

NATIONAL QUALITY FORUM

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BEHAVIORAL HEALTH STANDING COMMITTEE

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TUESDAY
FEBRUARY 28, 2017

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The Standing Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Peter Briss and Harold Pincus, Co-Chairs, presiding.

PRESENT:

PETER BRISS, MD, MPH, Co-Chair
HAROLD PINCUS, MD, Co-Chair
MADY CHALK, PhD, MSW, Treatment Research
Institute
SHANE COLEMAN, MD, MPH, Behavioral Health
Division Southcentral Foundation
DAVID EINZIG, MD, Children's Hospital and Clinics
of Minnesota
CHARLIE GROSS, PhD, Anthem, Inc.
CONSTANCE HORGAN, ScD, Brandeis University
LISA JENSEN, DNP, APRN, Veterans Health
Administration
DOLORES (DODI) KELLEHER, MS, DMH, D Kelleher
Consulting
KRAIG KNUDSEN, PhD, Ohio Department of Mental
Health and Addiction Services
MICHAEL LARDIERI, LCSW, Northwell Health
TAMI MARK, PhD, MBA, Truven Health Analytics
RAQUEL MAZON JEFFERS, MPH, MIA, The Nicholson
Foundation
BERNADETTE MELNYK, PhD, RN, CPNP/PMHNP, FAANP,
FNAP, FAAN, The Ohio State University*

BROOKE PARISH, MD, Blue Cross Blue Shield of New Mexico
 DAVID PATING, MD, Kaiser Permanente
 VANITA PINDOLIA, PharmD, Henry Ford Health System (HFHS)/Health Alliance Plan (HAP)
 RHONDA ROBINSON BEALE, MD, Blue Cross of Idaho
 LISA SHEA, MD, DFAPA, Butler Hospital; Care New England Health System
 ANDREW SPERLING, JD, National Alliance on Mental Illness
 JEFFERY SUSMAN, MD, Northeast Ohio Medical University
 MICHAEL TRANGLE, MD, HealthPartners Medical Group
 BONNIE ZIMA, MD, MPH, UCLA Semel Institute for Neuroscience and Human Behavior
 LESLIE ZUN, MD, MBA, Sinai Health System

NQF STAFF:

SHANTANU AGRAWAL, MD, President and CEO
 HELEN BURSTIN, MD, MPH, FACP, Chief Scientific Officer
 JASON GOLDWATER, MA, MPA, Senior Director
 ANN HAMMERSMITH, JD, General Counsel
 KAREN JOHNSON, Senior Director
 TRACY LUSTIG, DPM, MPH, Senior Director
 MELISSA MARINELARENA, RN, MPA, Senior Director
 ELISA MUNTHALI, MPH, Vice President, Quality Measurement
 DESMIRRA QUINNONEZ, Project Analyst
 KIRSTEN REED, Project Manager
 MARCIA WILSON, PhD, MBA, Senior Vice President, Quality Measurement

ALSO PRESENT:

MARY BARTON, MD, MPP, National Committee for
Quality Assurance

KYLE CAMPBELL, PharmD, MS, Health Services
Advisory Group

DANIEL GREEN, MD, Centers for Medicare and
Medicaid Services*

JAMIE JOUZA, MBA, CAPM, PCPI Foundation

JUNQING LIU, PhD, National Committee for
Quality Assurance

TIFFANY McNAIR, MD, MPH, Centers for Medicare and
Medicaid Services

GARY REZEK, West Virginia Medical Institute*

DAN ROMAN, National Committee for Quality
Assurance

KATHERINE SAPRA, PhD, MPH, Centers for Medicare
and Medicaid Services

ANDREW SAXON, MD, American Psychiatry
Association*

EDUARDO SEGOVIA, PCPI Foundation

ANITA SOMPLASKY, RN, CHTS-CP, CHTS-PW, Quality
Insights

SAM TIERNEY, MPH, PCPI Foundation

KERIANN WELLS, MPP, Mathematica Policy Research

JENNA WILLIAMS-BADER, MPH, National Committee for
Quality Assurance

ALMUT WINTERSTEIN, PhD, University of Florida

* present by teleconference

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

2 8:33 a.m.

3 DR. LUSTIG: Good morning. I'm Tracy
4 Lustig. I'm the Senior Director for the
5 Behavioral Health Committee. And I'm really glad
6 to meet everyone in person finally and welcoming
7 all of you here, our Committee Members, our
8 Chairs, our developers who are here and will
9 come, and everyone who's on the phone with us.

10 So, let's get the really important
11 information out front. Restrooms, for anyone who
12 needs them, right outside past the elevators and
13 to your right. We have a really packed agenda
14 today.

15 We are planning to have some breaks,
16 we will hopefully stay on close to the schedule
17 as we can. We will have lunch provided to the
18 Committee Members only and staff only around
19 12:30 and then we'll have an afternoon break.

20 For anyone that doesn't know or hasn't
21 figured it out, we do have the WiFi here. Anyone
22 can log in using the user name guest and then the

1 password NQFguest, with NQF in capitals. We want
2 to remind everyone on the phone and in person, if
3 you could mute your line or mute your cell phones
4 during the meeting. We do understand you may
5 need to run out quickly for personal reasons, but
6 please do that.

7 And one other thing that's not on
8 here, we always like to remind folks to be a
9 little bit closer to the microphone than you
10 expect, so that everyone on the line can hear us
11 and also get our transcripts. And so, I'd like
12 to, before we proceed, turn it over to our
13 President and CEO, Dr. Agrawal.

14 DR. AGRAWAL: Thank you. I won't make
15 very long comments, I just wanted to welcome you
16 all. This is actually my -- the start of the
17 fifth week on the job for me. So, I still
18 believe I have that new CEO smell, but we'll see.

19 And it's been a great really learning
20 exercise to come to all of these meetings. I try
21 to attend every one of them and stay as long as I
22 possibly can. It's really wonderful to see all

1 of the work that you are engaged in.

2 This Committee is particularly large
3 and I know we are really good at getting your
4 volunteer time. NQF is really masterful at that,
5 I've come to realize over the last five weeks.
6 This topic, I have to say, is really near and
7 dear to my heart, particularly the substance
8 abuse side of it.

9 I got my start in health policy,
10 working at a substance abuse policy center,
11 particularly on illicit drugs. I spent a summer
12 actually in D.C. at that time, working on tobacco
13 legislation. This was summer of '98, when
14 Congress was really taking on tobacco
15 legislation, and it was a major reform.

16 And then, I also wanted to extend my
17 thanks to Peter and Harold for their leadership.
18 They've been doing this for quite some time, I
19 mean, well before, I believe this is your fourth
20 phase of work, but my understanding is they've
21 been leading this work for far longer than that.
22 So, thank you very much.

1 Peter is a great connection to the
2 public sector for me. I'm just coming out of
3 CMS, so it's really wonderful to hear -- I think
4 wonderful to hear how things are going in the
5 government and I'm very, I'm hopefully that
6 things will ultimately work out well.

7 Harold, being at New York
8 Presbyterian, I actually did my med school at
9 Cornell and what people don't know, this sort of
10 fancy Upper East Side medical school was right
11 next to the freshman year dorm, there's a
12 methadone clinic.

13 And so, you walk by it every single
14 day, going to classes, and nobody realizes it
15 until we did a third-year public health rotation,
16 where I was assigned to the methadone clinic.
17 And it was just eye-opening, it was great.

18 So, that's it. I think I just wanted
19 to -- I know we have a few new Members, but I
20 won't steal your thunder, so that you get a
21 chance to highlight them.

22 I've looked over the measures under

1 consideration here, you have quite a long list,
2 but, again, I'm really excited about them. I'm
3 glad to see that we're addressing opioids, glad
4 to see that we're addressing tobacco cessation.
5 So, with that, I will turn it back.

6 DR. LUSTIG: Thank you. I like to hide
7 behind being new too, except I'm here almost a
8 year, so I can't do that anymore. Before we move
9 to you, I'd like to introduce or have introduced
10 the other members of my enormous team here at
11 NQF. We have two other folks, Kirsten?

12 MS. REED: Good morning, everyone. I'm
13 Kirsten Reed and I am the Project Manager for
14 this wonderful project. And I'm excited to be
15 here.

16 DR. LUSTIG: And hiding in the back, we
17 have Desi. You want to say hi, Desi?

18 MS. QUINNONEZ: Good morning. I'm Desi
19 Quinnonez and I'm the Project Analyst here on the
20 project. I'm looking forward to a great meeting.

21 DR. LUSTIG: Great. And now, I'll
22 finally turn to our Chairs to give their

1 welcomes.

2 CO-CHAIR PINCUS: So, hi, I'm Harold
3 Pincus. And welcome back everybody that's been
4 through this before and welcome to all the new
5 Members as well. Delighted to be here. It's a
6 long time in between meetings, and I know, if
7 you're anything like me, I'm kind of like an
8 Etch-A-Sketch at this point, where I have to sort
9 of go through the process again to sort of remind
10 myself about how to do this.

11 And I think it's probably the same for
12 many of you who have been through this and it
13 will also be somewhat new for the people, or will
14 obviously be new for the people who are joining
15 us for the first time.

16 There is a big agenda. There's some
17 important maintenance measures to look at, in
18 terms of whether they are still appropriate and
19 meaningful in terms of not only the way the
20 healthcare system has been shifting, but also in
21 terms of the kind of evidence that we need to
22 look at to renew those measures.

1 And then, there's a whole series of
2 newer measures that we need to look at. And so,
3 we have a lot of work ahead of us, but the
4 Committee has been really a very superb committee
5 in terms of the kind of substance of the
6 discussions that we've had and the way in which
7 the process has really moved through very well.
8 So, I look forward to working with all of you.

9 CO-CHAIR BRISS: So, ditto. Welcome or
10 welcome back. This is like our fourth cycle of
11 this stuff, so it feels like a room full of old
12 friends. I appreciate the chance to reconnect
13 and I'm looking forward to the next couple of
14 days.

15 DR. LUSTIG: Before I have Ann jump in,
16 I realize that I was remiss, we do have some
17 other NQF staff here I should let introduce
18 themselves. Karen, do you want to say hello?

19 MS. JOHNSON: Good morning. I'm Karen
20 Johnson. I'm one of the Senior Directors here at
21 NQF. And because Tracy is still new, this is her
22 first CDP, I was able to act as her buddy for

1 this project.

