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

(9:01 a.m.)

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

Lee, are you here?

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

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

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

CO-CHAIR FLEISHER: Thank you.

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

CO-CHAIR FLEISHER: Got it. Thank

you.

CO-CHAIR DUBOW: Okay.

Technologies that I am not familiar with.

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

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

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

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

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

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

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

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

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

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

MEMBER KEALEY: Minneapolis, Minnesota.

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

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

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

NQF. So is that disclosure? Thank you.

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

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

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

go there.

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

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

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

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

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

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

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

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

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

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

And I have no conflicts of interest.

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

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

failure community management program.

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

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

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

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

years.

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

(Laughter.)

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

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

I don't have any conflicts to report.

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

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

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

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

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

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

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

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

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

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

CO-CHAIR DUBOW: Okay. Thank you.

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

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

CO-CHAIR DUBOW: Please do.

THE OPERATOR: Okay. All lines are now opened.

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

My only conflict is my employer.

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

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

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

And I have nothing to disclose.

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

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

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

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

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

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

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

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

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

CO-CHAIR DUBOW: Thank you very much.

Helen?

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

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

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

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

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

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

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

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

measures we are all used to seeing.

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

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

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

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

SF-12 as a functional status measure.

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

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

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

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

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

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

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

towards measures that are more clinically based out of EHR.

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

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

Do you want to add anything, Joyce?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And realize that they are your

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

News and Resources.

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

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

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

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

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

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

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

As Sarah Callahan from our Education Department introduced herself, she

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

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

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

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

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

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

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

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

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

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

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

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

So, particularly over the last

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

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

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

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

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

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

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

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

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

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

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

better.

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

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

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

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

What were the problems I wanted to be solved?

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

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

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

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

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

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

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

We certainly are looking at

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

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

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

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

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

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

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

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

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

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

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

not making a lot of sense out there.

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

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

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

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

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

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

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

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

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

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

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

something we simply must tackle.

We are going to talk a little bit about the patient-focused episodes of care. This is some work that has been done at NQF trying to understand what an episode of care might be. And we have had work done in some of the topic areas that we are going to discuss, particularly around AMI and coronary artery disease and diabetes and cancer. And we are going to use some of that work to help us do some of our work.

Clearly that shared accountability is going to be embedded in outcome measures because ultimately the outcome of patient care will have contributions for all of the various factors. And so outcome measures you can see are becoming sort of a very integrated way of observing a lot of different aspects of health care.

Certainly another area of desire for measures is appropriateness measures. Should you be doing whatever was done? Should

you be doing it this way or that way?

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

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

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

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

risk adjustment around outcome measures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

very critical.

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

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

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

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

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

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

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

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

So what were the priorities and

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

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

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

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

area for NQF but certainly a very important one.

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

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

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

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

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

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

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

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

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

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

So if anybody has any questions? Yes, Barbara?

MEMBER YAWN: Just one comment

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

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

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

(Laughter.)

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

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

For example, I know that there was

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

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

DR. WINKLER: Do you want to?

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

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

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

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

DR. BURSTIN: Yes. There is actually --

DR. WINKLER: I didn't.

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

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

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

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

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

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

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

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

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

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

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

DR. BURSTIN: That is an excellent point.

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

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

So, for instance, some of the

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

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

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

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

process measure to actually achieve an outcome.

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

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

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

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

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

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

(Laughter.)

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

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

when the guideline itself changed?

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

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

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

MEMBER HOPKINS: Yes. I just

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

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

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

CO-CHAIR FLEISHER: No.

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

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

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

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

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

you.

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR DUBOW: Dianne?

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

translating across all the way to acute care. So if you could speak to that a little bit?

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

(Laughter.)

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

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

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

DR. BURSTIN: Yes?

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

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

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

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

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

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

DR. WINKLER: Let's talk about the

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

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

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

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

So things are still in draft, but

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

Did somebody on the phone want to say something?

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

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

MEMBER PINDOLIA: And how are you?

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

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

And our goal is to really get

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

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

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

Did I get cut off?

CO-CHAIR DUBOW: Vanita, we are

having a little trouble hearing. I heard outcomes that were not necessarily related to chronic diseases for the younger population. Did I get --

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

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

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

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

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

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

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

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

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

DR. WINKLER: Any other comments from anybody else who is on the phone? Anybody else want to say anything up there? You are speaking to us from the ceiling.

(No response.)

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

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

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

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

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

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

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

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

MEMBER HOPKINS: So, Reva, --

DR. WINKLER: Yes?

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

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

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

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

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

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

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

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

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

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

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

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

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

And it is going to be a growing

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

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

Sometimes it comes from, say, office equipment. Sometimes it comes from a patient as a historical element. Sometimes it comes from a lab value. Sometimes it comes from wherever?

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

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

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

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

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

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

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

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

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

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

oriented to our current set of measures.

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

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

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

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

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

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

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

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

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

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

MEMBER PINDOLIA: This is Vanita

again. I have a comment.

DR. WINKLER: Go ahead, Vanita.

MEMBER PINDOLIA: I have a comment. I was also on the NQF Medication Management Steering Committee. Just looking from a year ago, measures that we approved and CMS had a bunch related to like medication possession ratio to see if people are adhering, if they are taking things that they shouldn't, et cetera, and I just wanted you to understand the platform for medication has changed so much in that one year that that measure is not as useful anymore.

And that is something that I think NQF needs to look at. And once you endorse something, you need to see if that measure is something that can continue. And the reason is for seniors with all these $4 generic programs and free antibiotics and everything, they are not showing their insurance cards.

And so at least 65 to 70 percent of our patients in our program are unclaimed

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

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

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

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

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

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

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

MEMBER PINDOLIA: Okay. Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

cardiovascular conditions, specifically VCAD AMI heart failure group.

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

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

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

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

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

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

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

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

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

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

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

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

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

Barbara, you have a question?

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

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

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

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

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

And, admittedly, these are somewhat arbitrary breakdowns.

CO-CHAIR DUBOW: Ted?

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

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

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

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

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

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

But those will be limitations of

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

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

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

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

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

This is where being the staff

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

CO-CHAIR DUBOW: Dianne?

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

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

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

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

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

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

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

And having them intimately involved in the discussion around their

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

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

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

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

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

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

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

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

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

And this would be part of your

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. BURSTIN: Yes.

MEMBER AMARASINGHAM: -- readmission rate to any hospital?

DR. BURSTIN: They are going to. That is exactly what this other measure developer had done. So they are now trying to work together to think that through.

MEMBER AMARASINGHAM: And that is great. These are the kinds of questions that need to be discussed.

CO-CHAIR DUBOW: Dianne, did you have another question?

MEMBER JEWELL: Well, and I am realizing, Reva, when you were talking about the dialogue between individual panels and measure developers that there are things -- and this is a great example of it -- where the specific conversation on specific measures is really going to be that give and take.

I am realizing that I think my question was about whether, regardless of who the developers are and what the measures are,

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

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

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

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

will have that information.

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

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

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

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

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

DR. WINKLER: Right.

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

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

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

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

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

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

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

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

we reformat it for you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

and we need a measure.

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

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

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

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

So I just think it is so, so important.

DR. WINKLER: Okay. Very fair.

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

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

Do we have a formal definition for cross-cutting?

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

we need to create a definition.

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

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

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

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

So I thought of cross-cutting in a

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

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

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

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

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

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

think that is a really important point.

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

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

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

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

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

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

CO-CHAIR FLEISHER: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

often do the children actually miss school? I am not proposing that that is an actual measure, but that is a true outcome measure that you can judge a health system by.

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

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

the knowledge, skill, and confidence to do something?

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

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

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

Can you all hear me?

CO-CHAIR DUBOW: Yes. Is that Jonathan?

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

CO-CHAIR DUBOW: David Johnson?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

world of health care may be right now.

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

MEMBER YAWN: I understand that. And I have a sense of urgency --

(Laughter.)

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

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

every patient, please, but something.

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

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

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

address integral practice that practices need to do.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR DUBOW: Do.

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

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

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

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

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

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

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

MEMBER YAWN: We have used that for years.

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

MEMBER YAWN: We do.

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

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

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

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

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

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

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

pushing in one direction or another on its --

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER JUSTER: Could I say one

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

MEMBER YAWN: Any of them.

CO-CHAIR DUBOW: Yes.

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

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

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

MEMBER YAWN: But that is the

physician's part of this.

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

(No response.)

CO-CHAIR DUBOW: Okay, Reva.

DR. WINKLER: Yes.

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

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

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

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

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

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

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

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

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

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

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

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

amalgamation of the work we do with other folks.

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

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

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

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

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

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

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

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

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

are comments more suited to the measure developer.

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

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

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

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

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

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

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

information back from our members on how to adjust it, but ultimately this process is one that is blessed by the board of directors. And we don't have a lot of room to change it.

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

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

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

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

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

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

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

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

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

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

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

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

And then the Committee would

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

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

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

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

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

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

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

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

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

DR. WINKLER: Thank you, Joyce.

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

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

DR. WINKLER: Yes.

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

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

DR. BURSTIN: It is transparent to

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

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

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

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

about X.

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

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

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

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

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

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

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

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

reasons to reinforce a perspective.

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

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

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

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

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

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

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

topics.

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

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

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

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

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

When you are here sitting as a member of the Steering Committee, you are helping facilitate hat communication, but you are also here in your own expertise.

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

So that is the role of the TAP for

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

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

So questions around the TAPs. Dianne, why don't we start with you?

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

DR. WINKLER: Sure.

MEMBER JEWELL: I know I am one. I am the Bone and Joint TAP Chair.

DR. WINKLER: Right. Barbara? Barbara is Respiratory. Any of the others around? Alexis, why don't --

MEMBER JOHNSON: Dave Johnson, GI.

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

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

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

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

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

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

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

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

people.

MEMBER HOPKINS: Yes.

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

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

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

DR. BURSTIN: I think our expectation --

MEMBER HOPKINS: -- which is sort of interesting.

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

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

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

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

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

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

CO-CHAIR DUBOW: We have two

representatives. We have Lee Newcomer and --

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

CO-CHAIR DUBOW: Okay.

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

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

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

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

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

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

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

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

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

are not there.

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

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

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

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

We didn't get as many on some of

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

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

DR. BURSTIN: Yes, absolutely.

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

DR. BURSTIN: That would be wonderful.

CO-CHAIR DUBOW: Other questions? Comments?

(No response.)

CO-CHAIR DUBOW: Okay.

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

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

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

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

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

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

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

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

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

One of the things I just want to

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

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

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

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

And for those of you who were with

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

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

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

outcomes?

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

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

MEMBER YAWN: Maybe you are going to tell us what higher-level performance measure means. You are going to tell me about it?

DR. WINKLER: I am not sure I have that. I am going to punt that one to Helen and Joyce, actually.

DR. BURSTIN: Once again, it is the problem, the fact that it is my slide. The idea has been that we were trying to think about ways to strengthen the criteria to make

sure we get at the measures that seem more important so if you get at the measures that perhaps are more proximal to outcomes, the ones that have a title "Link to Outcomes," rather than trying to avoid some of the very narrow process measures that we are starting to see, so trying to raise the bar a bit.

CO-CHAIR DUBOW: And I would emphasize the raising the bar part. David may want to have some comments. There is a term that I am not allowed to use to describe the measures that we have in mind hat we don't want to see anymore, but we have a transcript. So I will tell you later. Sorry. Measures that are meaningful and just more rigorous and robust.

MEMBER HOPKINS: Do you want this sort of a specific example? I mean, we were getting measures of "Physician documented that" such and such occurred. And it was usually "I counseled the patient" or something.

There really is no evidence that a physician checking off on some form that they did that is linked to the outcomes, and that was our point.

CO-CHAIR DUBOW: I heard a lot in the past that it is important to have those kinds of measures because there is evidence that clinicians aren't doing something, which was the justification for many of the measures that have been endorsed heretofore.

But as a new Steering Committee, we have an opportunity to meet these criteria. There are lots of measures that are sort of in the works, but this is a new opportunity to apply these higher-bar criteria.

Dianne?

MEMBER JEWELL: So having just had an "aha" moment, I think that we might -- and I don't know if the "we" is this group -- have some work to do helping people understand what we mean by gaps in care because what you just described is the way I think a number of

stakeholders identify a gap in care.

The physician didn't. The physical therapist didn't. The nurse didn't. And so if, in fact, gap means something, has a higher bar in its definition, that will have to be re-explained because I will venture to guess that some of the reason we get those measures aside from their simplicity in tracking is because they really do feel like this is a gap in care.

And so, therefore, if it is documented, we have filled the gap. So perhaps we are in a vicious cycle there.

MEMBER HOPKINS: Can I respond to that? Because, I mean, you make an excellent point. I think what we were saying was two things. Clearly those aren't outcome measures. They are process measures. We don't have to debate that.

But the more important point was exactly what is being measured and by whom. So you are absolutely right. Things aren't

happening that need to happen, but I am not sure we have figured out the best way to measure that.

And I think Helen or Joyce referred earlier to these smoking cessation measures of hospital care that ended up truly being a check box on a nursing form and always got checked. And that is not helpful.

CO-CHAIR DUBOW: And I would agree. Point well-taken. I think it is just a matter of if we also want to not spend our time seeing those kinds of measures, part of the ability to do that is to help people better understand what is a gap in care, what is not, and what constitutes an appropriate measure. So I think we are saying the same thing.

DR. BURSTIN: And just one small nuance to that. I think there are at times where those measures where somebody did something, are, in fact, heavily evidence-based to be tied to an outcome, like

the act of a clinician encouraging a patient to quit smoking every single time is associated with higher rates of quitting smoking.

So to me that is a tighter link on that proximal/distal to outcomes piece. That is one. There is a tighter link to outcomes. So I think those are still really important.

MEMBER YAWN: I think there's also just the whole idea -- again I am going to use the "translation" word -- of translation of how do you use performance measures, just like how do you use guidelines.

We can talk about, okay. This is the performance measure, but I don't see that in and of itself an end at all. You know, it is not that helpful for me to know my performance is this, that, or the other, whether it is better or worse than the guy across the street. What I need to know is that it is not 100 percent. And there may be reasons it is not.

Now, how do I peel back from that down to figure out what it is I need to do? And it may be in going back that way I do need to do documentation. But hopefully I do the action as well as documenting.

So I think that we need to make that very clear to people, too. Sometimes people who think about performance measures get all caught up in the performance measure and forget that it is only a tool to improve patient outcomes. It is not just to measure patient outcomes.

CO-CHAIR DUBOW: We have two purposes: quality improvement and public reporting.

