 MEMBER JEWELL: Well, thinking
2 back to a point Pauline made earlier about the
3 balancing act we conduct when we are looking
4 at generic measures versus condition-specific
5 or region-specific measures.

6 For me the question isn't, how do
7 we gain the efficiencies? It is, when is it
8 most important or when is it most appropriate
9 to really pursue the efficiency opportunity in
10 measurement?

11 And what makes the most sense
12 because there clearly are out in the data, out
13 in the research, at least in my practice area,
14 times when it is much more appropriate to
15 stick with condition-specific measures that
16 guide our care and predict outcomes more
17 directly?

18 I guess when we talk about
19 principles of things, for me, it is easier to
20 ask questions, have a consistent set of
21 questions we all ask, to sort of check
22 ourselves to do that balancing thing than just

1 pushing in one direction or another on its --

2 CO-CHAIR DUBOW: Is there someone
3 on the phone who wants to make a comment?

4 CO-CHAIR FLEISHER: Yes. Hi. It
5 is Lee again. So one of my questions in
6 listening to this conversation is the issue of
7 local specialties and how we ensure if we
8 don't actually incent the hospital for the --
9 how do we incent the team and not have
10 unintended consequences becoming -- because
11 adherence is really a team sport?

12 MEMBER YAWN: I think we still
13 work for -- I think we have to think it back
14 through. I do think adherence is a very
15 important outcome measure. And I will keep
16 harping on that for a while.

17 I think there are other measures
18 that are one step further down the road, that
19 adherence is one part of the reason. For
20 example, if we think about hospitalization
21 rates, not for MI because you are supposed to
22 be in the hospital for those, but for COPD

1 exacerbations, we would like to get them
2 before they get in the hospital.

3 So if we can decrease or we can't
4 decrease or this group has much higher
5 hospitalization rates than that group, that is
6 an outcome measure. But then we take one step
7 back. Why are they having it?

8 And then adherence becomes
9 crucial. It is probably one of the most
10 crucial reasons people have poor outcomes is
11 because they are not adhering, either because
12 their physician to the best kind of care,
13 their physician, nurse, whoever didn't know
14 how to give it to them -- I mean, there are a
15 lot of reasons.

16 I see adherence in that sense and
17 think it is a crucial intermediate outcome
18 measure because things like mortality for
19 COPD, we can't do anything about it anyway.

20 CO-CHAIR DUBOW: I just have one
21 other reaction to the term "adherence," and I
22 know that is preferable to "compliance." I

1 still worry about a blaming the victim kind of
2 -- I know that is not an intent, but the
3 potential for having that atmosphere and
4 environment and providing the opportunity to
5 obviate the physician hospital provider
6 responsibility for the outcome by seeming to
7 dump it on the patient.

8 I think we need to be careful
9 about the kinds of measures and the kind of
10 messages that we send with respect to the
11 measures that we produce because that would be
12 a really bad outcome.

13 MEMBER YAWN: It would be
14 terrible. And if you can think of another
15 term for that, I would love it. I mean, I
16 always say that all lack of adherence is the
17 fault of the care provider, the clinician,
18 which they hate me when I say that.

19 But that is what I say. But I
20 know that is not the message. So I understand
21 what you are saying.

22 MEMBER JUSTER: Could I say one

1 more thing about adherence, just to use that
2 term, of course? There is also the question
3 of whether one step upstream is whether the
4 person should have done drugs. Should the
5 person have been taking that drug in the first
6 place?

7 MEMBER YAWN: Any of them.

8 CO-CHAIR DUBOW: Yes.

9 MEMBER JUSTER: So of 100 people
10 who should be taking a statin, 60 people are
11 taking it. Of the 60 people, 40 of them have
12 MPRs over 80 percent. I mean, that would be
13 a more complete metric.

14 And I understand that if you go
15 over to the U.K., for example, the guidelines
16 are very different for using statins and
17 primary prevention than they are here.

18 We have the guidelines we have.
19 We are not going to invent new ones here. But
20 that would give a more appropriate use plus
21 ignorance.

22 MEMBER YAWN: But that is the

1 physician's part of this.

2 CO-CHAIR DUBOW: Are there any
3 other comments before we move on?

4 (No response.)

5 CO-CHAIR DUBOW: Okay, Reva.

6 DR. WINKLER: Yes.

7 CO-CHAIR DUBOW: I was just going
8 to say at some point we should come back to
9 thinking about these principles that we
10 touched on.

11 MEMBER YAWN: I'm sorry. I said
12 right after we figure out how to do a
13 consensus, then we can come back.

14 DR. WINKLER: Just to kind of go
15 through a little bit about the NQF's process,
16 in terms of developing consensus, consensus is
17 not unanimity, but it is bringing everybody to
18 the table, hearing what they have to say, and
19 trying to negotiate a common ground we can all
20 live with.

21 NQF has a formal consensus
22 development process. We are going to go

1 through the steps. You are one of those
2 steps. You are part of that process. It is
3 formal, and it is fairly inflexible for some
4 very specific reasons.

5 Within that developing the
6 consensus and the conversations you have are
7 really the rich outcomes of the project. So
8 looking at our overall strategy, the
9 conversations you have just had are a very
10 important part. To the degree we are able to
11 capture it and embed it in the work and the
12 outcome of this project, we want you to keep
13 talking.

14 Developing consensus at NQF is
15 totally dependent on having multi-stakeholder
16 input into the conversation. And that is why
17 this group does represent a wide variety of
18 stakeholders.

19 One of the things that is unique
20 about NQF's process is because it comports
21 with federal law, because it is an open
22 process, it allows public members to sit on a

1 board of directors and be active in the
2 process. So we do have a true combining of
3 the public and the private sector
4 representation. And that is really fairly
5 unique.

6 Our entire focus is on the
7 continuum of health care. And while some of
8 our previous projects have focused in on
9 narrow aspects of it, this one we want to stay
10 as wide open as possible.

11 At the end of the day, endorsement
12 by NQF, the measures then take on the title of
13 "Voluntary Consensus Standards" because that
14 is essentially what we are doing through this
15 process.

16 When I say, "formal," we
17 definitely have the box diagram. And you are
18 in yellow. The national priorities and the
19 NQF program priorities kind of determine what
20 we are going to do as well as those of our
21 funders so that the specific project and
22 topics generally come to us through sort of an

1 amalgamation of the work we do with other
2 folks.

3 Every process has a steering
4 committee. And the steering is an important
5 aspect. You will provide guidance to the
6 overall project work plan, guidance to the
7 staff in terms of how we do things.

8 This whole discussion around what
9 are the definitions we are going to use, what
10 is the scope, which we will have after lunch,
11 those are the boundaries. What is in? What
12 is out? What is acceptable? What is not?

13 These are your decisions to make.
14 All right? So when you ask us questions about
15 what is allowed, I will turn it right back to
16 you and say what do you want to be allowed?
17 That is why the steering committee is really
18 a fundamental part of it.

19 The Steering Committee in some
20 projects may be aided by technical advisory
21 panels. In a package, such as ours, that is
22 very large, it has a lot of different topic

1 areas in it, it would be impossible to bring
2 the requisite expertise to the single
3 committee around a single table.

4 So that is why we use the guidance
5 and advice of the technical advisory panels,
6 but they are advisory to you. The Steering
7 Committee is sort of the major decision-making
8 body to recommend to the membership and board
9 of directors at large.

10 The draft results that you
11 recommend, which measures to endorse, what
12 associated recommendations go forward with
13 them, are published for member and public
14 comment. All right?

15 A 30-day comment period, we get
16 lots of comments. Most recent clinically
17 enriched admin. project, I've got over 800
18 comments. Alexis and I had lots of fun with
19 those.

20 We will ask the Steering Committee
21 to help us look at those comments, provide
22 responses to those comments. Sometimes there

1 are comments more suited to the measure
2 developer.

3 We get them to respond to the
4 comments so everybody gets to play because
5 essentially this is a public sort of
6 negotiation, discussion, if you will. And it
7 is a way of taking what we do in this room
8 with this group of people and taking it large
9 and getting their input, finding out what they
10 are thinking is an important part of it.

11 After that comment period and any
12 adjustments made by the Steering Committee
13 based on the comments that come in -- and that
14 is why it is important for the Steering
15 Committee to pay attention to them, to listen
16 to them, and to take them seriously -- is they
17 become the draft consensus standards that then
18 go out to our members for voting and go to the
19 Consensus Standards Approval Committee, of
20 which Joyce and David are members, for review.

21 Once those are reviewed, the
22 recommendations from the CSAC go to the board

1 for final ratification of the endorsement.
2 And the final process is a 30-day appeals
3 period, which any member of the public,
4 particularly if they may be impacted by the
5 results of the endorsement decision, may be
6 appealed. And that is heard by the CSAC on
7 behalf of the board of directors.

8 So those are kind of the steps in
9 a nutshell. And the reason the steps are
10 formal is because it does comport to the
11 federal law, both the NTTA that Helen
12 mentioned and OMB circular 119. And so we
13 make sure that we always stay in alignment so
14 that that keeps our relationship with the use
15 by the federal government nice and clean.

16 So that is how it lines up. We
17 will be going through the steps. We do it in
18 every single process or project. This process
19 has been tweaked but not majorly overhauled
20 multiple times through the years.

21 This is version 1.8. So we are
22 constantly hearing feedback and getting

1 information back from our members on how to
2 adjust it, but ultimately this process is one
3 that is blessed by the board of directors.

4 And we don't have a lot of room to change it.

5 Now the role of the Steering
6 Committee. What are you guys here to do? All
7 right? First and foremost, you are the proxy
8 for our membership. We can't bring all 400
9 member organizations into a room and ask them
10 to decide on anything. Aside from the
11 ultimate exercise in frustration, it is just
12 not feasible.

13 So that you are a proxy for our
14 multi-stakeholder membership. You come
15 representing different perspectives. And we
16 hope that you will bring those perspectives to
17 the discussion so that you do hear the
18 viewpoints and the various concerns and issues
19 from all aspects and all of the players in
20 this arena.

21 The Steering Committee's role is
22 to work with the staff to achieve the goals of

1 the project. We are under contract in this
2 particular case with the Department of Health
3 and Human Services to do the work of this
4 project. They are expecting a deliverable, an
5 outcome. There are things we have got to like
6 do.

7 And so you will be the guiding
8 force that works with us. We will come to you
9 with questions. A lot of the discussion we
10 are having today is forming the way we are
11 going to present this information to the
12 technical advisory panels. Ask them the
13 questions you want asked to get the
14 information back. Develop the relationships
15 among the measure developers. Go seeking the
16 measures we need to bring into the project.

17 You are helping us do the work we
18 need to do. So realize that we will keep you
19 on the consensus development process road map,
20 but you are going to tell us how to do each of
21 those pieces based on the expertise that you
22 bring to the table.

1 The Steering Committee is
2 ultimately the group that evaluates the
3 candidate measures against the formal measure
4 evaluation criteria.

5 Because this is a large project
6 addressing a lot of different conditions, we
7 have set up the eight tabs to advise you, but
8 they are advisory. We are going to talk in
9 more detail about what role each one has as we
10 go through the measure evaluation forms and
11 criteria later.

12 This is the group that ultimately
13 does the final evaluation of a measure. And
14 so to the degree you want and need the
15 information from the TAPs, the questions back
16 and forth, the dialogue, fine, it is up to you
17 all.

18 You will be making recommendations
19 for endorsement to the NQF membership. You
20 are acting as their proxy. You take the blank
21 piece of paper and turn it into something.
22 All right?

1 Then after that goes out for
2 comment, your audience that you are acting on
3 their behalf, you will listen to them. Do
4 they like it? Do they not? Does it need
5 editing? Does it need changing? Do we need
6 to revise? Do we need to rethink? So you
7 will respond to the comments submitted during
8 the review period.

9 Then that goes out for vote. We
10 are getting real close to the final product
11 now. And then the co-chairs will -- in this
12 case, it will be pretty easy -- come to the
13 CSAC and represent the Committee in the
14 thinking because many of the conversations
15 around the CSAC, they are looking at, did we
16 follow the process appropriately? Do we meet
17 the goals of the project? But they will ask,
18 why did you do this? Why not? They want to
19 know a lot of the greater issues, the big
20 picture issues that came down to the set of
21 recommendations.

22 And then the Committee would

1 respond to any direction from the CSAC. That
2 doesn't happen very often, but occasionally it
3 does. And so we have had steering committees
4 re-meet after to respond to some issues.

5 So these are the roles of the
6 Steering Committee. You are guiding the
7 project. You are working with the staff, in
8 your case Alexis, myself, and we have got
9 several other staff members on the team, to
10 try and make this all work and meet the goals
11 of the project.

12 So at this point, Joyce, did you
13 want to make any comments? I know you have
14 got some feelings about the role of the
15 Steering Committee and some things you would
16 like to add in here or, David, from your role
17 as the CSAC or any questions from anybody on
18 the Committee?

19 CO-CHAIR DUBOW: You know, some of
20 the issues have actually already come up. You
21 know, as a Steering Committee, when we have a
22 chance to look at a measure, it is the chance

1 to really look at the measure and to
2 anticipate some of the things that might
3 otherwise happen at the CSAC.

4 The CSAC has a strategic
5 perspective. And it is looking to raise the
6 bar. It is looking to ensure harmonization,
7 all of the things that Reva discussed. So we
8 are to be taking those things into account as
9 a Steering Committee to think about the
10 measures themselves in a more granular way to
11 be sure that we are achieving the objectives.
12 It should happen at the Steering Committee.
13 We should be listening to the membership and
14 their comments. I mean, this is where the
15 measures really ought to be shaped.

16 And, again, to reinforce something
17 that Reva mentioned, we are representing
18 perspectives here. That is why it is a
19 multi-stakeholder group.

20 And each of us brings another
21 perspective. And now is the chance, really,
22 to be sure that those perspectives are

1 represented so long as we have a common
2 understanding of where these measures have to
3 go and what their purposes will be.

4 DR. WINKLER: Thank you, Joyce.

5 Any questions from anybody in
6 terms of what we are doing and why we are here
7 and what were the expectations?

8 MEMBER McNULTY: Just one. So the
9 reviews that are then open to the public and
10 the membership are posted on the website?

11 DR. WINKLER: Yes.

12 MEMBER McNULTY: It is not like
13 through the Federal Register or something?

14 DR. WINKLER: No. It is posted on
15 the NQF website. That is why I say exploring
16 that website and seeing how it is all laid out
17 is a real important thing that I think all of
18 you should do so that you will be able to go,
19 you will know exactly where to go to get the
20 information, you can see exactly how it is
21 laid out.

22 DR. BURSTIN: It is transparent to

1 the point where, actually, the transcripts
2 that this nice gentleman here is typing will
3 also be posted. So the hallmark of everything
4 we do is transparency so everybody can see how
5 you came up with the decision you made at the
6 end of the day.

7 DR. WINKLER: It also plays a
8 particularly good role for you as a Steering
9 Committee with an advisory. Sometimes you
10 want to hear more about why they said what
11 they said.

12 If it is a conference call, you
13 will be able to go listen to it, but if it is
14 a meeting, it will have a transcript. And the
15 transcripts are usually bookmarked such that
16 you can at least search the measure or the
17 topic or the whatever because sometimes they
18 are quite lengthy.

19 But these will be great tools for
20 you as you come to sort of the end in making
21 those final evaluations. Maybe you want to
22 listen to hear the conversation the TAP had

1 about X.

2 You would be able to sit in and
3 listen as much as we will have, all of the
4 meetings will al have the ability for you to
5 call in if you would like to. But perhaps it
6 is a little more efficient if you want to look
7 at the transcript. And we will make those all
8 available to you. But they are posted as
9 well.

10 So the transparency is important.
11 It is a critical aspect of it. But it is also
12 informative. The nice thing for this is while
13 the two meetings of the Steering Committee are
14 six months apart, if you will, October to
15 April or so, there is going to be a lot of
16 intervening work.

17 You are going to be hearing from
18 us frequently. Something just happens. This
19 TAP just met. Their stuff is posted if you
20 want to listen.

21 I would suggest that it is not a
22 bad idea to keep up with the project. There

1 is enough time for you to kind of pay
2 attention to what else is happening.

3 I can tell you that at the end of
4 the day, when this funnels down to you from
5 eight different TAPs and a whole bunch of
6 measures and we have got two days to make
7 final decisions, that is going to get
8 interesting.

9 So the fact that you have this
10 opportunity to pull in all of this information
11 over a reasonable time, some of you have
12 worked with us before when we didn't have the
13 luxury of quite so much time and we were
14 moving beyond the speed of light. So all of
15 these resources will be available to you, and
16 I hope that you will take advantage of them.

17 CO-CHAIR DUBOW: If I could just
18 make one more observation? You know, when you
19 look at the public comments, it would be
20 really good if we could anticipate what we
21 will see in the public comment. Sometimes
22 those comments are made just for political

1 reasons to reinforce a perspective.

2 But those perspectives will have
3 been considered in our deliberations. Clearly
4 it is possible that you get new perspectives
5 coming across at the very end of the process,
6 but ideally those perspectives are represented
7 and presented in enough time so that we can
8 give it the due consideration.

9 So it is very useful to have
10 ongoing discussions with your colleagues and
11 stuff to have a really good understanding of
12 what is happening so that there are fewer
13 surprises so we can really have the time to
14 pay attention to what we are doing.

15 DR. WINKLER: As we have
16 mentioned, we do have eight technical advisory
17 panels. Their roles are advisory. You know,
18 we often hear people use the term "technical
19 expert panel." Yes, we hope they are experts,
20 too, but their role is to be advisory.

21 So the whole goal of having TAPs
22 for this project -- and we don't for many

1 projects, but this is a large one -- is to
2 bring clinical expertise to a large project
3 when it is addressing a lot of different
4 clinical conditions. I mean, it is just the
5 only way we can get everyone on board.

6 The role of a TAP is to advise the
7 Steering Committee to look at the information
8 submitted by the measure steward. I mean,
9 these are topical experts. Theoretically they
10 should be able to look at some of that
11 information. Is it complete? Are there other
12 bits of information not included? Is it
13 portrayed accurately? Does it include the
14 information for decision-making that is
15 appropriate? All right?

16 They will look at the measure
17 evaluation criteria, particularly at the
18 subcriteria under each of the four major
19 criteria. The four major criteria are
20 importance to measure and report, scientific
21 acceptability in measure properties,
22 usability, and feasibility. Those are the big

1 topics.

2 Underneath, within each of those
3 four categories, there are several
4 subcriteria. We are going to ask the TAP
5 members to draft, you know, sort of an
6 evaluation of the subcriteria, to help you.
7 But ultimately the evaluation of the four main
8 criteria remains with you. Okay? Again, we
9 need the multi-stakeholder perspective on the
10 measure evaluation.

11 They will respond to any questions
12 you ask. If you want them to tell you about
13 XYZ, you know, ask the question. We'll ask
14 them. And I will provide you back the
15 answers.

16 In addition to the measure
17 evaluation criteria, their comments, their
18 discussion is made available to you. We will
19 summarize it and try and highlight particular
20 strengths or weaknesses they want you to be
21 aware of as you do the final evaluation of the
22 measure going forward.

1 In this particular project, to
2 facilitate that communication, the chair of
3 each of those eight TAPs is a member of the
4 Steering Committee.

5 Those folks who kindly agreed to
6 be chairs of TAPs are wearing two hats. They
7 are helping to advise the advisory committee
8 knowing what the conversation was among the
9 Steering Committee, what the issues are, how
10 the thinking is going so that you can help
11 them provide the best advice possible.

12 When you are here sitting as a
13 member of the Steering Committee, you are
14 helping facilitate that communication, but you
15 are also here in your own expertise.

16 Most of you have some kind of
17 measurement outcomes background, in addition
18 to your clinical expertise. So it is not just
19 representing the TAP. It is representing
20 everything you bring to the table and the
21 people and perspectives you represent as well.

22 So that is the role of the TAP for

1 this project or the eight TAPs. We will also
2 have them do some thinking around the gaps
3 analysis, again the draft for you to think.