2 DR. LUSTIG: Great. So, I'll now turn
3 it over to Ann.

4 MS. HAMMERSMITH: Thanks, Tracy. I'm
5 Ann Hammersmith. I'm NQF's General Counsel. And
6 for those of you who are veterans of our
7 committees, you'll be familiar with our
8 disclosure of interest process. I will go over
9 it for new Members and also to remind our alumni
10 of how this works.

11 So, when you were nominated to the
12 Committee, you were required to fill out a rather
13 lengthy form in which we asked you some very
14 specific questions about your professional
15 activities. What we do in the oral disclosures
16 is we have you go around the table and tell us if
17 you have anything that you would like to
18 disclose.

19 Just because you disclose does not
20 mean that you have a conflict of interest. Part
21 of the reason we do this is for transparency
22 purposes, so that everyone knows where everyone

1 else is coming from. So, you can tell us that
2 you are involved in certain activities, but it
3 does not mean that you have a conflict of
4 interest.

5 Just remind you that you sit as
6 individuals, you are not a representative of your
7 employer or for anyone who nominated you for
8 service on this committee.

9 One thing that's a little bit
10 different about our disclosure is that we look
11 for financial disclosures, but we also look for
12 volunteer disclosures, only if they're relevant.
13 So, you may have been on a committee for your
14 professional society and you may have been a
15 volunteer on a committee and we would look for
16 you to disclose that, if it's relevant to the
17 subject matter before the Committee.

18 It doesn't mean you have a conflict,
19 but we would ask you to disclose that. I'm
20 trying to see anything else. I think we're ready
21 to go around the table. If you're on the phone,
22 I will call on you at the end of the in-person

1 disclosures.

2 Just a reminder, please don't
3 summarize your CV for us, only disclose things
4 that are relevant to the subject matter that the
5 Committee that will work on. So, I always start
6 with the Co-Chairs. Please tell us who you are,
7 who you're with, and if you have anything you
8 would like to disclose.

9 CO-CHAIR PINCUS: So, I'm Harold
10 Pincus. I'm Vice Chair and Professor at Columbia
11 University Department of Psychiatry. Also,
12 Director of Quality and Outcomes Research at New
13 York Presbyterian Hospital. I'm also adjunct
14 staff at the RAND Corporation.

15 I have been a consultant for both
16 Mathematica and for Montefiore Medical Center.
17 And I'm on advisory committees for a number of
18 academic medical centers, but specifically
19 relevant is both the American Psychiatric
20 Association, I'm on their quality committee, and
21 also on the Behavioral Health Advisory Committee
22 for NCQA.

1 CO-CHAIR BRISS: So, I'm Peter Briss.
2 And my day job's at CDC, although I think spend
3 more time in this room, actually. I'm the
4 Medical Director in the National Center for
5 Chronic Disease Prevention and Health Promotion.
6 I also direct the Office of Medicine and Science
7 there.

8 I've been involved in consulting on a
9 range of tobacco measures and, shockingly enough,
10 we think tobacco is important. And so, I've done
11 some consulting with CMS on 3229 and I've done a
12 fair amount of popularizing of NQF 28 in the
13 Million Hearts Initiative and other things.

14 MS. HAMMERSMITH: Dr. Beale?

15 MEMBER ROBINSON BEALE: Wasn't sure you
16 were going this way. Okay. My name is Rhonda
17 Robinson Beale. I'm a Senior VP and Chief
18 Medical Officer for Blue Cross of Idaho.
19 Disclosure, the only disclosure I have is the
20 work I do every day, which is creating value-
21 based payments and using performance measures in
22 order to do that.

1 So, my perspective and my bias will be
2 from the actual use of measures and the issues
3 that come out when you're trying to tie that to a
4 payment mechanism.

5 MEMBER CHALK: I'm Mady Chalk. I'm the
6 Senior Policy Advisor to the Treatment Research
7 Institute and a consultant on a number of
8 contracts to CMS on the Innovation Accelerator
9 Program and to ASPE on a variety of other things,
10 many of which are related to measures. And I
11 suspect I have a conflict, I think, with two of
12 the measures that are being looked at today, so I
13 will recuse myself on those measures.

14 MEMBER JENSEN: I'm Lisa Jensen. I'm
15 an Advanced Practice Psychiatric Nurse, I work
16 for Veterans Health Administration, just up the
17 street at 810 Vermont, but I actually live in
18 Salt Lake City, I'm a virtual employee. So, best
19 of all worlds. I don't have any disclosures that
20 I need to make.

21 MEMBER PINDOLIA: Good morning. I'm
22 Vanita Pindolia. I'm the Vice President of

1 Ambulatory Clinical Pharmacy Programs at Henry
2 Ford Health System's Health Alliance Plan. And I
3 really don't have any disclosures.

4 MEMBER MAZON JEFFERS: Good morning.
5 I'm Raquel Mazon Jeffers. I'm a Senior
6 Healthcare Program Officer at the Nicholson
7 Foundation in New Jersey. And I was formerly the
8 Addictions Director for the State of New Jersey.
9 And I don't have any disclosures.

10 MEMBER EINZIG: I'm David Einzig. I
11 did the triple board training in Salt Lake City.
12 I'm working at Children's Minnesota. I'm here to
13 give mostly clinical perspective, I see a couple
14 hundred patients a month, at least.

15 I work closely in the pediatric
16 clinic, doing collaborative care models. I see
17 mostly kids with co-morbid psychiatric and
18 medical illnesses, so kind of a complex
19 population. No disclosures.

20 MEMBER LARDIERI: Good morning, hi.
21 I'm Mike Lardieri. And I'm from Northwell
22 Health, I'm the AVP for Strategic Program

1 Development in the Behavioral Health Service
2 Line. Been on some committees with Office of
3 National Coordination for HIT implementation, EHR
4 usability.

5 I'm on the PPS Committee under the
6 DSRIP Program New York for New York City's PPS
7 and Managed Care Organization Committee. And
8 also, I'm on the clinical advisory committee for
9 an EHR vendor, Core Solutions.

10 MEMBER ZIMA: And hi, I'm Bonnie Zima
11 and I'm a Child Psychiatrist, Health Services
12 Researcher, Professor in Residence, UCLA. I'm on
13 the Committee on Research for the American
14 Academy of Child and Adolescent Psychiatry. And
15 I receive research funding from PCORI, the State
16 of California Department of Healthcare Services,
17 and Illinois Children's Healthcare Foundation.

18 MEMBER KELLEHER: I'm Dodi Kelleher.
19 I'm an independent consultant and I work
20 primarily with large, self-funded employers on
21 designing integrated behavioral health and fill-
22 in-the-blank programs, disability, medical, et

1 cetera. And I have no disclosures.

2 MEMBER SPERLING: Good morning. I'm
3 Andrew Sperling with the National Alliance on
4 Mental Illness. And I don't think I have any
5 disclosures, other than, I'm an unfunded consumer
6 representative to the National Association of
7 Insurance Commissions. I'm not sure if that's
8 relevant or not.

9 MEMBER KNUDSEN: I'm Kraig Knudsen. I
10 am the Chief of the Bureau of Research and
11 Evaluation at the Ohio Department of Mental
12 Health and Addiction Services. And I have no
13 disclosures.

14 MEMBER GROSS: Good morning. I'm
15 Charlie Gross, Vice President for Government
16 Business Division Anthem, that's
17 Medicare/Medicaid. No disclosures that I'm aware
18 of, other than it's been many years since I took
19 an advanced statistics course.

20 (Laughter.)

21 MEMBER COLEMAN: Shane Coleman, here
22 from Southcentral Foundation, which is an Alaskan

1 Native owned and operated healthcare system in
2 Alaska. Do some internal QA/QI and development
3 of measures and things like that, but that's
4 about it. Thanks.

5 MEMBER PARISH: Good morning. I'm
6 Brooke Parish. And I'm one of the Medical
7 Directors for HCSC, which is the Blue Cross for
8 five states. My really only disclosure, and I
9 don't think it is really a conflict, is I also
10 work as a surveyor for Joint Commission and have
11 been trained for a surveyor at NCQA. I'm also
12 President of our district branch in New Mexico
13 for the APA and an assembly member.

14 MEMBER TRANGLE: Michael Trangle. I'm
15 a psychiatrist at an integrated health system in
16 the Minneapolis-St. Paul area called Health
17 Partners. My conflicts are, I -- they're all
18 unpaid, I wouldn't say unfunded, somebody's
19 paying for the initiatives, but unpaid, voluntary
20 gigs for me.

21 But I chair every year a guideline for
22 a regional quality place called ICSI, the

1 Institute for Clinical Systems Improvement, the
2 Depression Guideline. And there are Minnesota
3 Community Measurements for depression that I'm
4 involved, so there was a revision of those
5 measures this past summer and I led that work
6 group. So, those depression measures, I need to
7 recuse myself.

8 And I was also involved for the
9 Quality Insights Measure that we're reviewing
10 here and I'm recusing myself for the -- oh, I had
11 it up here. It'll come up, it's the one
12 sponsored by Quality Insights having to do with
13 preventative screening for depression and follow-
14 up.

15 MEMBER SHEA: Good morning. I'm Lisa
16 Shea. I'm a psychiatrist at Butler Hospital in
17 Providence, Rhode Island, where I'm Medical
18 Director. I'm also a Clinical Associate
19 Professor at the Brown University Alpert School
20 of Medicine.

21 I sit on the Board of the National
22 Association of Psychiatric Health Systems and on

1 its Quality Committee. And I also was a
2 volunteer member of the HSAG TAP, where two of
3 the measures are coming up that I will recuse
4 myself from, 3205 and 3207.

5 MEMBER SUSMAN: I'm Jeff Susman. I'm
6 a family physician, geriatrician, and Dean
7 Emeritus at Northeast Ohio Medical University.
8 I've the best job in the world right now, which
9 is being on sabbatical.

10 (Laughter.)

11 MEMBER SUSMAN: And I don't have any
12 disclosures. Thank you.

13 MEMBER HORGAN: Good morning. I'm
14 Connie Horgan. I'm a health services researcher.
15 I'm a Professor at the Heller School at Brandeis
16 University and the Director of the Institute for
17 Behavioral Health. My conflicts are that I am on
18 the Behavioral Health Measurement Advisory Panel
19 for NCQA.