DR. WINKLER: Joyce, actually, this is a fairly good stopping point because I was going to talk a little bit more about the measure evaluation criteria, but we have got another agenda item for that. So it follows just fine. There is no reason to delay lunch. But also I was just going to say

we need to ask for public comment first.

CO-CHAIR DUBOW: Operator, could you open the phones for public comment? And we will start with a comment from here?

THE OPERATOR: Yes. All lines are open.

MR. HARDER: Hi. Can you hear me? Am I on? Hi. My name is Joel Harder. I am with the Society of Cardiovascular Angiography and Interventions. I am the staff representative.

There are three principles that I hope you all would talk about this afternoon that are of interest to our organization. And for your Cardiovascular TAP, the house of cardiology is not unified in the measures that are going to be presented. And so we were on the working group, but we are looking forward to engaging the TAP on explaining this in a much more public forum to see what happens.

The first thing I wanted to mention was we are eager. I am dealing with

the readmission measures. The area that is really contentious for us is planned procedures that happen in the 30-day window and how they are excluded and also targeting preventable readmissions, really getting at that.

For example, you are going to see in a 30-day window, there are a lot of gastroenterologists' procedures as well as a lot of orthopedic issues that got captured in a 30-day window. And we want to know from the TAP and the Steering Committee, is that really preventable readmissions related to the PCI procedure?

The second issue, inpatient versus outpatient, we argued to get the outpatient included, and it is. And we would argue that that should be the case because a lot of procedures are transitioning now from inpatient to outpatient.

And that is it. Those are the two issues I want to raise. Thanks.

CO-CHAIR DUBOW: Operator, is there anybody on the phone who wants to make a public comment?

THE OPERATOR: If you would like to ask a question, go ahead. Your lines are open.

CO-CHAIR DUBOW: Okay.

THE OPERATOR: And there do not seem to be any questions at this time.

CO-CHAIR DUBOW: All right. Thank you.

Okay. We are going to adjourn for lunch.

MEMBER AMARASINGHAM: I would just say in response to the first public comment that, in fact, I think a very valid point was brought up with respect to the hospital heart failure readmission measure. Elective procedures, to my understanding, is not currently included in the measure post-readmission.

I am not sure if this is going to

be considered in this, but there are quite a few hospitals which will admit a patient with heart failure, for example, and there is a planned AICD placement, -- that would be elective admission -- shouldn't be considered as a readmission.

DR. BURSTIN: Those are the issues we will delve into more deeply --

MEMBER AMARASINGHAM: Okay. Okay.

DR. BURSTIN: -- when we see the measure specifications themselves. I believe there is a new PCI readmission coming forward which I think is --

MEMBER YAWN: I would ask that we think about our alphabet soup, too, please, and try to limit it. I have no idea what you just said.

(Laughter.)

MEMBER AMARASINGHAM: Let me explain. AICD I meant defibrillator placement --

MEMBER YAWN: Thank you.

MEMBER AMARASINGHAM: -- after a heart failure admission. Thank you.

DR. WINKLER: Okay. Lunch. Outside in the hall, Alexis? Okay. The buffet is set up. We reconvene when, Joyce? One hour, 1:30. Time for phone calls, check your e-mail, eat lunch.

(Whereupon, a luncheon recess was taken at 12:26 p.m.)

A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

(1:31 p.m.)

CO-CHAIR DUBOW: So we are scheduled to talk about scope, but we are going to integrate our conversation about principles into this.

DR. WINKLER: Yes. I would like to introduce one of our colleagues. Karen Pace is with us. Karen has been a staff member at NQF for several years now. She is just winding up our most recent effort around outcomes since it was our hospital outcomes project. And as the staff person there, she has been through the ups and downs of the discussion of outcome measures.

And since we like to make sure that we learn from our ongoing activities and we bring the issues and lessons from those activities one project to another, Karen is here to kind of help perhaps interject some of the lessons learned or issues that have been raised and dealt with or tried to be dealt

with in the previous outcomes efforts. So Karen is going to kind of jump in as well.

You all brought up issues this morning that seem to form the basis of what would be principles around outcome measurement. And I think that works very well with the conversation I need you to have to help us.

And so feel free to jump in and make this very interactive and very informal because what I would like to start with is talking about the scope of this project. It is real easy to say, "outcomes," but then the devil is in the details.

What exactly are outcome measures? You know, what someone may think is someone else would disagree with. And this is going to be one of your primary roles to help us, the staff, know what is in and what is out. I mean, there is a very practical need for that.

But at the same time, the

discussion around why things are included, what should be included, the kinds of issues from the various perspectives of what outcomes are even important and measures of outcomes are going to be most useful to a wide variety of audiences.

So to kind of start this concept, we go back to our friend Donabedian with the measure construct of structure process outcome. In his world, the outcome refers to changes, both good and bad, to individuals and populations that are attributed to health care.

So I guess the first question is, is that a reasonable definition to work from? We will provide you lots of opportunities here, brave new worlds.

MEMBER YAWN: I don't want to take on Donabedian, although I take on everybody else. Why not? "Health care" is an interesting term. And what exactly do we mean "health care"?

Do we mean health care that is provided in sites that we currently designate as where health professionals interact with people who come to seek care or does this include what goes on at home, at school, and other places?

DR. PACE: I don't think it was meant to be restricted to just very formal medical care. You know, I think it is health care in its broadest sense, but that might be something to expand on or to identify for this project whether it should be narrow or broad.

MEMBER YAWN: I intentionally did not say medical. I said a site where health professionals are. So this could be public health. This could be Kmart, Wal-Mart, all of those kinds of places, hospice care at home, where a health professional does come in. Is that what we are talking about, all of that broad?

MEMBER AMARASINGHAM: I agree. And I would propose that we do consider it in

the broadest possible terms.

DR. WINKLER: To make it clear, would you like to define health care so we don't push back on Donabedian but at the same time say that by "health care," we mean all of these things? Is that generally the sense I am sort of starting to hear?

MEMBER JUSTER: Especially if we are going to use the word "attribution." So why has the smoking rate been cut so much in the last few decades? Probably because of a lot of things, some of which have nothing to do with health care, such as you pretty much can't light up in most places.

MEMBER YAWN: Except health care had a huge, huge impact on seeing that that happened.

DR. WINKLER: So does anybody want to kind of draft a proposed explanation, definition of the health care we mean within this just to be sure we are all clear?

MEMBER YAWN: Well, I tried.

DR. WINKLER: Okay.

MEMBER YAWN: And you can go from what I said. I think it was anything that is considered an interaction of someone who is a health professional with a person to whom they administer.

"Administer" is not a good word, but I don't know what other word to use. It could be education. It could be physical. It could be all of those different kinds of things.

I think a health professional needs to be involved in it in some way.

CO-CHAIR DUBOW: I have a friendly amendment. And that is to flip it and not make the clinician the center from which it originates but to make it originate from the patient.

In other words, I think it should be a patient-centered definition and that when you talk about anything that is derivative of an encounter with a clinical person, it feels

as though it is a clinician-centered kind of approach. I think we should think about it from the patient.

MEMBER YAWN: I said the patient --

CO-CHAIR DUBOW: You did.

MEMBER YAWN: -- person sought the interaction. So I don't know.

CO-CHAIR DUBOW: I am happy to do that, but --

MEMBER YAWN: If you can figure out how to make the words the other way around --

CO-CHAIR DUBOW: It must exist.

MEMBER AMARASINGHAM: Strawman sense. Maybe what if we said any activity intended to improve the health of a patient?

MEMBER YAWN: That could be a visit to the athletic club, could be a visit to the farmers' market.

MEMBER JEWELL: You know, it seems to me that we want to keep the intent of these

measures in mind, which is in some respects to shape provider performance.

So given that that is true, even though I heard what you just said, Joyce, I am not sure we can divorce the definition from the provider or I can't figure out a way to grammatically word it without it sounding provider-centered, even though philosophically I totally hear what you are saying.

I don't want to lose sight of that because that is really part of the purpose of all of this.

CO-CHAIR DUBOW: I understand what you are saying. And I can't wordsmith it now, but my guess is that we could actually think about the relationship of an individual to the clinical encounters. I mean, I think it is a doable thing.

I do think that we have to move away from thinking about the clinician as the -- you know, it was that graphic that we saw from the Aligning Forces that we didn't like

so much that had the patient in the middle of it.

And I think that is really how we have to think about what we are talking about. I can't do it right off the cuff, but I think it is doable.

DR. PACE: There are also some definitions that exist like I think the IOM has a -- I mean, we could look at some of those and see if that would be worthwhile adopting versus trying to create.

MEMBER YAWN: I wanted to move beyond. I intentionally said health professional, rather than provider or clinician, because those have certain definitions. And they are all different. They are all over the place.

But I wanted to get beyond the traditional nurse, physician, PA, occupational therapist because I do think there are all kinds of people, including our receptionist, who make huge impacts. I wanted it to be the

whole team of health professionals.

DR. BURSTIN: And I would have to say team, and it goes way beyond health professionals. To me team is my medical assistant who checks the patient in, does their blood pressure. You will get some debate on that.

I think we have heard the emphasis of where you want to go. We probably ought to move on.

DR. WINKLER: Yes. Just to mention, this is not the first time we have talked about definitional issues. I think one of the outcomes of this is we are going to draft up that list of things that you wanted to try to define.

And we will draft something based on what you said. We can play the e-mail game on, can you make this a better definition and agree on --

DR. BURSTIN: We have the sense of what you are talking about --

DR. WINKLER: Right. We will draft one based on --

DR. BURSTIN: -- broad and a team and, you know --

DR. WINKLER: Now, this is a list of outcome measures, types of outcome measures, that we have used. And I am not even exactly sure how we came to it, but we have used it. This was what was used in our proposal for actually to HHS as part of the contract. And I think it generated from some of our previous work.

And the question is, do we have the right list of things? Are there things that shouldn't be on here? Are there things that should be on here that aren't?

I wanted to get into some detail with this because I think that it will help us talk about what some of these principles of outcomes are that you started talking about this morning that we could help capture.

What is it about outcomes that are

the critical aspects that meet the needs? People keep saying, "We want outcome measures." What is it they really want? What information is really being sought?

This will also form sort of one of the aspects when we start doing a gaps analysis of each in the conditions and the cross-cutting is, are these the types of outcome measures we really want to see to fill those gaps? What are we missing? What are we not?

And so I really would like to spend a little bit of time with you all thinking about whether have we captured the types of outcome measures that we want to be talking about? You know, some of them don't belong. Some of them are not appropriate. Tell us when.

This sets the scope for the project such that if we have measures come in that are things that you don't think belong here, there are out. If they do address some

of these things, they are in.

And so I would kind of like to go through each of the bullets and just get your sense of them. And they are ordered not in any particular order except that I always put mortality last. I am really optimistic as a physician.

(Laughter.)

DR. WINKLER: But in the first one, it to me is really one of the more basic. If you are asking the question, why did the patient interact with the health care system defined however you want to define it, why did they come? And then what happened to them?

So patient functioning, symptoms or symptom management, symptom resolution. And a more long-term may be health-related quality of life and this being not limited but addressing physical, mental, social.

So in that realm, are those all outcomes that would be measures addressing what it would be.

MEMBER YAWN: I don't think there are. And people can argue with me that we should break them down, but I think role functioning and occupational functioning are very important.

And people will say, "Well, that is either because of physical or mental." It is not always so easy, I don't think, to separate those.

So in a perfect world, I would like occupational functioning and role functioning like parenting being the caretaker child of an adult whatever to be included.

MEMBER McNULTY: I would just like to clarify on this first point you have got patient function and symptoms, which could be reported by patients themselves or could be reported by somebody other than the patient themselves, could be observed by caregiver, could be observed by a clinician. So you need to distinguish there what you are after, what we are after.

Generally health-related quality of life I think of as a patient-reported measure that is going to be reported by the patient. And the term that is more broadly used now, at least within the sector of health care that I work in, is patient-reported outcomes. Health-related quality of life is considered specific to the dimensions that you have there, which are physical, mental, and social.

So if I am interacting with the FDA, for example, they will look at the term "health-related quality of life" as something that pertains to those dimensions. They prefer the term "patient-reported outcomes."

The term "quality of life" in and of itself fell out of favor a number of years ago because it was thought to be way too vague. You could be considering a person's financial status. You could be considering religion. You could be considering other factors that have nothing to do with their

health. That is when the term "health-related quality of life" came in that really gets superseded by the term "patient-reported outcomes."

So I think for me personally, this is one of the key pieces in terms of what are we after here? Are we interested in knowing from the patients' perspective how they come through the health care system, whatever their purpose in entering the health care system was, and they come out the other side of it or as they are going through it? What do we want to measure? What is it that we want to know?

That is a question. I don't know the answer to that. I don't know. I guess I have to learn more before I could have like a cemented opinion myself on it.

MEMBER JUSTER: It looks like those three domains are certainly interrelated, but they are independent. I could have more or less pain, and that is only somewhat correlated by how much function I

have.

And that is only somewhat correlated with my -- I will still use quality of life but whatever the terminology is. So how I feel, what I can do, and how I feel about it, meaning my assessment of my quality of life, seemed to be independent, somewhat independent.

MEMBER McNULTY: That is exactly right. I think it is how a patient functions or feels is the way it would be put.

MEMBER DEUTSCH: I just wanted to go back to what Barbara said. So the area that goes back to -- I think you mentioned occupation. In rehabilitation, we usually refer to that generally as participation. And so that is consistent with the international classification of functioning kind of terminology activities for the physical patient functioning. So I would just like to bring that up.

DR. BURSTIN: A question for the

group to ponder with this first group of patient-reported outcomes. We have had a lot of discussion internally about whether bringing a measure like this in in and of itself has value or only as it represents a delta.

So as you go back to the Donabedian example, if you are trying to understand the impact of health care on this, if somebody comes in the hospital at point A and they leave at point B, is that really what we should be measuring in the way we have sort of looked at some of the PT measures, for example, that we brought for the system?

But there are very, very, very few, precious few, examples of this in the literature. And I just want to open that up.

MEMBER DEUTSCH: Yes. Can I? So in rehabilitation, we have the functional dependence measure, which is used in every rehab hospital and also used in some other settings.

There is I would say not really consensus on whether you should look at the change in function, as opposed to discharge at function. And I was talking to David a little bit during lunch.

So what we do in rehab is we on admission look at clinicians observe the patient and report how independent they are on a seven-level scale, seven being the person is more independent, one being the person is dependent. And there are 18 items that are measured.

The cognition, which I think is probably your mental, not so solid, but the motor items are certainly well-regarded in general, at least 12 or 13 used in the payment system for rehab hospitals right now.