4 Ultimately it will be a product of
5 the Steering Committee, but they can use their
6 clinical expertise to help begin drafting
7 these out for you for your consideration.

8 So questions around the TAPs.

9 Dianne, why don't we start with you?

10 MEMBER JEWELL: So could the
11 people who are TAP chairs identify themselves?

12 DR. WINKLER: Sure.

13 MEMBER JEWELL: I know I am one.

14 I am the Bone and Joint TAP Chair.

15 DR. WINKLER: Right. Barbara?

16 Barbara is Respiratory. Any of the others
17 around? Alexis, why don't --

18 MEMBER JOHNSON: Dave Johnson, GI.

19 DR. WINKLER: Ted is for
20 Cardiovascular. Dave Johnson is GI.

21 MS. FORMAN: We have Sheldon
22 Greenfield as the Diabetes TAP Chair.

1 DR. WINKLER: That is really
2 Metabolic, which is diabetes and CKD together.

3 MS. FORMAN: For Eye Care TAP, we
4 have David Herman. For Infectious Disease, we
5 have Patchen Dellinger. For the Cancer TAP,
6 we have Lee Newcomer. And then on the phone,
7 we have David Johnson for the GI TAP.

8 MEMBER HOPKINS: So I have a
9 question about your first bullet. Do you mean
10 to limit it to clinical expertise? Because I
11 am thinking that other kinds of expertise are
12 valuable, if not essential, for this exercise.

13 Statistics in epidemiology is an
14 obvious one; more broadly, health services
15 researchers. And you sort of wonder when it
16 comes to gap analysis whether the perspective
17 of the consumer, the patient, shouldn't be
18 represented on the TAP.

19 Have you guys thought about that
20 in the makeup for the TAPs?

21 DR. WINKLER: Yes. David, one of
22 the problems is there are very few of those

1 people.

2 MEMBER HOPKINS: Yes.

3 DR. WINKLER: So we are using you
4 judiciously. And for the most part, that
5 expertise sits on the Steering Committee. And
6 so that is why we are saying the TAPs' role is
7 advisory.

8 They get to do some drafting, some
9 thinking, but ultimately to bring in that
10 expertise, which sits more on the Steering
11 Committee than on the TAP simply because of
12 availability of appropriate people.

13 MEMBER HOPKINS: But, see,
14 implicit in that is the clinical as primary,
15 --

16 DR. BURSTIN: I think our
17 expectation --

18 MEMBER HOPKINS: -- which is sort
19 of interesting.

20 DR. BURSTIN: -- is that clinical
21 is going to be critical just given the fact
22 that they are all very clinical

1 domain-specific but not exclusive. So we are
2 still filling out the TAPs.

3 MEMBER HOPKINS: I can see it as
4 foundational, but is it primary? That is the
5 question?

6 DR. BURSTIN: I don't know what
7 primary versus foundational means. It is we
8 need a blend. And I think we really need the
9 clinical expertise given the clinical
10 conditions. And that is why they are
11 constructed in that way.

12 But at the same time, if you have
13 other suggestions for health services
14 researches, epidemiologists, patients? For
15 example, Pat Haugen, who is not here today, is
16 actually a patient for National Breast Cancer
17 Coalition who will sit both on the Steering
18 Committee and the Cancer TAP.

19 So we are very open to that if you
20 have suggestions as we fill out the rest of
21 the TAPs.

22 CO-CHAIR DUBOW: We have two

1 representatives. We have Lee Newcomer and --

2 DR. BURSTIN: Yes. Pat wants to
3 both on both.

4 CO-CHAIR DUBOW: Okay.

5 MEMBER YAWN: I think also some of
6 us -- I'm sorry. Pretty soon you will figure
7 out I am the one with the gravelly voice. It
8 is not always quite this bad.

9 When I think of clinical -- and
10 you and I are going to go around -- I am very
11 broad with clinical, too. I think that
12 patients are a very important part of clinical
13 care.

14 I can't possibly do clinical care
15 without the patient participating and the
16 family participating. So I think that we need
17 to help our TAPs understand that they should
18 look at clinical from that perspective, plus
19 adding if we possibly can.

20 And I am also going to say I
21 really hope that you have primary care on each
22 one of those. Cardiology is nice, and

1 cardiologists are wonderful. But they take
2 care of 20 percent of it, and we take care of
3 80 percent of it.

4 If we don't do our job right, they
5 have much more to do. Giving statins and
6 things like that is what I am thinking, the
7 prevention. Before they get their coronary
8 artery disease, that is our job.

9 So I am hoping that we all try to
10 think as broadly as we can. I mean, I was
11 sitting here thinking, is there anybody from
12 AAP, American Academy of Pediatrics, on this?
13 Is there someone with a pediatric bent? I
14 know they are. I understand that. But the
15 other --

16 DR. BURSTIN: It is the other
17 steering committee. There is an entire Child
18 Health Steering Committee.

19 MEMBER YAWN: I understand that.
20 So I am going to make a real effort on asthma
21 to represent the pediatricians as well as the
22 family physicians and the internists if they

1 are not there.

2 DR. BURSTIN: I think our
3 perspective will also be that whatever comes
4 out of this Committee, we will share with the
5 Child Health Steering Committee and have them
6 make the assessment of which of the outcome
7 measures came forward but also be appropriate
8 for children.

9 And, in fact, we are going to be
10 doing an effort to go across the entire NQF
11 portfolio of measures and saying which of
12 these are oddly assigned to adults only and
13 probably would be applicable to children, but
14 this was at least a starting point.

15 MEMBER GIBBONS: Have the TAP
16 members been chosen? And how are they chosen?

17 DR. BURSTIN: Most of them have
18 been chosen. We are still filling out some
19 gaps if you have any specific people. They
20 were all submitted, the way you guys were,
21 through a process of call for nominations.

22 We didn't get as many on some of

1 the condition-specific work as we wanted. So,
2 again, we can share. Probably the next step
3 would be helpful to share what we have with
4 the folks here and see if you want to give us
5 some additional feedback. We will take one
6 more look at those lists and then share them.

7 MEMBER JOHNSON: Could you share
8 those lists specifically with each of the TAP
9 chairs, too?

10 DR. BURSTIN: Yes, absolutely.

11 MEMBER JOHNSON: We can help fill
12 in the gaps and maybe steer it a little bit,
13 too, to where we think people could really be
14 --

15 DR. BURSTIN: That would be
16 wonderful.

17 CO-CHAIR DUBOW: Other questions?
18 Comments?

19 (No response.)

20 CO-CHAIR DUBOW: Okay.

21 DR. WINKLER: Now, just to be
22 complete to all members, the staff has a role.

1 I think I have mentioned these, but our role
2 is to help achieve the goal of the project
3 working with you and ensure the adherence to
4 the consensus development project and the
5 contract obligations that we have.

6 So we did a lot of the logistics,
7 the organizing. We guide you through the
8 process. We shuffle the paper for you, if you
9 will, except we are doing it electronically
10 these days.

11 So, frankly, we all are grateful
12 we aren't killing as many trees as we used to.
13 But we are trying to be your communication hub
14 and conform to the process and keep everything
15 from getting totally chaotic.

16 That said, Alexis, myself, anybody
17 on the project, we are available to you at any
18 time. Do not hesitate to contact us.

19 During the course of a project, I
20 do talk with the members of the Steering
21 Committee on a regular basis. You will get
22 group e-mails from us with the latest

1 whatevers, but if you have an idea, if you
2 have a thought, if you have a question, if you
3 have a concern, any of those things, e-mail,
4 call, whatever, send up a smoke signal, that
5 is what we need, too, because your role of
6 guiding this and the thoughts and ideas of the
7 wonderful thinking that is going on is what
8 makes this work. And we can't put it into
9 play if we don't hear it.

10 So it is important that you do
11 stay in touch with us when you have thoughts
12 and ideas and do not hesitate because,
13 frankly, that is our job. Our job is to be
14 there for you and to help you do this. Unlike
15 the rest of you who have day jobs, this is our
16 day job. So put the burden on us. That is
17 what we are here for.

18 Like I say, we essentially do all
19 of the work. We do the posting to the
20 website. You know, we do all of this other
21 junk.

22 One of the things I just want to

1 briefly because -- later on we are going to
2 talk about the measure evaluation criteria,
3 but I just want to mention a couple of things
4 that perhaps Joyce and David will want to
5 comment on. And that is, about a year ago,
6 NQF revised and updated their measure
7 endorsement criteria.

8 We have always since the beginning
9 of NQF time, which I actually remember, used
10 four basic criteria to evaluate the measures,
11 the importance, scientific acceptability,
12 usability, feasibility. So nothing has
13 changed there.

14 However, as we had experienced, as
15 we endorse measures and we start getting
16 feedback about measures, people started using
17 measures, we learned a lot.

18 And so last year, a subcommittee
19 of CSAC looked at the measure evaluation
20 criteria and revised them for a couple of
21 reasons.

22 And for those of you who were with

1 us in the past, you will have seen the old
2 criteria. The new ones are not markedly
3 different, but there are some important
4 differences that I would like to highlight.

5 The purpose of the revisions is to
6 clarify, strengthen, and recommend changes to
7 achieve several goals. One was a stronger
8 link to the national priorities -- now you can
9 see how things are starting to fall together
10 -- and higher-level performance measures. We
11 want measures that are more robust and really
12 help drive quality improvement to a greater
13 degree.

14 Greater measure harmonization,
15 trying to address sort of the chaos of
16 disharmony out there, greater emphasis on
17 outcome measures. This is why you are here.
18 This is why this project is focused the way it
19 is. And for the process measures, a tighter
20 outcome process link. Going back to the
21 evidence of for this process, do we know it
22 really does something good in terms of patient

1 outcomes?

2 So the endorsement criteria were
3 revised to meet these criteria. They have
4 only been in place for a couple of projects
5 over the past year.

6 We are still learning whether they
7 are going to meet these goals and achieve what
8 we want. But for those of you who worked with
9 us in the past with the older criteria, it is
10 important that we do understand them. And so
11 here is --

12 MEMBER YAWN: Maybe you are going
13 to tell us what higher-level performance
14 measure means. You are going to tell me about
15 it?

16 DR. WINKLER: I am not sure I have
17 that. I am going to punt that one to Helen
18 and Joyce, actually.

19 DR. BURSTIN: Once again, it is
20 the problem, the fact that it is my slide.
21 The idea has been that we were trying to think
22 about ways to strengthen the criteria to make

1 sure we get at the measures that seem more
2 important so if you get at the measures that
3 perhaps are more proximal to outcomes, the
4 ones that have a title "Link to Outcomes,"
5 rather than trying to avoid some of the very
6 narrow process measures that we are starting
7 to see, so trying to raise the bar a bit.

8 CO-CHAIR DUBOW: And I would
9 emphasize the raising the bar part. David may
10 want to have some comments. There is a term
11 that I am not allowed to use to describe the
12 measures that we have in mind that we don't
13 want to see anymore, but we have a transcript.
14 So I will tell you later. Sorry. Measures
15 that are meaningful and just more rigorous and
16 robust.

17 MEMBER HOPKINS: Do you want this
18 sort of a specific example? I mean, we were
19 getting measures of "Physician documented
20 that" such and such occurred. And it was
21 usually "I counseled the patient" or
22 something.

1 There really is no evidence that a
2 physician checking off on some form that they
3 did that is linked to the outcomes, and that
4 was our point.

5 CO-CHAIR DUBOW: I heard a lot in
6 the past that it is important to have those
7 kinds of measures because there is evidence
8 that clinicians aren't doing something, which
9 was the justification for many of the measures
10 that have been endorsed heretofore.

11 But as a new Steering Committee,
12 we have an opportunity to meet these criteria.
13 There are lots of measures that are sort of in
14 the works, but this is a new opportunity to
15 apply these higher-bar criteria.

16 Dianne?

17 MEMBER JEWELL: So having just had
18 an "aha" moment, I think that we might -- and
19 I don't know if the "we" is this group -- have
20 some work to do helping people understand what
21 we mean by gaps in care because what you just
22 described is the way I think a number of

1 stakeholders identify a gap in care.

2 The physician didn't. The
3 physical therapist didn't. The nurse didn't.
4 And so if, in fact, gap means something, has
5 a higher bar in its definition, that will have
6 to be re-explained because I will venture to
7 guess that some of the reason we get those
8 measures aside from their simplicity in
9 tracking is because they really do feel like
10 this is a gap in care.

11 And so, therefore, if it is
12 documented, we have filled the gap. So
13 perhaps we are in a vicious cycle there.

14 MEMBER HOPKINS: Can I respond to
15 that? Because, I mean, you make an excellent
16 point. I think what we were saying was two
17 things. Clearly those aren't outcome
18 measures. They are process measures. We
19 don't have to debate that.

20 But the more important point was
21 exactly what is being measured and by whom.
22 So you are absolutely right. Things aren't

1 happening that need to happen, but I am not
2 sure we have figured out the best way to
3 measure that.

4 And I think Helen or Joyce
5 referred earlier to these smoking cessation
6 measures of hospital care that ended up truly
7 being a check box on a nursing form and always
8 got checked. And that is not helpful.

9 CO-CHAIR DUBOW: And I would
10 agree. Point well-taken. I think it is just
11 a matter of if we also want to not spend our
12 time seeing those kinds of measures, part of
13 the ability to do that is to help people
14 better understand what is a gap in care, what
15 is not, and what constitutes an appropriate
16 measure. So I think we are saying the same
17 thing.

18 DR. BURSTIN: And just one small
19 nuance to that. I think there are at times
20 where those measures where somebody did
21 something, are, in fact, heavily
22 evidence-based to be tied to an outcome, like

1 the act of a clinician encouraging a patient
2 to quit smoking every single time is
3 associated with higher rates of quitting
4 smoking.

5 So to me that is a tighter link on
6 that proximal/distal to outcomes piece. That
7 is one. There is a tighter link to outcomes.
8 So I think those are still really important.

9 MEMBER YAWN: I think there's also
10 just the whole idea -- again I am going to use
11 the "translation" word -- of translation of
12 how do you use performance measures, just like
13 how do you use guidelines.

14 We can talk about, okay. This is
15 the performance measure, but I don't see that
16 in and of itself an end at all. You know, it
17 is not that helpful for me to know my
18 performance is this, that, or the other,
19 whether it is better or worse than the guy
20 across the street. What I need to know is
21 that it is not 100 percent. And there may be
22 reasons it is not.

1 Now, how do I peel back from that
2 down to figure out what it is I need to do?
3 And it may be in going back that way I do need
4 to do documentation. But hopefully I do the
5 action as well as documenting.

6 So I think that we need to make
7 that very clear to people, too. Sometimes
8 people who think about performance measures
9 get all caught up in the performance measure
10 and forget that it is only a tool to improve
11 patient outcomes. It is not just to measure
12 patient outcomes.

13 CO-CHAIR DUBOW: We have two
14 purposes: quality improvement and public
15 reporting.

16 DR. WINKLER: Joyce, actually,
17 this is a fairly good stopping point because
18 I was going to talk a little bit more about
19 the measure evaluation criteria, but we have
20 got another agenda item for that. So it
21 follows just fine. There is no reason to
22 delay lunch. But also I was just going to say

1 we need to ask for public comment first.

2 CO-CHAIR DUBOW: Operator, could
3 you open the phones for public comment? And
4 we will start with a comment from here?

5 THE OPERATOR: Yes. All lines are
6 open.

7 MR. HARDER: Hi. Can you hear me?
8 Am I on? Hi. My name is Joel Harder. I am
9 with the Society of Cardiovascular Angiography
10 and Interventions. I am the staff
11 representative.

12 There are three principles that I
13 hope you all would talk about this afternoon
14 that are of interest to our organization. And
15 for your Cardiovascular TAP, the house of
16 cardiology is not unified in the measures that
17 are going to be presented. And so we were on
18 the working group, but we are looking forward
19 to engaging the TAP on explaining this in a
20 much more public forum to see what happens.

21 The first thing I wanted to
22 mention was we are eager. I am dealing with

1 the readmission measures. The area that is
2 really contentious for us is planned
3 procedures that happen in the 30-day window
4 and how they are excluded and also targeting
5 preventable readmissions, really getting at
6 that.

7 For example, you are going to see
8 in a 30-day window, there are a lot of
9 gastroenterologists' procedures as well as a
10 lot of orthopedic issues that got captured in
11 a 30-day window. And we want to know from the
12 TAP and the Steering Committee, is that really
13 preventable readmissions related to the PCI
14 procedure?

15 The second issue, inpatient versus
16 outpatient, we argued to get the outpatient
17 included, and it is. And we would argue that
18 that should be the case because a lot of
19 procedures are transitioning now from
20 inpatient to outpatient.

21 And that is it. Those are the two
22 issues I want to raise. Thanks.

1 CO-CHAIR DUBOW: Operator, is
2 there anybody on the phone who wants to make
3 a public comment?

4 THE OPERATOR: If you would like
5 to ask a question, go ahead. Your lines are
6 open.

7 CO-CHAIR DUBOW: Okay.

8 THE OPERATOR: And there do not
9 seem to be any questions at this time.

10 CO-CHAIR DUBOW: All right. Thank
11 you.

12 Okay. We are going to adjourn for
13 lunch.

14 MEMBER AMARASINGHAM: I would just
15 say in response to the first public comment
16 that, in fact, I think a very valid point was
17 brought up with respect to the hospital heart
18 failure readmission measure. Elective
19 procedures, to my understanding, is not
20 currently included in the measure
21 post-readmission.

22 I am not sure if this is going to

1 be considered in this, but there are quite a
2 few hospitals which will admit a patient with
3 heart failure, for example, and there is a
4 planned AICD placement, -- that would be
5 elective admission -- shouldn't be considered
6 as a readmission.

7 DR. BURSTIN: Those are the issues
8 we will delve into more deeply --

9 MEMBER AMARASINGHAM: Okay. Okay.

10 DR. BURSTIN: -- when we see the
11 measure specifications themselves. I believe
12 there is a new PCI readmission coming forward
13 which I think is --

14 MEMBER YAWN: I would ask that we
15 think about our alphabet soup, too, please,
16 and try to limit it. I have no idea what you
17 just said.

18 (Laughter.)

19 MEMBER AMARASINGHAM: Let me
20 explain. AICD I meant defibrillator placement
21 --

22 MEMBER YAWN: Thank you.

1 MEMBER AMARASINGHAM: -- after a
2 heart failure admission. Thank you.

3 DR. WINKLER: Okay. Lunch.
4 Outside in the hall, Alexis? Okay. The
5 buffet is set up. We reconvene when, Joyce?
6 One hour, 1:30. Time for phone calls, check
7 your e-mail, eat lunch.

8 (Whereupon, a luncheon recess was
9 taken at 12:26 p.m.)

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1 A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

2 (1:31 p.m.)

3 CO-CHAIR DUBOW: So we are
4 scheduled to talk about scope, but we are
5 going to integrate our conversation about
6 principles into this.

7 DR. WINKLER: Yes. I would like
8 to introduce one of our colleagues. Karen
9 Pace is with us. Karen has been a staff
10 member at NQF for several years now. She is
11 just winding up our most recent effort around
12 outcomes since it was our hospital outcomes
13 project. And as the staff person there, she
14 has been through the ups and downs of the
15 discussion of outcome measures.

16 And since we like to make sure
17 that we learn from our ongoing activities and
18 we bring the issues and lessons from those
19 activities one project to another, Karen is
20 here to kind of help perhaps interject some of
21 the lessons learned or issues that have been
22 raised and dealt with or tried to be dealt

1 with in the previous outcomes efforts. So
2 Karen is going to kind of jump in as well.

3 You all brought up issues this
4 morning that seem to form the basis of what
5 would be principles around outcome
6 measurement. And I think that works very well
7 with the conversation I need you to have to
8 help us.

9 And so feel free to jump in and
10 make this very interactive and very informal
11 because what I would like to start with is
12 talking about the scope of this project. It
13 is real easy to say, "outcomes," but then the
14 devil is in the details.