20 My Institute also works as a
21 subcontractor to Mathematica on the MIDS Project,
22 funded by CMS. And my research is predominately

1 funded by NIH grants and I'm the Principal
2 Investigator on the Brandeis/Harvard NIDA
3 Research Center, that focuses on system
4 improvement for substance use disorders. And we
5 do a lot of work with performance measures and
6 improving them, we hope. Thank you.

7 MS. HAMMERSMITH: Okay. Thank you. Is
8 Bernadette Melnyk on the phone?

9 MEMBER MELNYK: Yes. Good morning. I
10 have the flu very badly and I didn't want to
11 expose you to that. I am Vice President for
12 Health Promotion and Chief Wellness Officer for
13 the Ohio State University. I'm also a
14 psychiatric mental health and pediatric nurse
15 practitioner.

16 I have one conflict to disclose. I
17 have a company called COPE2Thrive that
18 disseminates my evidence-based cognitive behavior
19 therapy-based programs for children and teens.

20 MS. HAMMERSMITH: Okay, thank you.
21 Thank you, everyone, for your disclosures. One
22 more reminder, before I leave you, if during the

1 meeting you think you have a conflict of
2 interest, if you think someone else has a
3 conflict of interest, or if you think that
4 someone is behaving in an extremely biased
5 manner, please speak up in real-time.

6 We don't want to get two or three
7 months down the road and then have someone say,
8 you know, I think I had a conflict of interest.
9 We'd like to know now.

10 You're always free to speak up in a
11 meeting, in open session. You can also go to
12 your Co-Chairs, who will consult with NQF staff.
13 And you can always go directly to NQF staff and
14 they'll discuss it with you and reach a
15 resolution. Any questions or comments?

16 MEMBER ZUN: Yes. This is Dr. Zun.
17 I'm on the way over from the airport and I did
18 want to give my disclosure statement, if that's
19 okay?

20 MS. HAMMERSMITH: Sure.

21 MEMBER ZUN: Well, in brief, I have
22 nothing to disclose.

1 (Laughter.)

2 MEMBER ZUN: However, I am a Professor
3 and Chair of Emergency Medicine with a secondary
4 appointment in the Department of Psychiatry at
5 Chicago Medical School. I am System Chair for
6 Emergency Medicine in the Sinai Health System.

7 I also am President of the American
8 Association for Emergency Psychiatry. At this
9 point in time, we have not developed any
10 standards, although we are -- one subcommittee is
11 looking at that.

12 I do have a grant, actually a couple
13 of grants. One from Teva looking at agitation
14 and one from the Emergency Medical Foundation,
15 again looking at agitation in the emergency
16 setting. So, I think I've covered most of my
17 involvements, but I don't see any conflicts with
18 the measures being discussed today.

19 MS. HAMMERSMITH: Okay, thank you.
20 Anybody else on the phone that we missed? Okay.
21 Thank you, everyone. Have a good meeting.

22 DR. LUSTIG: Thank you. Before we move

1 on, I wanted to give my other colleague here a
2 chance to introduce herself, who just joined us.

3 MS. MUNTHALI: Good morning. Thank
4 you. And sorry for being late. My name is Elisa
5 Munthali, I'm Vice President for Quality
6 Measurement at NQF. And I just wanted to welcome
7 you and thank you so much for being on the
8 Committee.

9 DR. LUSTIG: So, this next slide here
10 says portfolio overview. We're actually going to
11 have a significant amount of time tomorrow to
12 really take a step back and look at the
13 behavioral health portfolio overall, where there
14 are measures, try to identify where the gaps are
15 and where we think we should be focusing effort.

16 So, for right now, we just really
17 wanted to give you the overview of the measures
18 that we'll be looking at today. Sorry, there we
19 go. It's always technology. Since our call that
20 we had a couple of weeks ago, we actually had
21 some more measures added to this meeting.

22 So, overall, we do have 13 measures

1 we'll be looking at. One of the measures, we're
2 not going to be voting on, we'll just be having
3 more of a discussion on, and that's the ECHO
4 measure. That will be tomorrow morning.

5 But of the others, we do have seven
6 new measures. Two of them are eMeasure versions
7 of some of the maintenance measures we'll be also
8 looking at. And so, we're covering, as usual, I
9 think a wide range of topics.

10 We have tobacco use and follow-up
11 after ADHD medication, follow-up after
12 hospitalization, some depression measures,
13 alcohol use, opioid use, medication
14 reconciliation, medication continuation measures.
15 And so, we're really going to be covering a gamut
16 of things.

17 We have a very busy day today, looking
18 at ten of the 13, so we're going to try to get
19 through that process very quickly. And I know we
20 had a long call going over our criteria. It's
21 always good to go over it once again, just to
22 give you a refresher.

1 So, the NQF process, we do have major
2 criteria and the specific processes for going
3 through these criteria. First, again, we'll be
4 looking at the importance to measure and report.
5 This is a must-pass criterion and we have two
6 different votes on this. One is on the evidence
7 itself and then, one is on the gap.

8 Next, we'll be looking at the
9 scientific acceptability of the measure. This is
10 reliability and validity. Again, this is a must-
11 pass criterion. So, we will discuss and vote
12 separately, first reliability and then validity.

13 Next, we'll be looking at feasibility.
14 Again, we want to cause as little burden as
15 possible, consider alternatives. We will discuss
16 and vote on feasibility, but feasibility is not a
17 must-pass criterion.

18 And I guess I should have mentioned,
19 when I say must-pass, if a criterion that is
20 must-pass does not pass, we do not continue
21 discussion, it ends right there and the measure
22 is not -- and that does not pass. For usability

1 and use --

2 CO-CHAIR PINCUS: Tracy, one question.

3 DR. LUSTIG: Yes?

4 CO-CHAIR PINCUS: Even though we stop
5 discussion, is the material that has been
6 prepared, in terms of the reviewers getting
7 feedback on it, does that go to the measure
8 developer so they can potentially improvement or
9 address some of this?

10 DR. LUSTIG: Yes. The measure
11 worksheets, as they stand, actually have already
12 been made available to all of the developers.
13 So, after we discuss and vote usability and use,
14 we actually have a final vote. And that's the
15 overall, do we recommend this measure for
16 endorsement?

17 And then, we will have some
18 discussion, if needed, on related. We don't have
19 any competing measures this time, which means we
20 don't have to choose a best-in-class. We may
21 need to defer some of that discussion to
22 tomorrow, depending on how long our timing goes

1 today.

2 As a reminder, and you all have
3 handouts for some of our criteria here, we have
4 very specific algorithms that we use to decide
5 whether it's rated as high, moderate, low, or
6 insufficient.

7 For some of the measures, and we will
8 be telling you this, based on our analysis, there
9 are cases where high is not a possible rating.
10 And so, we have -- so, the first one was for
11 evidence. Next, we have an algorithm for
12 reliability. And then, third, an algorithm for
13 validity.

14 And one other thing to let you know is
15 that, for our maintenance measures, we have had
16 some changes to our processes here. These
17 measures have been looked at already in the past.
18 And for some of the criteria, specifically
19 evidence, not necessarily gap, but the basis of
20 the evidence and testing, there may not be
21 anything new from the developer, and that's okay.

22 And the Committee, in those cases, may

1 decide to simply accept the prior evaluation and
2 not need to revote on it. So, for example, if
3 it's a maintenance measure, in the past they've
4 provided systematic review of guidelines as the
5 evidentiary basis, there's nothing new to that
6 evidence base, there may be more and in the same
7 direction, meaning it's even stronger evidence,
8 we may choose to say, this passed before, we're
9 going to pass again and not need to go through
10 the actual process of revoting. But you don't
11 have to not vote. We also --

12 MEMBER MARK: Can I ask you a question
13 on that? The --

14 DR. LUSTIG: Yes.

15 MEMBER MARK: -- Maintenance, the
16 standing work, so, there's no requirement that
17 any work be done if something's submitted for
18 maintenance? Meaning --

19 DR. LUSTIG: Oh, no --

20 MEMBER MARK: -- by work, I mean
21 there's no requirement that they do a systematic
22 review again or do -- I was a little confused

1 going through the material as to what exactly was
2 required when someone resubmits something for
3 maintenance.

4 DR. LUSTIG: So, we do expect that if
5 there is -- we ask them if there is any new
6 evidence since they submitted it. So, we do
7 expect that they've looked to see if there's
8 anything new. And so, those are the updates we
9 expect.

10 But if the updates, if there was a
11 guideline and the guideline has been updated, but
12 the basis of it doesn't affect the evidence of
13 what we're looking for, it only makes the case
14 stronger, then we would say that we don't
15 necessarily need to revote on it.

16 But that's also different than gap.
17 The gap is something we do still vote on. But we
18 can go through this as we're going through the
19 actual process.

20 CO-CHAIR PINCUS: But I think, also,
21 one of the reasons why we have experts around the
22 table is -- if there's a claim that there's no

1 new information, maybe we'll identify the fact
2 that there is new information.

3 MEMBER PINDOLIA: So, can I clarify?
4 So, a measure that's coming up for renewal, there
5 is an opportunity to share concerns if it should
6 continue? Or no?

7 DR. LUSTIG: Yes, absolutely. Yes,
8 we'll still begin with a discussion of every
9 criterion and subcriterion. The question will
10 be, at the end of that discussion, do people feel
11 that there is a need to revote?

12 And in that same vein is what I think
13 some of you are alluding to, in our processes,
14 what we're saying is that, for a measure
15 maintenance, we really should be putting more
16 focus on current performance and opportunity for
17 improvement, that's what we call gap, and also on
18 usability and use, is the measure being used, has
19 it had any impact, are there any unexpected
20 findings in terms of the use of the measure?

21 So, what we're -- by saying, not
22 needing to vote, is if people think that the

1 evidence, and the testing in particular, are
2 solid and thought it last time and still think
3 that, let's not spend time revoting and instead,
4 focus more on the use of it.

5 CO-CHAIR PINCUS: You mean voting on
6 that criterion?

7 DR. LUSTIG: Correct.

8 CO-CHAIR PINCUS: Yes.

9 DR. LUSTIG: Voting on that particular
10 criterion.

11 CO-CHAIR BRISS: Yes. And so, as a
12 practical matter, this is things like, if you
13 believe that last time we discussed tobacco or
14 depression that it was an important topic that
15 there were treatments that those were
16 underutilized, which I suspect we might be able
17 to fairly quickly get to some agreement on. We
18 don't have to spend a lot of time sort of
19 relitigating that and we can move on to the other
20 criteria.