And so basically what people do is they rate the person on how independent they are, on the 12 or 13 items, eating, grooming, bathing, dressing upper body, dressing lower body. And then there are some mobility items

for transfers.

So those items are added together to a sum score on admission and discharge. A lot of people do look at the change. And typically patients gain about 20 points on the scale from admission to discharge. So it is basically when they come into rehab and when they rehab.

So I think in our preparation materials, there is a comment about it should be at a time post-stroke or post. And we don't do that, right?

What I wanted to bring up is that when you compare scores on admission and discharge, it assumes that you have kind of the same functional ruler on admission and discharge. And there has been some evidence that the ruler actually doesn't do that.

And I can maybe explain this a little bit better in writing later or may have some material on my flash drive that I can show.

Basically people get a score of 12 to 84 based on the person who gets one on all of the items would get a 12. The person who gets a 7 on all 12 items gets an 84. And so kind of that is a ruler.

And so on admission, when you use that ruler, everybody who used to be a one, are they at the same level of one? They may or may not. And it is particularly at the floor and ceilings. So that is definitely a debate.

I know in the published literature, I submitted change in function. And some people, the reviewers, don't like that. And sometimes I will do "discharge function," and some reviewers don't like that.

So I don't think there is a consensus. There are techniques that can be used to translate these ordinal levels, measures, into interval level.

Rasch analysis is one of the procedures that I have used. The good news is

when I compared my outcomes in the traditional, just the score added up versus the Rasch measures, I haven't seen a difference, but a measurement person would say you have to use measures.

So I can talk more later about it, but --

CO-CHAIR DUBOW: You know, from the patient perspective, staffing at discharge is probably really inadequate, but I know that it presents a measurement challenge.

I remember being on a committee once thinking about hip fracture and ambulation six months out. And the problem was how you could get that assessment as a measurement issue. But that is what a patient really wants to know. You know, can I walk as I walked before my hip fracture?

And if you give it a longitudinal picture, then you have a better sense of it. And I think we are going to face some measurement challenges here.

MEMBER DEUTSCH: In rehabilitation, we actually do have an accreditation group that emphasizes post-discharge status. And so there are quite a few.

We have hospitals. We actually do call patients three to six months after discharge and ask them how they are doing. And they do a phone interview. So this becomes the patient-reported version.

CO-CHAIR DUBOW: I did some research to find that recall was really lousy. Yes. And you also found in general they get the patients who are really easy to find. And so people who end up in nursing homes aren't included. And so there are a lot of methodologic problems with that.

MEMBER GIBBONS: I just wonder if there is some other intermediate outcome that needs to be looked at. I don't so much mean intermediate. I just think that when you look at patient function, symptoms, and

health-related quality of life as some objective measure and then look at patient experience with the care, there is really not an outcome that looks at whether the patient attributed their condition to the health intervention.

And what I mean by that is, in a lot of questionnaires, patients' rating of health care givers and hospitals and clinics, whether you use Press Ganey scores or so forth, may at times not be an accurate reflection of what the outcome was in terms of the actual intervention. But they are confused with the health care.

So I just wonder if there is some other outcome that actually measures whether the patient felt that there was a close relationship between the health care they got and where they sit or is that too cynical?

MEMBER YAWN: No.

CO-CHAIR DUBOW: Yes.

MEMBER YAWN: No. I don't think

it is too cynical, but, I mean, when we believe that less than ten percent of health is based on anything we do at all, I sort of wonder if the patients are going to be better at attributing things to us than the world does.

CO-CHAIR DUBOW: I don't think it is the right question, though. I mean, I think, first of all, Press Ganey is not an NQF-endorsed --

MEMBER GIBBONS: Okay.

DR. BURSTIN: They are actually just a purveyor of whatever surveys are used.

CO-CHAIR DUBOW: Right.

DR. BURSTIN: Right, right.

CO-CHAIR DUBOW: But the instrument, the CAHPS tool measured experience. And whether a patient understands what made her well is not -- who cares?

I mean, the issue is how she experiences and how she experienced the care processes and how she feels now. So there is

a lot of emphasis on communication because we know that has an important relationship to outcomes.

There are questions about the experience of the transactions. You know, did people communicate? Did you get the care that you needed when you needed it? You know, you know the kinds of questions that are in those CAHPS instruments.

I think that is what we want to know. I don't really know if I get an immunization. You know, I don't have to understand that. I think what we want to know from the patient is what the patient can best report. And that is how she experiences things that we believe to be integral to the process of achieving a better outcome.

So I think I would think about it from that perspective.

MEMBER AMARASINGHAM: I think this is an important point. The point I would also make, though, is that depending on the

population, some populations tend to rate their caregivers differently. For example, lower socioeconomic populations tend to be more forgiving.

CO-CHAIR DUBOW: That is why we are asking about experiences.

MEMBER AMARASINGHAM: Right, right. Yes. So I think it is important. I think both perspectives are important: the perspective of it doesn't matter necessarily what the objective outcome was to the patient. Was the patient happy with the experience? And I think we need to know specifically what happened, whether the right thing was done. I think that is really important.

The other point I would make, getting back to Helen's question, I think your question was, which would be the preferable measure, the measure that requires a delta or one that could be measured independently at any time?

And I would say as a goal, a

measure that could be done at any time independently without requiring a delta would be the preference in my view but that it would have to be an extraordinarily standardized measure.

And that is challenging because it is going to be hard to find measures like that. And probably we will be left with delta measures.

MEMBER HOPKINS: Just to build on that thought, I mean, what would be wrong to have the SF-12 be an NQF-endorsed measure of patient functional status? It could be applied in a number of different ways.

And if you come up with the other answer, which is it has to be built into a measure like the measures we know, then you end up having somebody decide, well, do you do it four months after the event or six months after the event? Do we need to standardize that? Maybe we do. And then is it with reference to some value prior to that? And if

so, when?

Do we have to decide that before we conclude the SF-12 is a standardized measure that is well used for measuring functional health status or some more specific instrument that works for hip fracture patients or something?

DR. PACE: Okay. Let me throw out some ideas about that. One is that we have endorsed something similar to that in the ESRD project. It is a process measure, which is that end-stage renal disease patients have a quality life assessment, released annually, using the specific SF-12 modification. I think they call it the KDQOL. It is a modification of SF-12 specifically for end-stage renal disease patients.

That is something that can be measured at the provider level, which is what our quality measures are. I think it was brought up earlier. The purpose of these measures is to get an assessment of the

quality of care being provided by some entity, whether it is a hospital, a clinic, a doctor's office, et cetera.

So the process measure is certainly one way to get at that kind of thing. But when we are talking about an outcome measure that is using this, you have to have some way of accumulating, aggregating the patient-level scores, whether it is a changed score or just the one point in time where you have an average.

You have to have some way of making that information aggregated to a provider level if we are talking about a provider-level quality measure, if we are talking about trying to use a score to assess the quality of care.

Otherwise you have all of these individual scores. And they are great for clinical care and hopefully directing what you do for the care of that patient, but it doesn't mean that we have a quality measure

that will be used to assess the quality of the health care entity.

So that is kind of where we are at. And so NQF typically has not endorsed individual scares. We often refer to having endorsed the CAHPS, but the CAHPS, actually, what we are endorsing are those measures that are computed out of the CAHPS items, not necessarily the survey.

Obviously once you endorse a measure, whether it is a process measure or an outcome measure, you are, in essence, endorsing the data behind that, whether it is the CAHPS or the SF-12 or the OASIS for computing a home health function measure. So it is more of an indirect way of trying to endorse that, where that data is coming from, as well.

That is kind of at least how I see the distinction of endorsing that instrument, how you could do it as a process measure, and what we would need to have that as a basis for

an outcome measure and certainly welcome other viewpoints or discussion about that.

MEMBER YAWN: I need to understand if we are talking about across conditions of deltas versus actual measures. I love going across conditions and being able to lump all of a system. I don't know what the word "provider" means anymore, so either a system or an individual's scores.

But I am very reluctant to do that across multiple chronic conditions if we are saying, "I am only going to do it for hip fracture patients" or something else, because there are several chronic conditions, COPD being one of them I can think of quickly, in which you expect the score to go down.

That is the nature of the disease and the fact we have no disease-modifying therapy. So they are going to get worse, and they are going to die of heart disease. But that is just the way it is.

So I can't mix COPD with diabetes

perhaps. I don't know what I would do with that. I can do just diabetes or just COPD for a delta score, but I don't know how to mix them.

MEMBER JUSTER: So what do you do when they have both of them?

MEMBER YAWN: That is part of the problem, is what do you do? Do you say, "Okay. I am happy if they only go down slowly"? You know, I don't know what you do.

MEMBER JUSTER: Well, presumably they might be able to go up from their diabetes and down from their COPD on some even item in the -- I would have to go one by one item, but I am sure there are some items that can go up from one disease and down from another.

Meanwhile the person is just thinking, "How many flights of stairs can I climb now compared to the number that I have to?"

MEMBER YAWN: Right.

DR. PACE: I think, you know, you could have measures either way. But I think what you are pointing out is the issues that we talk about with risk adjustment.

So typically with outcome measures, you need to account for what the patient is bringing with them at the start of the health care experience or health care episode. So how many chronic conditions do they have, which chronic conditions, et cetera?

And there would be various ways to handle this. A lot of the SF-12, you know, they have reference populations when it is a discrete condition.

So that is the challenge of trying to get an outcome measure using these. And that was actually an issue that was brought up when we were initially looking at the measure for end-stage renal disease project, that it really was identified that the preference was to have some type of outcome measure, whether

it would be average score at some point in time or how that would be constructed.

And the measure developers at that time said they did not recommend an outcome type of measure because they hadn't worked out the case mix or risk adjustment for that. And that is why we ended up with a process measure in that particular project.

But, you know, it is an important consideration if you are talking about administering it across all types of conditions that you have to have some method for accounting for some of those differences.

MEMBER YAWN: I think that you bring up another point that I think we are going to have to spend some time on, and that is risk adjustment. I think risk adjustment for multiple chronic conditions just by counting them up has been shown multiple times to be a minimal, if at all, useful way. And that is how most people still do it.

If somebody has two or three of

our conditions, cardiovascular disease condition is not being dealt with well, then their COPD probably isn't going so well either or their hip fracture's rehabilitation is not doing so well because they can't walk because they can't breathe.

So risk adjustment I think is going to be a fascinating topic and maybe one of those in which we can get sort of groupings of measures maybe. I mean, that has been my fantasy for a long time to figure out how to do risk adjustment based on how well they are doing with each of the conditions and not just one, pretending to ignore the others or count them by number.

CO-CHAIR DUBOW: Is there somebody on the phone who wanted to make a comment?

CO-CHAIR FLEISHER: Yes. It is Lee. I am just wondering if you had, by chance, or anybody discussed any kind of like template matching as another type of risk adjustment or actually looking at any kind of

group analysis, rather than trying to risk-adjust, another way to get to the outcomes.

DR. PACE: This is Karen. And yes, we are not only talking about statistical risk models. Certainly stratification so that you are comparing like groups, subgroups, is one way of addressing that, those issues, the differences. Another way that we have seen is really making the measure much more narrow so that you are only measuring it on a more homogenous population.

So each of these has different advantages and disadvantages. And we are certainly open to measures using any method. You know we want people to have some rationale and defend the methodology that they put forward but certainly baseline to recognize when outcomes can be influenced by different patient care characteristics.

CO-CHAIR FLEISHER: Thank you. My interest group is beginning to think that even

process measures may need to be stratified because the level of comorbidities in patient populations may not be equal. And, therefore, you are really not targeting for the patients in whom you could make the greatest impact.

So I just want to make sure that we open that up as we classify for outcome measures, creative ways of dealing with the process defiance of risk adjustment that is still developing.

CO-CHAIR DUBOW: Okay. Thank you.

Dianne?

MEMBER JEWELL: So I think I need a little reorientation to the direction this conversation is taking. Are we talking generally about the challenges that we have in dealing with outcome measures given that in their current state, they are pretty limited, partly because of the data that is available to do the risk adjustment, for one thing?

And so we have to come up with principles to deal with them such as they are

with the idea that we will drive them to be better by our standards or are we saying we won't deal with these limited measures, we are going to set the bar high now? I am not sure where we are headed here.

DR. WINKLER: I think you have addressed both the practical and the idealistic world we live in. And I think we need to deal in the real world. And it is nice to have some wishful thinking on the margins in the world we would like it to be perhaps.

Many times we would like to talk about things that are a little beyond the ability stretch, if you will, because it helps point in a direction of where to go, rather than just staying put where you are and doing more of the same.

So to the degree that you can find the balance in there and albeit it is a very difficult one, part of it is reaching this discussion is having a common understanding of

what we need.

The fact that the function has prompted this discussion, do we all understand what we mean by patient function? Is it an outcome measure? Perhaps it has got a lot of different characteristics to it, such as Barbara brought up, role versus occupational activities of daily living, all of these elements of it.

Does anyone disagree that any of the things we have talked about are not outcomes, not important outcomes?

(No response.)

DR. WINKLER: Okay. So, I mean, to the degree we are trying to reach a common understanding of what we are going to be discussing, the issue will be, are there any measures in this realm?

We are having a hard time finding a lot of them or any, but, again, one of the questions we are going to be asking ongoing and very poignantly later today is, do you

know of any? Where might we find them? What rock have not we looked under?

MEMBER HOPKINS: So, Reva, help us out here. Let's suppose that we are looking for functional health status assessment of stay with your fracture patients and we find that there is a well-standardized instrument that is widely used, like, for instance, in that field, but the problem is in reference to this conversation, nobody has been through the exercise exactly pinning down and getting broad consensus about what is the right time period of measurement pre and post and what is the measure? To use your term, is it the absolute? Is it the delta?

Can't we sponsor something that would lead to that discussion taking place and that consensus being built so we finally have a measure because these are really important measures or do we just say, "Gee, it is too bad nobody has been through that. So I guess we can't endorse any measures that are

functional health status for hip fracture patients"?

CO-CHAIR DUBOW: So what do mean by "sponsor"? I mean, what are you thinking about? We need to have measures.

MEMBER HOPKINS: Right. So I think that NQF would think seriously about how they could make that happen. It is not done by NQF. It is done by I don't know who but the entities that sort of take responsibility for caring for patients.

I am suddenly becoming very aware that this is going to call for some proactive action or we are going to be left empty. And I hate to think of us coming up dry on this.