15 What exactly are outcome measures?
16 You know, what someone may think is someone
17 else would disagree with. And this is going
18 to be one of your primary roles to help us,
19 the staff, know what is in and what is out.
20 I mean, there is a very practical need for
21 that.

22 But at the same time, the

1 discussion around why things are included,
2 what should be included, the kinds of issues
3 from the various perspectives of what outcomes
4 are even important and measures of outcomes
5 are going to be most useful to a wide variety
6 of audiences.

7 So to kind of start this concept,
8 we go back to our friend Donabedian with the
9 measure construct of structure process
10 outcome. In his world, the outcome refers to
11 changes, both good and bad, to individuals and
12 populations that are attributed to health
13 care.

14 So I guess the first question is,
15 is that a reasonable definition to work from?
16 We will provide you lots of opportunities
17 here, brave new worlds.

18 MEMBER YAWN: I don't want to take
19 on Donabedian, although I take on everybody
20 else. Why not? "Health care" is an
21 interesting term. And what exactly do we mean
22 "health care"?

1 Do we mean health care that is
2 provided in sites that we currently designate
3 as where health professionals interact with
4 people who come to seek care or does this
5 include what goes on at home, at school, and
6 other places?

7 DR. PACE: I don't think it was
8 meant to be restricted to just very formal
9 medical care. You know, I think it is health
10 care in its broadest sense, but that might be
11 something to expand on or to identify for this
12 project whether it should be narrow or broad.

13 MEMBER YAWN: I intentionally did
14 not say medical. I said a site where health
15 professionals are. So this could be public
16 health. This could be Kmart, Wal-Mart, all of
17 those kinds of places, hospice care at home,
18 where a health professional does come in. Is
19 that what we are talking about, all of that
20 broad?

21 MEMBER AMARASINGHAM: I agree.
22 And I would propose that we do consider it in

1 the broadest possible terms.

2 DR. WINKLER: To make it clear,
3 would you like to define health care so we
4 don't push back on Donabedian but at the same
5 time say that by "health care," we mean all of
6 these things? Is that generally the sense I
7 am sort of starting to hear?

8 MEMBER JUSTER: Especially if we
9 are going to use the word "attribution." So
10 why has the smoking rate been cut so much in
11 the last few decades? Probably because of a
12 lot of things, some of which have nothing to
13 do with health care, such as you pretty much
14 can't light up in most places.

15 MEMBER YAWN: Except health care
16 had a huge, huge impact on seeing that that
17 happened.

18 DR. WINKLER: So does anybody want
19 to kind of draft a proposed explanation,
20 definition of the health care we mean within
21 this just to be sure we are all clear?

22 MEMBER YAWN: Well, I tried.

1 DR. WINKLER: Okay.

2 MEMBER YAWN: And you can go from
3 what I said. I think it was anything that is
4 considered an interaction of someone who is a
5 health professional with a person to whom they
6 administer.

7 "Administer" is not a good word,
8 but I don't know what other word to use. It
9 could be education. It could be physical. It
10 could be all of those different kinds of
11 things.

12 I think a health professional
13 needs to be involved in it in some way.

14 CO-CHAIR DUBOW: I have a friendly
15 amendment. And that is to flip it and not
16 make the clinician the center from which it
17 originates but to make it originate from the
18 patient.

19 In other words, I think it should
20 be a patient-centered definition and that when
21 you talk about anything that is derivative of
22 an encounter with a clinical person, it feels

1 as though it is a clinician-centered kind of
2 approach. I think we should think about it
3 from the patient.

4 MEMBER YAWN: I said the patient
5 --

6 CO-CHAIR DUBOW: You did.

7 MEMBER YAWN: -- person sought the
8 interaction. So I don't know.

9 CO-CHAIR DUBOW: I am happy to do
10 that, but --

11 MEMBER YAWN: If you can figure
12 out how to make the words the other way around
13 --

14 CO-CHAIR DUBOW: It must exist.

15 MEMBER AMARASINGHAM: Strawman
16 sense. Maybe what if we said any activity
17 intended to improve the health of a patient?

18 MEMBER YAWN: That could be a
19 visit to the athletic club, could be a visit
20 to the farmers' market.

21 MEMBER JEWELL: You know, it seems
22 to me that we want to keep the intent of these

1 measures in mind, which is in some respects to
2 shape provider performance.

3 So given that that is true, even
4 though I heard what you just said, Joyce, I am
5 not sure we can divorce the definition from
6 the provider or I can't figure out a way to
7 grammatically word it without it sounding
8 provider-centered, even though philosophically
9 I totally hear what you are saying.

10 I don't want to lose sight of that
11 because that is really part of the purpose of
12 all of this.

13 CO-CHAIR DUBOW: I understand what
14 you are saying. And I can't wordsmith it now,
15 but my guess is that we could actually think
16 about the relationship of an individual to the
17 clinical encounters. I mean, I think it is a
18 doable thing.

19 I do think that we have to move
20 away from thinking about the clinician as the
21 -- you know, it was that graphic that we saw
22 from the Aligning Forces that we didn't like

1 so much that had the patient in the middle of
2 it.

3 And I think that is really how we
4 have to think about what we are talking about.
5 I can't do it right off the cuff, but I think
6 it is doable.

7 DR. PACE: There are also some
8 definitions that exist like I think the IOM
9 has a -- I mean, we could look at some of
10 those and see if that would be worthwhile
11 adopting versus trying to create.

12 MEMBER YAWN: I wanted to move
13 beyond. I intentionally said health
14 professional, rather than provider or
15 clinician, because those have certain
16 definitions. And they are all different.
17 They are all over the place.

18 But I wanted to get beyond the
19 traditional nurse, physician, PA, occupational
20 therapist because I do think there are all
21 kinds of people, including our receptionist,
22 who make huge impacts. I wanted it to be the

1 whole team of health professionals.

2 DR. BURSTIN: And I would have to
3 say team, and it goes way beyond health
4 professionals. To me team is my medical
5 assistant who checks the patient in, does
6 their blood pressure. You will get some
7 debate on that.

8 I think we have heard the emphasis
9 of where you want to go. We probably ought to
10 move on.

11 DR. WINKLER: Yes. Just to
12 mention, this is not the first time we have
13 talked about definitional issues. I think one
14 of the outcomes of this is we are going to
15 draft up that list of things that you wanted
16 to try to define.

17 And we will draft something based
18 on what you said. We can play the e-mail game
19 on, can you make this a better definition and
20 agree on --

21 DR. BURSTIN: We have the sense of
22 what you are talking about --

1 DR. WINKLER: Right. We will
2 draft one based on --

3 DR. BURSTIN: -- broad and a team
4 and, you know --

5 DR. WINKLER: Now, this is a list
6 of outcome measures, types of outcome
7 measures, that we have used. And I am not
8 even exactly sure how we came to it, but we
9 have used it. This was what was used in our
10 proposal for actually to HHS as part of the
11 contract. And I think it generated from some
12 of our previous work.

13 And the question is, do we have
14 the right list of things? Are there things
15 that shouldn't be on here? Are there things
16 that should be on here that aren't?

17 I wanted to get into some detail
18 with this because I think that it will help us
19 talk about what some of these principles of
20 outcomes are that you started talking about
21 this morning that we could help capture.

22 What is it about outcomes that are

1 the critical aspects that meet the needs?
2 People keep saying, "We want outcome
3 measures." What is it they really want? What
4 information is really being sought?

5 This will also form sort of one of
6 the aspects when we start doing a gaps
7 analysis of each in the conditions and the
8 cross-cutting is, are these the types of
9 outcome measures we really want to see to fill
10 those gaps? What are we missing? What are we
11 not?

12 And so I really would like to
13 spend a little bit of time with you all
14 thinking about whether have we captured the
15 types of outcome measures that we want to be
16 talking about? You know, some of them don't
17 belong. Some of them are not appropriate.
18 Tell us when.

19 This sets the scope for the
20 project such that if we have measures come in
21 that are things that you don't think belong
22 here, there are out. If they do address some

1 of these things, they are in.

2 And so I would kind of like to go
3 through each of the bullets and just get your
4 sense of them. And they are ordered not in
5 any particular order except that I always put
6 mortality last. I am really optimistic as a
7 physician.

8 (Laughter.)

9 DR. WINKLER: But in the first
10 one, it to me is really one of the more basic.
11 If you are asking the question, why did the
12 patient interact with the health care system
13 defined however you want to define it, why did
14 they come? And then what happened to them?

15 So patient functioning, symptoms
16 or symptom management, symptom resolution.
17 And a more long-term may be health-related
18 quality of life and this being not limited but
19 addressing physical, mental, social.

20 So in that realm, are those all
21 outcomes that would be measures addressing
22 what it would be.

1 MEMBER YAWN: I don't think there
2 are. And people can argue with me that we
3 should break them down, but I think role
4 functioning and occupational functioning are
5 very important.

6 And people will say, "Well, that
7 is either because of physical or mental." It
8 is not always so easy, I don't think, to
9 separate those.

10 So in a perfect world, I would
11 like occupational functioning and role
12 functioning like parenting being the caretaker
13 child of an adult whatever to be included.

14 MEMBER McNULTY: I would just like
15 to clarify on this first point you have got
16 patient function and symptoms, which could be
17 reported by patients themselves or could be
18 reported by somebody other than the patient
19 themselves, could be observed by caregiver,
20 could be observed by a clinician. So you need
21 to distinguish there what you are after, what
22 we are after.

1 Generally health-related quality
2 of life I think of as a patient-reported
3 measure that is going to be reported by the
4 patient. And the term that is more broadly
5 used now, at least within the sector of health
6 care that I work in, is patient-reported
7 outcomes. Health-related quality of life is
8 considered specific to the dimensions that you
9 have there, which are physical, mental, and
10 social.

11 So if I am interacting with the
12 FDA, for example, they will look at the term
13 "health-related quality of life" as something
14 that pertains to those dimensions. They
15 prefer the term "patient-reported outcomes."

16 The term "quality of life" in and
17 of itself fell out of favor a number of years
18 ago because it was thought to be way too
19 vague. You could be considering a person's
20 financial status. You could be considering
21 religion. You could be considering other
22 factors that have nothing to do with their

1 health. That is when the term "health-related
2 quality of life" came in that really gets
3 superseded by the term "patient-reported
4 outcomes."

5 So I think for me personally, this
6 is one of the key pieces in terms of what are
7 we after here? Are we interested in knowing
8 from the patients' perspective how they come
9 through the health care system, whatever their
10 purpose in entering the health care system
11 was, and they come out the other side of it or
12 as they are going through it? What do we want
13 to measure? What is it that we want to know?

14 That is a question. I don't know
15 the answer to that. I don't know. I guess I
16 have to learn more before I could have like a
17 cemented opinion myself on it.

18 MEMBER JUSTER: It looks like
19 those three domains are certainly
20 interrelated, but they are independent. I
21 could have more or less pain, and that is only
22 somewhat correlated by how much function I

1 have.

2 And that is only somewhat
3 correlated with my -- I will still use quality
4 of life but whatever the terminology is. So
5 how I feel, what I can do, and how I feel
6 about it, meaning my assessment of my quality
7 of life, seemed to be independent, somewhat
8 independent.

9 MEMBER McNULTY: That is exactly
10 right. I think it is how a patient functions
11 or feels is the way it would be put.

12 MEMBER DEUTSCH: I just wanted to
13 go back to what Barbara said. So the area
14 that goes back to -- I think you mentioned
15 occupation. In rehabilitation, we usually
16 refer to that generally as participation. And
17 so that is consistent with the international
18 classification of functioning kind of
19 terminology activities for the physical
20 patient functioning. So I would just like to
21 bring that up.

22 DR. BURSTIN: A question for the

1 group to ponder with this first group of
2 patient-reported outcomes. We have had a lot
3 of discussion internally about whether
4 bringing a measure like this in in and of
5 itself has value or only as it represents a
6 delta.

7 So as you go back to the
8 Donabedian example, if you are trying to
9 understand the impact of health care on this,
10 if somebody comes in the hospital at point A
11 and they leave at point B, is that really what
12 we should be measuring in the way we have sort
13 of looked at some of the PT measures, for
14 example, that we brought for the system?

15 But there are very, very, very
16 few, precious few, examples of this in the
17 literature. And I just want to open that up.

18 MEMBER DEUTSCH: Yes. Can I? So
19 in rehabilitation, we have the functional
20 dependence measure, which is used in every
21 rehab hospital and also used in some other
22 settings.

1 There is I would say not really
2 consensus on whether you should look at the
3 change in function, as opposed to discharge at
4 function. And I was talking to David a little
5 bit during lunch.

6 So what we do in rehab is we on
7 admission look at clinicians observe the
8 patient and report how independent they are on
9 a seven-level scale, seven being the person is
10 more independent, one being the person is
11 dependent. And there are 18 items that are
12 measured.

13 The cognition, which I think is
14 probably your mental, not so solid, but the
15 motor items are certainly well-regarded in
16 general, at least 12 or 13 used in the payment
17 system for rehab hospitals right now.

18 And so basically what people do is
19 they rate the person on how independent they
20 are, on the 12 or 13 items, eating, grooming,
21 bathing, dressing upper body, dressing lower
22 body. And then there are some mobility items

1 for transfers.

2 So those items are added together
3 to a sum score on admission and discharge. A
4 lot of people do look at the change. And
5 typically patients gain about 20 points on the
6 scale from admission to discharge. So it is
7 basically when they come into rehab and when
8 they rehab.

9 So I think in our preparation
10 materials, there is a comment about it should
11 be at a time post-stroke or post. And we
12 don't do that, right?

13 What I wanted to bring up is that
14 when you compare scores on admission and
15 discharge, it assumes that you have kind of
16 the same functional ruler on admission and
17 discharge. And there has been some evidence
18 that the ruler actually doesn't do that.

19 And I can maybe explain this a
20 little bit better in writing later or may have
21 some material on my flash drive that I can
22 show.

1 Basically people get a score of 12
2 to 84 based on the person who gets one on all
3 of the items would get a 12. The person who
4 gets a 7 on all 12 items gets an 84. And so
5 kind of that is a ruler.

6 And so on admission, when you use
7 that ruler, everybody who used to be a one,
8 are they at the same level of one? They may
9 or may not. And it is particularly at the
10 floor and ceilings. So that is definitely a
11 debate.

12 I know in the published
13 literature, I submitted change in function.
14 And some people, the reviewers, don't like
15 that. And sometimes I will do "discharge
16 function," and some reviewers don't like that.

17 So I don't think there is a
18 consensus. There are techniques that can be
19 used to translate these ordinal levels,
20 measures, into interval level.

21 Rasch analysis is one of the
22 procedures that I have used. The good news is

1 when I compared my outcomes in the
2 traditional, just the score added up versus
3 the Rasch measures, I haven't seen a
4 difference, but a measurement person would say
5 you have to use measures.

6 So I can talk more later about it,
7 but --

8 CO-CHAIR DUBOW: You know, from
9 the patient perspective, staffing at discharge
10 is probably really inadequate, but I know that
11 it presents a measurement challenge.

12 I remember being on a committee
13 once thinking about hip fracture and
14 ambulation six months out. And the problem
15 was how you could get that assessment as a
16 measurement issue. But that is what a patient
17 really wants to know. You know, can I walk as
18 I walked before my hip fracture?

19 And if you give it a longitudinal
20 picture, then you have a better sense of it.
21 And I think we are going to face some
22 measurement challenges here.

1 MEMBER DEUTSCH: In
2 rehabilitation, we actually do have an
3 accreditation group that emphasizes
4 post-discharge status. And so there are quite
5 a few.

6 We have hospitals. We actually do
7 call patients three to six months after
8 discharge and ask them how they are doing.
9 And they do a phone interview. So this
10 becomes the patient-reported version.

11 CO-CHAIR DUBOW: I did some
12 research to find that recall was really lousy.
13 Yes. And you also found in general they get
14 the patients who are really easy to find. And
15 so people who end up in nursing homes aren't
16 included. And so there are a lot of
17 methodologic problems with that.

18 MEMBER GIBBONS: I just wonder if
19 there is some other intermediate outcome that
20 needs to be looked at. I don't so much mean
21 intermediate. I just think that when you look
22 at patient function, symptoms, and

1 health-related quality of life as some
2 objective measure and then look at patient
3 experience with the care, there is really not
4 an outcome that looks at whether the patient
5 attributed their condition to the health
6 intervention.

7 And what I mean by that is, in a
8 lot of questionnaires, patients' rating of
9 health care givers and hospitals and clinics,
10 whether you use Press Ganey scores or so
11 forth, may at times not be an accurate
12 reflection of what the outcome was in terms of
13 the actual intervention. But they are
14 confused with the health care.

15 So I just wonder if there is some
16 other outcome that actually measures whether
17 the patient felt that there was a close
18 relationship between the health care they got
19 and where they sit or is that too cynical?

20 MEMBER YAWN: No.

21 CO-CHAIR DUBOW: Yes.

22 MEMBER YAWN: No. I don't think

1 it is too cynical, but, I mean, when we
2 believe that less than ten percent of health
3 is based on anything we do at all, I sort of
4 wonder if the patients are going to be better
5 at attributing things to us than the world
6 does.

7 CO-CHAIR DUBOW: I don't think it
8 is the right question, though. I mean, I
9 think, first of all, Press Ganey is not an
10 NQF-endorsed --

11 MEMBER GIBBONS: Okay.

12 DR. BURSTIN: They are actually
13 just a purveyor of whatever surveys are used.

14 CO-CHAIR DUBOW: Right.

15 DR. BURSTIN: Right, right.

16 CO-CHAIR DUBOW: But the
17 instrument, the CAHPS tool measured
18 experience. And whether a patient understands
19 what made her well is not -- who cares?

20 I mean, the issue is how she
21 experiences and how she experienced the care
22 processes and how she feels now. So there is

1 a lot of emphasis on communication because we
2 know that has an important relationship to
3 outcomes.

4 There are questions about the
5 experience of the transactions. You know, did
6 people communicate? Did you get the care that
7 you needed when you needed it? You know, you
8 know the kinds of questions that are in those
9 CAHPS instruments.

10 I think that is what we want to
11 know. I don't really know if I get an
12 immunization. You know, I don't have to
13 understand that. I think what we want to know
14 from the patient is what the patient can best
15 report. And that is how she experiences
16 things that we believe to be integral to the
17 process of achieving a better outcome.

18 So I think I would think about it
19 from that perspective.

20 MEMBER AMARASINGHAM: I think this
21 is an important point. The point I would also
22 make, though, is that depending on the

1 population, some populations tend to rate
2 their caregivers differently. For example,
3 lower socioeconomic populations tend to be
4 more forgiving.

5 CO-CHAIR DUBOW: That is why we
6 are asking about experiences.

7 MEMBER AMARASINGHAM: Right,
8 right. Yes. So I think it is important. I
9 think both perspectives are important: the
10 perspective of it doesn't matter necessarily
11 what the objective outcome was to the patient.
12 Was the patient happy with the experience?
13 And I think we need to know specifically what
14 happened, whether the right thing was done.
15 I think that is really important.

16 The other point I would make,
17 getting back to Helen's question, I think your
18 question was, which would be the preferable
19 measure, the measure that requires a delta or
20 one that could be measured independently at
21 any time?

22 And I would say as a goal, a

1 measure that could be done at any time
2 independently without requiring a delta would
3 be the preference in my view but that it would
4 have to be an extraordinarily standardized
5 measure.

6 And that is challenging because it
7 is going to be hard to find measures like
8 that. And probably we will be left with delta
9 measures.

10 MEMBER HOPKINS: Just to build on
11 that thought, I mean, what would be wrong to
12 have the SF-12 be an NQF-endorsed measure of
13 patient functional status? It could be
14 applied in a number of different ways.

15 And if you come up with the other
16 answer, which is it has to be built into a
17 measure like the measures we know, then you
18 end up having somebody decide, well, do you do
19 it four months after the event or six months
20 after the event? Do we need to standardize
21 that? Maybe we do. And then is it with
22 reference to some value prior to that? And if

1 so, when?