21 DR. LUSTIG: Yes?

22 MEMBER TRANGLE: You mentioned earlier

1 about that we might talk about competing
2 measures. And I also know that somewhere in our
3 schedule later on is harmonization of measures.
4 Is that going to mainly be talked about tomorrow
5 and we shouldn't do it piece-by-piece here today?
6 What's your thought?

7 DR. LUSTIG: Yes. So, we don't have a
8 lot of related and competing measures. We --
9 and, actually, in this particular portfolio,
10 don't have what we call competing measures, which
11 are two measures that are head-to-head doing the
12 same thing and we would need to pick the better.

13 We do have some that are related and
14 that's where the harmonization discussion comes
15 up. We have, I think, one measure that had a
16 related measure that we'll definitely discuss
17 today.

18 One of the things we had talked about
19 was, we have a lot of smoking measures and
20 there's question as to whether they are
21 completely harmonized or if they're harmonized as
22 much as possible. We will try to do that today,

1 I think, but it just depends on, we have a really
2 packed day today, so we may defer that discussion
3 until tomorrow.

4 So, I know we've got a lot of
5 questions here, but are there any other questions
6 before we move on to the nuts and bolts of
7 voting?

8 CO-CHAIR PINCUS: One thing, you might
9 want to remind people about the difference in the
10 process for an eMeasure review.

11 DR. LUSTIG: So, actually, we have, I
12 mentioned, two eMeasures today. And we actually
13 have our resident expert in eMeasures, who's
14 going to come up and explain all of that to us.
15 And so, we'll probably go over it mostly then.

16 One of the -- the big thing, though,
17 for the maintenance measure and then, now, the
18 eMeasure version of it is, we don't need to
19 revote on evidence, because the evidence piece
20 itself is going to be exactly the same. So,
21 whatever is voted on in terms of the maintenance
22 measure, we'll automatically assign that vote to

1 the eMeasure, the pass or no-pass.

2 But I'm going to let Jason explain
3 eMeasures, much better than I ever could. All
4 right. So, with that, I'm going to turn to
5 Kirsten, who's going to go over, like I said, the
6 nuts and bolts of voting.

7 MS. REED: Yes. All right. So, the
8 next couple of slides are just going to talk
9 about how today is going to work and your role in
10 today. So, I know this slide here, we've really
11 gone over quite a bit in the last two webinars,
12 so I won't discuss this again, unless anyone has
13 any questions on this.

14 Again, we've gone over this as well,
15 kind of your role as a Standing Committee Member.
16 We've asked everyone to come prepared today, in
17 reviewing the measures that you were assigned
18 specifically, but also asked that you kind of
19 familiarize yourself with all of the measures.

20 So, we will be having a brief
21 introduction by the developers. You'll see a
22 number of them are in the back of the room, so we

1 want to thank them for attending today's meeting.
2 We will also be asking them to briefly introduce
3 their measure as they come up for discussion.

4 There's obviously a place right here
5 at the main table for them to sit down and they
6 will kind of go through the measure and address
7 any issues that were kind of brought up during
8 the PAs and also your analysis.

9 Following their introduction, we will
10 ask the lead discussants for that measure to kind
11 of begin the discussion, provide a summary of any
12 pre-meeting evaluation comments, and, like I
13 said, emphasize any areas of concern.

14 The developers will then have the
15 opportunity to respond to those questions. And
16 then, we will open it up to the full Committee to
17 discuss that measure and then, vote on each of
18 the criteria before moving on to the next
19 criteria. All right.

20 So, how does the voting work? Voting
21 is by criterion in the order presented on the
22 measure worksheet. As Tracy mentioned in her

1 discussion, the evidence, performance gap,
2 reliability, and validity are all must-pass
3 criteria.

4 And then, we'll go on to usability and
5 use, feasibility, and the overall suitability for
6 endorsement. If a measure does fail on one of
7 the must-pass criteria, there is no further
8 discussion or voting on that measure and we will
9 move on to the next one. All right.

10 So, in front of you, each of you have
11 this fun little clicker and this is what we'll be
12 using to vote. We ask that when it becomes time
13 to vote, you point your clicker towards Desi, who
14 is over there by the window.

15 And when you do vote, the remote will
16 kind of display what you chose in that little red
17 area. You are able to change your response
18 without duplicating it and only the last option
19 pressed before voting closed will actually
20 register in the system. All right.

21 So, for achieving consensus, again, I
22 think Tracy covered this, but at least 60 percent

1 of the Committee Members who are eligible to
2 submit votes must vote to make decisions. The
3 Standing Committee has not reached consensus if
4 the vote on importance to measure and report,
5 scientific acceptability, or overall
6 recommendation is between 40 and 60 percent.

7 If the vote on subcriteria under
8 importance or scientific acceptability is between
9 40 and 60 percent, the Committee will vote on all
10 criteria and a final recommendation. If the vote
11 on either must-pass criteria is less than 40
12 percent, then there is no further evaluation.

13 And any measures where consensus is not
14 reached will move forward to comment and the
15 Committee will revote at a later time. Sorry, I
16 have too many computers in front of me. All
17 right. Any questions on how today will work?
18 Yes?

19 MEMBER KELLEHER: You have six or seven
20 discussants for each measure, who will be the
21 lead-off if the developer doesn't sort of
22 introduce it sufficiently? It's just different

1 from how it's been before.

2 MS. REED: Honestly, whoever wants to
3 speak up, yes. Unless, do you want to assign a
4 certain one for each measure?

5 DR. LUSTIG: What we planned is that
6 someone could start off, one of the lead
7 discussants, and then, what we would ask is that,
8 other people can join in and voice concerns, but
9 not necessarily repeat anything. We'd ask you
10 just bring up new issues.

11 But, certainly, we're not even just
12 limiting it to -- we expect the lead discussants
13 will be the ones that really dug in the deepest,
14 but if anyone else around the table has concerns
15 about any measure, they should feel free to speak
16 up.

17 MEMBER KELLEHER: Thank you.

18 CO-CHAIR PINCUS: And if nobody speaks
19 up, we'll call on somebody.

20 (Laughter.)

21 MS. REED: Are there any other
22 questions? All right. Then, I am going to pass

1 it over to Peter and Harold and they are going to
2 begin the process for the first measure up, which
3 is 3148. And do we have our developers with us
4 for that measure?

5 DR. LUSTIG: While our developer is
6 coming up, one technical thing I wanted to point
7 out. People may be confused about new numbers,
8 you see that we have measure 04 -- you remember
9 0418, what happens is that when an eMeasure
10 version is introduced of a maintenance measure,
11 they both get renumbered. So, measure 0418 is
12 now measure 3148, but we left them both there to
13 remind you.

14 CO-CHAIR BRISS: And let me try to set
15 a couple of additional things in terms of
16 managing the discussion. So, we'll try to do the
17 -- if you want to take a turn on the floor,
18 please let us know by turning your card up.

19 We came without our binoculars today,
20 so it's a little hard to see everybody from a
21 distance, so please do the best you can in
22 turning your cards so that we can see them. The

1 -- try to be efficient in your comments.

2 As we've said already, we've got a lot
3 of measures to get through today and we want to
4 make sure everybody has a turn. And it's
5 probably good if we try not to duplicate comments
6 that have already been said. So, with that, I
7 will get out of the way and we'll open with the
8 first measure.

9 MEMBER LARDIERI: I have a question.

10 Yes. And it has to do with the renumbering.

11 There's a lot of effort across the country to
12 keep these things straight and when you start to
13 renumber, has anybody evaluated the cost of that?
14 In EHRs, other systems?

15 I know, with my system, with some of
16 the measures that we're using now, if you
17 renumber them, I have to retool all over the
18 place. So, I don't understand the purpose of
19 just changing the number. Maybe we could talk
20 about that.

21 MS. MUNTHALI: It's a great question.

22 We -- when we renumbered, we were trying to make

1 a distinction between the paper-based and the
2 eMeasure, the electronic-based measure. But we
3 realize that the numbers are not really
4 intuitive, so we are going through another effort
5 to see how we can better align the numbers.

6 So, once you're looking at a claims-
7 based measure that might have been in rural, you
8 can see that this measure may be associated with
9 it. But the consideration with EHRs is a good
10 input as well.

11 DR. BURSTIN: And just to add to that,
12 one question for you, as we've struggled with
13 this, you want to make it clear they are
14 different measures. They have different testing
15 at times.

16 And so, one question, would it be
17 better to have the same number with some
18 indication, for example, that it's an eMeasure,
19 as another potential way to look at this? We
20 would welcome your input on that, whether now or
21 later.

22 MEMBER SUSMAN: We were talking about

1 just kibitzing, why not just call it e3148?

2 MEMBER LARDIERI: Or just put an E
3 behind it if it's an eMeasure? I mean, this 3225
4 that was 0028, I didn't notice that was an
5 eMeasure. That's an eMeasure?

6 DR. LUSTIG: So, it -- and I think the
7 conversation is a little confusing. So, the new
8 eMeasure gets a new number, but the old measure
9 gets renumbered. And I think that's where people
10 are confused.

11 MEMBER LARDIERI: Yes, so maybe we
12 could explain what 3225 is and in parenthesis
13 0028. It looked to me like it's exactly the
14 same.

15 DR. LUSTIG: Yes, you're correct. It's
16 an issue that we're having ongoing discussion
17 here. But, yes, the old measure, 0028, because an
18 eMeasure was introduced, the eMeasure has a new
19 number and then, the old measure gets renumbered.

20 MEMBER LARDIERI: So, maybe we should
21 just consider the cost that it's going to be for
22 everyone to retool to rename your measure. And

1 then, also, if you look in an EHR and you're
2 tracking that measure over time, how do I flip
3 now in the EHR from 0028 to 3225 without a whole
4 bunch of retooling? And that retooling is all
5 across the country, not just one provider.

6 DR. BURSTIN: I'll just add, this is
7 something that was an internal NQF decision, so
8 it's -- if your advice is strong, I think it's
9 something we can potentially look at fixing,
10 putting it back to the old numbers and adding an
11 E, which I always thought made a whole lot more
12 sense. Harder from a numbering perspective, but
13 we'll see what we can do.