DR. PACE: Well, one of the things that I think we would like to have you engage in discussion about and maybe partly today and partly when you get into gaps and it becomes even more evident, the lack of measures, is whether a path of endorsing process measures related to some of these functional assessment

kinds of tools is a reasonable path and whether --

MEMBER HOPKINS: That doesn't help me at all. If your concept of process measure is that such and such an instrument was administered, that tells me nothing. I mean, I want to know what was done with it. I want to know if the patient got better.

DR. BURSTIN: Can I try a simple example, though, just a real clinical example? So my committee routinely has the medical system. As soon as somebody walks in the door, administers the PFQ-9, which is the depression screen, prints it right into my EHR, it is color-coded. That person's PFQ-9 score is high, meaning risk for depression. It is highlighted in red. And I now know what to do.

That seems pretty important. You might, in fact, want a measure that says, "I am just making this up" for the proportion of the time patients, new patients, arriving for

primary care services are screened for depression using a standardized depression tool.

It might be very useful, even though at the end you could alternatively say proportion of patients who had a high PFQ-9 who are referred for mental health. Again, that still doesn't necessarily get you an outcome, but that is part of the problem here.

If we endorse the PFQ-9, that is very nice, but how do we actually use it to guide the principles of NQF, which is to be able to look at measures appropriate for public reporting and quality improvement?

This is where it gets tricky. You are not trying to like say we don't want it. I would love to bring these measures through. I would love to use smart people to help us think this through.

MEMBER HOPKINS: You know, it is not just about the health status measures. I think everything on your list here raises

those same questions.

DR. BURSTIN: Although some of the things that are inherently bad are easier: complications, death. I mean, you don't have to get to the delta too much there. You know, those are inherently bad. It is the issues where you are trying to assess the good side that it gets more complicated.

DR. PACE: And I know that this would be outside of the scope as currently configured for, of course, a project on outcomes, but I think some discussion and perhaps being able to bring in some of these measures with the rationale that it is the only way we are going to get to our ultimate goal of outcomes or it will help facilitate, get there, may be worth your discussion, whether you think it -- you know, if you think it would be worthless, then there would be no point. But I think there might be some areas for discussion.

MEMBER HOPKINS: I guess you are

answering my question, not the answer that I was hoping to hear, but it is that we really can't, that NQF really can't, do anything to push the developers further and faster to decide those issues, the when, the what instruments, and what is the measure.

CO-CHAIR DUBOW: I didn't quite hear that. I heard that in doing it -- I mean, this is sort of a last resort if we can't identify outcomes for these particular areas -- that as an interim, presumably there would be some conversation and identification of the gaps and the need for genuine outcome measures but as an interim step, it might be that there was, you know, to use Helen's example, for example, something that integrated a tool into the process of care that potentially hopefully there is going to become evidence attached to the use of the tool to achieve the better outcome.

So it is the making the silk purse out of the sow's ear kind of approach once we

determine that there is no outcome measure available for that particular area.

DR. BURSTIN: There may be outcomes, like, for example, a six-minute walk, some of the cardiovascular. I mean, there are known more physiologic outcomes. And we would be delighted to bring those through.

The presumption is doing better on those is a good thing. But, again, the risk adjustment there would get complicated, but it is less of that, I think, the delta.

DR. PACE: I think that the two challenges are with these. And I think the confusion is that they are often called measures. It is a patient measure. And we are talking about quality measures. So there is a lot of confusion of what we are talking about.

But to me the issue is you have to be able to aggregate to a level where you are going to make a decision about the quality of

whatever entity it is. And then certainly any outcome measure has some issues regarding risk adjustment.

MEMBER YAWN: My goal is to some day be on panels like this where we don't believe the gap analysis may be the most important part, but I don't think we are there yet. I really don't, unfortunately.

I think we can come up with some interim things plus a few good measures, but I still think the gap analysis is going to be the most productive part of this.

MEMBER DEUTSCH: I just wanted to mention that on the instrument side, so the items being collected, a couple of things. There is the Promise Group that is at Northwestern University. And they are trying to report patient-reported outcomes.

Their focus is on really integrating research. They are taking depression, for example, and saying, what are all the tools or instruments that are out

there and how can they link up so they have a very strong measurement perspective. So they have got that ruler thing to make sure that you can do that.

Dave Selle is the person at Northwestern who leads that group. David Tulsky is a leading researcher in the health-related quality of life. And he is trying to link up.

So he has got an NIH project called Neuroqual, Neurologic Quality of Life, quite focused on stroke right now. He is also putting one together or also is funded to do one for spinal cord injury.

So they are trying to put these data banks together so that some of the items are the same for the diagnoses, but some of them are different because these are different issues. So he would also be a resource.

And then the last thing I wanted to mention, just in terms of work, one of the projects that I work on is through a

subcontract with RTI International. And they are funded by Medicare to create a new standardized patient assessment tool, the CARE tool.

And so that kind of could tie into some of this because eventually that would replace the FIM, the OASIS, and DS. So I am listening carefully here because I am quite involved.

And that is about 30 percent of my work effort right now. So I know they keep up with what is going on. And so that is potential in terms of where things are going.

We have the PHQ-2 on there right now, but when we have pain and we have functional status and it is used both in all of the post-acute care settings, so home care, skilled nursing facilities, rehab hospitals, but also in acute care.

And so I have been one of the main trainers to go out and teach people how to collect the data. And so it has been kind of

an interesting experience for the acute care nurses to think about measuring functional status. And often times we end up with training the therapists.

DR. WINKLER: Just to respond to David, the exercise around identifying the needed outcome measures is not just one for fun.

I mean, there is an audience of folks out there who are really looking forward to the output of this with the idea towards promoting the development.

And it is not a 101. This person will do that three days after we decide. I mean, it is not quite that definite. But at the same time, I think that there is a growing audience of folks wanting this and realizing that it will just take the right people doing the right thing.

And so it really is not a theoretical for fun exercise we are going to be doing. I mean, I think there is very much

an eager audience for the outcome of this project, certainly on that gap side.

So to your frustrations and totally ease, the fact is that it is not just going to go into the great abyss, never to be heard from again, I think is not likely to happen.

MEMBER McNULTY: Okay. Can I just add to what Anne said? The Promise data bank is certainly a place to look because they are putting together items that can be used. And it is an NIH-funded project. So it is definitely publicly available.

And, as I was mentioning to Reva during the lunch hour, there are a couple of other things. One is that there is something called a PRO Consortium. That is a private partnership. It is being run by the C-Path Institute. And it is basically FDA's interest, pharmaceutical industry, academics, others coming together, again, to look at areas where mostly they feel that there are

gaps in terms of patient-reported measures and trying to come together as a consortium to develop measures into the future. So it is not here right now, but it is something that you probably ought to be aware of that is happening.

The other is there are a couple of sources of databases that you could go to to look for what patient-reported measures or even clinician-reported measures exist. One of them is a database called OLGA, O-L-G-A, which is maintained by Penny Erickson.

And the other one is ProQolid, which is maintained, owned and maintained, by a company called Mapi that does a lot of patient-reported outcomes work.

Both of these are databases that you have to pay annual subscriptions to get access to them, but, on the other hand, there might be some way of talking to each of these groups and seeing if you could get some access for some period of time. And I would

certainly be willing to help you with that.

DR. PACE: So can you describe what kinds of measures would be in these?

MEMBER McNULTY: What they try to do is they try to keep up with all of the patient-reported outcomes measures that have been developed and keep information about them, not just the fact that they exist but like the psychometric data around them, who developed them, how you get to use them, because in some instances, they will be completely accessible publicly. In some instances, they may be privately held. And how do you access the people who will give you that access?

DR. PACE: And are they primarily patient-level instruments or do you know if any work has been done on any of these to aggregate them to get at like a provider entity, whatever entity, health care provider level?

MEMBER McNULTY: I would say the

majority of them are patient-level. I don't think that there has been a huge amount of aggregate stuff that has happened.

DR. WINKLER: All right. So I think some of these bullets on these types of outcome measures are fairly straightforward and don't need a lot of discussion, but I think some of them do. So I do want to go down the list, the next one being intermediate clinical outcomes, whether biochemical or physiologic.

We have a handful of these measures in the portfolio. This is, you know, blood pressure less than X, hemoglobin A1c less than X. Pick your favorite number, some of these, lipid values.

So those are the typical ones. Primarily around diabetes is where we have them.

DR. BURSTIN: Dialysis adequacy as well.

DR. WINKLER: Yes, dialysis

adequacy is another one. So that there is an actual clinical intermediate outcome that can be measured.

So we do have a few of those. We have seen what those are like. David and I had a conversation earlier about these kinds of measures being built around thresholds when, in fact, the data collection could be done such that you could use a continuous variable, rather than dichotomous variables, and how that might change measurement.

I think that is something that needs to be thrown into the consideration of measures because having the actual value and then doing whatever you want to in the future, as opposed to a "Yes"/"No," you know, how do you follow that along? So I think there are some elements of that that can be put into the consideration.

Dianne?

MEMBER JEWELL: So for measures like that -- I probably should know this from

the panel I sat on before, but measures that are not developed specifically by anybody, who brings those forward? So in my case, I am thinking about gait speed.

The gait speed assessment in my world is huge because it is so tightly linked to mortality, to a number of things, but it is not owned by anybody.

So who would bring something like that forward, how fast one walks? Sorry. Let me start again. Walking speed, otherwise known as gait in my world, is actually -- you know, you could turn that process measure into a do something with it when you get the score kind of thing, but it is not a measure developed by anybody. It is what physical therapists do.

So who brings that forward, something like that?

DR. WINKLER: Yes. I think there are a lot of things that have yet been translated from either research clinical

practice into performance measures.

MEMBER JEWELL: Right.

DR. WINKLER: I mean, and so that translation again is like all of the translational from research into practice sorts of things. So the question is again a lot like the SF-12 tools, things you use, but the measure will need a little bit more around it to support it to be able to meet standardized use, when do you do it, how do you do it, and some of the definitional aspects of it.

I think at this point it would be great to encourage a more traditional measure developer to adopt it or in your field, whoever does measures in that realm, create the measure. It may be very simple and very well.

Measures are living things, really. I mean, they don't exist without need for change and revision and reconsideration on an ongoing basis. And that is why one of

NQF's requirements is that each measure has a steward that kind of raises it and acts as its parent and keeps it fresh and alive and cares about it because the worst thing we could have is a measure that loses its attachment with science.

You know, it is sitting there on the shelf. It gets old and moldy, and nobody is caring for it. And then it is of no use to anyone. So the steward aspect is really an important one.

Helen, did you want to say something? I didn't mean to cut you off.

DR. PACE: I would just add to that that it is not unlike a measure about blood pressure level. You know, there is no one that owns the blood pressure measurement. And someone has taken that and crafted a quality measure by identifying what is the target population. Are there any exclusions? How do you aggregate that information for the target population and the denominator and

numerator?

And, as Reva said, partnering with a group that develops measures or from your discipline that develops measures would be the ideal way so that somebody could actually maintain that.

MEMBER JUSTER: The thing that makes it a blood pressure performance measure, though, is not what is the blood pressure but this somewhat artificial and dichotomous cutoff.

MEMBER YAWN: It changing.

MEMBER JUSTER: Yes. I mean, we all know that it probably actually is better to have a blood pressure of 138 than 140, but you have to cut it off somewhere. And so they have.

The same thing with gait speed, you would have to say the percentage of people who had a gait speed over whatever it is, 6, 5, 7, 12. I mean, it could be stratified, but that is what converts it to a performance

measure, right?

DR. PACE: Well, if those benchmarks are known. I mean, the other way is to have -- I mean, one other way -- there may be others -- is you have an average across your patient population and it is risk-adjusted and you are able to compare your performance against other providers.

So, I mean, there are various ways. And it depends on what you are measuring, if there are those known benchmarks associated with morbidity and mortality.

So there are a variety of ways to construct measures. And it should flow from the information we know.

CO-CHAIR DUBOW: Somebody is on the phone. Is there a question?

(No response.)

CO-CHAIR DUBOW: Okay.

MEMBER HOPKINS: So just a little bit more on this point of taking a continuous variable --

CO-CHAIR DUBOW: One second. We will be with you in a minute.

Go on, David.

MEMBER HOPKINS: -- of taking a continuous variable, like a lab reading or blood pressure and constructing a measure that is dichotomous. Think about the information that is lost. You know, the way that a HEDIS measure on blood pressure has been collected for all this time -- and it is almost all from charts -- is somebody goes in and looks. Is it under 140/90 or 130/80 or not, "Yes"/"No"?

And we could have constructed a database, for gosh sakes. And now we are entering an era where comparative effectiveness research is hopefully going to get funded.

Maybe NQF could help a little bit by saying when you provide a measure like that, start with a continuous variable. Record that. Then the measure --

DR. BURSTIN: As those measures

get retooled for EHRs, much of that will automatically happen because the data source will be there for the --

MEMBER HOPKINS: We all know what happens with blood pressure in EHRs, where it doesn't get in the data field, blood pressure readings.

DR. BURSTIN: It is the one thing I can assure you is always there.

MEMBER HOPKINS: Not the ones I hear about. They put it in their notes.

DR. BURSTIN: Yes. And this is the kind of thing where, again, if you look at the full breadth of what we are trying to do in the quality data set, it doesn't just say what the data element is. It says where to find it.

And so the EHRs have to build it such that the data type is connected to, data element is connected to, exactly where you are going to find an EHR to standardize it.

That is part of the issue here, is

part of this effort is also standardizing where you would find it and what kind of field.

MEMBER HOPKINS: Behavioral piece.

DR. BURSTIN: Behavioral pieces.

MEMBER HOPKINS: The reports I get from a lot of folks who use CMRs is it is easier to type the blood pressure reading into the notes than to pull down the menu and put it in the data fields.

DR. BURSTIN: I think less and less so as people move towards team-based care. I never enter blood pressures at all. They are done by my MA as they walk in the door. I mean, I don't physically enter them at all other than reporting in my assessment plan "Looks good" or "Up this," "Change this."

Things have changed as you have moved to more of a team model. And, increasingly, it is the non-physician clinician who is entering a lot of those data, flu shots, vital signs, smoking status. I

don't enter any of those, depression screening.

MEMBER YAWN: Maybe it is because they do it much better than --

CO-CHAIR DUBOW: Lee, did you have a question?

MEMBER FILLIPO: This is Brian Fillipo.

CO-CHAIR DUBOW: Sorry? Go on.

MEMBER FILLIPO: This is Brian Fillipo. I just had a comment I would like to make. I know we have talked a lot about the use of intermediate clinical outcomes indicators.

I think that there are clearly times when that is really necessary because we don't have good, easily measurable outcomes indicators, but I think we all recognize the literature is riddled with examples where we have used intermediate outcomes indicators to measure a new intervention.