2 Do we have to decide that before
3 we conclude the SF-12 is a standardized
4 measure that is well used for measuring
5 functional health status or some more specific
6 instrument that works for hip fracture
7 patients or something?

8 DR. PACE: Okay. Let me throw out
9 some ideas about that. One is that we have
10 endorsed something similar to that in the ESRD
11 project. It is a process measure, which is
12 that end-stage renal disease patients have a
13 quality life assessment, released annually,
14 using the specific SF-12 modification. I
15 think they call it the KDQOL. It is a
16 modification of SF-12 specifically for
17 end-stage renal disease patients.

18 That is something that can be
19 measured at the provider level, which is what
20 our quality measures are. I think it was
21 brought up earlier. The purpose of these
22 measures is to get an assessment of the

1 quality of care being provided by some entity,
2 whether it is a hospital, a clinic, a doctor's
3 office, et cetera.

4 So the process measure is
5 certainly one way to get at that kind of
6 thing. But when we are talking about an
7 outcome measure that is using this, you have
8 to have some way of accumulating, aggregating
9 the patient-level scores, whether it is a
10 changed score or just the one point in time
11 where you have an average.

12 You have to have some way of
13 making that information aggregated to a
14 provider level if we are talking about a
15 provider-level quality measure, if we are
16 talking about trying to use a score to assess
17 the quality of care.

18 Otherwise you have all of these
19 individual scores. And they are great for
20 clinical care and hopefully directing what you
21 do for the care of that patient, but it
22 doesn't mean that we have a quality measure

1 that will be used to assess the quality of the
2 health care entity.

3 So that is kind of where we are
4 at. And so NQF typically has not endorsed
5 individual scores. We often refer to having
6 endorsed the CAHPS, but the CAHPS, actually,
7 what we are endorsing are those measures that
8 are computed out of the CAHPS items, not
9 necessarily the survey.

10 Obviously once you endorse a
11 measure, whether it is a process measure or an
12 outcome measure, you are, in essence,
13 endorsing the data behind that, whether it is
14 the CAHPS or the SF-12 or the OASIS for
15 computing a home health function measure. So
16 it is more of an indirect way of trying to
17 endorse that, where that data is coming from,
18 as well.

19 That is kind of at least how I see
20 the distinction of endorsing that instrument,
21 how you could do it as a process measure, and
22 what we would need to have that as a basis for

1 an outcome measure and certainly welcome other
2 viewpoints or discussion about that.

3 MEMBER YAWN: I need to understand
4 if we are talking about across conditions of
5 deltas versus actual measures. I love going
6 across conditions and being able to lump all
7 of a system. I don't know what the word
8 "provider" means anymore, so either a system
9 or an individual's scores.

10 But I am very reluctant to do that
11 across multiple chronic conditions if we are
12 saying, "I am only going to do it for hip
13 fracture patients" or something else, because
14 there are several chronic conditions, COPD
15 being one of them I can think of quickly, in
16 which you expect the score to go down.

17 That is the nature of the disease
18 and the fact we have no disease-modifying
19 therapy. So they are going to get worse, and
20 they are going to die of heart disease. But
21 that is just the way it is.

22 So I can't mix COPD with diabetes

1 perhaps. I don't know what I would do with
2 that. I can do just diabetes or just COPD for
3 a delta score, but I don't know how to mix
4 them.

5 MEMBER JUSTER: So what do you do
6 when they have both of them?

7 MEMBER YAWN: That is part of the
8 problem, is what do you do? Do you say,
9 "Okay. I am happy if they only go down
10 slowly"? You know, I don't know what you do.

11 MEMBER JUSTER: Well, presumably
12 they might be able to go up from their
13 diabetes and down from their COPD on some even
14 item in the -- I would have to go one by one
15 item, but I am sure there are some items that
16 can go up from one disease and down from
17 another.

18 Meanwhile the person is just
19 thinking, "How many flights of stairs can I
20 climb now compared to the number that I have
21 to?"

22 MEMBER YAWN: Right.

1 DR. PACE: I think, you know, you
2 could have measures either way. But I think
3 what you are pointing out is the issues that
4 we talk about with risk adjustment.

5 So typically with outcome
6 measures, you need to account for what the
7 patient is bringing with them at the start of
8 the health care experience or health care
9 episode. So how many chronic conditions do
10 they have, which chronic conditions, et
11 cetera?

12 And there would be various ways to
13 handle this. A lot of the SF-12, you know,
14 they have reference populations when it is a
15 discrete condition.

16 So that is the challenge of trying
17 to get an outcome measure using these. And
18 that was actually an issue that was brought up
19 when we were initially looking at the measure
20 for end-stage renal disease project, that it
21 really was identified that the preference was
22 to have some type of outcome measure, whether

1 it would be average score at some point in
2 time or how that would be constructed.

3 And the measure developers at that
4 time said they did not recommend an outcome
5 type of measure because they hadn't worked out
6 the case mix or risk adjustment for that. And
7 that is why we ended up with a process measure
8 in that particular project.

9 But, you know, it is an important
10 consideration if you are talking about
11 administering it across all types of
12 conditions that you have to have some method
13 for accounting for some of those differences.

14 MEMBER YAWN: I think that you
15 bring up another point that I think we are
16 going to have to spend some time on, and that
17 is risk adjustment. I think risk adjustment
18 for multiple chronic conditions just by
19 counting them up has been shown multiple times
20 to be a minimal, if at all, useful way. And
21 that is how most people still do it.

22 If somebody has two or three of

1 our conditions, cardiovascular disease
2 condition is not being dealt with well, then
3 their COPD probably isn't going so well either
4 or their hip fracture's rehabilitation is not
5 doing so well because they can't walk because
6 they can't breathe.

7 So risk adjustment I think is
8 going to be a fascinating topic and maybe one
9 of those in which we can get sort of groupings
10 of measures maybe. I mean, that has been my
11 fantasy for a long time to figure out how to
12 do risk adjustment based on how well they are
13 doing with each of the conditions and not just
14 one, pretending to ignore the others or count
15 them by number.

16 CO-CHAIR DUBOW: Is there somebody
17 on the phone who wanted to make a comment?

18 CO-CHAIR FLEISHER: Yes. It is
19 Lee. I am just wondering if you had, by
20 chance, or anybody discussed any kind of like
21 template matching as another type of risk
22 adjustment or actually looking at any kind of

1 group analysis, rather than trying to
2 risk-adjust, another way to get to the
3 outcomes.

4 DR. PACE: This is Karen. And
5 yes, we are not only talking about statistical
6 risk models. Certainly stratification so that
7 you are comparing like groups, subgroups, is
8 one way of addressing that, those issues, the
9 differences. Another way that we have seen is
10 really making the measure much more narrow so
11 that you are only measuring it on a more
12 homogenous population.

13 So each of these has different
14 advantages and disadvantages. And we are
15 certainly open to measures using any method.
16 You know we want people to have some rationale
17 and defend the methodology that they put
18 forward but certainly baseline to recognize
19 when outcomes can be influenced by different
20 patient care characteristics.

21 CO-CHAIR FLEISHER: Thank you. My
22 interest group is beginning to think that even

1 process measures may need to be stratified
2 because the level of comorbidities in patient
3 populations may not be equal. And, therefore,
4 you are really not targeting for the patients
5 in whom you could make the greatest impact.

6 So I just want to make sure that
7 we open that up as we classify for outcome
8 measures, creative ways of dealing with the
9 process defiance of risk adjustment that is
10 still developing.

11 CO-CHAIR DUBOW: Okay. Thank you.

12 Dianne?

13 MEMBER JEWELL: So I think I need
14 a little reorientation to the direction this
15 conversation is taking. Are we talking
16 generally about the challenges that we have in
17 dealing with outcome measures given that in
18 their current state, they are pretty limited,
19 partly because of the data that is available
20 to do the risk adjustment, for one thing?

21 And so we have to come up with
22 principles to deal with them such as they are

1 with the idea that we will drive them to be
2 better by our standards or are we saying we
3 won't deal with these limited measures, we are
4 going to set the bar high now? I am not sure
5 where we are headed here.

6 DR. WINKLER: I think you have
7 addressed both the practical and the
8 idealistic world we live in. And I think we
9 need to deal in the real world. And it is
10 nice to have some wishful thinking on the
11 margins in the world we would like it to be
12 perhaps.

13 Many times we would like to talk
14 about things that are a little beyond the
15 ability stretch, if you will, because it helps
16 point in a direction of where to go, rather
17 than just staying put where you are and doing
18 more of the same.

19 So to the degree that you can find
20 the balance in there and albeit it is a very
21 difficult one, part of it is reaching this
22 discussion is having a common understanding of

1 what we need.

2 The fact that the function has
3 prompted this discussion, do we all understand
4 what we mean by patient function? Is it an
5 outcome measure? Perhaps it has got a lot of
6 different characteristics to it, such as
7 Barbara brought up, role versus occupational
8 activities of daily living, all of these
9 elements of it.

10 Does anyone disagree that any of
11 the things we have talked about are not
12 outcomes, not important outcomes?

13 (No response.)

14 DR. WINKLER: Okay. So, I mean,
15 to the degree we are trying to reach a common
16 understanding of what we are going to be
17 discussing, the issue will be, are there any
18 measures in this realm?

19 We are having a hard time finding
20 a lot of them or any, but, again, one of the
21 questions we are going to be asking ongoing
22 and very poignantly later today is, do you

1 know of any? Where might we find them? What
2 rock have not we looked under?

3 MEMBER HOPKINS: So, Reva, help us
4 out here. Let's suppose that we are looking
5 for functional health status assessment of
6 stay with your fracture patients and we find
7 that there is a well-standardized instrument
8 that is widely used, like, for instance, in
9 that field, but the problem is in reference to
10 this conversation, nobody has been through the
11 exercise exactly pinning down and getting
12 broad consensus about what is the right time
13 period of measurement pre and post and what is
14 the measure? To use your term, is it the
15 absolute? Is it the delta?

16 Can't we sponsor something that
17 would lead to that discussion taking place and
18 that consensus being built so we finally have
19 a measure because these are really important
20 measures or do we just say, "Gee, it is too
21 bad nobody has been through that. So I guess
22 we can't endorse any measures that are

1 functional health status for hip fracture
2 patients"?

3 CO-CHAIR DUBOW: So what do mean
4 by "sponsor"? I mean, what are you thinking
5 about? We need to have measures.

6 MEMBER HOPKINS: Right. So I
7 think that NQF would think seriously about how
8 they could make that happen. It is not done
9 by NQF. It is done by I don't know who but
10 the entities that sort of take responsibility
11 for caring for patients.

12 I am suddenly becoming very aware
13 that this is going to call for some proactive
14 action or we are going to be left empty. And
15 I hate to think of us coming up dry on this.

16 DR. PACE: Well, one of the things
17 that I think we would like to have you engage
18 in discussion about and maybe partly today and
19 partly when you get into gaps and it becomes
20 even more evident, the lack of measures, is
21 whether a path of endorsing process measures
22 related to some of these functional assessment

1 kinds of tools is a reasonable path and
2 whether --

3 MEMBER HOPKINS: That doesn't help
4 me at all. If your concept of process measure
5 is that such and such an instrument was
6 administered, that tells me nothing. I mean,
7 I want to know what was done with it. I want
8 to know if the patient got better.

9 DR. BURSTIN: Can I try a simple
10 example, though, just a real clinical example?
11 So my committee routinely has the medical
12 system. As soon as somebody walks in the
13 door, administers the PFQ-9, which is the
14 depression screen, prints it right into my
15 EHR, it is color-coded. That person's PFQ-9
16 score is high, meaning risk for depression.
17 It is highlighted in red. And I now know what
18 to do.

19 That seems pretty important. You
20 might, in fact, want a measure that says, "I
21 am just making this up" for the proportion of
22 the time patients, new patients, arriving for

1 primary care services are screened for
2 depression using a standardized depression
3 tool.

4 It might be very useful, even
5 though at the end you could alternatively say
6 proportion of patients who had a high PFQ-9
7 who are referred for mental health. Again,
8 that still doesn't necessarily get you an
9 outcome, but that is part of the problem here.

10 If we endorse the PFQ-9, that is
11 very nice, but how do we actually use it to
12 guide the principles of NQF, which is to be
13 able to look at measures appropriate for
14 public reporting and quality improvement?

15 This is where it gets tricky. You
16 are not trying to like say we don't want it.
17 I would love to bring these measures through.
18 I would love to use smart people to help us
19 think this through.

20 MEMBER HOPKINS: You know, it is
21 not just about the health status measures. I
22 think everything on your list here raises

1 those same questions.

2 DR. BURSTIN: Although some of the
3 things that are inherently bad are easier:
4 complications, death. I mean, you don't have
5 to get to the delta too much there. You know,
6 those are inherently bad. It is the issues
7 where you are trying to assess the good side
8 that it gets more complicated.

9 DR. PACE: And I know that this
10 would be outside of the scope as currently
11 configured for, of course, a project on
12 outcomes, but I think some discussion and
13 perhaps being able to bring in some of these
14 measures with the rationale that it is the
15 only way we are going to get to our ultimate
16 goal of outcomes or it will help facilitate,
17 get there, may be worth your discussion,
18 whether you think it -- you know, if you think
19 it would be worthless, then there would be no
20 point. But I think there might be some areas
21 for discussion.

22 MEMBER HOPKINS: I guess you are

1 answering my question, not the answer that I
2 was hoping to hear, but it is that we really
3 can't, that NQF really can't, do anything to
4 push the developers further and faster to
5 decide those issues, the when, the what
6 instruments, and what is the measure.

7 CO-CHAIR DUBOW: I didn't quite
8 hear that. I heard that in doing it -- I
9 mean, this is sort of a last resort if we
10 can't identify outcomes for these particular
11 areas -- that as an interim, presumably there
12 would be some conversation and identification
13 of the gaps and the need for genuine outcome
14 measures but as an interim step, it might be
15 that there was, you know, to use Helen's
16 example, for example, something that
17 integrated a tool into the process of care
18 that potentially hopefully there is going to
19 become evidence attached to the use of the
20 tool to achieve the better outcome.

21 So it is the making the silk purse
22 out of the sow's ear kind of approach once we

1 determine that there is no outcome measure
2 available for that particular area.

3 DR. BURSTIN: There may be
4 outcomes, like, for example, a six-minute
5 walk, some of the cardiovascular. I mean,
6 there are known more physiologic outcomes.
7 And we would be delighted to bring those
8 through.

9 The presumption is doing better on
10 those is a good thing. But, again, the risk
11 adjustment there would get complicated, but it
12 is less of that, I think, the delta.

13 DR. PACE: I think that the two
14 challenges are with these. And I think the
15 confusion is that they are often called
16 measures. It is a patient measure. And we
17 are talking about quality measures. So there
18 is a lot of confusion of what we are talking
19 about.

20 But to me the issue is you have to
21 be able to aggregate to a level where you are
22 going to make a decision about the quality of

1 whatever entity it is. And then certainly any
2 outcome measure has some issues regarding risk
3 adjustment.

4 MEMBER YAWN: My goal is to some
5 day be on panels like this where we don't
6 believe the gap analysis may be the most
7 important part, but I don't think we are there
8 yet. I really don't, unfortunately.

9 I think we can come up with some
10 interim things plus a few good measures, but
11 I still think the gap analysis is going to be
12 the most productive part of this.

13 MEMBER DEUTSCH: I just wanted to
14 mention that on the instrument side, so the
15 items being collected, a couple of things.
16 There is the Promise Group that is at
17 Northwestern University. And they are trying
18 to report patient-reported outcomes.

19 Their focus is on really
20 integrating research. They are taking
21 depression, for example, and saying, what are
22 all the tools or instruments that are out

1 there and how can they link up so they have a
2 very strong measurement perspective. So they
3 have got that ruler thing to make sure that
4 you can do that.

5 Dave Selle is the person at
6 Northwestern who leads that group. David
7 Tulskey is a leading researcher in the
8 health-related quality of life. And he is
9 trying to link up.

10 So he has got an NIH project
11 called Neuroqual, Neurologic Quality of Life,
12 quite focused on stroke right now. He is also
13 putting one together or also is funded to do
14 one for spinal cord injury.

15 So they are trying to put these
16 data banks together so that some of the items
17 are the same for the diagnoses, but some of
18 them are different because these are different
19 issues. So he would also be a resource.

20 And then the last thing I wanted
21 to mention, just in terms of work, one of the
22 projects that I work on is through a

1 subcontract with RTI International. And they
2 are funded by Medicare to create a new
3 standardized patient assessment tool, the CARE
4 tool.

5 And so that kind of could tie into
6 some of this because eventually that would
7 replace the FIM, the OASIS, and DS. So I am
8 listening carefully here because I am quite
9 involved.

10 And that is about 30 percent of my
11 work effort right now. So I know they keep up
12 with what is going on. And so that is
13 potential in terms of where things are going.

14 We have the PHQ-2 on there right
15 now, but when we have pain and we have
16 functional status and it is used both in all
17 of the post-acute care settings, so home care,
18 skilled nursing facilities, rehab hospitals,
19 but also in acute care.

20 And so I have been one of the main
21 trainers to go out and teach people how to
22 collect the data. And so it has been kind of

1 an interesting experience for the acute care
2 nurses to think about measuring functional
3 status. And often times we end up with
4 training the therapists.

5 DR. WINKLER: Just to respond to
6 David, the exercise around identifying the
7 needed outcome measures is not just one for
8 fun.

9 I mean, there is an audience of
10 folks out there who are really looking forward
11 to the output of this with the idea towards
12 promoting the development.

13 And it is not a 101. This person
14 will do that three days after we decide. I
15 mean, it is not quite that definite. But at
16 the same time, I think that there is a growing
17 audience of folks wanting this and realizing
18 that it will just take the right people doing
19 the right thing.

20 And so it really is not a
21 theoretical for fun exercise we are going to
22 be doing. I mean, I think there is very much

1 an eager audience for the outcome of this
2 project, certainly on that gap side.

3 So to your frustrations and
4 totally ease, the fact is that it is not just
5 going to go into the great abyss, never to be
6 heard from again, I think is not likely to
7 happen.

8 MEMBER McNULTY: Okay. Can I just
9 add to what Anne said? The Promise data bank
10 is certainly a place to look because they are
11 putting together items that can be used. And
12 it is an NIH-funded project. So it is
13 definitely publicly available.

14 And, as I was mentioning to Reva
15 during the lunch hour, there are a couple of
16 other things. One is that there is something
17 called a PRO Consortium. That is a private
18 partnership. It is being run by the C-Path
19 Institute. And it is basically FDA's
20 interest, pharmaceutical industry, academics,
21 others coming together, again, to look at
22 areas where mostly they feel that there are

1 gaps in terms of patient-reported measures and
2 trying to come together as a consortium to
3 develop measures into the future. So it is
4 not here right now, but it is something that
5 you probably ought to be aware of that is
6 happening.

7 The other is there are a couple of
8 sources of databases that you could go to to
9 look for what patient-reported measures or
10 even clinician-reported measures exist. One
11 of them is a database called OLGA, O-L-G-A,
12 which is maintained by Penny Erickson.

13 And the other one is ProQolid,
14 which is maintained, owned and maintained, by
15 a company called Mapi that does a lot of
16 patient-reported outcomes work.

17 Both of these are databases that
18 you have to pay annual subscriptions to get
19 access to them, but, on the other hand, there
20 might be some way of talking to each of these
21 groups and seeing if you could get some access
22 for some period of time. And I would

1 certainly be willing to help you with that.

2 DR. PACE: So can you describe
3 what kinds of measures would be in these?

4 MEMBER McNULTY: What they try to
5 do is they try to keep up with all of the
6 patient-reported outcomes measures that have
7 been developed and keep information about
8 them, not just the fact that they exist but
9 like the psychometric data around them, who
10 developed them, how you get to use them,
11 because in some instances, they will be
12 completely accessible publicly. In some
13 instances, they may be privately held. And
14 how do you access the people who will give you
15 that access?

16 DR. PACE: And are they primarily
17 patient-level instruments or do you know if
18 any work has been done on any of these to
19 aggregate them to get at like a provider
20 entity, whatever entity, health care provider
21 level?