14 CO-CHAIR BRISS: So, I'd like to
15 suggest, this is a really important topic. It's
16 clearly broader than just this Committee, so why
17 don't we kick this back to staff to make some
18 decision about and, if that's okay, we'll move on
19 to the first measure.

20 DR. LUSTIG: So, thank you to our
21 developers and please get started.

22 MS. SOMPLASKY: Thank you. Good

1 morning. We are pleased to introduce NQF 0418:
2 Preventative Care and Screening: Screening for --

3 CO-CHAIR PINCUS: Could you please
4 identify yourself?

5 MS. SOMPLASKY: Oh, I'm sorry. My name
6 is Anita Somplasky. I'm from Quality Insights.
7 We're a measure developer for CMS.

8 MS. WELLS: Hi. I'm KeriAnn Wells. I
9 work at Mathematica Policy Research and led the
10 testing effort for these measures.

11 MS. SOMPLASKY: Take two. We are
12 pleased to introduce NQF 0418: Preventative Care
13 and Screening: Screening for Depression and
14 Follow-Up Plan, for consideration of NQF re-
15 endorsement.

16 We will discuss two versions of the
17 measure. The first is NQF 3148, the claims and
18 registry-based measure, and the second is NQF
19 3132, the Electronic Clinical Quality Measure, or
20 eCQM.

21 The claims and registry-based measure
22 was first implemented in the Physician Quality

1 Reporting System, or PQRS, in 2008 and the eCQM
2 was added to the Electronic Health Record
3 Incentive Program, commonly referred to as
4 meaningful use, in 2012, and is now included in
5 the Quality Payment Program, or QPP, under MACRA.

6 This measure was initially developed
7 and implemented in CMS Quality Reporting Programs
8 to promote the evaluation and treatment of
9 depression through routine screening.

10 Substantial evidence indicates negative patient
11 outcomes are associated with depression, making
12 it critical to identify and treat depression in
13 its early stages.

14 The intent of this process measure is
15 that all eligible professionals screen patients
16 12 years and older using an age appropriate
17 standardized depression screening tool and, if
18 the screening is positive, a follow-up plan is
19 documented on the date of the positive screen.

20 The measure requires that eligible
21 professionals document a follow-up plan, for
22 example, referral to a specialist such as a

1 psychiatrist or psychologist, to ensure that
2 positive depression screenings signal a treatment
3 plan. This measure focuses on children and
4 adults and includes all visits during the 12
5 month reporting period.

6 This measure is supported by clinical
7 practice guidelines, the United States
8 Preventative Services Task Force recommendations
9 for adults and adolescents, and the Institute for
10 Clinical Systems Improvement healthcare guideline
11 Adult Depression in Primary Care.

12 In young adulthood, major depressive
13 disorder is associated with early pregnancy,
14 decreased school performance, and impaired work,
15 social, and family functioning. While primary
16 care providers serve as the first line of defense
17 in the detection of depression, studies show that
18 PCPs fail to recognize up to half of depressed
19 patients.

20 Based on the evidence and on reported
21 performance rates, this measure reflects an
22 important care process that clinicians are not

1 regularly providing. The average 2014 PQRS
2 performance rate for this measure was 26 percent,
3 with 7.5 percent of eligible professionals
4 reporting.

5 Reported performance rates indicate
6 substantial variation in both claims and registry
7 data and demonstrate that many clinicians have
8 the potential to improve the rates of depression
9 screening and follow-up.

10 This measure has the potential to
11 incentivize eligible professionals to detect more
12 patients with depression earlier, which in turn
13 improves community and population health and
14 reduces cost.

15 In addition to establishing the
16 importance of the measure and illustrating the
17 performance gap across providers, we have also
18 tested the claim and registry measure and the
19 eCQM and found each to be reliable, valid, and
20 feasible. Thank you for your consideration and
21 we look forward to the Committee's questions and
22 discussion.

1 CO-CHAIR BRISS: So, with that, would
2 one of the lead discussants like to kick this
3 off?

4 MEMBER SUSMAN: So, I think this is a
5 measure where the evidence is largely the same,
6 if not a bit stronger. The rationale has been
7 well discussed. My only substantial question in
8 general is around frequency screening and,
9 therefore, follow-up and treatment.

10 I'm not aware of any new evidence that
11 speaks directly to that issue, but it's somewhat
12 of a more trivial or picky concern. I think the
13 transition to an eMeasure, while not the focus of
14 this current discussion, is fairly
15 straightforward. So, overall, my sense is, we
16 could endorse the discussion of evidence from our
17 prior time and move forward.

18 CO-CHAIR BRISS: So, in terms of
19 evidence, I think what we're going to try to do
20 in these cases where we believe that the
21 importance to measure may not have changed
22 greatly, we'll give the Committee an opportunity

1 to hear that kind of a discussion and see if
2 anybody has -- see if any of the other primary
3 reviewers want to add to that on importance and
4 then, see if anybody else on the Committee wants
5 to have further discussion. Is that okay?

6 CO-CHAIR PINCUS: Let's see if anybody
7 objects to moving on.

8 CO-CHAIR BRISS: So, the first question
9 on the table is, is this still important to
10 measure and report?

11 MEMBER SUSMAN: I think it's clearly
12 important and there's a gap and we,
13 unfortunately, haven't made much gains, which I
14 sort of can trivially ask, well, jeez, if we can
15 never improve this, why are we measuring it? But
16 that's probably a nihilistic perspective.

17 MEMBER ZIMA: I just had a question.
18 Do you have any performance gap information on
19 teens?

20 DR. LUSTIG: So, actually, we're going
21 to talk about gap next, but this vote is
22 specifically just on the evidence base, on the

1 importance to measure. And so, like was alluded
2 to, this is a case where, unless there is
3 objection, we can accept the vote from the last
4 time this was looked at, so this would pass and
5 we'd move on to looking at gap.

6 CO-CHAIR PINCUS: But we don't actually
7 have to vote on this specific thing.

8 MEMBER COLEMAN: I think I would accept
9 it as-is. The one thing I wanted to mention was
10 that, I think part of the evidence base and part
11 of why it landed on moderate was due to the lack
12 of evidence for improving depression through
13 treatment plans of sorts, at least in adult
14 populations in primary care.

15 And the one thing I wasn't sure how to
16 reconcile that with is some of the integrated
17 data. Because nonintegrated, mental health
18 integrated systems, have a problem, but there's a
19 lot of good evidence that if you integrate mental
20 health services in the right way, you can
21 actually get really good depression outcomes of
22 sorts.

1 So, it might change that piece of
2 evidence and it wasn't present. I don't know
3 that it's that important. Again, I don't feel
4 like we have to vote on it, but I just wanted to
5 say that there's some new evidence that might fit
6 into this in some way.

7 CO-CHAIR BRISS: So, I don't -- I've
8 heard sort of a feeling around the table that
9 this may still be important to measure and
10 report. Anybody have an objection to that? Yes,
11 so it sounds like Jeff thought that this might be
12 still important to measure and report.

13 I don't think I've heard or seen an
14 objection to that around the table, so could we
15 accept the last Committee vote about this is
16 still important and move on to the next
17 criterion?

18 MEMBER COLEMAN: Yes.

19 MEMBER HORGAN: Do you want the other
20 assigned reviewers to say we agree? I mean, is
21 that the process here?

22 DR. LUSTIG: I think if anyone had an

1 objection --

2 MEMBER HORGAN: Yes, okay.

3 DR. LUSTIG: -- but like Peter said,
4 this is -- instead of taking a vote about whether
5 we should vote, what we're saying is, unless we
6 hear an objection, we think we can move on.

7 CO-CHAIR PINCUS: Yes. Basically, what
8 we're trying to do is, the voting takes some time
9 and so, if there's clearly -- it's been voted on
10 before, not a lot of new information to change
11 that basic information, then we can just simply
12 see if somebody objects, and then we don't have
13 to go through the whole voting process.

14 CO-CHAIR BRISS: And, Connie, I think
15 we said at the beginning that, if what you were
16 going to say has already been said, we don't --
17 there may not be a strong reason to do a lot of
18 repeating ourselves. And on this one, on this
19 particular criterion --

20 MEMBER HORGAN: It's been said more
21 eloquently than I would have said.

22 CO-CHAIR BRISS: Yes. I suspect we've

1 said what needs to be said. So, let's take, I
2 think we'll take that as consensus for the --
3 that we still think this is important to measure
4 and report and we can move on to the next
5 criterion.

6 DR. LUSTIG: So, this means that we
7 turn back to our lead discussants and we're going
8 to move on and talk about performance gap. And
9 so, this is where, I think, we start having some
10 questions be raised.

11 MEMBER SUSMAN: I can basically say,
12 there's still a substantial performance gap. And
13 there's a lot of data around this in a lot of
14 different settings. So, it seems to me that this
15 is a measure that is still important in that
16 dimension.

17 MEMBER ZIMA: I think my point was, it
18 looks like the performance gap was based mostly
19 on Medicare data. Any information on teens?

20 MS. WELLS: So, for the claims/registry
21 version, we did only have access to Medicare
22 data, which, of course, doesn't have many teens.

1 On the eMeasure, we were able to kind of look at
2 rates in different age strata. And the 12 to 17
3 had an average performance rate of 53.7, which
4 was comparable to 18 to 64. And then, we see
5 higher rates among 65 plus on the eMeasure.

6 CO-CHAIR BRISS: Other thoughts on the
7 gap?

8 MEMBER PINDOLIA: I just had a comment
9 for clarification. So, I notice that every year,
10 it's been getting worse instead of better and I
11 was trying to understand -- and it's a pretty
12 drastic drop from 82 to 52 percent, but then you
13 had a higher percent of eligibles, so is it just
14 you've got more people and it really shows the
15 problem is worse than what we thought?

16 MS. WELLS: Exactly.

17 MEMBER PINDOLIA: Okay.

18 MS. WELLS: The pool of reporters went
19 from, I think, about 1700 to 61,000 between 2012
20 and 2014. So, we wouldn't expect stable
21 performance. And we think a lot of physicians
22 are really working on the reporting mechanism at

1 this time, more so than the performance rate.