And it has turned out, although we

have improved an intermediate outcome intervention, we have actually worsened measurable outcomes or stroke or death or whatever other. So I just think we need to be careful there.

DR. PACE: I think that is a great point. And one of the things in our evaluation criteria is that for intermediate outcomes, we want to see the association with the desired outcome. So that would be part of the evidence that we would be asking for in the submission.

MEMBER GROAH: I just wanted to come back to David's point. And that is that many of the EMRs now actually require the blood pressure to be in a specific place. And you can't close out that record unless it is there.

MEMBER YAWN: I wanted to follow up on what you were saying, too. I think we need to make sure that we get some of our statistical colleagues involved a little bit,

too, because I can give you 14 different groups of blood pressures that all come out to an average of whatever. And they have huge differences in what I would consider quality.

I mean, you can have a bimodal. They are either all hypotensive or grossly hypertensive. But on average, they are normotensive.

And so I think that we really, really need to talk about distributions, means, medians, standard deviations. We need to have people help understand those so we don't collect it as a "Yes"/"No" or at least if you can do a "Yes"/"No" and plus or minus whatever.

But we have got to be realistic about these things because the consumers of this information are much smarter now. I don't particularly enjoy going back and arguing with this whole group of physicians about, well, mine is a bimodal or mine is this or something when I gave them an average.

So let's make darn sure that we think about those, please.

DR. WINKLER: Yes. Let's move on to the third bullet. And this is another one of these areas there. And you may not agree that the aggregated topic is included, but this is the area of patient experience with care, knowledge, understanding, and motivation. And we have talked a little bit about this health risk status or behavior and included adherence in this.

And so the question is, are all of these outcomes? Should we relate them that way? Should we characterize it differently?

MEMBER HOPKINS: You know, it is a really good question.

DR. WINKLER: We stomped on Linda.

MEMBER HOPKINS: I'm sorry.

MEMBER GROAH: I have a problem with patient experience. It is really their perception. There is a big difference between the experience and perception. And that is

really what -- that perception makes a big difference on their socioeconomic status.

I think we really need to narrow that one down and maybe even divide it up, but that is a real issue. That is what CAHPS is measuring, is perception, not really experience, if you really look at those questions.

DR. BURSTIN: Most of the understanding of CAHPS with the exception of a couple of global ratings scores, all the rest of the items are actually patient reports of care.

So they are not perception. They are, "Did you get your discharge instructions? Did you get your medications explained to you?"

So they are intentionally done that way so they are objective and not subjective. So they are intentionally done as a way to get at patient experience.

The nice part about them, at

least, in my experience -- you know, I used to run quality for a teaching hospital once. We could move those scores in a way that I couldn't move good to fair, you know, not fair, God forbid, fair to excellent or something like that; whereas, I could move a portion of patients who reported they got discharge instructions in a way they could understand.

MEMBER GROAH: Right, like Press Ganey, for instance, is the other opposite of that, where the perceptions really are --

DR. BURSTIN: Right. The patient experience of care is really intentionally thought to be something very different than patient satisfaction and perception.

MEMBER YAWN: I would suggest that even those are based on their perception. I mean, we have done several of those where we have actually observed what was happening because we videotaped it. And then we ask the clinician, and then we ask the patient what

happened. And they don't always remember.

And so I think it is very important. And I know the CAHPS has worked toward that to get the things that we think are most crucial.

And, yes, discharge instructions would be one of those. But we need to be very careful as people try to expand those things about what really happened during the encounter.

It is the patient's perception, just like it is the clinician's perception of what happened in the encounter, not necessarily what really happened.

CO-CHAIR DUBOW: Okay. But, you know, when you ask a patient if X happened "always, sometimes, never," that is how the patient experiences something.

MEMBER YAWN: It is their perception. I'm sorry. You know, it is. It depends on how you want to define experience, how they experienced it, yes.

DR. BURSTIN: It is still an outcome. So I think we are --

CO-CHAIR DUBOW: Would you put your mike on and just introduce yourself, please?

MEMBER HAUGEN: I am Pat Haugen, and I am representing the National Breast Cancer Coalition.

CO-CHAIR DUBOW: Thank you and welcome. Nice to have you here. We are just talking about the types of outcome measures we are going to be considering.

David, did you want to say something?

MEMBER HOPKINS: Yes. I was just going to comment on the last part of that because my first reaction was health risk status, behavior, and adherence, how could that be an outcome.

But the more I thought about it, those things can be influenced by the health care system. And to the extent that they can,

I think they properly belong there.

Does that make sense? Is that what you guys were thinking?

DR. WINKLER: Yes. In terms of adherence, when I first saw it, I was a little bit startled, too. But then when I went back to the definition influenced by the health care system defined however you want to, it seems like that is actually one of the strongest influences.

And when we were talking earlier today about adherence, it is not just to medications, but it is to any aspect of the treatment plan, adherence to doing the stop smoking activity, diet, whatever, all of those things, because certainly I know throughout all of the discussions that we have all been part of, it is not under the influence of the provider. Well, maybe it is, not completely, but it certainly has a large aspect of it.

And so the outcome of that influence is their adherence. So that is the

way we were looking at it in terms of behaviors and the other.

And this morning we have already said knowledge is an outcome. How we measure it is a different issue, but the fact that knowledge is an outcome, understanding and motivation I think are subsets of knowledge, but that is the way we were looking at it.

Again, we would just ask all of you, do you agree, do you want to expand on it? Do you want to revise or change or whatever? Because to the degree we could find measures of that, we would want to include them.

MEMBER YAWN: I was wondering if under knowledge, understanding, and motivation, knowledge doesn't strike me as nearly as important as understanding or motivation. To be able to regurgitate something, yes, that is really nice. And that might be that is our schools' definition of knowledge nowadays anyway to be able to

regurgitate.

I think understanding and motivation would be a higher standard. I am not saying we know how to do it yet, but I am hoping we are moving that way because that just seems much more important to me.

DR. PACE: I mean, I agree that is the ultimate goal. And sometimes it is easier to measure knowledge than understanding, yes. And I think the other thing about these is in a way they are also kind of intermediate outcomes because the ultimate outcome is improving function, et cetera. But they are more on the psychosocial realm of intermediate outcomes.

MEMBER JUSTER: Question about the risk. Do you mean healthy behavior risks, like smoking or exercise, et cetera? So that would be, like I said, not quite the experience of care, but that is just one of the items. Okay.

So that might be like the

Eddington things or something, the health behavior risks.

DR. WINKLER: Well, that would be one.

MEMBER JUSTER: Not handling stress well, whatever.

DR. WINKLER: Yes. Well, that could be one tool, but the most obvious one is smoking status or stopping smoking rates or things like that.

MEMBER YAWN: Or risky drinking behavior.

DR. WINKLER: Yes. The next one is service utilization as a proxy for an outcome, such as the changing edition. This is where things like readmissions or ED visits, particularly when you don't have the kind of condition that you necessarily always need to go to the ED for but do anyway, as a potential indicator of both efficiency but also quality of the antecedent care. This is where you sometimes see some of the measures,

the ambulatory care-sensitive indicators, things like that.

Does that work for everybody as an outcome measure? I have had push-back from members saying readmission is not an outcome measure. So I am just -- well, this is folks I think who look at outcomes very narrowly, and it is what happened to the patient. I said, "Well, going to the hospital, what happened to the patient?"

And they said, "But that isn't what I mean. I mean, what do they physically experience?"

I am just telling you I had this conversation. So I want to be sure everybody is kind of on the same page in terms of looking at this as an outcome.

MEMBER AMARASINGHAM: I mean, I would say absolutely that needs to be an outcome. I think one of the concerns that has been voiced with respect to readmissions but, really, for a lot of these service utilization

outcomes is, do we have the proper risk adjustment? And should we have stratification for some patient characteristics that health systems believe they have a hard time modifying?

For example, in heart therapy admission, cocaine use on admission is difficult to modify. And it can greatly affect readmission rates, but that is not included as part of the thing.

Now, it can be modified. And the hospital systems that believe they can do it want to be rewarded for that if they can overcome some of those difficult cycles.

But I think that has been some of the push-back on readmissions. As a measure, I think it is a superb measure towards integrating a continuum of care.

CO-CHAIR DUBOW: All right. So we have raised issues that are cross-cutting to our definition in terms of data source and risk adjustment, but still we seem to have

some consensus here that the type of service utilization that Reva mentioned is in our view definitely an outcome measure. So we will have to tackle those other challenges.

MEMBER YAWN: Sometimes increased service utilization is a good outcome. For example, if you are talking about outpatient non-urgent care, if we could get people with asthma, COPD, heart disease, renal disease, all kinds of diseases to come in for continuing maintenance care, that would be positive.

So I just want us not to step into that very quickly thinking increased service utilization of all kinds is bad. Frequently we would love to move from the ED or the hospital to outpatient.

And there are some times that ED is absolutely appropriate. If somebody has an MI, I would really rather they go to the ER than to my office. They can come to my office, and I will send them there, but --

MEMBER HOPKINS: We need to add potentially "avoidable" or something to the front of that so that captures it.

DR. PACE: I think the tricky thing about service utilization is in some contexts, it could be process measure and in others outcome.

I think what we are trying to -- and that is why we wanted to specifically say as a proxy for outcome because basically, like Reva said, people say, "Well, why didn't you just measure what was the reason?"

But generally it is, again, an easier way to measure that there was some change, deterioration. If you are talking about readmission, deterioration in health status, it is indicating that. So it can be kind of context.

CO-CHAIR DUBOW: Did you want to add something?

MEMBER GIBBONS: No. I actually agree that it is important to include as an

outcome measure because it does reflect the antecedent care, but I think that there is still a problem in reporting by a variety of organizations in terms of attribution so that in a given community, someone may be readmitted for heart failure where the previous admission was to another institution.

And it is not always reported that way. So that the ownership of the particular management issue may become cloudy.

CO-CHAIR DUBOW: Okay. Sorry, Anne.

MEMBER DEUTSCH: I just wanted to add another one. So for those of us who work in post-acute care, often discharge to community is a major outcome. So I would put that in this particular group.

And we have a specific definition for use; again, case-mix adjustment, always important. But a lot of people also look at return to acute care, which is basically rehospitalization also.

DR. WINKLER: The next one is non-retaliative clinical morbidity, something bad happening because we didn't prevent it by appropriate care related to disease control and treatment.

An easy-to-understand example is diabetic patients undergoing amputation because their diabetes has not been under good control. And so we do have a couple of measures like that. I think that is pretty straightforward as an outcome.

And then the next big category -- and, in fact, this is one of the larger categories -- is the adverse events or complications, bad things happening to people that you wish hadn't happened, of course, the biggest one being mortality, which sort of speaks for itself.

So from this group, I think everybody agrees that everything that is on this list should be on this list. What isn't on the list?

MEMBER JUSTER: I am just wanting to raise the productivity thing again, so absenteeism/presenteeism.

DR. WINKLER: Okay.

MEMBER HOPKINS: That was exactly mine. I think I have sort of layman-focused outcomes or something like that. And it actually would include school days missed by kids because their parents got to stay or one parent got to stay home from work a lot.

DR. WINKLER: Okay. That is a good one. Okay.

MEMBER YAWN: And I think those go back under patient function. I mean, that is when I was talking about occupation.

MEMBER HOPKINS: Okay.

MEMBER YAWN: I think that that has to do with absenteeism and presenteeism. And role function has to do with having to stay home because your kid is sick.

MEMBER HOPKINS: I didn't fully understand your concept.

MEMBER YAWN: You did a nice job of explaining it for me. Thank you.

CO-CHAIR DUBOW: Dianne?

MEMBER JEWELL: So I just need a memory job about a conversation we had on that first bullet. Did we decide one way or the other about the utility of performance-based functional measures, as opposed to self-report measures?

We spent a lot of time talking about the self-report measures. But did we decide one way or the other about the others? My argument would be to keep performance-based measures in the next -- I just didn't know if there were --

CO-CHAIR DUBOW: Actually, we didn't come to any great conclusion. And in my mind, I simply saw that as a data source issue. I think there will be patient-reported measures as well as other kinds. But I see that as a source of data, as opposed to a kind of outcome measure.

MEMBER JEWELL: Thanks.

CO-CHAIR DUBOW: Does everybody have any -- is there agreement about that? Okay. That is where I got my data source before in my --

MEMBER JEWELL: Thanks. Okay.

MEMBER McNULTY: Wasn't cost something that you wanted to put on as an outcome measure? You had mentioned that earlier in the day. No?

DR. WINKLER: Well, I think it belongs in the list as a type of outcome because certainly I think a lot of people do look at that, but that is actually already predetermined not to be within our scope. So the decision was made for you.

Actually, NQF is doing further work on the cost-resource issue. And, actually, hopefully if all comes out as planned, the quality work we are doing plus their work come together. And we may have efficiency in the future.

MEMBER GIBBONS: I just have one misgiving, I think, about bullet three in that I think that there are two separate classifications of outcome. One is the patient's experience and increase of knowledge, motivation, and understanding. But the other is a harder piece of data, which is actually a delta in health risk status and behavior.

I am not sure. I just think that we should call that out as a distinction.

DR. WINKLER: We can list that separately. That is the kind of input I'm looking. A lot of the discussion you are having will find its way into the final report and how we characterize things. And that is why these comments are important to help do that. So it is perfectly fine.

CO-CHAIR DUBOW: In other words, where the bullets go.

DR. WINKLER: Yes.

CO-CHAIR DUBOW: Right, right. I

think we will get another crack at it, but I think probably in a couple of places, we may want to put bullets in additional places. But we do have a chance to look at that in hard copy and give some input.

Barbara?

MEMBER YAWN: Thank you.

I think that health services utilization and patient experience are connection in both positive and negative ways. I have some experience with some organizations that do every test and every consultation known to man versus across the street tends to be a little more focused.

And the patient experience, if you ask them with exactly the same outcomes for functional status and understanding and knowledge, "This was a much better experience because I saw 12 specialists. So it must have been better."

So how do we take that into account because that with health care reform

is going to be a huge, huge issue? We already have somebody up there in the White House saying this is a great model.

DR. PACE: That is exactly what efficiency is getting at.

CO-CHAIR DUBOW: I was just going to say.

DR. PACE: And so, you know, the issue is if you have the same outcomes but one at double the cost, that is what we are trying to get at with efficiency, which, as Reva said, our definition is both the combination of quality measures and cost measures or resource measures, but that is exactly what the whole efficiency issue is about.