22 MEMBER McNULTY: I would say the

1 majority of them are patient-level. I don't
2 think that there has been a huge amount of
3 aggregate stuff that has happened.

4 DR. WINKLER: All right. So I
5 think some of these bullets on these types of
6 outcome measures are fairly straightforward
7 and don't need a lot of discussion, but I
8 think some of them do. So I do want to go
9 down the list, the next one being intermediate
10 clinical outcomes, whether biochemical or
11 physiologic.

12 We have a handful of these
13 measures in the portfolio. This is, you know,
14 blood pressure less than X, hemoglobin A1c
15 less than X. Pick your favorite number, some
16 of these, lipid values.

17 So those are the typical ones.
18 Primarily around diabetes is where we have
19 them.

20 DR. BURSTIN: Dialysis adequacy as
21 well.

22 DR. WINKLER: Yes, dialysis

1 adequacy is another one. So that there is an
2 actual clinical intermediate outcome that can
3 be measured.

4 So we do have a few of those. We
5 have seen what those are like. David and I
6 had a conversation earlier about these kinds
7 of measures being built around thresholds
8 when, in fact, the data collection could be
9 done such that you could use a continuous
10 variable, rather than dichotomous variables,
11 and how that might change measurement.

12 I think that is something that
13 needs to be thrown into the consideration of
14 measures because having the actual value and
15 then doing whatever you want to in the future,
16 as opposed to a "Yes"/"No," you know, how do
17 you follow that along? So I think there are
18 some elements of that that can be put into the
19 consideration.

20 Dianne?

21 MEMBER JEWELL: So for measures
22 like that -- I probably should know this from

1 the panel I sat on before, but measures that
2 are not developed specifically by anybody, who
3 brings those forward? So in my case, I am
4 thinking about gait speed.

5 The gait speed assessment in my
6 world is huge because it is so tightly linked
7 to mortality, to a number of things, but it is
8 not owned by anybody.

9 So who would bring something like
10 that forward, how fast one walks? Sorry. Let
11 me start again. Walking speed, otherwise
12 known as gait in my world, is actually -- you
13 know, you could turn that process measure into
14 a do something with it when you get the score
15 kind of thing, but it is not a measure
16 developed by anybody. It is what physical
17 therapists do.

18 So who brings that forward,
19 something like that?

20 DR. WINKLER: Yes. I think there
21 are a lot of things that have yet been
22 translated from either research clinical

1 practice into performance measures.

2 MEMBER JEWELL: Right.

3 DR. WINKLER: I mean, and so that
4 translation again is like all of the
5 translational from research into practice
6 sorts of things. So the question is again a
7 lot like the SF-12 tools, things you use, but
8 the measure will need a little bit more around
9 it to support it to be able to meet
10 standardized use, when do you do it, how do
11 you do it, and some of the definitional
12 aspects of it.

13 I think at this point it would be
14 great to encourage a more traditional measure
15 developer to adopt it or in your field,
16 whoever does measures in that realm, create
17 the measure. It may be very simple and very
18 well.

19 Measures are living things,
20 really. I mean, they don't exist without need
21 for change and revision and reconsideration on
22 an ongoing basis. And that is why one of

1 NQF's requirements is that each measure has a
2 steward that kind of raises it and acts as its
3 parent and keeps it fresh and alive and cares
4 about it because the worst thing we could have
5 is a measure that loses its attachment with
6 science.

7 You know, it is sitting there on
8 the shelf. It gets old and moldy, and nobody
9 is caring for it. And then it is of no use to
10 anyone. So the steward aspect is really an
11 important one.

12 Helen, did you want to say
13 something? I didn't mean to cut you off.

14 DR. PACE: I would just add to
15 that that it is not unlike a measure about
16 blood pressure level. You know, there is no
17 one that owns the blood pressure measurement.
18 And someone has taken that and crafted a
19 quality measure by identifying what is the
20 target population. Are there any exclusions?
21 How do you aggregate that information for the
22 target population and the denominator and

1 numerator?

2 And, as Reva said, partnering with
3 a group that develops measures or from your
4 discipline that develops measures would be the
5 ideal way so that somebody could actually
6 maintain that.

7 MEMBER JUSTER: The thing that
8 makes it a blood pressure performance measure,
9 though, is not what is the blood pressure but
10 this somewhat artificial and dichotomous
11 cutoff.

12 MEMBER YAWN: It changing.

13 MEMBER JUSTER: Yes. I mean, we
14 all know that it probably actually is better
15 to have a blood pressure of 138 than 140, but
16 you have to cut it off somewhere. And so they
17 have.

18 The same thing with gait speed,
19 you would have to say the percentage of people
20 who had a gait speed over whatever it is, 6,
21 5, 7, 12. I mean, it could be stratified, but
22 that is what converts it to a performance

1 measure, right?

2 DR. PACE: Well, if those
3 benchmarks are known. I mean, the other way
4 is to have -- I mean, one other way -- there
5 may be others -- is you have an average across
6 your patient population and it is
7 risk-adjusted and you are able to compare your
8 performance against other providers.

9 So, I mean, there are various
10 ways. And it depends on what you are
11 measuring, if there are those known benchmarks
12 associated with morbidity and mortality.

13 So there are a variety of ways to
14 construct measures. And it should flow from
15 the information we know.

16 CO-CHAIR DUBOW: Somebody is on
17 the phone. Is there a question?

18 (No response.)

19 CO-CHAIR DUBOW: Okay.

20 MEMBER HOPKINS: So just a little
21 bit more on this point of taking a continuous
22 variable --

1 CO-CHAIR DUBOW: One second. We
2 will be with you in a minute.

3 Go on, David.

4 MEMBER HOPKINS: -- of taking a
5 continuous variable, like a lab reading or
6 blood pressure and constructing a measure that
7 is dichotomous. Think about the information
8 that is lost. You know, the way that a HEDIS
9 measure on blood pressure has been collected
10 for all this time -- and it is almost all from
11 charts -- is somebody goes in and looks. Is
12 it under 140/90 or 130/80 or not, "Yes"/"No"?

13 And we could have constructed a
14 database, for gosh sakes. And now we are
15 entering an era where comparative
16 effectiveness research is hopefully going to
17 get funded.

18 Maybe NQF could help a little bit
19 by saying when you provide a measure like
20 that, start with a continuous variable.
21 Record that. Then the measure --

22 DR. BURSTIN: As those measures

1 get retooled for EHRs, much of that will
2 automatically happen because the data source
3 will be there for the --

4 MEMBER HOPKINS: We all know what
5 happens with blood pressure in EHRs, where it
6 doesn't get in the data field, blood pressure
7 readings.

8 DR. BURSTIN: It is the one thing
9 I can assure you is always there.

10 MEMBER HOPKINS: Not the ones I
11 hear about. They put it in their notes.

12 DR. BURSTIN: Yes. And this is
13 the kind of thing where, again, if you look at
14 the full breadth of what we are trying to do
15 in the quality data set, it doesn't just say
16 what the data element is. It says where to
17 find it.

18 And so the EHRs have to build it
19 such that the data type is connected to, data
20 element is connected to, exactly where you are
21 going to find an EHR to standardize it.

22 That is part of the issue here, is

1 part of this effort is also standardizing
2 where you would find it and what kind of
3 field.

4 MEMBER HOPKINS: Behavioral piece.

5 DR. BURSTIN: Behavioral pieces.

6 MEMBER HOPKINS: The reports I get
7 from a lot of folks who use CMRs is it is
8 easier to type the blood pressure reading into
9 the notes than to pull down the menu and put
10 it in the data fields.

11 DR. BURSTIN: I think less and
12 less so as people move towards team-based
13 care. I never enter blood pressures at all.
14 They are done by my MA as they walk in the
15 door. I mean, I don't physically enter them
16 at all other than reporting in my assessment
17 plan "Looks good" or "Up this," "Change this."

18 Things have changed as you have
19 moved to more of a team model. And,
20 increasingly, it is the non-physician
21 clinician who is entering a lot of those data,
22 flu shots, vital signs, smoking status. I

1 don't enter any of those, depression
2 screening.

3 MEMBER YAWN: Maybe it is because
4 they do it much better than --

5 CO-CHAIR DUBOW: Lee, did you have
6 a question?

7 MEMBER FILLIPO: This is Brian
8 Fillipo.

9 CO-CHAIR DUBOW: Sorry? Go on.

10 MEMBER FILLIPO: This is Brian
11 Fillipo. I just had a comment I would like to
12 make. I know we have talked a lot about the
13 use of intermediate clinical outcomes
14 indicators.

15 I think that there are clearly
16 times when that is really necessary because we
17 don't have good, easily measurable outcomes
18 indicators, but I think we all recognize the
19 literature is riddled with examples where we
20 have used intermediate outcomes indicators to
21 measure a new intervention.

22 And it has turned out, although we

1 have improved an intermediate outcome
2 intervention, we have actually worsened
3 measurable outcomes or stroke or death or
4 whatever other. So I just think we need to be
5 careful there.

6 DR. PACE: I think that is a great
7 point. And one of the things in our
8 evaluation criteria is that for intermediate
9 outcomes, we want to see the association with
10 the desired outcome. So that would be part of
11 the evidence that we would be asking for in
12 the submission.

13 MEMBER GROAH: I just wanted to
14 come back to David's point. And that is that
15 many of the EMRs now actually require the
16 blood pressure to be in a specific place. And
17 you can't close out that record unless it is
18 there.

19 MEMBER YAWN: I wanted to follow
20 up on what you were saying, too. I think we
21 need to make sure that we get some of our
22 statistical colleagues involved a little bit,

1 too, because I can give you 14 different
2 groups of blood pressures that all come out to
3 an average of whatever. And they have huge
4 differences in what I would consider quality.

5 I mean, you can have a bimodal.
6 They are either all hypotensive or grossly
7 hypertensive. But on average, they are
8 normotensive.

9 And so I think that we really,
10 really need to talk about distributions,
11 means, medians, standard deviations. We need
12 to have people help understand those so we
13 don't collect it as a "Yes"/"No" or at least
14 if you can do a "Yes"/"No" and plus or minus
15 whatever.

16 But we have got to be realistic
17 about these things because the consumers of
18 this information are much smarter now. I
19 don't particularly enjoy going back and
20 arguing with this whole group of physicians
21 about, well, mine is a bimodal or mine is this
22 or something when I gave them an average.

1 So let's make darn sure that we
2 think about those, please.

3 DR. WINKLER: Yes. Let's move on
4 to the third bullet. And this is another one
5 of these areas there. And you may not agree
6 that the aggregated topic is included, but
7 this is the area of patient experience with
8 care, knowledge, understanding, and
9 motivation. And we have talked a little bit
10 about this health risk status or behavior and
11 included adherence in this.

12 And so the question is, are all of
13 these outcomes? Should we relate them that
14 way? Should we characterize it differently?

15 MEMBER HOPKINS: You know, it is a
16 really good question.

17 DR. WINKLER: We stomped on Linda.

18 MEMBER HOPKINS: I'm sorry.

19 MEMBER GROAH: I have a problem
20 with patient experience. It is really their
21 perception. There is a big difference between
22 the experience and perception. And that is

1 really what -- that perception makes a big
2 difference on their socioeconomic status.

3 I think we really need to narrow
4 that one down and maybe even divide it up, but
5 that is a real issue. That is what CAHPS is
6 measuring, is perception, not really
7 experience, if you really look at those
8 questions.

9 DR. BURSTIN: Most of the
10 understanding of CAHPS with the exception of
11 a couple of global ratings scores, all the
12 rest of the items are actually patient reports
13 of care.

14 So they are not perception. They
15 are, "Did you get your discharge instructions?
16 Did you get your medications explained to
17 you?"

18 So they are intentionally done
19 that way so they are objective and not
20 subjective. So they are intentionally done as
21 a way to get at patient experience.

22 The nice part about them, at

1 least, in my experience -- you know, I used to
2 run quality for a teaching hospital once. We
3 could move those scores in a way that I
4 couldn't move good to fair, you know, not
5 fair, God forbid, fair to excellent or
6 something like that; whereas, I could move a
7 portion of patients who reported they got
8 discharge instructions in a way they could
9 understand.

10 MEMBER GROAH: Right, like Press
11 Ganey, for instance, is the other opposite of
12 that, where the perceptions really are --

13 DR. BURSTIN: Right. The patient
14 experience of care is really intentionally
15 thought to be something very different than
16 patient satisfaction and perception.

17 MEMBER YAWN: I would suggest that
18 even those are based on their perception. I
19 mean, we have done several of those where we
20 have actually observed what was happening
21 because we videotaped it. And then we ask the
22 clinician, and then we ask the patient what

1 happened. And they don't always remember.

2 And so I think it is very
3 important. And I know the CAHPS has worked
4 toward that to get the things that we think
5 are most crucial.

6 And, yes, discharge instructions
7 would be one of those. But we need to be very
8 careful as people try to expand those things
9 about what really happened during the
10 encounter.

11 It is the patient's perception,
12 just like it is the clinician's perception of
13 what happened in the encounter, not
14 necessarily what really happened.

15 CO-CHAIR DUBOW: Okay. But, you
16 know, when you ask a patient if X happened
17 "always, sometimes, never," that is how the
18 patient experiences something.

19 MEMBER YAWN: It is their
20 perception. I'm sorry. You know, it is. It
21 depends on how you want to define experience,
22 how they experienced it, yes.

1 DR. BURSTIN: It is still an
2 outcome. So I think we are --

3 CO-CHAIR DUBOW: Would you put
4 your mike on and just introduce yourself,
5 please?

6 MEMBER HAUGEN: I am Pat Haugen,
7 and I am representing the National Breast
8 Cancer Coalition.

9 CO-CHAIR DUBOW: Thank you and
10 welcome. Nice to have you here. We are just
11 talking about the types of outcome measures we
12 are going to be considering.

13 David, did you want to say
14 something?

15 MEMBER HOPKINS: Yes. I was just
16 going to comment on the last part of that
17 because my first reaction was health risk
18 status, behavior, and adherence, how could
19 that be an outcome.

20 But the more I thought about it,
21 those things can be influenced by the health
22 care system. And to the extent that they can,

1 I think they properly belong there.

2 Does that make sense? Is that
3 what you guys were thinking?

4 DR. WINKLER: Yes. In terms of
5 adherence, when I first saw it, I was a little
6 bit startled, too. But then when I went back
7 to the definition influenced by the health
8 care system defined however you want to, it
9 seems like that is actually one of the
10 strongest influences.

11 And when we were talking earlier
12 today about adherence, it is not just to
13 medications, but it is to any aspect of the
14 treatment plan, adherence to doing the stop
15 smoking activity, diet, whatever, all of those
16 things, because certainly I know throughout
17 all of the discussions that we have all been
18 part of, it is not under the influence of the
19 provider. Well, maybe it is, not completely,
20 but it certainly has a large aspect of it.

21 And so the outcome of that
22 influence is their adherence. So that is the

1 way we were looking at it in terms of
2 behaviors and the other.

3 And this morning we have already
4 said knowledge is an outcome. How we measure
5 it is a different issue, but the fact that
6 knowledge is an outcome, understanding and
7 motivation I think are subsets of knowledge,
8 but that is the way we were looking at it.

9 Again, we would just ask all of
10 you, do you agree, do you want to expand on
11 it? Do you want to revise or change or
12 whatever? Because to the degree we could find
13 measures of that, we would want to include
14 them.

15 MEMBER YAWN: I was wondering if
16 under knowledge, understanding, and
17 motivation, knowledge doesn't strike me as
18 nearly as important as understanding or
19 motivation. To be able to regurgitate
20 something, yes, that is really nice. And that
21 might be that is our schools' definition of
22 knowledge nowadays anyway to be able to

1 regurgitate.

2 I think understanding and
3 motivation would be a higher standard. I am
4 not saying we know how to do it yet, but I am
5 hoping we are moving that way because that
6 just seems much more important to me.

7 DR. PACE: I mean, I agree that is
8 the ultimate goal. And sometimes it is easier
9 to measure knowledge than understanding, yes.
10 And I think the other thing about these is in
11 a way they are also kind of intermediate
12 outcomes because the ultimate outcome is
13 improving function, et cetera. But they are
14 more on the psychosocial realm of intermediate
15 outcomes.

16 MEMBER JUSTER: Question about the
17 risk. Do you mean healthy behavior risks,
18 like smoking or exercise, et cetera? So that
19 would be, like I said, not quite the
20 experience of care, but that is just one of
21 the items. Okay.

22 So that might be like the

1 Eddington things or something, the health
2 behavior risks.

3 DR. WINKLER: Well, that would be
4 one.

5 MEMBER JUSTER: Not handling
6 stress well, whatever.

7 DR. WINKLER: Yes. Well, that
8 could be one tool, but the most obvious one is
9 smoking status or stopping smoking rates or
10 things like that.

11 MEMBER YAWN: Or risky drinking
12 behavior.

13 DR. WINKLER: Yes. The next one
14 is service utilization as a proxy for an
15 outcome, such as the changing edition. This
16 is where things like readmissions or ED
17 visits, particularly when you don't have the
18 kind of condition that you necessarily always
19 need to go to the ED for but do anyway, as a
20 potential indicator of both efficiency but
21 also quality of the antecedent care. This is
22 where you sometimes see some of the measures,

1 the ambulatory care-sensitive indicators,
2 things like that.

3 Does that work for everybody as an
4 outcome measure? I have had push-back from
5 members saying readmission is not an outcome
6 measure. So I am just -- well, this is folks
7 I think who look at outcomes very narrowly,
8 and it is what happened to the patient. I
9 said, "Well, going to the hospital, what
10 happened to the patient?"

11 And they said, "But that isn't
12 what I mean. I mean, what do they physically
13 experience?"

14 I am just telling you I had this
15 conversation. So I want to be sure everybody
16 is kind of on the same page in terms of
17 looking at this as an outcome.

18 MEMBER AMARASINGHAM: I mean, I
19 would say absolutely that needs to be an
20 outcome. I think one of the concerns that has
21 been voiced with respect to readmissions but,
22 really, for a lot of these service utilization

1 outcomes is, do we have the proper risk
2 adjustment? And should we have stratification
3 for some patient characteristics that health
4 systems believe they have a hard time
5 modifying?

6 For example, in heart therapy
7 admission, cocaine use on admission is
8 difficult to modify. And it can greatly
9 affect readmission rates, but that is not
10 included as part of the thing.

11 Now, it can be modified. And the
12 hospital systems that believe they can do it
13 want to be rewarded for that if they can
14 overcome some of those difficult cycles.

15 But I think that has been some of
16 the push-back on readmissions. As a measure,
17 I think it is a superb measure towards
18 integrating a continuum of care.

19 CO-CHAIR DUBOW: All right. So we
20 have raised issues that are cross-cutting to
21 our definition in terms of data source and
22 risk adjustment, but still we seem to have

1 some consensus here that the type of service
2 utilization that Reva mentioned is in our view
3 definitely an outcome measure. So we will
4 have to tackle those other challenges.

5 MEMBER YAWN: Sometimes increased
6 service utilization is a good outcome. For
7 example, if you are talking about outpatient
8 non-urgent care, if we could get people with
9 asthma, COPD, heart disease, renal disease,
10 all kinds of diseases to come in for
11 continuing maintenance care, that would be
12 positive.

13 So I just want us not to step into
14 that very quickly thinking increased service
15 utilization of all kinds is bad. Frequently
16 we would love to move from the ED or the
17 hospital to outpatient.

18 And there are some times that ED
19 is absolutely appropriate. If somebody has an
20 MI, I would really rather they go to the ER
21 than to my office. They can come to my
22 office, and I will send them there, but --

1 MEMBER HOPKINS: We need to add
2 potentially "avoidable" or something to the
3 front of that so that captures it.

4 DR. PACE: I think the tricky
5 thing about service utilization is in some
6 contexts, it could be process measure and in
7 others outcome.

8 I think what we are trying to --
9 and that is why we wanted to specifically say
10 as a proxy for outcome because basically, like
11 Reva said, people say, "Well, why didn't you
12 just measure what was the reason?"