2 MS. SOMPLASKY: CMS, as more providers
3 have moved to Alternative Payment Models or
4 Advanced Payment Models, this is a required
5 measure if you are in an ACO and it comes in
6 under the claims version, under that group
7 reporting. So, we saw a big upsurge as more and
8 more providers started falling under that ACO
9 umbrella.

10 CO-CHAIR BRISS: You see this in nearly
11 every quality measure that I've ever looked at.
12 As the -- in the early years, the people that
13 were reporting on measures, as a general rule,
14 were kind of high performers and as you get a
15 broader pool, the average goes down.

16 So, it sounds like there's a thought
17 on the table that there may be a remaining
18 performance gap. Anybody else want to make -- do
19 we need to vote this criterion? Yes. Anybody
20 else have anything they want to say before we
21 vote?

22 CO-CHAIR PINCUS: We don't need to

1 vote.

2 DR. LUSTIG: Sorry. The first measure
3 always takes a while, especially with a new
4 process. We did not have to vote on evidence,
5 but we do vote on gap.

6 CO-CHAIR PINCUS: Oh, we do vote on
7 gap?

8 DR. LUSTIG: Yes.

9 CO-CHAIR BRISS: Because the gap could
10 have closed.

11 DR. LUSTIG: Right.

12 MS. QUINNONEZ: Are we ready to vote on
13 gap? Okay. We are now voting on gaps for
14 measure 3148: Preventative Care and Screening:
15 Screening for Clinical Depression and Follow-Up
16 Plan. I will give you your options.

17 For those of you who are on the phone,
18 if you could send Kirsten your chat message, your
19 vote over the chat line, that would be great, and
20 we'll calculate that for you. For all those
21 others in the room, if you would just direct your
22 clickers this way and I will read you your

1 options.

2 For performance gap of measure 3148,
3 Option 1 is high, Option 2 is moderate, Option 3
4 is low, and Option 4 is insufficient. Voting for
5 the gaps for measure 3148: Option 1, high; Option
6 2, moderate; Option 3, low; and Option 4,
7 insufficient.

8 We'll give you a second for all your
9 votes to get in. Okay. All votes are in and
10 voting is now closed. The results for
11 performance gap of measure 3148: 74 percent voted
12 high, 26 percent voted moderate, zero percent for
13 low, and zero percent for insufficient. So, this
14 passes with 74 percent.

15 CO-CHAIR BRISS: So, I think that moves
16 us to our reliability discussion, is that right?
17 So, anybody want to tee up reliability of the
18 measure for us? So, let's let somebody other
19 than Jeff take a turn. Maybe, David, you want to
20 -- can you tee up reliability for us?

21 MEMBER EINZIG: So, I don't know if I'm
22 the best person to speak on reliability and

1 validity, I'm not the statistician. If any other
2 takers want to do it? I certainly can otherwise.
3 All right.

4 CO-CHAIR BRISS: Why don't you take a
5 first shot and --

6 MEMBER EINZIG: Okay.

7 CO-CHAIR BRISS: -- we'll go around the
8 table if we need to?

9 MEMBER EINZIG: So, I'm just going to
10 go with using the guidance from the -- going off
11 comments. The preliminary rating for reliability
12 was high from the Committee. I really have
13 nothing to add to that, other than just that.

14 CO-CHAIR BRISS: Anybody like to add?

15 MEMBER SUSMAN: Ditto.

16 (Laughter.)

17 CO-CHAIR BRISS: Yes, Harold?

18 CO-CHAIR PINCUS: So, I had a question
19 about the reliability for the follow-up
20 information, because it seems to me that that is
21 potentially more problematic. And so, what do we
22 know about that right now?

1 MS. WELLS: Well, I think the follow-up
2 can be a feasibility issue, in terms of
3 collecting it. Although that affects the
4 performance score and even -- so the performance
5 scores themselves we did find to be highly
6 reliable in that the ratio of signal to noise was
7 high. And that was true for even clinicians with
8 fewer than ten patients.

9 MS. SOMPLASKY: For the claims and
10 registry version that we're currently discussing,
11 there are HCPCS codes that allow them to document
12 the follow-up plan. And it says that they either
13 have or they have not. Much easier, when we get
14 to the eMeasure, being able to have that in a
15 reported field. But on the claims and registry,
16 it was much more reliable.

17 MEMBER SUSMAN: Isn't the big issue, to
18 me is, measuring a plan versus measuring what
19 actually happens and persistence of treatment?
20 Which presumes that the data is available. So,
21 in some ways, I think the bar is low enough that
22 there's probably pretty good reliability here.

1 CO-CHAIR PINCUS: Is there a concern
2 that the bar is too low?

3 MEMBER SUSMAN: -- for the bar, so I'm
4 not sure putting it higher will make it easier.
5 Only if you put it high enough that we can walk
6 under the bar.

7 CO-CHAIR PINCUS: Lisa?

8 MEMBER SHEA: I was just interested in
9 one of the exclusions, of people who refuse, and
10 how often that's used, because it seems to me
11 people who are depressed might be more inclined
12 to not want to engage in any kind of activity.

13 MS. WELLS: Right. So, people who are
14 actively diagnosed with depression are actually
15 excluded from the measure. I think the
16 assumption is that they're already in treatment,
17 so they don't need to be screened again.

18 (Off microphone comment.)

19 MS. WELLS: Well, I know in the
20 eMeasure, we actually see very low patient
21 refusals. Let me check on the claims/registry.
22 I believe our exclusion rate was -- I think it

1 was fairly low for patient refused. We're seeing
2 most of it coming out of the active diagnosis of
3 depression.

4 And that's a great question, because
5 a patient refusal can be -- it's kind of -- it's
6 got its pluses and minuses in a measure. I think
7 our perspective is that we're concerned about
8 clinician/patient tension if patients refuse the
9 measure and then that affects the clinician's
10 score. So, we do keep that in there, but we
11 actually don't see it used very often.

12 MEMBER LARDIERI: Yes, and just a
13 question. So, how do those G-codes get entered?
14 And providers, and I'm concerned about the ones
15 where they say they didn't do something, they
16 actually enter that, and where?

17 MS. SOMPLASKY: That is part of -- so,
18 within folks who may -- we have many folks who
19 have an EHR and are still reporting that registry
20 version, and that just gets into a whole
21 different set of issues with vendors' ability to
22 report these measures.

1 But those HCPCS codes are loaded. For
2 folks who really still are on paper, those HCPCS
3 codes are part of their super-bill, if you will,
4 that they are picking when they report the
5 measure.

6 And you do, for PQRS, report your
7 intention to be reporting certain measures.
8 That's something that you are setting up as part
9 of your submission, if you will.

10 MEMBER LARDIERI: And when PQRS goes
11 away?

12 MS. SOMPLASKY: It's now -- as I said,
13 it will be in the MIPS program. The claims and
14 registry version will remain in case those
15 providers not included in this new QPP program,
16 such as social workers, psychologists, physical
17 therapists, folks who have traditionally been
18 reporting this are able to still report it, it's
19 just not going into a payment program.

20 MEMBER JENSEN: I have a question about
21 exclusions. So, patients are excluded if they
22 come in for emergent visit, which makes sense to

1 me. But what if that emergent visit is a result
2 of some risk-taking behavior that is related to
3 depression? Do you know what I'm saying, does
4 that make sense?

5 MS. WELLS: Yes. And, actually, the
6 medication exception allows providers to still
7 screen those patients and include them in the
8 denominator and numerator if a depression
9 screening is appropriate.

10 CO-CHAIR BRISS: And it might help for
11 all the exclusions just to have a sense of how
12 important that is, it sort of relates to how
13 often it's taken. So, are any of the exclusions
14 common?

15 MS. WELLS: The active diagnosis of
16 depression is by far the most common --

17 CO-CHAIR BRISS: Okay.

18 MS. WELLS: -- exclusion that we see,
19 yes.

20 MEMBER MAZON JEFFERS: I had just a
21 question back to is the bar too low point that
22 was raised earlier. And it's hard for me to

1 think about this in a vacuum, are there other
2 measures that are looking a little bit more
3 closely at the quality of the plan that's in
4 place and whether or not that plan has been acted
5 upon? Could you just put it in context for me?

6 MS. SOMPLASKY: We are the only measure
7 that actually asks for a follow-up plan. And
8 that's been the differentiator. There are a few
9 measures that have not sought to get their re-
10 endorsement for NQF that were doing screenings,
11 but they are no longer NQF measures.

12 But we're the only one who is looking
13 for and asking for documentation of a plan. We
14 then -- we don't get into being prescriptive,
15 though, what that plan has to be, because we
16 don't want to scare people off from doing that
17 basic important screening.

18 MEMBER COLEMAN: I just wanted to
19 mention that, I guess, I think it's important to
20 also screen those with depression and bipolar.
21 And, in fact, we know primary care has challenges
22 in treating those folks, so I'm not sure why you

1 would exclude them.

2 In my mind, the prevalence is going to
3 be way higher in that population, of sorts, and
4 the assumption that they're getting treatment is
5 probably not a good one in primary care in
6 general. So, I just think it would be great if
7 you would think about including them.

8 MS. SOMPLASKY: The focus when this
9 measure was initially developed, CMS wanted to
10 see screenings done. We were not looking to
11 treat, because, again, we don't want to scare off
12 those folks who otherwise feel like, wait a
13 minute, now I'm going to be responsible for
14 treating that depression. We're trying to
15 identify new cases and make sure that they get
16 the follow-up that they need.

17 MEMBER COLEMAN: I guess with the --
18 but you are following to see if there's a
19 treatment plan, so I think anybody who's
20 suffering a current period or episode of
21 depression should have some sort of treatment
22 plan. And I just think it's not the best

1 assumption to assume that because they have a
2 diagnosis, they are in treatment or have a
3 treatment plan. If that makes any sense.

4 MEMBER PATING: Just wanted to ask a
5 question between this and other measures, I don't
6 know if that should be now or in any kind of
7 harmonization discussion. But the NCQA
8 depression measure, I can't remember, first of
9 all, whether we have reviewed that here and
10 whether that is a competing, you consider that a
11 competing measure.

12 MS. WELLS: So, we talked to NCQA and
13 they let us know that they actually didn't submit
14 their depression measures for re-endorsement.
15 So, I actually don't think those are in use
16 currently, that's my understanding.