CO-CHAIR DUBOW: But in the meantime, that problem probably hits everybody equally. And so you don't have to adjust for it. And I think in time when people get to see the relationship between outcomes and resource use, we will see changes in that over time. I think it is a matter of public

education, et cetera. But in the meantime, I think that issue hits everybody the same way.

You see that in differences in clinical scores and CAHPS scores. You know, that is what happens.

MEMBER YAWN: I don't know how it affects everybody the same. Especially if you live across the street from a very large institution, you feel it very acutely.

And so I guess what I am trying to get at is that perhaps the idea of patient satisfaction in the way that it is frequently -- not what we are talking here with knowledge and understanding, but the idea of patient satisfaction to me is a much less desirable outcome than understanding and motivation. And then knowledge is even better than it is.

And so I guess that is what I was trying to get at perhaps as an overriding measure.

DR. PACE: You know, that is a good point. I mean, we don't have patient

satisfaction on here.

MEMBER YAWN: I know you didn't.

DR. PACE: So is there anyone advocating that patient satisfaction be put on this list?

MEMBER YAWN: But, see, I wanted to say intentionally was not on the list, which is different than it just not being there because then somebody will say, "Oh, you forgot it." Oh, no, we didn't forget it.

MEMBER McNULTY: I would again ask, patient satisfaction with what? Because it could be with so many pieces in the health care system.

CO-CHAIR DUBOW: This conversation has happened at NQF.

MEMBER McNULTY: I don't see it as a problem because, again, just thinking from the patient's perspective, the patient experiences with the patient experiences and, again, depending on the questions that you are asking them, whatever answer they give you is

a valid answer from their perspective.

MEMBER YAWN: I didn't say it wasn't valid from their perspective, just not to drive up here.

CO-CHAIR DUBOW: All right. Ted, did you want to make a point?

MEMBER GIBBONS: There is a difference between patient satisfaction and the perception of value. And I think that is what you are getting at. And that is what third party payers and hopefully health care will get at it.

The value is different from patient satisfaction because they are multiple aspects of it. And that is something that we are not measuring.

DR. WINKLER: Two questions that have come up in my mind and hopefully maybe if there are others, you will bring them up. In terms of outcome measures, looking at the existing sets of outcome measures and the conditions we are actually looking at, we have

got both acute conditions and we have got chronic conditions. There are two acute conditions: AMI and hip/pelvic fracture. Then you have got chronic conditions.

Now, we certainly have mortality measures for acute things like AMI and some of the more -- you know, clearly this happened, went to the hospital, very emergent and critical situation. So mortality makes sense.

However, we have also got a very long list of chronic conditions: diabetes, chronic kidney disease. Does mortality make sense as an outcome measure? Now, I mean, at least not within the time frame that measurement makes a certain amount of sense.

Is there some way that the group would like us to look at the acute conditions in terms of the outcomes differently or the same as we would for the chronic conditions?

Are there different ways of looking at them and thinking about them because just the information you are going to

get around an acute condition I think is somewhat different than the information you can get and the potential outcomes you want to look at in the more chronic conditions? And so I would like to hear if you have a sense of it.

What I am trying to do is build this framework, if you will, around what the outcomes should be such that it will help our ultimate gaps analysis.

So are they the same? Are they different? How are they related? And I would like to hear what you think about that.

MEMBER YAWN: One of the things that I have played around with and wanted to work with was the number, the average number of life-years lost. And that may be a little different concept, difficult concept.

And I apologize, but the average age at which a woman dies is, we'll say, 72 just for a number. And in your population of people with diabetes, how many women die more

than one standard deviation from that because I know half are going to die before and half after if that is the mean age or if it is median age?

It is different for men and women. So it is sort of like having age-adjusted, gender-adjusted life expectancy, but it is a delta. It is a change from what you would like, which is everybody to be able to reach average life expectancy.

It is not one that New England Journal likes very well, but I do think it is one maybe to try to think through. It may not be ready for prime time, but is there something like that we can do for chronic conditions?

I don't want to throw mortality away entirely. I want people who are dying a lot younger than we think they should be with this chronic condition to somehow become obvious.

And it can't be done with just

mortality rates in your group because if you have a lot of older people. And just all kinds of things need to be considered. But it is one I would like us -- I don't know if anybody is doing it, but it might be something for gap analysis.

CO-CHAIR DUBOW: So I need some help in thinking, in articulating what I am thinking about. But it seems to me that there is a distinction that thinking about shared decision-making fits into this construct. So that is one thing I would think about.

And on the chronic side, it feels as though the engagement self-efficacy stuff fits. And I don't quite know. I guess we could structure that as some kind of an outcome, but it feels that those two pieces fit into those two areas that you are talking about.

Does that make sense?

DR. WINKLER: And you would say less so for the acute circumstances?

CO-CHAIR DUBOW: Yes, yes. But shared decision-making does have a role. I mean, an assessment of shared decision-making in acute care I think is the preference sensitive stuff. I think we could find areas where it would be quite directly applicable.

MEMBER HOPKINS: So how does that fit into our framework? I'm like you. I am really interested in seeing this embed your decision-making if we can.

CO-CHAIR DUBOW: Anne?

MEMBER DEUTSCH: Just I am thinking about functional status and how that will be an outcome measure. And it might have -- there might be different goals.

So in acute care, somebody who is elderly, you know, they are not that fit before they come. Dianne and I have talked about these examples.

So they are going through a lot. They have had surgery. And so the goal would be to make sure that they improve their

functional status a little bit, but they don't have major deficits in terms of ADLs. Well, they are in the hospital, but you want to be sure they don't get to the point that they are debilitated but actually need post-acute care.

You want to be sure that they are getting some activity and having good functional status.

CO-CHAIR DUBOW: Is maintenance a function?

MEMBER DEUTSCH: Perhaps.

CO-CHAIR DUBOW: Yes. I mean, that is a criterion we have used, actually, as a regulatory criterion --

MEMBER DEUTSCH: Yes.

CO-CHAIR DUBOW: -- that people be restored to maximum function, to regain maximum function.

MEMBER DEUTSCH: Right. And there has been some research looking at healthy elderly people who lay in bed for ten days. And they become debilitated, basically.

So preventing that would be a goal during the acute care stay. Let's say somebody has had a stroke or perhaps a brain injury. For some patients, the goal may be that their functional status is maintained.

For another group of patients, for hopefully the majority, the goal would be restorative care. And they would come into an inpatient rehab facility hopefully and get intensive therapy and have a fair bit of functional gain.

But that is not always the goal for every patient. So I think, you know, depending on whatever is negotiated as the goal for the patient, there might be very different expected outcomes for those two groups. They will both fit potentially under the chronic, but it just kind of is what else is going on.

You know, maybe they have many other things going on. Maybe it is different, for whatever reason. So it just comes to

mind.

MEMBER JEWELL: So one of the things that I am wrestling with is this notion that there is a line between acute and chronic because, really, it seems to me that there are acute episodes all along the continuum.

And so maybe because of the need to measure or because of what we need to try to measure, it is easier to draw that line, so the hip fracture example being one.

I could make a really I think pretty solid case to argue that that is actually just, even if they don't have underlying OA or RA, that that is linked to a chronic condition of its own and it is just an acute event within it.

So I don't know. I am thinking out loud here. I guess I need some sense of is it easier, simpler, and more workable to frame it as hip fracture is an acute event, AMI is an acute event, we only consider them sort of like that, and then we call conditions

like coronary artery disease, rheumatoid arthritis chronic.

I know diagnostically in the ICD nomenclature, that is how we do it, but I am just wondering from a measurement perspective, is that also simpler?

Because I could make it -- you know, we have acute flare-ups in osteoarthritis all the time. It is why they come back to me. And so at that moment, what they are experiencing is acute for them.

I don't know if I am making it harder than it needs to be, but that is where I am wresting a little bit.

MEMBER KEALEY: Yes. I sort of agree with that. That is kind of what I was leading toward, too. I do think that they are part of the continuum, but I also think that they are discrete enough where you can measure them.

I think the pitfall that we have fallen into so far is just that we have really

defined it as when they leave the hospital, we stop measuring. And so that in the acute event, we need to think about expanding our definition.

I think the graphic there went out to a year. And that is a lot of the data post-MI looking at depression. And the whole episode of care is what we keep in mind as we create measurements.

MEMBER JUSTER: There actually may not be that much of a dichotomy going back to the diagram with all of the circles and phases and all of that sort of thing or COPD.

There could be metrics involved and methodologies perhaps involved in the management of the acute phase of a chronic illness, just like a hip fracture usually is part of osteoporosis, not always, and so on.

MEMBER GIBBONS: I was going to say that it is actually easier to measure the hard outcomes of acute care. And the interval of time over which you measure the hard

outcomes of chronic care may not be at the interval reported.

So that a lot of the similarities between acute and chronic care have to do with the preventive aspects; for instance, with cardiovascular disease, in introducing aspirin beta blockers, ACE inhibitors, and so forth; whereas, in the outpatient setting, chronic setting, those same preventive measures are introduced, but they are intermediate outcomes, rather than hard outcomes, because you are not really measuring mortality or not necessarily measuring morbidity, at least in the ones that have been proposed.

So I think the ones that have been proposed are still adequate. It is just that they are measuring different things.

MEMBER YAWN: Thinking of cardiovascular disease, one of the things that I think is -- I mean, not too many people have an acute MI that have not had cardiovascular disease for several years. There are some

acute events that have no underlying other things that have been going on for the last 20 years, but those are darn few.

One of the things that I think would be interesting is thinking about how many of those people when they had acute MI had not only their risk factors assessed but also had a diagnosis of coronary artery disease.

I mean, we have looked at that. And I can give you some data on that. And how many of them that had their coronary artery disease diagnosed had the risk factors addressed.

So I think there are some things that could make an acute event part of chronic also because the acute MI becomes primarily hospital and cardiologist. That is where we have to send almost everybody now and should probably.

But to try to make it primary care, also it is that before and not always

just after that we ought to look at because you do have that green bubble before. How do we address that?

DR. BURSTIN: I am just going to point out that hospital discharge is a fairly artificial distinction. And, in fact, in the surgical world, it is fairly routine. It is more of our medical model as an internist that a patient kind of transitions to the next person.

But we, for example, already have endorsed a 30-day surgical site infection measure. So there is no reason why if it is the right approach you couldn't look at it.

In fact, there are some emergency measures being developed around an acute MI episode probably being to ER the first 30 days as the logical time period. And then 30 days to a year perhaps is the next.

So, I mean, I think this is exactly what we hoped you guys would kind of give us thoughts on. And hopefully as we do

the measure gap analysis piece, this is exactly what I think the world needs as you begin thinking about some of the emerging payment models as well.

MEMBER GIBBONS: In fact, I was must reviewing this last week. People don't emphasize the fact that although we constantly talk about the 30-day readmission rate for heart failure, the 30-day readmission rate for MI is higher than that for heart failure. But, yet, we are not including that as an outcome measure in many reporting. It is 50 percent heart.

I just looked at the CMS reporting data.

DR. BURSTIN: What are they coming back in for? Related to the MI or is it --

MEMBER GIBBONS: Well, it is all cause readmission, but they are coming in for elective procedures. They are coming in for chest pain. They are coming in for arrhythmias.

DR. WINKLER: Another similar kind of thing when looking through our list of outcome measures, NQF has endorsed a wide variety of measures.

But some of these outcome measures are characterized as the more typical individual measures, as we have seen with the hospital outcome mortality of an individual, you know, how many died within this hospital within this year versus populations where the denominator is some event per hundred thousand.

How are those related? How do we think about them differently or the same? How do we utilize both types of outcome measures in the ultimate set that Helen is talking about, in the ultimate descriptor of the quality of care for patients with X or patients in general? How do we bring those two together? The list of current endorsed measures has both.

And how do you want to address

that? Because they are different. They are characterized different. The data collection is somewhat different. But they have to be related because ultimately they are the same patients.

MEMBER AMARASINGHAM: You know, I would like to make a point on that. I think both are extremely important. This to me seems primarily an attribution question.

If you are looking at a health system that cares for 1.2 million patients, you absolutely want to look at the population as well as the cardiology group that is taking care of X number of cardiovascular patients.

So I think you would have to include both for sure.

DR. WINKLER: Just to carry on, would you say it would be desirable for each condition or each topic area that you actually would want both types of measures? That is what I heard you say.

MEMBER AMARASINGHAM: If it is

available, yes. I think the biggest thing is attribution. I think also obviously the data source in this case because obviously in major metropolitan areas, you are going to have people moving from different systems.

So who is ultimately responsible? You could almost wonder whether communities start becoming responsible.

CO-CHAIR DUBOW: When you talk about attribution, are you talking about accountability? I mean, I see them differently. I just want to be sure I understand what you are saying.

MEMBER AMARASINGHAM: Well, ultimately it is accountability, I think. If this person is under my care, let's say, then what is my individual outcome for that patient?

Then obviously if it is a systems care and so forth, I think people talk about, can you get adequate attribution as to who it is.

Now, the question becomes in team-based care, who is ultimately responsible? And when you have a person that is moving between different systems, who is responsible? I think those are very challenging, even on this readmission question.

But absolutely we need both.

MEMBER YAWN: Well, and your definition of population and mine are going to be different. I am going to approach it from a typical epidemiologist definition.

And it is not the people insured by Health Partners or Kaiser or whatever. It is the people who live within a geographic area, just a different definition.

MEMBER AMARASINGHAM: And I don't disagree.

MEMBER YAWN: Oh, I was sure you didn't, but I think then this idea of the community's responsibility because we do now have somewhere between 7 and 12, 15 percent of

people uninsured. So they don't fall under the Kaiser's group health, but they also don't come in to see it.

I mean, I have been through this several times. People say, "Well, if you just bring them in, I will take care of them." No, no, no. That is not the point.

So I think we have to have geographic population measures because we do have to recognize, especially in disparity issues, those people who do not come in for health care for many, many reasons. And I think they are still our responsibility. How I am not too sure, but I do think we need to know about them.

CO-CHAIR DUBOW: Bonnie Zell is going to tell us about it, who is the NQF person --

MEMBER YAWN: Yes, right.

CO-CHAIR DUBOW: -- who is doing population medicine.

MEMBER JUSTER: Could you consider

that there is individual versus population? So population also might be the right of -- I don't know -- eye exams per 1,000 diabetics. It could also be how much eye improved.

So that is my own individual pre/post, I guess. And it could be reported as a population of 1,000 people like me, compare their pre and posts, and then back to the numerator and denominator thing.

Of all the things that I should be doing or have done for me, how many of them did I, which would be completely patient-centric because the next person over wouldn't fit all the same denominators.