13 But generally it is, again, an
14 easier way to measure that there was some
15 change, deterioration. If you are talking
16 about readmission, deterioration in health
17 status, it is indicating that. So it can be
18 kind of context.

19 CO-CHAIR DUBOW: Did you want to
20 add something?

21 MEMBER GIBBONS: No. I actually
22 agree that it is important to include as an

1 outcome measure because it does reflect the
2 antecedent care, but I think that there is
3 still a problem in reporting by a variety of
4 organizations in terms of attribution so that
5 in a given community, someone may be
6 readmitted for heart failure where the
7 previous admission was to another institution.

8 And it is not always reported that
9 way. So that the ownership of the particular
10 management issue may become cloudy.

11 CO-CHAIR DUBOW: Okay. Sorry,
12 Anne.

13 MEMBER DEUTSCH: I just wanted to
14 add another one. So for those of us who work
15 in post-acute care, often discharge to
16 community is a major outcome. So I would put
17 that in this particular group.

18 And we have a specific definition
19 for use; again, case-mix adjustment, always
20 important. But a lot of people also look at
21 return to acute care, which is basically
22 rehospitalization also.

1 DR. WINKLER: The next one is
2 non-retaliative clinical morbidity, something
3 bad happening because we didn't prevent it by
4 appropriate care related to disease control
5 and treatment.

6 An easy-to-understand example is
7 diabetic patients undergoing amputation
8 because their diabetes has not been under good
9 control. And so we do have a couple of
10 measures like that. I think that is pretty
11 straightforward as an outcome.

12 And then the next big category --
13 and, in fact, this is one of the larger
14 categories -- is the adverse events or
15 complications, bad things happening to people
16 that you wish hadn't happened, of course, the
17 biggest one being mortality, which sort of
18 speaks for itself.

19 So from this group, I think
20 everybody agrees that everything that is on
21 this list should be on this list. What isn't
22 on the list?

1 MEMBER JUSTER: I am just wanting
2 to raise the productivity thing again, so
3 absenteeism/presenteeism.

4 DR. WINKLER: Okay.

5 MEMBER HOPKINS: That was exactly
6 mine. I think I have sort of layman-focused
7 outcomes or something like that. And it
8 actually would include school days missed by
9 kids because their parents got to stay or one
10 parent got to stay home from work a lot.

11 DR. WINKLER: Okay. That is a
12 good one. Okay.

13 MEMBER YAWN: And I think those go
14 back under patient function. I mean, that is
15 when I was talking about occupation.

16 MEMBER HOPKINS: Okay.

17 MEMBER YAWN: I think that that
18 has to do with absenteeism and presenteeism.
19 And role function has to do with having to
20 stay home because your kid is sick.

21 MEMBER HOPKINS: I didn't fully
22 understand your concept.

1 MEMBER YAWN: You did a nice job
2 of explaining it for me. Thank you.

3 CO-CHAIR DUBOW: Dianne?

4 MEMBER JEWELL: So I just need a
5 memory job about a conversation we had on that
6 first bullet. Did we decide one way or the
7 other about the utility of performance-based
8 functional measures, as opposed to self-report
9 measures?

10 We spent a lot of time talking
11 about the self-report measures. But did we
12 decide one way or the other about the others?
13 My argument would be to keep performance-based
14 measures in the next -- I just didn't know if
15 there were --

16 CO-CHAIR DUBOW: Actually, we
17 didn't come to any great conclusion. And in
18 my mind, I simply saw that as a data source
19 issue. I think there will be patient-reported
20 measures as well as other kinds. But I see
21 that as a source of data, as opposed to a kind
22 of outcome measure.

1 MEMBER JEWELL: Thanks.

2 CO-CHAIR DUBOW: Does everybody
3 have any -- is there agreement about that?
4 Okay. That is where I got my data source
5 before in my --

6 MEMBER JEWELL: Thanks. Okay.

7 MEMBER McNULTY: Wasn't cost
8 something that you wanted to put on as an
9 outcome measure? You had mentioned that
10 earlier in the day. No?

11 DR. WINKLER: Well, I think it
12 belongs in the list as a type of outcome
13 because certainly I think a lot of people do
14 look at that, but that is actually already
15 predetermined not to be within our scope. So
16 the decision was made for you.

17 Actually, NQF is doing further
18 work on the cost-resource issue. And,
19 actually, hopefully if all comes out as
20 planned, the quality work we are doing plus
21 their work come together. And we may have
22 efficiency in the future.

1 MEMBER GIBBONS: I just have one
2 misgiving, I think, about bullet three in that
3 I think that there are two separate
4 classifications of outcome. One is the
5 patient's experience and increase of
6 knowledge, motivation, and understanding. But
7 the other is a harder piece of data, which is
8 actually a delta in health risk status and
9 behavior.

10 I am not sure. I just think that
11 we should call that out as a distinction.

12 DR. WINKLER: We can list that
13 separately. That is the kind of input I'm
14 looking. A lot of the discussion you are
15 having will find its way into the final report
16 and how we characterize things. And that is
17 why these comments are important to help do
18 that. So it is perfectly fine.

19 CO-CHAIR DUBOW: In other words,
20 where the bullets go.

21 DR. WINKLER: Yes.

22 CO-CHAIR DUBOW: Right, right. I

1 think we will get another crack at it, but I
2 think probably in a couple of places, we may
3 want to put bullets in additional places. But
4 we do have a chance to look at that in hard
5 copy and give some input.

6 Barbara?

7 MEMBER YAWN: Thank you.

8 I think that health services
9 utilization and patient experience are
10 connection in both positive and negative ways.
11 I have some experience with some organizations
12 that do every test and every consultation
13 known to man versus across the street tends to
14 be a little more focused.

15 And the patient experience, if you
16 ask them with exactly the same outcomes for
17 functional status and understanding and
18 knowledge, "This was a much better experience
19 because I saw 12 specialists. So it must have
20 been better."

21 So how do we take that into
22 account because that with health care reform

1 is going to be a huge, huge issue? We already
2 have somebody up there in the White House
3 saying this is a great model.

4 DR. PACE: That is exactly what
5 efficiency is getting at.

6 CO-CHAIR DUBOW: I was just going
7 to say.

8 DR. PACE: And so, you know, the
9 issue is if you have the same outcomes but one
10 at double the cost, that is what we are trying
11 to get at with efficiency, which, as Reva
12 said, our definition is both the combination
13 of quality measures and cost measures or
14 resource measures, but that is exactly what
15 the whole efficiency issue is about.

16 CO-CHAIR DUBOW: But in the
17 meantime, that problem probably hits everybody
18 equally. And so you don't have to adjust for
19 it. And I think in time when people get to
20 see the relationship between outcomes and
21 resource use, we will see changes in that over
22 time. I think it is a matter of public

1 education, et cetera. But in the meantime, I
2 think that issue hits everybody the same way.

3 You see that in differences in
4 clinical scores and CAHPS scores. You know,
5 that is what happens.

6 MEMBER YAWN: I don't know how it
7 affects everybody the same. Especially if you
8 live across the street from a very large
9 institution, you feel it very acutely.

10 And so I guess what I am trying to
11 get at is that perhaps the idea of patient
12 satisfaction in the way that it is frequently
13 -- not what we are talking here with knowledge
14 and understanding, but the idea of patient
15 satisfaction to me is a much less desirable
16 outcome than understanding and motivation.
17 And then knowledge is even better than it is.

18 And so I guess that is what I was
19 trying to get at perhaps as an overriding
20 measure.

21 DR. PACE: You know, that is a
22 good point. I mean, we don't have patient

1 satisfaction on here.

2 MEMBER YAWN: I know you didn't.

3 DR. PACE: So is there anyone
4 advocating that patient satisfaction be put on
5 this list?

6 MEMBER YAWN: But, see, I wanted
7 to say intentionally was not on the list,
8 which is different than it just not being
9 there because then somebody will say, "Oh, you
10 forgot it." Oh, no, we didn't forget it.

11 MEMBER McNULTY: I would again
12 ask, patient satisfaction with what? Because
13 it could be with so many pieces in the health
14 care system.

15 CO-CHAIR DUBOW: This conversation
16 has happened at NQF.

17 MEMBER McNULTY: I don't see it as
18 a problem because, again, just thinking from
19 the patient's perspective, the patient
20 experiences with the patient experiences and,
21 again, depending on the questions that you are
22 asking them, whatever answer they give you is

1 a valid answer from their perspective.

2 MEMBER YAWN: I didn't say it
3 wasn't valid from their perspective, just not
4 to drive up here.

5 CO-CHAIR DUBOW: All right. Ted,
6 did you want to make a point?

7 MEMBER GIBBONS: There is a
8 difference between patient satisfaction and
9 the perception of value. And I think that is
10 what you are getting at. And that is what
11 third party payers and hopefully health care
12 will get at it.

13 The value is different from
14 patient satisfaction because they are multiple
15 aspects of it. And that is something that we
16 are not measuring.

17 DR. WINKLER: Two questions that
18 have come up in my mind and hopefully maybe if
19 there are others, you will bring them up. In
20 terms of outcome measures, looking at the
21 existing sets of outcome measures and the
22 conditions we are actually looking at, we have

1 got both acute conditions and we have got
2 chronic conditions. There are two acute
3 conditions: AMI and hip/pelvic fracture.
4 Then you have got chronic conditions.

5 Now, we certainly have mortality
6 measures for acute things like AMI and some of
7 the more -- you know, clearly this happened,
8 went to the hospital, very emergent and
9 critical situation. So mortality makes sense.

10 However, we have also got a very
11 long list of chronic conditions: diabetes,
12 chronic kidney disease. Does mortality make
13 sense as an outcome measure? Now, I mean, at
14 least not within the time frame that
15 measurement makes a certain amount of sense.

16 Is there some way that the group
17 would like us to look at the acute conditions
18 in terms of the outcomes differently or the
19 same as we would for the chronic conditions?

20 Are there different ways of
21 looking at them and thinking about them
22 because just the information you are going to

1 get around an acute condition I think is
2 somewhat different than the information you
3 can get and the potential outcomes you want to
4 look at in the more chronic conditions? And
5 so I would like to hear if you have a sense of
6 it.

7 What I am trying to do is build
8 this framework, if you will, around what the
9 outcomes should be such that it will help our
10 ultimate gaps analysis.

11 So are they the same? Are they
12 different? How are they related? And I would
13 like to hear what you think about that.

14 MEMBER YAWN: One of the things
15 that I have played around with and wanted to
16 work with was the number, the average number
17 of life-years lost. And that may be a little
18 different concept, difficult concept.

19 And I apologize, but the average
20 age at which a woman dies is, we'll say, 72
21 just for a number. And in your population of
22 people with diabetes, how many women die more

1 than one standard deviation from that because
2 I know half are going to die before and half
3 after if that is the mean age or if it is
4 median age?

5 It is different for men and women.
6 So it is sort of like having age-adjusted,
7 gender-adjusted life expectancy, but it is a
8 delta. It is a change from what you would
9 like, which is everybody to be able to reach
10 average life expectancy.

11 It is not one that New England
12 Journal likes very well, but I do think it is
13 one maybe to try to think through. It may not
14 be ready for prime time, but is there
15 something like that we can do for chronic
16 conditions?

17 I don't want to throw mortality
18 away entirely. I want people who are dying a
19 lot younger than we think they should be with
20 this chronic condition to somehow become
21 obvious.

22 And it can't be done with just

1 mortality rates in your group because if you
2 have a lot of older people. And just all
3 kinds of things need to be considered. But it
4 is one I would like us -- I don't know if
5 anybody is doing it, but it might be something
6 for gap analysis.

7 CO-CHAIR DUBOW: So I need some
8 help in thinking, in articulating what I am
9 thinking about. But it seems to me that there
10 is a distinction that thinking about shared
11 decision-making fits into this construct. So
12 that is one thing I would think about.

13 And on the chronic side, it feels
14 as though the engagement self-efficacy stuff
15 fits. And I don't quite know. I guess we
16 could structure that as some kind of an
17 outcome, but it feels that those two pieces
18 fit into those two areas that you are talking
19 about.

20 Does that make sense?

21 DR. WINKLER: And you would say
22 less so for the acute circumstances?

1 CO-CHAIR DUBOW: Yes, yes. But
2 shared decision-making does have a role. I
3 mean, an assessment of shared decision-making
4 in acute care I think is the preference
5 sensitive stuff. I think we could find areas
6 where it would be quite directly applicable.

7 MEMBER HOPKINS: So how does that
8 fit into our framework? I'm like you. I am
9 really interested in seeing this embed your
10 decision-making if we can.

11 CO-CHAIR DUBOW: Anne?

12 MEMBER DEUTSCH: Just I am
13 thinking about functional status and how that
14 will be an outcome measure. And it might have
15 -- there might be different goals.

16 So in acute care, somebody who is
17 elderly, you know, they are not that fit
18 before they come. Dianne and I have talked
19 about these examples.

20 So they are going through a lot.
21 They have had surgery. And so the goal would
22 be to make sure that they improve their

1 functional status a little bit, but they don't
2 have major deficits in terms of ADLs. Well,
3 they are in the hospital, but you want to be
4 sure they don't get to the point that they are
5 debilitated but actually need post-acute care.

6 You want to be sure that they are
7 getting some activity and having good
8 functional status.

9 CO-CHAIR DUBOW: Is maintenance a
10 function?

11 MEMBER DEUTSCH: Perhaps.

12 CO-CHAIR DUBOW: Yes. I mean,
13 that is a criterion we have used, actually, as
14 a regulatory criterion --

15 MEMBER DEUTSCH: Yes.

16 CO-CHAIR DUBOW: -- that people be
17 restored to maximum function, to regain
18 maximum function.

19 MEMBER DEUTSCH: Right. And there
20 has been some research looking at healthy
21 elderly people who lay in bed for ten days.
22 And they become debilitated, basically.

1 So preventing that would be a goal
2 during the acute care stay. Let's say
3 somebody has had a stroke or perhaps a brain
4 injury. For some patients, the goal may be
5 that their functional status is maintained.

6 For another group of patients, for
7 hopefully the majority, the goal would be
8 restorative care. And they would come into an
9 inpatient rehab facility hopefully and get
10 intensive therapy and have a fair bit of
11 functional gain.

12 But that is not always the goal
13 for every patient. So I think, you know,
14 depending on whatever is negotiated as the
15 goal for the patient, there might be very
16 different expected outcomes for those two
17 groups. They will both fit potentially under
18 the chronic, but it just kind of is what else
19 is going on.

20 You know, maybe they have many
21 other things going on. Maybe it is different,
22 for whatever reason. So it just comes to

1 mind.

2 MEMBER JEWELL: So one of the
3 things that I am wrestling with is this notion
4 that there is a line between acute and chronic
5 because, really, it seems to me that there are
6 acute episodes all along the continuum.

7 And so maybe because of the need
8 to measure or because of what we need to try
9 to measure, it is easier to draw that line, so
10 the hip fracture example being one.

11 I could make a really I think
12 pretty solid case to argue that that is
13 actually just, even if they don't have
14 underlying OA or RA, that that is linked to a
15 chronic condition of its own and it is just an
16 acute event within it.

17 So I don't know. I am thinking
18 out loud here. I guess I need some sense of
19 is it easier, simpler, and more workable to
20 frame it as hip fracture is an acute event,
21 AMI is an acute event, we only consider them
22 sort of like that, and then we call conditions

1 like coronary artery disease, rheumatoid
2 arthritis chronic.

3 I know diagnostically in the ICD
4 nomenclature, that is how we do it, but I am
5 just wondering from a measurement perspective,
6 is that also simpler?

7 Because I could make it -- you
8 know, we have acute flare-ups in
9 osteoarthritis all the time. It is why they
10 come back to me. And so at that moment, what
11 they are experiencing is acute for them.

12 I don't know if I am making it
13 harder than it needs to be, but that is where
14 I am wrestling a little bit.

15 MEMBER KEALEY: Yes. I sort of
16 agree with that. That is kind of what I was
17 leading toward, too. I do think that they are
18 part of the continuum, but I also think that
19 they are discrete enough where you can measure
20 them.

21 I think the pitfall that we have
22 fallen into so far is just that we have really

1 defined it as when they leave the hospital, we
2 stop measuring. And so that in the acute
3 event, we need to think about expanding our
4 definition.

5 I think the graphic there went out
6 to a year. And that is a lot of the data
7 post-MI looking at depression. And the whole
8 episode of care is what we keep in mind as we
9 create measurements.

10 MEMBER JUSTER: There actually may
11 not be that much of a dichotomy going back to
12 the diagram with all of the circles and phases
13 and all of that sort of thing or COPD.

14 There could be metrics involved
15 and methodologies perhaps involved in the
16 management of the acute phase of a chronic
17 illness, just like a hip fracture usually is
18 part of osteoporosis, not always, and so on.

19 MEMBER GIBBONS: I was going to
20 say that it is actually easier to measure the
21 hard outcomes of acute care. And the interval
22 of time over which you measure the hard

1 outcomes of chronic care may not be at the
2 interval reported.

3 So that a lot of the similarities
4 between acute and chronic care have to do with
5 the preventive aspects; for instance, with
6 cardiovascular disease, in introducing aspirin
7 beta blockers, ACE inhibitors, and so forth;
8 whereas, in the outpatient setting, chronic
9 setting, those same preventive measures are
10 introduced, but they are intermediate
11 outcomes, rather than hard outcomes, because
12 you are not really measuring mortality or not
13 necessarily measuring morbidity, at least in
14 the ones that have been proposed.

15 So I think the ones that have been
16 proposed are still adequate. It is just that
17 they are measuring different things.

18 MEMBER YAWN: Thinking of
19 cardiovascular disease, one of the things that
20 I think is -- I mean, not too many people have
21 an acute MI that have not had cardiovascular
22 disease for several years. There are some

1 acute events that have no underlying other
2 things that have been going on for the last 20
3 years, but those are darn few.

4 One of the things that I think
5 would be interesting is thinking about how
6 many of those people when they had acute MI
7 had not only their risk factors assessed but
8 also had a diagnosis of coronary artery
9 disease.

10 I mean, we have looked at that.
11 And I can give you some data on that. And how
12 many of them that had their coronary artery
13 disease diagnosed had the risk factors
14 addressed.

15 So I think there are some things
16 that could make an acute event part of chronic
17 also because the acute MI becomes primarily
18 hospital and cardiologist. That is where we
19 have to send almost everybody now and should
20 probably.

21 But to try to make it primary
22 care, also it is that before and not always

1 just after that we ought to look at because
2 you do have that green bubble before. How do
3 we address that?

4 DR. BURSTIN: I am just going to
5 point out that hospital discharge is a fairly
6 artificial distinction. And, in fact, in the
7 surgical world, it is fairly routine. It is
8 more of our medical model as an internist that
9 a patient kind of transitions to the next
10 person.

11 But we, for example, already have
12 endorsed a 30-day surgical site infection
13 measure. So there is no reason why if it is
14 the right approach you couldn't look at it.

15 In fact, there are some emergency
16 measures being developed around an acute MI
17 episode probably being to ER the first 30 days
18 as the logical time period. And then 30 days
19 to a year perhaps is the next.

20 So, I mean, I think this is
21 exactly what we hoped you guys would kind of
22 give us thoughts on. And hopefully as we do

1 the measure gap analysis piece, this is
2 exactly what I think the world needs as you
3 begin thinking about some of the emerging
4 payment models as well.

5 MEMBER GIBBONS: In fact, I was
6 must reviewing this last week. People don't
7 emphasize the fact that although we constantly
8 talk about the 30-day readmission rate for
9 heart failure, the 30-day readmission rate for
10 MI is higher than that for heart failure.
11 But, yet, we are not including that as an
12 outcome measure in many reporting. It is 50
13 percent heart.

14 I just looked at the CMS reporting
15 data.

16 DR. BURSTIN: What are they coming
17 back in for? Related to the MI or is it --

18 MEMBER GIBBONS: Well, it is all
19 cause readmission, but they are coming in for
20 elective procedures. They are coming in for
21 chest pain. They are coming in for
22 arrhythmias.