17 MEMBER PATING: Okay.

18 CO-CHAIR PINCUS: Yes. I just want to
19 endorse what Shane was saying. Actually, a
20 number of years ago, Jurgen Unutzer, Wayne Katon,
21 and I did a study looking at claims, from a large
22 group of Medicare patients, looking at claims

1 compared to PHQ-9 scores and found that, if you
2 were looking for the people who were really
3 depressed, it was the people that were currently
4 in treatment.

5 CO-CHAIR BRISS: Raquel?

6 MEMBER MAZON JEFFERS: Does the -- if
7 someone has a -- if someone is receiving a
8 prescription for a psychopharmaceutical for
9 depression, does that include -- is that counted
10 as a treatment plan?

11 MS. SOMPLASKY: They would be excluded
12 from the denominator, because they would already
13 be considered to have a diagnosis of depression.

14 MS. WELLS: If the pharmaceutical was
15 in response to the screening, they would be
16 captured as a -- that would count as a follow-up.

17 MS. SOMPLASKY: With a new.

18 MS. WELLS: Correct.

19 DR. LUSTIG: If I could just jump in to
20 make a clarification, measure 0518, actually
21 they've withdrawn from consideration for
22 endorsement. We do still have some measures in

1 our pediatric and child portfolios, but that
2 measure is no longer related or competing.

3 CO-CHAIR BRISS: So, does anybody have
4 anything that hasn't been said that they'd like
5 to get on the table before we vote on
6 reliability? Hearing none, let's try to vote.

7 MS. QUINNONEZ: Voting is now open for
8 the reliability of measure 3148: option 1, high;
9 option 2, moderate; option 3, low; and option 4,
10 insufficient. We are now voting on the
11 reliability of measure 3148: option 1, high;
12 option 2, moderate; option 3, low; and option 4,
13 insufficient.

14 All votes are in and voting is now
15 closed. For the reliability of measure 3148: 35
16 percent voted high, 61 percent voted moderate,
17 four percent voted low, and zero percent voted
18 for insufficient.

19 CO-CHAIR BRISS: So, that passes and we
20 can move on to validity. And maybe, Shane, would
21 you be willing to speak first on this point?

22 MEMBER COLEMAN: Sure. Which, sorry,

1 which one are we on again?

2 CO-CHAIR BRISS: Validity.

3 MEMBER COLEMAN: So, I think we've
4 already talked about some of this. I think the
5 validity data looked pretty good. I was a little
6 bit confused about some of the G-codes that were
7 included in the numerator.

8 I thought that it was saying that
9 there was no documentation that the screening had
10 occurred and it was still be counted, I thought,
11 which I wasn't sure about. But, overall, I
12 actually thought the data looked good. Let me
13 look at my other comments.

14 MS. WELLS: So, if I could clarify your
15 question about the G-codes. There's sort of two
16 rates, there's the reporting rate and the
17 performance rate. And so, the four G-codes that
18 are showing in the numerator are actually for the
19 reporting rate.

20 And so, that includes patients who
21 both met the numerator and did not. But for the
22 performance rate, if there was no screening or if

1 there was a screening without follow-up, that
2 actually is not in the numerator.

3 MEMBER COLEMAN: I think I probably
4 gave my other comment a little bit early. That
5 is, including those with the diagnosis of
6 depression or bipolar, maybe speaks more to
7 validity than reliability, so I guess I'd kind of
8 move that into this segment.

9 CO-CHAIR BRISS: Would any of the other
10 primary discussants -- Connie?

11 MEMBER HORGAN: I agree with the
12 previous comments. I'd like to question the new
13 testing that was done on the face validity with
14 the 12 clinicians. That seems like a small
15 number, could you talk a little bit about the
16 noes or the disagree? I think it was about 25
17 percent?

18 MS. WELLS: Sure. So, the noes
19 mentioned things related to documentation burden.
20 One wanted more specificity around the
21 instruments that we use, but we actually wanted
22 to be open-ended so that physicians could use, as

1 long as they were valid instruments, that they
2 could use the ones that they were comfortable
3 with. And I believe those were the major
4 concerns that were raised.

5 MEMBER SUSMAN: I think my biggest
6 concern about this is just around frequency. And
7 I wonder if developers have investigated this at
8 all, or in your review of the literature, around
9 screening each visit versus some specified period
10 of time. Recognizing that depression is a waxing
11 and waning phenomenon.

12 MS. SOMPLASKY: We have not found any
13 evidence with a recommended frequency. We do not
14 require every visit, we require it to be once in
15 that screening year.

16 They can screen more and we look at
17 the -- if something has changed, if a patient has
18 come in, for example, with weight loss and that
19 physician feels like maybe we ought -- even
20 though six months ago, you were okay, let's
21 screen again. But we only ask for it once in
22 that reporting period.

1 MEMBER SUSMAN: And that's fine. I'm
2 not -- I don't think this is a major issue from
3 my perspective. I don't know about --

4 CO-CHAIR BRISS: And it looks like,
5 Les, is your card up?

6 MEMBER ZUN: Let me try this again.
7 I'm a little concerned that there is no empiric
8 validity data for this measure. I just -- why is
9 there reliance on the face validity?

10 MS. WELLS: There's a few reasons. We
11 weren't able to find, like, a comparable measure
12 with the same population to do a more empirical
13 validity testing, we did look into that. We
14 would have liked to have included data element
15 validity, unfortunately, we had a very
16 constrained timeline. Just to be very candid
17 with you, we were unfortunately unable to get
18 that data together in time.

19 CO-CHAIR BRISS: And is there more that
20 should be said about threats to validity? We've
21 talked about exclusions already at some length.
22 Any inappropriate exclusions and anything else

1 anybody wants to talk about?

2 MEMBER PARISH: The one exclusion that
3 hasn't been mentioned would be adjustment
4 disorder with depressed mood, where you would
5 have a treatment plan that may be overly
6 aggressive when it's an adjustment disorder
7 versus depression.

8 CO-CHAIR BRISS: So, are you arguing
9 that there might be an -- you might want to add
10 an exclusion? Is that what you're -- is that the
11 argument you're making?

12 MEMBER PARISH: Yes.

13 MS. WELLS: An exclusion for, I'm
14 sorry, did you say adjustment disorder?

15 MEMBER PARISH: With depressed mood.

16 MS. WELLS: Oh, okay. Thank you for
17 that, we'll look into it.

18 CO-CHAIR PINCUS: And just a little bit
19 more about the rationale for why that should be
20 excluded?

21 MEMBER PARISH: If someone comes in
22 with an adjustment disorder with depressed mood,

1 to have a requirement, grant it with a treatment
2 plan that requires referral to a licensed
3 counselor or psychologist/psychiatrist or be put
4 on medication, that might be overly aggressive
5 when they may need more of a pastoral counselor
6 or other social supports.

7 MS. SOMPLASKY: We are not prescriptive
8 as to what that follow-up plan is. So, if they
9 referred to a pastoral counselor, that meets the
10 intent of the measure. That was just an example,
11 about referred to a psychiatrist or psychologist
12 or medication. A follow-up plan could also be,
13 have the patient return to clinic in two weeks to
14 do another recheck and perhaps rescreen.

15 CO-CHAIR PINCUS: So, which is
16 basically watchful waiting?

17 MS. SOMPLASKY: As long as the
18 documentation is there.

19 DR. LUSTIG: And I just want to clarify
20 that, in terms of NQF process, we don't require
21 score-level validity and we don't require updated
22 testing if it has passed. I mean, we can still

1 discuss it, but those are what our criteria are.

2 MEMBER SUSMAN: When you say, score-
3 level validity, are you talking about elements
4 within or the total score? I'm trying to -- I'm
5 a little lost.

6 DR. LUSTIG: I would do my best, but
7 I'm going to rely on my statistician over here.

8 MS. JOHNSON: So, the data element
9 validity is things like checking inter-rater
10 reliability --

11 MEMBER SUSMAN: Right.

12 MS. JOHNSON: -- looking at the
13 individual data elements and comparing, make sure
14 you can consistently pull those. Score-level
15 validity, that's the NQF-speak for looking at the
16 results and comparing results.

17 So, often, you might see, looking at
18 things like how does this measure track with
19 other measures, if they are available? And
20 sometimes it's hard to find measures that you can
21 correlate with.

22 MEMBER SUSMAN: Okay.

1 MS. JOHNSON: That sort of thing.

2 MEMBER SUSMAN: Thank you.

3 CO-CHAIR PINCUS: Tami?

4 MEMBER MARK: So, what is the validity
5 requirement? I mean, you're essentially saying
6 there's no need to recheck validity for the
7 maintenance measures?

8 MS. JOHNSON: We do not require, at
9 this point, that developers retest. It would be
10 great if they did, but we do understand there are
11 resource constraints that may prohibit that.

12 CO-CHAIR BRISS: Rhonda?

13 MEMBER ROBINSON BEALE: I have a
14 question under exclusions, I'm not quite sure I
15 understand. Under exclusion, you said situations
16 where the patient's functional capacity, I
17 understand that one, or motivation to improve may
18 impact the accuracy of results in the
19 standardized depression assessment tool.
20 Question, give me an example of a patient with
21 motivation to improve may impact the accuracy of
22 the results?

1 MS. SOMPLASKY: We have had -- one of
2 the discussions that came up with our expert work
3 group were patients who were being forced to be
4 examined. We've had juvenile cases where they
5 were asked to be evaluated and there's
6 noncompliance, they don't want to be part of the
7 screening.

8 Or we also had, with certain prison
9 situations, where the patients were saying that
10 they were depressed and there were questions
11 about it. So, it was an exclusion for that
12 provider to be able to make that judgment.

13 MEMBER ROBINSON BEALE: So, the reason
14 why I ask this is that the -- in health plans,
15 you look for ways of understanding whether or not
16 the primary care practice is screening
17 sufficiently enough. This exclusion is kind of
18 unclear. If I was a practitioner and didn't ask
19 that question, I really wouldn't have known what
20 that meant.

21 My concern is that, as a plan, I would
22 use this measure to understand whether or not

1 enough screening is going on. With the provider
2 being able to exclude certain people out of that
3 denominator, I'm not sure it's giving me a good
4 reading on the completeness of their applying the
5 screening for depression in a population 12 years
6 and older. Does that make sense?