And this notion of a tipping point, there is a little research on it, not nearly enough. A lot of it is in kidney disease. If there are, let's say, five metrics, you get 20 percent better with each one. It seems that almost nothing happens until you are getting about 80 percent of them. Then, all of a sudden, you get all of

the benefit you are going to get, at least, from hitting all of them.

DR. WINKLER: Are there any other of these kinds of issues about outcome --

MEMBER HOPKINS: Summarize what you think we said about individuals versus --

DR. WINKLER: Both types of measures are important. Neither is out of scope. How exactly they are related isn't totally clear, but when you are looking at diabetes, for instance, there is important information to be obtained, outcomes measured at the individual level as well as at the population level.

I wanted to know if you wanted to keep the population measures in or out.

MEMBER HOPKINS: Okay. I mean, does that make it simpler to realize that the thing that you are measuring is the constant? And to what are you applying it is the question? You know the analysis.

DR. PACE: One of the things we

have discovered is that -- and from a strictly measurement perspective, it does matter that you have thoughtfully constructed a measure that can be applied to different levels of analysis, rather than just saying, "Here is the measure. And you can apply it to any level." There may be differences in exclusion, the attribution.

I mean, from a measurement standpoint, it does make a difference, not that we shouldn't do it. It is just that we should be thoughtful of constructing it so that it is still a valid measure at whatever level you want to use it.

CO-CHAIR DUBOW: For a practical matter, as I recall, the population-based measures that we have endorsed are ARQH measures. Most of them are ARQH measures.

So ARQH comes with a perspective of looking at the population. I mean, to the extent that we are beholding on the measure developers and what comes across the transom,

it is going to be those measure developers interested in population health that are going to come forth with this unit of analysis. And I assume they will take into account those specific measure attributes.

DR. PACE: What I am talking about is sometimes we have measures submitted. And when we ask about the settings and level of analysis, people have a tendency to want to check everything, like it would be nice if we could measure it there, but we don't actually have specifications that are --

DR. WINKLER: In terms of setting the scope, I mean, I think we have had a discussion that keeps the scope very broad and consistent.

Two things. In your discussion, did you feel that you addressed topics that we could maybe discover the principles? You had started talking about some of these or are there some other things about outcome measurement that are going to help us

understand the work we need to do, help the TAPs do the work to provide you the best advice possible to help us just move everything forward that we haven't yet discussed because, again, we are starting to build this framework thing.

And I am trying to characterize, what were those things about that we could characterize as principles that came out of the discussion? Was there anything else?

MEMBER YAWN: I am still not entirely comfortable with the comorbidities or I don't think they are comorbidities. I think people have multiple morbidities. And say we are going to count up their morbidities and risk assessment.

It is just still not comfortable for me because I know very well that people with COPD almost always die of coronary artery disease.

So we don't have to look at mortality. It is all his fault, their TAP.

It is for sure.

(Laughter.)

MEMBER YAWN: Okay. Thank you very much, but we never send them to you.

There are things like that. And depression and chronic disease is such a huge barrier to outcomes and improvements that without addressing those other than just saying we are counting them and checking them off really bothers me.

Now, I know that there may not be good measures yet, but to say we accept as acceptable an outcome measure for COPD that does not look at coronary artery disease and depression, at least, -- those are the two major ones -- is quite uncomfortable for me and I think will be for many of my primary care colleagues.

MEMBER HOPKINS: Two other areas where maybe we could provide some more guidance, some measures that we have endorsed are outcomes. And I think a good example is

pressure ulcers. They were formulated by the caregivers.

So the measure is how many pressure ulcers per -- I forget if it is 1,000 patient days. I had a problem with that because that is not the patient-oriented measure. The patient wants to know what are the chances that I am going to get this outcome if I go to this hospital.

So if we could provide some guidelines on that situation, that it is per person, not per person days or whatever. Do you see what I am saying? Okay.

That was one thing. And then I had written myself this other note. Back to that tricky question about a measure having to have built into the threshold value in order to make it a measure.

Then we have to grapple with how that threshold is set and with reference to what and can we provide guidance on that. So, for example, we recently endorsed a measure

that happens to be visual acuity after cataract surgery, where we were told that 96 percent of the time, the patient makes the measure or the entity that is being measured hits the measure.

It seemed to some of us at least that that was kind of a low threshold because it had baked into it an exact value for visual acuity post-cataract.

So it struck me there is some principle that there we are missing about a threshold value that is not sort of given that you have to work to achieve if that is going to be a property of a measure as well.

DR. BURSTIN: I will just say this was a fascinating measure for those of you who have been following eye care at NQF. It is interesting because I think it brings up a lot of really important issues.

To me the issue is less so the threshold of 20/40 acuity post-cataract. That is pretty good vision post-cataract. I mean,

I think that is up to the ophthalmologists to argue about the threshold per se.

The bigger issue is the fact that all we had was one registry-based study by a voluntary group of ophthalmologists, who all came together, submitted their data post-cataract, in which they had 96 percent of patients who achieved 20/40 acuity. So the bigger issue is we often don't actually know what the gap is.

So if you looked in the community of ophthalmologists who are not self-selected ophthalmologists who read through part of the registry, we actually have no idea what the level of performance is. We certainly hope that it is nice and high, although we don't actually know that it is.

The second issue that came up methodologically, which I think is also important, is there was a discussion that even, say, it is 90 percent. Just given purely the volume of cataracts done in

America, it is such a huge impact on the patients who wind up being at the doc's, just purely the numbers of patients who wound up being exposed to poor quality docs because on acuity which was really alarmingly high.

So there are just so many interesting methods issues as soon as you craft outcomes on --

MEMBER HOPKINS: That was a good answer to how did you set that threshold value in my value. You had a limited data set. They observed from the data set that 96 percent met it. But was that the way they set the threshold -- I am not sure -- or was it somebody's sense of "Gee, that is pretty good visual acuity"?

DR. PACE: And I can't speak to what was in their measure submission, but the way we would like to see those threshold sets is that the threshold is tied to evidence about performance.

So, in having some discussion with

-- you know, I think there have been -- and I don't know if they presented this, but I think there have been studies about visual acuity on the scale that we measure tied to patient-reported function.

And so that is what we would like to see when you have these thresholds included in the measure, is what is the evidence for setting that threshold, similar to blood pressure, the evidence that above a certain threshold, there is higher incidence of mortality, morbidity, et cetera. So that is what we would like to see. I can't tell you specifically if that is what was submitted.

CO-CHAIR DUBOW: So as a general principle, that is okay, but, again, when we examine the individual measure, we will have to examine the individual measure.

I mean, it is a good principle. And I think that was a guiding principle. And it is a question of interpretation. So I think that I am okay with a general principle

like that, but I don't want to go beyond that because I think we have to see what comes before us.

We are going to be looking at specific measures. You know, we are not going to be dreaming up new measures here. These measures are coming to us. And we are going to have to evaluate them.

So I like matters of principle. I could live with that one.

DR. PACE: I would just say another thing is that when you start seeing measures, you will realize that it is hard to come up with these absolutes because, even that idea about is the denominator patients or patient days, some of that depends on the incidence of those occurring. So if it is a rare occurrence measure, from a measurement standpoint, it might be preferable to measure it over patient days.

I am just saying there are a lot of factors that sometimes come into

constructing a measure that is ultimately going to actually be able to distinguish some differences.

MEMBER HOPKINS: I would think the right answer there is make it per 1,000 patients or 100,000 patients and then answer the question of whether it is statistically meaningful.

CO-CHAIR DUBOW: Okay. We will get a chance to look at that, those kinds of issues. But I think we do have a principle here.

MEMBER YAWN: Okay. That is what I was going to ask. The principle is --

CO-CHAIR DUBOW: Yes.

MEMBER YAWN: -- they should provide evidence for why they chose the denominator and the threshold.

CO-CHAIR DUBOW: Right. It should have an evidence base.

Ted?

MEMBER GIBBONS: One of the

concepts I think that need to be emphasized there is the harmonization concept that was brought up earlier. It strikes me when I was reading the ischemic vascular disease measure that has not been yet endorsed, -- it was from the Minnesota database; it is on the website -- that they include various types of cerebrovascular disease, peripheral vascular disease, renal vascular, hypertension, atherosclerotic, but they don't include diabetes. That is not really in harmony with the ATP and the National Cholesterol Education Program of defining diabetes as a coronary disease risk equivalent.

And it seems that that gets to Barbara's point about the comorbidity. If we know that a patient population should be included in that general category of chronic illness and people have begun practicing that way, that we should look at having that revision.

And if COPD is not included as a

coronary disease risk equivalent or chronic kidney disease, which has been endorsed by the Society of Nephrology, then it still is something that we should question in terms of the steward for that.

CO-CHAIR DUBOW: Okay. So can you or Barbara or anybody else phrase our concern, characterize our concern, as a principle, the concern about comorbidities and taking those into account? What is the principle with respect to the --

MEMBER GIBBONS: The principle is risk. If the principle is risk and we want to address risk adjustment or risk assessment, as it is commonly acknowledged, then that should have the broadest possible scope if it is a recognized discrete entity.

So that, for instance, if coronary disease -- and I will go atherosclerotic, significant atherosclerotic disease is considered a coronary disease, risk-equivalent, which should be subject to

very aggressive secondary prevention measures.

And we have already acknowledged that diabetes is, that we would want to cast a wider net so that now the next phase of ATP will include chronic kidney disease. And perhaps it will include COPD, although I don't think so.

What I am saying is if the general principle is that there is a recognized large population that should be included in a measure, that that go back to the steward and say, or the organization proposing it, "Shouldn't that be broader?"

DR. BURSTIN: It is actually interesting because there is actually an identical measure for diabetes, unfortunately. So there is also this issue of the fact that it is actually covered but in another measure in a sort of lumper versus split-away.

But I still see your point. I think you want to be able to whenever possible have measures be harmonized for all of the

populations at risk, rather than kind of pulled apart.

MEMBER GIBBONS: Correct. And since 10 to 15 percent of the patients who have those, that presentation of atherosclerosis, have undiagnosed diabetes, the reverse --

MEMBER JUSTER: Just to bring it back to risk adjustment, then, just like we were asking for evidence-based threshold setting, are we asking for evidence-based risk adjustment? Why did you select that risk adjustment method?

Now, I realize there is less evidence base for risk-adjusting things than there is for thresholds, but you can't just say, "Well, four comorbidities are twice as bad as two." There is no evidence for that. And it is probably very measure-sensitive.

MEMBER YAWN: But that is what they do now.

MEMBER JUSTER: Yes, but it is for

evidence --

DR. WINKLER: Iver, tomorrow we are going to go over the measure evaluation criteria in a great deal of detail, including one of the examples of a submitted measure. You can see what you are going to get to work with. And so you will be able to see.

And if we need to break down the questions a little bit more detailed to address the issues for this particular project, this will be the opportunity for you to tell us. And we can get back to the measure developers. We can run that through the TAPs.

And we can get more finely tuned because I believe it is a bit of a -- the question at this point is, are you using a risk-adjusted methodology? And what is the evidence base for doing it and how?

But it is more wide open and not necessarily perhaps all of the questions that you may want. So you will need to maybe give

some guidance in that.

CO-CHAIR DUBOW: But the question of whether that rises to a principle is a fair one, I think.

DR. WINKLER: Absolutely.

CO-CHAIR DUBOW: You know, if that is why you were throwing that on the table, I think for my money, that is a fair --

MEMBER JUSTER: The principle, then, is explain why you selected that method of risk adjustment for this particular measure.

MEMBER AMARASINGHAM: I also think a counter principle, the converse principle, is why didn't you select a particular -- I think the concern for a lot of safety net providers is maybe not adjusting but at least stratifying out for specific social and behavioral characteristics.

MEMBER DEUTSCH: Perhaps we will talk about this tomorrow, but the way the applications are currently set up, you have a

numerator and denominator. So you do have to have that threshold.

I am just wondering if for functional status, the way we currently measure it in rehab is either actual discharge functional score or, as you said, the change in function. And so you don't really have a numerator/denominator per se. So I was just --

DR. PACE: You would. In one case, it would just be the actual scores would be the numerator. And so it just depends on how the measure is constructed.

DR. BURSTIN: Do you want to give an example of improvement in as an example?

DR. PACE: Right. In the home health measures, improvement in function, improvement in walking, improvement in ambulation, it is the data are at the patient level. And they identify which patients have improved. So those that have improved are in the numerators.

So how we would want to see that submitted is that the numerator is the number of patients improved. And then in the details, we would have an explanation of how it was determined that a patient improved, which was a change, a higher level of functioning from baseline.

MEMBER DEUTSCH: So I think maybe we will talk about this in more detail tomorrow, but I think in rehab, I mean, usually people look at where somebody came in, where they left, and what that actual change is. And so where you put that threshold would make a huge difference.

I mean, theoretically everybody has a --

DR. PACE: Right. And, again, these are all of the tradeoffs of measurement that, as you were mentioning earlier, these scales are not necessarily interval scales. You can't say that going from one to two is equal to going to two to three.

And so in the case of the home health measures, they recognized that. And they adopted to just do improvement, regardless of how many changes.

So the point is that there are no hard and fast absolute rules of how you have to do this. The point is to see what data you have and what makes sense in the context. And that is what makes this difficult, is that we can't say, you know, you have to do it this way or that way because a lot of it is dependent on the data and the various tradeoffs that you make when you are doing these measures.

MEMBER DEUTSCH: So would it be possible to not have a numerator/denominator or would that not be possible?

DR. PACE: So what kind of measure would not have it?

MEMBER DEUTSCH: That you actually report the person's, let's say, functional status score at discharge, the actual value --

DR. PACE: Right.

MEMBER DEUTSCH: -- that is reported --

DR. PACE: So you aggregate that at a provider level. You would either be doing an average, a median, --

MEMBER DEUTSCH: Right, an average.

DR. PACE: -- or a distribution. So the average would still have a denominator of the patient population.

MEMBER DEUTSCH: Okay. So you are calculated based on all of your patients and doing it that way?

DR. PACE: Right. Okay. So you point out some excellent issues that we have --

MEMBER DEUTSCH: Yes.

DR. PACE: -- of explaining --

MEMBER DEUTSCH: It is much more complicated.

DR. PACE: -- measure submission

form and what goes where. We appreciate that because we know that it is complicated. Thanks.

CO-CHAIR DUBOW: And you also have to worry about what you report out in terms of how people understand it.

MEMBER DEUTSCH: Yes. Actually, with one of the projects I do, we go to the seniors at senior centers and ask them to look at some data that we put out in rehab and, you know, do they understand it.