1 DR. WINKLER: Another similar kind
2 of thing when looking through our list of
3 outcome measures, NQF has endorsed a wide
4 variety of measures.

5 But some of these outcome measures
6 are characterized as the more typical
7 individual measures, as we have seen with the
8 hospital outcome mortality of an individual,
9 you know, how many died within this hospital
10 within this year versus populations where the
11 denominator is some event per hundred
12 thousand.

13 How are those related? How do we
14 think about them differently or the same? How
15 do we utilize both types of outcome measures
16 in the ultimate set that Helen is talking
17 about, in the ultimate descriptor of the
18 quality of care for patients with X or
19 patients in general? How do we bring those
20 two together? The list of current endorsed
21 measures has both.

22 And how do you want to address

1 that? Because they are different. They are
2 characterized different. The data collection
3 is somewhat different. But they have to be
4 related because ultimately they are the same
5 patients.

6 MEMBER AMARASINGHAM: You know, I
7 would like to make a point on that. I think
8 both are extremely important. This to me
9 seems primarily an attribution question.

10 If you are looking at a health
11 system that cares for 1.2 million patients,
12 you absolutely want to look at the population
13 as well as the cardiology group that is taking
14 care of X number of cardiovascular patients.

15 So I think you would have to
16 include both for sure.

17 DR. WINKLER: Just to carry on,
18 would you say it would be desirable for each
19 condition or each topic area that you actually
20 would want both types of measures? That is
21 what I heard you say.

22 MEMBER AMARASINGHAM: If it is

1 available, yes. I think the biggest thing is
2 attribution. I think also obviously the data
3 source in this case because obviously in major
4 metropolitan areas, you are going to have
5 people moving from different systems.

6 So who is ultimately responsible?
7 You could almost wonder whether communities
8 start becoming responsible.

9 CO-CHAIR DUBOW: When you talk
10 about attribution, are you talking about
11 accountability? I mean, I see them
12 differently. I just want to be sure I
13 understand what you are saying.

14 MEMBER AMARASINGHAM: Well,
15 ultimately it is accountability, I think. If
16 this person is under my care, let's say, then
17 what is my individual outcome for that
18 patient?

19 Then obviously if it is a systems
20 care and so forth, I think people talk about,
21 can you get adequate attribution as to who it
22 is.

1 Now, the question becomes in
2 team-based care, who is ultimately
3 responsible? And when you have a person that
4 is moving between different systems, who is
5 responsible? I think those are very
6 challenging, even on this readmission
7 question.

8 But absolutely we need both.

9 MEMBER YAWN: Well, and your
10 definition of population and mine are going to
11 be different. I am going to approach it from
12 a typical epidemiologist definition.

13 And it is not the people insured
14 by Health Partners or Kaiser or whatever. It
15 is the people who live within a geographic
16 area, just a different definition.

17 MEMBER AMARASINGHAM: And I don't
18 disagree.

19 MEMBER YAWN: Oh, I was sure you
20 didn't, but I think then this idea of the
21 community's responsibility because we do now
22 have somewhere between 7 and 12, 15 percent of

1 people uninsured. So they don't fall under
2 the Kaiser's group health, but they also don't
3 come in to see it.

4 I mean, I have been through this
5 several times. People say, "Well, if you just
6 bring them in, I will take care of them." No,
7 no, no. That is not the point.

8 So I think we have to have
9 geographic population measures because we do
10 have to recognize, especially in disparity
11 issues, those people who do not come in for
12 health care for many, many reasons. And I
13 think they are still our responsibility. How
14 I am not too sure, but I do think we need to
15 know about them.

16 CO-CHAIR DUBOW: Bonnie Zell is
17 going to tell us about it, who is the NQF
18 person --

19 MEMBER YAWN: Yes, right.

20 CO-CHAIR DUBOW: -- who is doing
21 population medicine.

22 MEMBER JUSTER: Could you consider

1 that there is individual versus population?
2 So population also might be the right of -- I
3 don't know -- eye exams per 1,000 diabetics.
4 It could also be how much eye improved.

5 So that is my own individual
6 pre/post, I guess. And it could be reported
7 as a population of 1,000 people like me,
8 compare their pre and posts, and then back to
9 the numerator and denominator thing.

10 Of all the things that I should be
11 doing or have done for me, how many of them
12 did I, which would be completely
13 patient-centric because the next person over
14 wouldn't fit all the same denominators.

15 And this notion of a tipping
16 point, there is a little research on it, not
17 nearly enough. A lot of it is in kidney
18 disease. If there are, let's say, five
19 metrics, you get 20 percent better with each
20 one. It seems that almost nothing happens
21 until you are getting about 80 percent of
22 them. Then, all of a sudden, you get all of

1 the benefit you are going to get, at least,
2 from hitting all of them.

3 DR. WINKLER: Are there any other
4 of these kinds of issues about outcome --

5 MEMBER HOPKINS: Summarize what
6 you think we said about individuals versus --

7 DR. WINKLER: Both types of
8 measures are important. Neither is out of
9 scope. How exactly they are related isn't
10 totally clear, but when you are looking at
11 diabetes, for instance, there is important
12 information to be obtained, outcomes measured
13 at the individual level as well as at the
14 population level.

15 I wanted to know if you wanted to
16 keep the population measures in or out.

17 MEMBER HOPKINS: Okay. I mean,
18 does that make it simpler to realize that the
19 thing that you are measuring is the constant?
20 And to what are you applying it is the
21 question? You know the analysis.

22 DR. PACE: One of the things we

1 have discovered is that -- and from a strictly
2 measurement perspective, it does matter that
3 you have thoughtfully constructed a measure
4 that can be applied to different levels of
5 analysis, rather than just saying, "Here is
6 the measure. And you can apply it to any
7 level." There may be differences in
8 exclusion, the attribution.

9 I mean, from a measurement
10 standpoint, it does make a difference, not
11 that we shouldn't do it. It is just that we
12 should be thoughtful of constructing it so
13 that it is still a valid measure at whatever
14 level you want to use it.

15 CO-CHAIR DUBOW: For a practical
16 matter, as I recall, the population-based
17 measures that we have endorsed are ARQH
18 measures. Most of them are ARQH measures.

19 So ARQH comes with a perspective
20 of looking at the population. I mean, to the
21 extent that we are beholding on the measure
22 developers and what comes across the transom,

1 it is going to be those measure developers
2 interested in population health that are going
3 to come forth with this unit of analysis. And
4 I assume they will take into account those
5 specific measure attributes.

6 DR. PACE: What I am talking about
7 is sometimes we have measures submitted. And
8 when we ask about the settings and level of
9 analysis, people have a tendency to want to
10 check everything, like it would be nice if we
11 could measure it there, but we don't actually
12 have specifications that are --

13 DR. WINKLER: In terms of setting
14 the scope, I mean, I think we have had a
15 discussion that keeps the scope very broad and
16 consistent.

17 Two things. In your discussion,
18 did you feel that you addressed topics that we
19 could maybe discover the principles? You had
20 started talking about some of these or are
21 there some other things about outcome
22 measurement that are going to help us

1 understand the work we need to do, help the
2 TAPs do the work to provide you the best
3 advice possible to help us just move
4 everything forward that we haven't yet
5 discussed because, again, we are starting to
6 build this framework thing.

7 And I am trying to characterize,
8 what were those things about that we could
9 characterize as principles that came out of
10 the discussion? Was there anything else?

11 MEMBER YAWN: I am still not
12 entirely comfortable with the comorbidities or
13 I don't think they are comorbidities. I think
14 people have multiple morbidities. And say we
15 are going to count up their morbidities and
16 risk assessment.

17 It is just still not comfortable
18 for me because I know very well that people
19 with COPD almost always die of coronary artery
20 disease.

21 So we don't have to look at
22 mortality. It is all his fault, their TAP.

1 It is for sure.

2 (Laughter.)

3 MEMBER YAWN: Okay. Thank you
4 very much, but we never send them to you.

5 There are things like that. And
6 depression and chronic disease is such a huge
7 barrier to outcomes and improvements that
8 without addressing those other than just
9 saying we are counting them and checking them
10 off really bothers me.

11 Now, I know that there may not be
12 good measures yet, but to say we accept as
13 acceptable an outcome measure for COPD that
14 does not look at coronary artery disease and
15 depression, at least, -- those are the two
16 major ones -- is quite uncomfortable for me
17 and I think will be for many of my primary
18 care colleagues.

19 MEMBER HOPKINS: Two other areas
20 where maybe we could provide some more
21 guidance, some measures that we have endorsed
22 are outcomes. And I think a good example is

1 pressure ulcers. They were formulated by the
2 caregivers.

3 So the measure is how many
4 pressure ulcers per -- I forget if it is 1,000
5 patient days. I had a problem with that
6 because that is not the patient-oriented
7 measure. The patient wants to know what are
8 the chances that I am going to get this
9 outcome if I go to this hospital.

10 So if we could provide some
11 guidelines on that situation, that it is per
12 person, not per person days or whatever. Do
13 you see what I am saying? Okay.

14 That was one thing. And then I
15 had written myself this other note. Back to
16 that tricky question about a measure having to
17 have built into the threshold value in order
18 to make it a measure.

19 Then we have to grapple with how
20 that threshold is set and with reference to
21 what and can we provide guidance on that. So,
22 for example, we recently endorsed a measure

1 that happens to be visual acuity after
2 cataract surgery, where we were told that 96
3 percent of the time, the patient makes the
4 measure or the entity that is being measured
5 hits the measure.

6 It seemed to some of us at least
7 that that was kind of a low threshold because
8 it had baked into it an exact value for visual
9 acuity post-cataract.

10 So it struck me there is some
11 principle that there we are missing about a
12 threshold value that is not sort of given that
13 you have to work to achieve if that is going
14 to be a property of a measure as well.

15 DR. BURSTIN: I will just say this
16 was a fascinating measure for those of you who
17 have been following eye care at NQF. It is
18 interesting because I think it brings up a lot
19 of really important issues.

20 To me the issue is less so the
21 threshold of 20/40 acuity post-cataract. That
22 is pretty good vision post-cataract. I mean,

1 I think that is up to the ophthalmologists to
2 argue about the threshold per se.

3 The bigger issue is the fact that
4 all we had was one registry-based study by a
5 voluntary group of ophthalmologists, who all
6 came together, submitted their data
7 post-cataract, in which they had 96 percent of
8 patients who achieved 20/40 acuity. So the
9 bigger issue is we often don't actually know
10 what the gap is.

11 So if you looked in the community
12 of ophthalmologists who are not self-selected
13 ophthalmologists who read through part of the
14 registry, we actually have no idea what the
15 level of performance is. We certainly hope
16 that it is nice and high, although we don't
17 actually know that it is.

18 The second issue that came up
19 methodologically, which I think is also
20 important, is there was a discussion that
21 even, say, it is 90 percent. Just given
22 purely the volume of cataracts done in

1 America, it is such a huge impact on the
2 patients who wind up being at the doc's, just
3 purely the numbers of patients who wound up
4 being exposed to poor quality docs because on
5 acuity which was really alarmingly high.

6 So there are just so many
7 interesting methods issues as soon as you
8 craft outcomes on --

9 MEMBER HOPKINS: That was a good
10 answer to how did you set that threshold value
11 in my value. You had a limited data set.
12 They observed from the data set that 96
13 percent met it. But was that the way they set
14 the threshold -- I am not sure -- or was it
15 somebody's sense of "Gee, that is pretty good
16 visual acuity"?

17 DR. PACE: And I can't speak to
18 what was in their measure submission, but the
19 way we would like to see those threshold sets
20 is that the threshold is tied to evidence
21 about performance.

22 So, in having some discussion with

1 -- you know, I think there have been -- and I
2 don't know if they presented this, but I think
3 there have been studies about visual acuity on
4 the scale that we measure tied to
5 patient-reported function.

6 And so that is what we would like
7 to see when you have these thresholds included
8 in the measure, is what is the evidence for
9 setting that threshold, similar to blood
10 pressure, the evidence that above a certain
11 threshold, there is higher incidence of
12 mortality, morbidity, et cetera. So that is
13 what we would like to see. I can't tell you
14 specifically if that is what was submitted.

15 CO-CHAIR DUBOW: So as a general
16 principle, that is okay, but, again, when we
17 examine the individual measure, we will have
18 to examine the individual measure.

19 I mean, it is a good principle.
20 And I think that was a guiding principle. And
21 it is a question of interpretation. So I
22 think that I am okay with a general principle

1 like that, but I don't want to go beyond that
2 because I think we have to see what comes
3 before us.

4 We are going to be looking at
5 specific measures. You know, we are not going
6 to be dreaming up new measures here. These
7 measures are coming to us. And we are going
8 to have to evaluate them.

9 So I like matters of principle. I
10 could live with that one.

11 DR. PACE: I would just say
12 another thing is that when you start seeing
13 measures, you will realize that it is hard to
14 come up with these absolutes because, even
15 that idea about is the denominator patients or
16 patient days, some of that depends on the
17 incidence of those occurring. So if it is a
18 rare occurrence measure, from a measurement
19 standpoint, it might be preferable to measure
20 it over patient days.

21 I am just saying there are a lot
22 of factors that sometimes come into

1 constructing a measure that is ultimately
2 going to actually be able to distinguish some
3 differences.

4 MEMBER HOPKINS: I would think the
5 right answer there is make it per 1,000
6 patients or 100,000 patients and then answer
7 the question of whether it is statistically
8 meaningful.

9 CO-CHAIR DUBOW: Okay. We will
10 get a chance to look at that, those kinds of
11 issues. But I think we do have a principle
12 here.

13 MEMBER YAWN: Okay. That is what
14 I was going to ask. The principle is --

15 CO-CHAIR DUBOW: Yes.

16 MEMBER YAWN: -- they should
17 provide evidence for why they chose the
18 denominator and the threshold.

19 CO-CHAIR DUBOW: Right. It should
20 have an evidence base.

21 Ted?

22 MEMBER GIBBONS: One of the

1 concepts I think that need to be emphasized
2 there is the harmonization concept that was
3 brought up earlier. It strikes me when I was
4 reading the ischemic vascular disease measure
5 that has not been yet endorsed, -- it was from
6 the Minnesota database; it is on the website
7 -- that they include various types of
8 cerebrovascular disease, peripheral vascular
9 disease, renal vascular, hypertension,
10 atherosclerotic, but they don't include
11 diabetes. That is not really in harmony with
12 the ATP and the National Cholesterol Education
13 Program of defining diabetes as a coronary
14 disease risk equivalent.

15 And it seems that that gets to
16 Barbara's point about the comorbidity. If we
17 know that a patient population should be
18 included in that general category of chronic
19 illness and people have begun practicing that
20 way, that we should look at having that
21 revision.

22 And if COPD is not included as a

1 coronary disease risk equivalent or chronic
2 kidney disease, which has been endorsed by the
3 Society of Nephrology, then it still is
4 something that we should question in terms of
5 the steward for that.

6 CO-CHAIR DUBOW: Okay. So can you
7 or Barbara or anybody else phrase our concern,
8 characterize our concern, as a principle, the
9 concern about comorbidities and taking those
10 into account? What is the principle with
11 respect to the --

12 MEMBER GIBBONS: The principle is
13 risk. If the principle is risk and we want to
14 address risk adjustment or risk assessment, as
15 it is commonly acknowledged, then that should
16 have the broadest possible scope if it is a
17 recognized discrete entity.

18 So that, for instance, if coronary
19 disease -- and I will go atherosclerotic,
20 significant atherosclerotic disease is
21 considered a coronary disease,
22 risk-equivalent, which should be subject to

1 very aggressive secondary prevention measures.

2 And we have already acknowledged
3 that diabetes is, that we would want to cast
4 a wider net so that now the next phase of ATP
5 will include chronic kidney disease. And
6 perhaps it will include COPD, although I don't
7 think so.

8 What I am saying is if the general
9 principle is that there is a recognized large
10 population that should be included in a
11 measure, that that go back to the steward and
12 say, or the organization proposing it,
13 "Shouldn't that be broader?"

14 DR. BURSTIN: It is actually
15 interesting because there is actually an
16 identical measure for diabetes, unfortunately.
17 So there is also this issue of the fact that
18 it is actually covered but in another measure
19 in a sort of lumped versus split-away.

20 But I still see your point. I
21 think you want to be able to whenever possible
22 have measures be harmonized for all of the

1 populations at risk, rather than kind of
2 pulled apart.

3 MEMBER GIBBONS: Correct. And
4 since 10 to 15 percent of the patients who
5 have those, that presentation of
6 atherosclerosis, have undiagnosed diabetes,
7 the reverse --

8 MEMBER JUSTER: Just to bring it
9 back to risk adjustment, then, just like we
10 were asking for evidence-based threshold
11 setting, are we asking for evidence-based risk
12 adjustment? Why did you select that risk
13 adjustment method?

14 Now, I realize there is less
15 evidence base for risk-adjusting things than
16 there is for thresholds, but you can't just
17 say, "Well, four comorbidities are twice as
18 bad as two." There is no evidence for that.
19 And it is probably very measure-sensitive.

20 MEMBER YAWN: But that is what
21 they do now.

22 MEMBER JUSTER: Yes, but it is for

1 evidence --

2 DR. WINKLER: Iver, tomorrow we
3 are going to go over the measure evaluation
4 criteria in a great deal of detail, including
5 one of the examples of a submitted measure.
6 You can see what you are going to get to work
7 with. And so you will be able to see.

8 And if we need to break down the
9 questions a little bit more detailed to
10 address the issues for this particular
11 project, this will be the opportunity for you
12 to tell us. And we can get back to the
13 measure developers. We can run that through
14 the TAPs.

15 And we can get more finely tuned
16 because I believe it is a bit of a -- the
17 question at this point is, are you using a
18 risk-adjusted methodology? And what is the
19 evidence base for doing it and how?

20 But it is more wide open and not
21 necessarily perhaps all of the questions that
22 you may want. So you will need to maybe give

1 some guidance in that.

2 CO-CHAIR DUBOW: But the question
3 of whether that rises to a principle is a fair
4 one, I think.

5 DR. WINKLER: Absolutely.

6 CO-CHAIR DUBOW: You know, if that
7 is why you were throwing that on the table, I
8 think for my money, that is a fair --

9 MEMBER JUSTER: The principle,
10 then, is explain why you selected that method
11 of risk adjustment for this particular
12 measure.

13 MEMBER AMARASINGHAM: I also think
14 a counter principle, the converse principle,
15 is why didn't you select a particular -- I
16 think the concern for a lot of safety net
17 providers is maybe not adjusting but at least
18 stratifying out for specific social and
19 behavioral characteristics.

20 MEMBER DEUTSCH: Perhaps we will
21 talk about this tomorrow, but the way the
22 applications are currently set up, you have a

1 numerator and denominator. So you do have to
2 have that threshold.

3 I am just wondering if for
4 functional status, the way we currently
5 measure it in rehab is either actual discharge
6 functional score or, as you said, the change
7 in function. And so you don't really have a
8 numerator/denominator per se. So I was just
9 --

10 DR. PACE: You would. In one
11 case, it would just be the actual scores would
12 be the numerator. And so it just depends on
13 how the measure is constructed.

14 DR. BURSTIN: Do you want to give
15 an example of improvement in as an example?

16 DR. PACE: Right. In the home
17 health measures, improvement in function,
18 improvement in walking, improvement in
19 ambulation, it is the data are at the patient
20 level. And they identify which patients have
21 improved. So those that have improved are in
22 the numerators.

1 So how we would want to see that
2 submitted is that the numerator is the number
3 of patients improved. And then in the
4 details, we would have an explanation of how
5 it was determined that a patient improved,
6 which was a change, a higher level of
7 functioning from baseline.

8 MEMBER DEUTSCH: So I think maybe
9 we will talk about this in more detail
10 tomorrow, but I think in rehab, I mean,
11 usually people look at where somebody came in,
12 where they left, and what that actual change
13 is. And so where you put that threshold would
14 make a huge difference.

15 I mean, theoretically everybody
16 has a --

17 DR. PACE: Right. And, again,
18 these are all of the tradeoffs of measurement
19 that, as you were mentioning earlier, these
20 scales are not necessarily interval scales.
21 You can't say that going from one to two is
22 equal to going to two to three.

1 And so in the case of the home
2 health measures, they recognized that. And
3 they adopted to just do improvement,
4 regardless of how many changes.

5 So the point is that there are no
6 hard and fast absolute rules of how you have
7 to do this. The point is to see what data you
8 have and what makes sense in the context. And
9 that is what makes this difficult, is that we
10 can't say, you know, you have to do it this
11 way or that way because a lot of it is
12 dependent on the data and the various
13 tradeoffs that you make when you are doing
14 these measures.

15 MEMBER DEUTSCH: So would it be
16 possible to not have a numerator/denominator
17 or would that not be possible?

18 DR. PACE: So what kind of measure
19 would not have it?

20 MEMBER DEUTSCH: That you actually
21 report the person's, let's say, functional
22 status score at discharge, the actual value --

1 DR. PACE: Right.

2 MEMBER DEUTSCH: -- that is
3 reported --

4 DR. PACE: So you aggregate that
5 at a provider level. You would either be
6 doing an average, a median, --

7 MEMBER DEUTSCH: Right, an
8 average.

9 DR. PACE: -- or a distribution.
10 So the average would still have a denominator
11 of the patient population.

12 MEMBER DEUTSCH: Okay. So you are
13 calculated based on all of your patients and
14 doing it that way?

15 DR. PACE: Right. Okay. So you
16 point out some excellent issues that we have
17 --

18 MEMBER DEUTSCH: Yes.

19 DR. PACE: -- of explaining --

20 MEMBER DEUTSCH: It is much more
21 complicated.

22 DR. PACE: -- measure submission

1 form and what goes where. We appreciate that
2 because we know that it is complicated.

3 Thanks.

4 CO-CHAIR DUBOW: And you also have
5 to worry about what you report out in terms of
6 how people understand it.

7 MEMBER DEUTSCH: Yes. Actually,
8 with one of the projects I do, we go to the
9 seniors at senior centers and ask them to look
10 at some data that we put out in rehab and, you
11 know, do they understand it.

12 So we have average like mobility
13 scores. They said, "Well, I don't want to be
14 average. I want to be better than average."

15 CO-CHAIR DUBOW: Okay. Barbara?

16 MEMBER YAWN: I am not sure yet
17 that I can put it in the form of a principle.
18 So I am going to ask people's indulgence to
19 continue thinking about it. But it seems to
20 me that there are some of these measures that
21 you have to measure dual outcomes or dual
22 diagnoses or something if you are going to

1 really be able to understand.

2 If I am going to understand the
3 COPD outcome, I have to have some
4 understanding of what has happened with
5 depression. Has it even been recognized? Has
6 it been dealt with?

7 And I am not sure how to put that
8 in a principle at this time, but it is the
9 idea of there are certain conditions which are
10 not sufficiently broadly defined that another
11 condition really impacts their outcomes.

12 And I don't know how to put that
13 in a principle format, but I will keep
14 thinking about it. And if anybody else can
15 think about how to do it, please.

16 DR. PACE: Well, I think one place
17 this comes up is in risk adjustment if you are
18 talking about outcomes and the effect of
19 depression on outcomes. And that would be a
20 reasonable thing to be thinking about as a
21 risk adjuster.

22 But, again, the practical

1 realities of these things are what data are
2 available. So, you know, risk adjustment is
3 often limited by the burden of data
4 collection. So these are all --

5 MEMBER YAWN: And I understand
6 that. And that is why I said I am not ready
7 yet because, just throwing depression in as a
8 risk adjustment just doesn't get it for me
9 because there are all those people whose
10 depression is not recognized.

11 It is known that over half of them
12 aren't recognized. And half of them that are
13 recognized aren't treated and drop out of
14 treatment within four weeks and all kinds of
15 other things that really affect.

16 And so just knowing they have
17 depression isn't enough, I don't believe, but
18 I don't know how to go the next step.

19 CO-CHAIR DUBOW: So I don't see
20 this as a principle, but there is the
21 opportunity of paring measures that have when
22 you want to link them.

1 We have examples in the NQF. Are
2 we calling it a library? Portfolio of paired
3 measures. Is that a possibility?

4 DR. PACE: Sure. And I think the
5 opportunity is to look at these conditions and
6 identifying where there are gaps in
7 measurements.

8 What I am hearing you saying is
9 that quality of care for COPD patients
10 includes addressing depression. And so if we
11 were doing a project just on COPD, we would
12 have the Steering Committee saying, you know,
13 we need measures related to depression
14 screening, treatment, outcomes.

15 And so whether we get these in
16 this project or not, you will have the
17 opportunity in those TAPs to identify those
18 things and also to look through our NQF
19 portfolio.

20 I think we do have some depression
21 measures. And those can be identified that
22 they are important to be measured.

1 MEMBER YAWN: So maybe that is a
2 principle that we do need to think about
3 should we be looking for things that should be
4 paired measures and we believe would make a
5 large difference to whatever we do in the
6 TAPs.

7 MEMBER JEWELL: And, actually, I
8 was thinking about your question from a
9 different point of view, which is the notion
10 that to me what you are describing is an
11 argument for really doing some population
12 analysis.

13 So if you are looking, if you are
14 stratifying within the cohort of patients with
15 COPD, people who have different levels of
16 depression and the extent to which that
17 affects their outcome, I guess a principle
18 would be that we could derive out of that,
19 besides pairing measures when possible, the
20 notion of asking at least the measure
21 developers the extent to which they have or
22 have the opportunity to reanalyze their data,

1 really looking at it in terms of
2 subpopulations, stratifying, as opposed to
3 just doing the easier risk adjustment sort of
4 count the comorbidities thing.

5 So I don't know if that is a
6 principle, but it is just an opportunity to
7 really ask measure developers along that way
8 because otherwise I am not clear that the
9 evidence really says entirely that counting
10 comorbidities is completely an invalid way to
11 do it at this point.

12 DR. PACE: And also I will just
13 have the mention that we have many outcome
14 measures where the risk adjustment is not just
15 counting. In fact, that may be the minority.
16 So maybe what you are familiar with is only
17 that, but we have a lot of measures that have
18 very detailed risk models.

19 MEMBER McNULTY: Can I just say
20 one thing with this example that Barbara has
21 been bringing up from the patient-reported
22 outcomes perspective? What would happen is --

1 this is just to kind of throw into the mix of
2 everything that has been said.

3 What should happen is that if you
4 were developing a measure for COPD. Now, I
5 don't know what exists out there. I don't
6 know enough about COPD.

7 Say there was nothing and you were
8 going to go develop a measure. The first
9 thing that you would do is you would go to
10 patients. And you would do qualitative
11 research. So you would do in-depth
12 interviews. You would do focus groups,
13 whatever.

14 And I would imagine, given what I
15 have heard Barbara say now several times since
16 depression is so prevalent in COPD patients,
17 that that would emerge from the qualitative
18 research that you do.

19 And then as you go about
20 developing your measure to administer to
21 patients, that would be one of the facets, one
22 of the domains of the measure that would end

1 up happening.

2 So that is just kind of from the
3 patient-reported outcomes perspective. That
4 is how you would go about bringing that into
5 the picture for an outcome measure there.

6 DR. WINKLER: Nice job. Through
7 all of the notes that we have taken, the
8 transcript that will be reviewed 1,000 times,
9 we will try and cast these principles for you
10 and then circulate them again for your review
11 and edits and further thinking and evolution
12 and maturation and all of that good stuff that
13 we are going to do.

14 At the same time, realize that
15 these are tools that we are going to share
16 with the TAPs and remind yourselves that these
17 are the principles that you established when
18 you go forward to look at measures and measure
19 evaluation.

20 So it actually is an important
21 foundational work for setting the stage for
22 the work that is going to go ahead. So I

1 hope, luckily for transcripts, recordings, and
2 14 people taking notes, we have probably got
3 it somewhere.

4 Okay. Joyce, I think we are --

5 CO-CHAIR DUBOW: We are overdue
6 for a break. So why don't we do that now and
7 come back at 4:00. Okay? Let's do that.

8 (Whereupon, the above-entitled
9 matter went off the record at 3:43 p.m. and
10 resumed at 4:00 p.m.)

11 CO-CHAIR DUBOW: I hope we still
12 have our colleagues on the phone. But,
13 anyway, we will pretend you are there. We
14 have one more issue to discuss this afternoon.

15 Then we will have public comment
16 if there is any. Maybe there is somebody on
17 the phone listening. And then we will adjourn
18 probably early and reconvene tomorrow morning.
19 Breakfast is at 8:30, I think. And we will
20 start at 9:00 o'clock in the same room, right.
21 Thank you.

22 So the remaining item is if you

1 flip the -- isn't it identifying outcome
2 measures? So, Reva, do you want to just --

3 DR. WINKLER: To date on the
4 project, as with all of our projects, we have
5 done a call for measures. We have done a call
6 for the phase one measures. We have received
7 15 measures so far. In your materials, you
8 have a table with them. That is what we have
9 got. All right?

10 We have been doing ongoing
11 outreach efforts. We are expecting four more,
12 including two more cross-cutting measures. So
13 that will bring the cross-cutting measures to
14 four. There is one more heart measure and one
15 more COPD measure.

16 Phase two, which is all of the
17 other subjects, the call is currently ongoing.
18 And it closes on October 30th. We have been
19 spreading the word. Helen goes out and gives
20 a talk. The next thing you know, we get three
21 calls about measures. So that is one way.

22 There is awareness growing. But

1 this is a relatively limited number of
2 measures. So, therefore, to the Steering
3 Committee, we need you to steer.

4 Are you aware of any additional
5 outcome measures that we need to identify and
6 go seek out? What other avenues should we
7 pursue to try and identify additional outcome
8 measures? You all live in different worlds
9 than we live in. And so your awareness and
10 knowledge base we are hoping to take advantage
11 of.

12 Again, last week at our annual
13 policy conference membership meeting, we were
14 talking it up. We were talking to people
15 about things. I have got several phone calls
16 coming up this week with people following up.
17 I am not sure if there is going to be anything
18 there or not. Sometimes we have to see the
19 measures to get a sense of really whether they
20 belong in the project or not. So this is
21 really one of the critical aspects of how
22 robust this project will be going forward.

1 One of the things I sent you
2 yesterday, which I didn't expect you to have
3 a chance to read, is an environmental scan
4 that our staff has put together looking for
5 measures.

6 And we use the sort of usual
7 places, the National Measures Clearinghouse
8 and all the stuff on there, as well as our
9 membership and the people who are the
10 organizations that work with measures a lot,
11 lots of Google, lots of Pub. Med.-ish sort of
12 things.

13 But what we found is sort of what
14 you see. And this again is meant to be a
15 living ongoing document. If you can provide
16 us additional guidance on where to go
17 searching, we will go dig up the rocks. But
18 we need to know where the rocks might be
19 located before we can go dig.

20 So sometimes what we found in the
21 past is people are a part of organizations
22 that are doing things more in house, but you

1 are doing it all of the time. You have got
2 what well-specced-out measures. You are using
3 them.

4 You know, you may not be one of
5 those 70 official measure developers or think
6 of yourselves that way, but if you are aware
7 of measures that are being used within your
8 organizations, particularly to evaluate
9 performance, you know, that is a learning
10 laboratory that is probably as good as a lot
11 of formal measure development activity.

12 And so we are searching. Where do
13 we go? What do we do next?

14 MEMBER JUSTER: So how do we that
15 short of going through -- do you want us to go
16 through the formal? I saw an SF-97 that I
17 want to -- not really. I am just kidding you.
18 I saw an XYZ. Do I go through the formal or
19 just send you an e-mail and say, "This looks
20 interesting"?

21 DR. WINKLER: Anything you want to
22 do, send me an e-mail, tell me a name, say

1 something today, right now we will take it any
2 old way you want to package it and send it
3 because then we will follow up and see what we
4 can identify.

5 MEMBER AMARASINGHAM: Now, how
6 does it work, like, for example, if we did
7 find in our local regional measure that there
8 is a measure that could be a suitable
9 candidate?

10 I imagine that the people who
11 might be owners of this measure would have to
12 put in a good amount of time to get it ready
13 for presentation here, as opposed to a measure
14 developer, who does this all the time.

15 DR. WINKLER: You are right. We
16 will talk about this a little bit more
17 tomorrow. We actually have an electronic
18 submission process where it is an online kind
19 of tool form that is filled out.

20 And to provide you with the fairly
21 detailed amount of information you are going
22 to need to go through all of the evaluation

1 criteria, the number of questions is not
2 small. So yes, they would need to be able to
3 fill that out.

4 On the website, you can go to the
5 measuring performance. If you drop down that
6 menu, one of them is submitting measures. And
7 it talks about all of the stuff. For measures
8 that are pretty much from the government and
9 the public domain, the measure steward, there
10 is a measure steward agreement they agreed to
11 that they own the measure, they have the right
12 to the intellectual property, and that they
13 will maintain the measure going forward and
14 those sorts of things. So the conditions are
15 listed out. So that information is available
16 for you for any potential candidate.

17 We would need the measure
18 information submitted through the electronic
19 submission process because, frankly, that is
20 how we get it into a usable form. And then
21 we can do a lot of things with it once it is
22 there.

1 We have hopefully left all of the
2 paper behind us.

3 MEMBER AMARASINGHAM: A quick
4 follow-up point. For those who might be
5 developing the measure, that is not part of
6 these sort of 70-plus standard groups. What
7 would be the potential incentive that I could
8 really to them?

9 DR. WINKLER: Aside from just the
10 -- you know, I guess you would have to ask
11 other measure developers, why do they want
12 their measures endorsed by NQF? A couple of
13 reasons. They are likely to be used more
14 broadly. They would have both the
15 responsibility but the credit, but you will,
16 of being the owner of an NQF-endorsed measure
17 potential that could be adopted and more
18 widely spread. And bring some into this more
19 national wider enterprise of quality
20 measurement, rather than stay at home, you're
21 going national.

22 Can anybody else help me out on

1 that?

2 MEMBER HOPKINS: So a couple of
3 thoughts. Have you fully queried the logical
4 vendors in this space? You know, I am
5 thinking of like Care Science, which I guess
6 is now part of Premier, University Health Care
7 Consortium. It might not be a vendor but
8 trade group or whatever. I am sure you have
9 got the specialty societies lined up. They
10 are logical.

11 When it comes to cancer care
12 outcomes, I am thinking not only of NCI, which
13 would be logical, but you know about NCCN?
14 Yes. They have got all of these guidelines
15 and I would hope outcomes. No measures?

16 DR. BURSTIN: Actually, the TAP
17 Chair Leon Newcomer, who is going to --

18 MEMBER HOPKINS: Oh, yes.

19 DR. BURSTIN: -- be doing a lot of
20 power work right now between NCCN and clinical
21 data --

22 MEMBER HOPKINS: Yes.

1 DR. BURSTIN: So he will be
2 following up on some of --

3 MEMBER HOPKINS: That is my list.

4 CO-CHAIR DUBOW: Is there anybody
5 on the phone who has any ideas?

6 MEMBER AMARASINGHAM: I am curious
7 also whether or not you have investigated the
8 Dartmouth Group. Its charge is the Atlas.

9 DR. WINKLER: We are certainly
10 aware of the Atlas. And we have a certain
11 number of contacts with them. But in terms of
12 actual measures, I am not sure that Dartmouth
13 has the actual performance quality measure.
14 They have got a lot of data. That is for sure
15 but in terms of the actual measures. But we
16 can certainly double check.

17 MEMBER KEALEY: How about the VA?

18 DR. WINKLER: That is a good one.

19 MEMBER KEALEY: COPD?

20 DR. WINKLER: Yes. VA we have
21 certainly seen measures of theirs before. And
22 one of the issues we have had to deal with is

1 they tend to define their population in
2 VA-speak. That doesn't mean those aren't real
3 people that we can't find a translation and
4 get it into the rest of the world.

5 And so I think that might have
6 been an artificial barrier that we let kind of
7 hold us back. But we should be able to
8 translate from VA-speak to normal language.

9 And so that is a very good avenue
10 to pursue.

11 CO-CHAIR DUBOW: Did you check
12 through the ACOG measures to see if there is
13 anything you could pick out there as outcomes?

14 DR. WINKLER: You know, I have
15 looked at the ACOG measures. And, in fact,
16 the way they are set up as the "if/then"
17 statements, we have had conversations with
18 RAND and the various developers on that.

19 And we have actually had some of
20 the ACOG measures come through. Most of them
21 are process measures for the most part, but I
22 will double check them again.

1 CO-CHAIR DUBOW: They were meant
2 as improvement measures. I mean, they have to
3 be converted into --

4 DR. WINKLER: Right. Yes.

5 MEMBER AMARASINGHAM: Another
6 question I wonder about is, have you sent out
7 a sort of request to the Academy of Health
8 membership? They have so many health service
9 researchers. I was at the last Academy of
10 Health. There are a lot of new measures
11 proliferated.

12 DR. WINKLER: We will have to
13 figure out how to get there, though.

14 MEMBER KEALEY: Any international
15 partners?

16 DR. WINKLER: We have not done a
17 lot. I am not saying we have never done
18 anything internationally. We have, especially
19 in patient safety, yes, and Canadian, but we
20 haven't done a lot international in terms of
21 measures. The question is, how translatable?
22 Hard to know.

1 MEMBER HOPKINS: Patients are
2 people.

3 DR. WINKLER: Yes, especially
4 outcomes. Okay.

5 CO-CHAIR DUBOW: Well, clearly
6 this is something to think about when you take
7 a shower, when you go jogging, you know. Do
8 your best thinking --

9 DR. WINKLER: Whenever it is.

10 CO-CHAIR DUBOW: -- because it
11 would be really good to be sure that we have
12 as broad a sweep as possible for when we
13 consider this stuff.

14 DR. BURSTIN: And I would say any
15 of the people who are involved in the TAPs, in
16 particular, we really especially welcome your
17 expertise.

18 I mean, we have had some
19 conversations, for example, Ted, with ACC.
20 And there are a couple of other measures
21 potentially in the hopper which we could share
22 with you that we are maybe bringing in.

1 But if you have specific thoughts
2 about what would be useful procedurally or
3 whatever the case may be, please let us know.
4 We can reach out to ACC or AHA or others.

5 MEMBER JUSTER: And, then, in the
6 areas, two areas, that I think we would excel
7 in cross-cutting measures would be the HIE
8 people and the patient-centered medical home.
9 I don't know if AMIA, the American Medical
10 Informatics Association, is doing anything
11 with HIE metrics, you know.

12 CO-CHAIR DUBOW: Operator, can you
13 please see if there are any comments from the
14 public to open the lines up, please?

15 THE OPERATOR: All lines are open.

16 CO-CHAIR DUBOW: All right. And
17 is there anybody in the audience who wants to
18 say anything?

19 (No response.)

20 CO-CHAIR DUBOW: Okay. So I think
21 we have an early adjournment today. Thank you
22 very much for your full participation. I

1 think we had a fruitful meeting.

2 DR. WINKLER: You will need to
3 take all of your belongings with you because
4 they are going to reset up this for a dinner
5 tonight contiguous with the other rooms and
6 then reset up for us. So please take
7 everything with you. We will take care of
8 that.

9 CO-CHAIR DUBOW: Are we going to
10 meet in this room tomorrow?

11 DR. WINKLER: Yes.

12 CO-CHAIR DUBOW: So we are going
13 to reconvene in this room tomorrow 8:30 for
14 breakfast. Nine o'clock the meeting will
15 start. Okay?

16 DR. BURSTIN: You are also in the
17 hub of some wonderful restaurants if anybody
18 wants any dinner suggestions.

19 (Whereupon, the above-entitled
20 matter was recessed at 4:13 p.m., to be
21 reconvened on Tuesday, October 20, 2009, at
22 9:00 a.m.)

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