So we have average like mobility scores. They said, "Well, I don't want to be average. I want to be better than average."

CO-CHAIR DUBOW: Okay. Barbara?

MEMBER YAWN: I am not sure yet that I can put it in the form of a principle. So I am going to ask people's indulgence to continue thinking about it. But it seems to me that there are some of these measures that you have to measure dual outcomes or dual diagnoses or something if you are going to

really be able to understand.

If I am going to understand the COPD outcome, I have to have some understanding of what has happened with depression. Has it even been recognized? Has it been dealt with?

And I am not sure how to put that in a principle at this time, but it is the idea of there are certain conditions which are not sufficiently broadly defined that another condition really impacts their outcomes.

And I don't know how to put that in a principle format, but I will keep thinking about it. And if anybody else can think about how to do it, please.

DR. PACE: Well, I think one place this comes up is in risk adjustment if you are talking about outcomes and the effect of depression on outcomes. And that would be a reasonable thing to be thinking about as a risk adjuster.

But, again, the practical

realities of these things are what data are available. So, you know, risk adjustment is often limited by the burden of data collection. So these are all --

MEMBER YAWN: And I understand that. And that is why I said I am not ready yet because, just throwing depression in as a risk adjustment just doesn't get it for me because there are all those people whose depression is not recognized.

It is known that over half of them aren't recognized. And half of them that are recognized aren't treated and drop out of treatment within four weeks and all kinds of other things that really affect.

And so just knowing they have depression isn't enough, I don't believe, but I don't know how to go the next step.

CO-CHAIR DUBOW: So I don't see this as a principle, but there is the opportunity of paring measures that have when you want to link them.

We have examples in the NQF. Are we calling it a library? Portfolio of paired measures. Is that a possibility?

DR. PACE: Sure. And I think the opportunity is to look at these conditions and identifying where there are gaps in measurements.

What I am hearing you saying is that quality of care for COPD patients includes addressing depression. And so if we were doing a project just on COPD, we would have the Steering Committee saying, you know, we need measures related to depression screening, treatment, outcomes.

And so whether we get these in this project or not, you will have the opportunity in those TAPs to identify those things and also to look through our NQF portfolio.

I think we do have some depression measures. And those can be identified that they are important to be measured.

MEMBER YAWN: So maybe that is a principle that we do need to think about should we be looking for things that should be paired measures and we believe would make a large difference to whatever we do in the TAPs.

MEMBER JEWELL: And, actually, I was thinking about your question from a different point of view, which is the notion that to me what you are describing is an argument for really doing some population analysis.

So if you are looking, if you are stratifying within the cohort of patients with COPD, people who have different levels of depression and the extent to which that affects their outcome, I guess a principle would be that we could derive out of that, besides pairing measures when possible, the notion of asking at least the measure developers the extent to which they have or have the opportunity to reanalyze their data,

really looking at it in terms of subpopulations, stratifying, as opposed to just doing the easier risk adjustment sort of count the comorbidities thing.

So I don't know if that is a principle, but it is just an opportunity to really ask measure developers along that way because otherwise I am not clear that the evidence really says entirely that counting comorbidities is completely an invalid way to do it at this point.

DR. PACE: And also I will just have the mention that we have many outcome measures where the risk adjustment is not just counting. In fact, that may be the minority. So maybe what you are familiar with is only that, but we have a lot of measures that have very detailed risk models.

MEMBER McNULTY: Can I just say one thing with this example that Barbara has been bringing up from the patient-reported outcomes perspective? What would happen is --

this is just to kind of throw into the mix of everything that has been said.

What should happen is that if you were developing a measure for COPD. Now, I don't know what exists out there. I don't know enough about COPD.

Say there was nothing and you were going to go develop a measure. The first thing that you would do is you would go to patients. And you would do qualitative research. So you would do in-depth interviews. You would do focus groups, whatever.

And I would imagine, given what I have heard Barbara say now several times since depression is so prevalent in COPD patients, that that would emerge from the qualitative research that you do.

And then as you go about developing your measure to administer to patients, that would be one of the facets, one of the domains of the measure that would end

up happening.

So that is just kind of from the patient-reported outcomes perspective. That is how you would go about bringing that into the picture for an outcome measure there.

DR. WINKLER: Nice job. Through all of the notes that we have taken, the transcript that will be reviewed 1,000 times, we will try and cast these principles for you and then circulate them again for your review and edits and further thinking and evolution and maturation and all of that good stuff that we are going to do.

At the same time, realize that these are tools that we are going to share with the TAPs and remind yourselves that these are the principles that you established when you go forward to look at measures and measure evaluation.

So it actually is an important foundational work for setting the stage for the work that is going to go ahead. So I

hope, luckily for transcripts, recordings, and 14 people taking notes, we have probably got it somewhere.

Okay. Joyce, I think we are --

CO-CHAIR DUBOW: We are overdue for a break. So why don't we do that now and come back at 4:00. Okay? Let's do that.

(Whereupon, the above-entitled matter went off the record at 3:43 p.m. and resumed at 4:00 p.m.)

CO-CHAIR DUBOW: I hope we still have our colleagues on the phone. But, anyway, we will pretend you are there. We have one more issue to discuss this afternoon.

Then we will have public comment if there is any. Maybe there is somebody on the phone listening. And then we will adjourn probably early and reconvene tomorrow morning. Breakfast is at 8:30, I think. And we will start at 9:00 o'clock in the same room, right. Thank you.

So the remaining item is if you

flip the -- isn't it identifying outcome measures? So, Reva, do you want to just --

DR. WINKLER: To date on the project, as with all of our projects, we have done a call for measures. We have done a call for the phase one measures. We have received 15 measures so far. In your materials, you have a table with them. That is what we have got. All right?

We have been doing ongoing outreach efforts. We are expecting four more, including two more cross-cutting measures. So that will bring the cross-cutting measures to four. There is one more heart measure and one more COPD measure.

Phase two, which is all of the other subjects, the call is currently ongoing. And it closes on October 30th. We have been spreading the word. Helen goes out and gives a talk. The next thing you know, we get three calls about measures. So that is one way.

There is awareness growing. But

this is a relatively limited number of measures. So, therefore, to the Steering Committee, we need you to steer.

Are you aware of any additional outcome measures that we need to identify and go seek out? What other avenues should we pursue to try and identify additional outcome measures? You all live in different worlds than we live in. And so your awareness and knowledge base we are hoping to take advantage of.

Again, last week at our annual policy conference membership meeting, we were talking it up. We were talking to people about things. I have got several phone calls coming up this week with people following up. I am not sure if there is going to be anything there or not. Sometimes we have to see the measures to get a sense of really whether they belong in the project or not. So this is really one of the critical aspects of how robust this project will be going forward.

One of the things I sent you yesterday, which I didn't expect you to have a chance to read, is an environmental scan that our staff has put together looking for measures.

And we use the sort of usual places, the National Measures Clearinghouse and all the stuff on there, as well as our membership and the people who are the organizations that work with measures a lot, lots of Google, lots of Pub. Med.-ish sort of things.

But what we found is sort of what you see. And this again is meant to be a living ongoing document. If you can provide us additional guidance on where to go searching, we will go dig up the rocks. But we need to know where the rocks might be located before we can go dig.

So sometimes what we found in the past is people are a part of organizations that are doing things more in house, but you

are doing it all of the time. You have got what well-specced-out measures. You are using them.

You know, you may not be one of those 70 official measure developers or think of yourselves that way, but if you are aware of measures that are being used within your organizations, particularly to evaluate performance, you know, that is a learning laboratory that is probably as good as a lot of formal measure development activity.

And so we are searching. Where do we go? What do we do next?

MEMBER JUSTER: So how do we that short of going through -- do you want us to go through the formal? I saw an SF-97 that I want to -- not really. I am just kidding you. I saw an XYZ. Do I go through the formal or just send you an e-mail and say, "This looks interesting"?

DR. WINKLER: Anything you want to do, send me an e-mail, tell me a name, say

something today, right now we will take it any old way you want to package it and send it because then we will follow up and see what we can identify.

MEMBER AMARASINGHAM: Now, how does it work, like, for example, if we did find in our local regional measure that there is a measure that could be a suitable candidate?

I imagine that the people who might be owners of this measure would have to put in a good amount of time to get it ready for presentation here, as opposed to a measure developer, who does this all the time.

DR. WINKLER: You are right. We will talk about this a little bit more tomorrow. We actually have an electronic submission process where it is an online kind of tool form that is filled out.

And to provide you with the fairly detailed amount of information you are going to need to go through all of the evaluation

criteria, the number of questions is not small. So yes, they would need to be able to fill that out.

On the website, you can go to the measuring performance. If you drop down that menu, one of them is submitting measures. And it talks about all of the stuff. For measures that are pretty much from the government and the public domain, the measure steward, there is a measure steward agreement they agreed to that they own the measure, they have the right to the intellectual property, and that they will maintain the measure going forward and those sorts of things. So the conditions are listed out. So that information is available for you for any potential candidate.

We would need the measure information submitted through the electronic submission process because, frankly, that is how we get it into a usaable form. And then we can do a lot of things with it once it is there.

We have hopefully left all of the paper behind us.

MEMBER AMARASINGHAM: A quick follow-up point. For those who might be developing the measure, that is not part of these sort of 70-plus standard groups. What would be the potential incentive that I could really to them?

DR. WINKLER: Aside from just the -- you know, I guess you would have to ask other measure developers, why do they want their measures endorsed by NQF? A couple of reasons. They are likely to be used more broadly. They would have both the responsibility but the credit, but you will, of being the owner of an NQF-endorsed measure potential that could be adopted and more widely spread. And bring some into this more national wider enterprise of quality measurement, rather than stay at home, you're going national.

Can anybody else help me out on

that?

MEMBER HOPKINS: So a couple of thoughts. Have you fully queried the logical vendors in this space? You know, I am thinking of like Care Science, which I guess is now part of Premier, University Health Care Consortium. It might not be a vendor but trade group or whatever. I am sure you have got the specialty societies lined up. They are logical.

When it comes to cancer care outcomes, I am thinking not only of NCI, which would be logical, but you know about NCCN? Yes. They have got all of these guidelines and I would hope outcomes. No measures?

DR. BURSTIN: Actually, the TAP Chair Leon Newcomer, who is going to --

MEMBER HOPKINS: Oh, yes.

DR. BURSTIN: -- be doing a lot of power work right now between NCCN and clinical data --

MEMBER HOPKINS: Yes.

DR. BURSTIN: So he will be following up on some of --

MEMBER HOPKINS: That is my list.

CO-CHAIR DUBOW: Is there anybody on the phone who has any ideas?

MEMBER AMARASINGHAM: I am curious also whether or not you have investigated the Dartmouth Group. Its charge is the Atlas.

DR. WINKLER: We are certainly aware of the Atlas. And we have a certain number of contacts with them. But in terms of actual measures, I am not sure that Dartmouth has the actual performance quality measure. They have got a lot of data. That is for sure but in terms of the actual measures. But we can certainly double check.

MEMBER KEALEY: How about the VA?

DR. WINKLER: That is a good one.

MEMBER KEALEY: COPD?

DR. WINKLER: Yes. VA we have certainly seen measures of theirs before. And one of the issues we have had to deal with is

they tend to define their population in VA-speak. That doesn't mean those aren't real people that we can't find a translation and get it into the rest of the world.

And so I think that might have been an artificial barrier that we let kind of hold us back. But we should be able to translate from VA-speak to normal language.

And so that is a very good avenue to pursue.

CO-CHAIR DUBOW: Did you check through the ACOG measures to see if there is anything you could pick out there as outcomes?

DR. WINKLER: You know, I have looked at the ACOG measures. And, in fact, the way they are set up as the "if/then" statements, we have had conversations with RAND and the various developers on that.

And we have actually had some of the ACOG measures come through. Most of them are process measures for the most part, but I will double check them again.

CO-CHAIR DUBOW: They were meant as improvement measures. I mean, they have to be converted into --

DR. WINKLER: Right. Yes.

MEMBER AMARASINGHAM: Another question I wonder about is, have you sent out a sort of request to the Academy of Health membership? They have so many health service researchers. I was at the last Academy of Health. There are a lot of new measures proliferated.

DR. WINKLER: We will have to figure out how to get there, though.

MEMBER KEALEY: Any international partners?

DR. WINKLER: We have not done a lot. I am not saying we have never done anything internationally. We have, especially in patient safety, yes, and Canadian, but we haven't done a lot international in terms of measures. The question is, how translatable? Hard to know.

MEMBER HOPKINS: Patients are people.

DR. WINKLER: Yes, especially outcomes. Okay.

CO-CHAIR DUBOW: Well, clearly this is something to think about when you take a shower, when you go jogging, you know. Do your best thinking --

DR. WINKLER: Whenever it is.

CO-CHAIR DUBOW: -- because it would be really good to be sure that we have as broad a sweep as possible for when we consider this stuff.

DR. BURSTIN: And I would say any of the people who are involved in the TAPs, in particular, we really especially welcome your expertise.

I mean, we have had some conversations, for example, Ted, with ACC. And there are a couple of other measures potentially in the hopper which we could share with you that we are maybe bringing in.

But if you have specific thoughts about what would be useful procedurally or whatever the case may be, please let us know. We can reach out to ACC or AHA or others.

MEMBER JUSTER: And, then, in the areas, two areas, that I think we would excel in cross-cutting measures would be the HIE people and the patient-centered medical home. I don't know if AMIA, the American Medical Informatics Association, is doing anything with HIE metrics, you know.

CO-CHAIR DUBOW: Operator, can you please see if there are any comments from the public to open the lines up, please?

THE OPERATOR: All lines are open.

CO-CHAIR DUBOW: All right. And is there anybody in the audience who wants to say anything?

(No response.)

CO-CHAIR DUBOW: Okay. So I think we have an early adjournment today. Thank you very much for your full participation. I

think we had a fruitful meeting.

DR. WINKLER: You will need to take all of your belongings with you because they are going to reset up this for a dinner tonight contiguous with the other rooms and then reset up for us. So please take everything with you. We will take care of that.

CO-CHAIR DUBOW: Are we going to meet in this room tomorrow?

DR. WINKLER: Yes.

CO-CHAIR DUBOW: So we are going to reconvene in this room tomorrow 8:30 for breakfast. Nine o'clock the meeting will start. Okay?

DR. BURSTIN: You are also in the hub of some wonderful restaurants if anybody wants any dinner suggestions.

(Whereupon, the above-entitled matter was recessed at 4:13 p.m., to be reconvened on Tuesday, October 20, 2009, at 9:00 a.m.)

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