7 MS. WELLS: It does, and thank you for
8 that. Again, I think this is one of those things
9 in measurement where there's pluses and minuses.
10 And we didn't want physicians to be held
11 accountable for screening people who are court-
12 mandated to be screened and where the treatment
13 wasn't likely to yield much. So, we give them
14 the option to take them out or keep them in, but
15 I do appreciate your point.

16 CO-CHAIR BRISS: One thing that I think
17 might help you as you think about submissions in
18 the future is giving us a sense of, perhaps a
19 better sense of how many total people are being
20 excluded. Sorry. One thing that might help you
21 in future submissions is giving us a better sense
22 of how many total people are being excluded.

1 MS. WELLS: Yes. And we actually
2 didn't see -- I don't know that we saw anybody
3 excluded for that particular. We saw some with
4 the patient refusal or emergent medical, although
5 I don't think we actually observed any in that
6 particular exception.

7 MEMBER ROBINSON BEALE: I think, if
8 people are using this for accountability, I think
9 that would be helpful and that's a good
10 suggestion, Peter, to be able to collect that
11 kind of information.

12 CO-CHAIR PINCUS: One question about
13 clarification and the second one just in terms of
14 validity. So, in terms of clarification, this
15 applies not just to primary care providers, it
16 applies to all specialists, including behavioral
17 health specialists. Just to clarify that.

18 Number two, in terms of the validity
19 data, it seems to me, since this is a registry or
20 claims-based data, the important thing is to see
21 whether what people sort of put down on a claim
22 has actually happened and whether it's documented

1 in the chart. And it looks like there was
2 reasonable kappas as you did that.

3 The question I had had to do with the
4 representativeness of the population of
5 physicians that you looked at. And it comes up
6 because I recently reviewed a paper that actually
7 showed very high performance on this and other
8 ratings, but it turned out to be -- it was
9 particularly large, highly infrastructured
10 primary care organizations.

11 And I just want to get a sense of what
12 kind of practices were looked at in terms of the
13 physicians that were included in the validity
14 study.

15 MS. SOMPLASKY: For the claims and
16 registry, we do a random sampling. Now, it's
17 voluntary for those practices to submit the copy
18 of their charts. We do reimburse for the
19 copying, but, again, we can't make it mandatory
20 for them to send it in. So, I don't know, we
21 just do a representative of the claims and --

22 CO-CHAIR PINCUS: So, all --

1 MS. SOMPLASKY: Yes.

2 CO-CHAIR BRISS: So, Raquel? I'd like
3 to move us pretty quickly towards a vote on this
4 criterion. So, Raquel?

5 MEMBER MAZON JEFFERS: Yes. So,
6 exactly the question you just brought up, this
7 measure is not only for use in a primary care
8 setting, but also in a behavioral health, like
9 specialty care setting regular outpatient
10 program.

11 So, I have trouble getting my head
12 around the first part of a screening in an
13 outpatient setting, because someone has showed up
14 for an outpatient visit in a specialty care
15 setting, I don't believe they need to be
16 screened. What you're really testing is whether
17 they have a plan in place, is that how you see
18 this measure applying in that setting?

19 MS. SOMPLASKY: No. It's open to --
20 there are people who maybe don't have that
21 diagnosis of depression and are being seen by
22 behavioral specialists or psychologists and

1 social workers, who can also report this,
2 physical therapists, occupational therapists.
3 So, it's just part of that assessment of that
4 patient, the overall assessment.

5 MEMBER MAZON JEFFERS: But a screening
6 is different than a diagnosis.

7 MS. SOMPLASKY: Correct. And that's
8 what we're saying is that we are trying to
9 increase the screening rates to get to a point of
10 diagnosing that depression.

11 CO-CHAIR BRISS: All right. So, I see
12 no further cards up. I'd like to try to move us
13 towards a vote on validity and see if we can get
14 through another vote.

15 MS. QUINNONEZ: Voting is now open for
16 the validity of measure 3148: Option 1 is
17 moderate; option 2 is low; and option 3,
18 insufficient. Option 1, moderate; option 2, low;
19 and option 3, insufficient.

20 DR. LUSTIG: And I just should have
21 jumped in to say, this is one of those cases
22 where when you follow our algorithm, the highest

1 possible rating is moderate, because of the lack
2 of score-level testing.

3 MS. QUINNONEZ: Okay. All votes are in
4 and voting is now closed. For the validity of
5 measure 3148: 78 percent voted moderate, 13
6 percent voted low, nine percent voted
7 insufficient. So, this passes with moderate.

8 CO-CHAIR BRISS: So, we're getting
9 close to the final turn.

10 (Laughter.)

11 CO-CHAIR BRISS: The feasibility to
12 measure, how about, Andrew Sperling, can you tee
13 this up for us? Or did I do this wrong? I'm
14 sorry, Andrew, I called on the wrong person. No
15 wonder I was getting that look. Connie, can you
16 tee this up for us?

17 MEMBER HORGAN: It's highly feasible on
18 everything that was noted.

19 CO-CHAIR BRISS: All right. Is --

20 MEMBER HORGAN: Do you want me to go
21 through it?

22 CO-CHAIR BRISS: So, adequate

1 feasibility, if you think it's straightforward,
2 there's nothing wrong with being straightforward.
3 Shane, wanted to add something?

4 MEMBER HORGAN: They only provided the
5 feasibility on electronic sources, they did not
6 report any implementation challenges at all.

7 CO-CHAIR BRISS: Shane?

8 MEMBER COLEMAN: I think my question
9 around feasibility was just around the treatment
10 planning piece, which corresponds to each of
11 those pieces that were acceptable as the
12 treatment plan and how does it kind of fall out
13 across systems, I guess, in a standardized way?

14 MS. WELLS: Sure. So, with the
15 claims/registry version, they do make use of the
16 HCPCS codes for reporting. And so, they select
17 one of six and that would decide whether it's
18 excluded or meets or fails performance. And so,
19 that's why the feasibility of the claims/registry
20 is pretty straightforward.

21 CO-CHAIR BRISS: Anybody have anything
22 to add? Why don't we try to vote on feasibility,

1 please?

2 MS. QUINNONEZ: Voting is now open for
3 the feasibility of measure 3148: Option 1, high;
4 option 2, moderate; option 3, low; and option 4,
5 insufficient. For the feasibility of measure
6 3148: Option 1, high; option 2, moderate; option
7 3, low; and option 4, insufficient.

8 Looking for one more vote, if you
9 could direct your clickers this way. Okay.
10 Voting is now closed. For the feasibility of
11 measure 3148, the results are: 55 percent voted
12 high, 41 percent voted moderate, five percent
13 voted low, and zero percent for insufficient.
14 This passes.

15 CO-CHAIR BRISS: So, that gets us to
16 the last one, usability and use. Maybe, Connie,
17 can I call on you again to do the last -- to
18 bring us home? Usability and use?

19 MEMBER HORGAN: I don't -- oh, yes.
20 The usability, it was widely used in various CMS
21 programs. It will be replaced by MIPS and has been
22 --

1 CO-CHAIR BRISS: Closer.

2 MEMBER HORGAN: Closer?

3 MEMBER SUSMAN: You got to get right --

4 MEMBER HORGAN: Oh, I'm sorry. It is
5 widely used in various CMS programs. And the
6 only concern I have, which was raised earlier,
7 was the performance declining over time from 2011
8 to 2014, from 82 percent to 52 percent, but it
9 was explained by the number of professionals
10 increasing. It still is not widely used, so we
11 are sort of angels dancing on the head of a pin
12 when you have such small numbers. That was a
13 highly statistical statement, I think.

14 (Laughter.)

15 CO-CHAIR BRISS: Anybody else want to
16 add to that? David?

17 MEMBER EINZIG: So, just in terms of
18 leading to improved outcomes, it would be nice to
19 see more data on, if this is used, does it
20 actually lead to improve outcomes? Do people
21 actually follow through with the treatment plan
22 and does it help?

1 And then, on another level, and this
2 is sort of my soapbox, but I think there's a lack
3 of treating in primary care, where they can
4 screen for things, but then as far as actually
5 treating, I think more focus should be put on
6 earlier levels of folks in medical school and
7 nursing school and residency programs and look
8 more at piece also.

9 MEMBER PATING: My question is on the
10 usability of the measure. With the declining
11 averages, how does that affect reporting and
12 percentiles over time? I could see you can still
13 use it for quality improvement internally, but
14 for external comparisons, I just was wondering,
15 what's been the impact of that, when you're
16 comparing across plans?

17 MS. SOMPLASKY: We don't compare across
18 plans. We -- the only claims that we have access
19 to and look at are the CMS Medicare claims. So,
20 we don't have anything across other plans, we
21 don't have access to that.

22 MS. WELLS: Just to add to that, I

1 think what might be happening with the
2 performance rate, again, is that there's a lot of
3 new participants in the program that are really
4 focused on their reporting mechanism, and it
5 might be part of an annual wellness visit menu of
6 screenings, that kind of thing.

7 So, we think that they're focused on
8 reporting more than performance right now,
9 because I don't believe there are penalties on
10 this data on their pay just yet. So, hopefully
11 that would -- that allows them to kind of get the
12 process in place before those penalties get -

13 MEMBER PATING: I think that's really
14 my concern. So, if this ever gets incorporated
15 into any sort of Stars measure and the n keeps
16 changing or the denominator keeps changing and
17 driving down the average, you just get really
18 skewed performance year-over-year. So, I would
19 hope the measure gets more stability before you
20 develop that as a publicly accountable measure.

21 MEMBER ROBINSON BEALE: I think David
22 kind of asked the question I had, and that was,

1 the usability of this measure as a comparative
2 measure, and I think you've answered that that
3 was not the way it was designed at this point.
4 Then, let me understand, what was the purpose of
5 the measure in terms of how you are using it? In
6 terms of your organization?

7 DR. GREEN: I can take this one. This
8 is Dan Green from CMS. So, we're using the
9 measure to identify, obviously, the under-
10 diagnosis of depression and encourage primary
11 care, or any physician or caregiver that wants to
12 participate in the measure, to screen their
13 patients for depression. I think the declining
14 numbers with more people reporting it is good
15 evidence of a gap and an opportunity for
16 improvement.

17 In terms of publicly reporting these,
18 I mean, any measure that are in our quality
19 programs, PQRS currently or PQRS through 2016 and
20 MIPS going forward, could be reported publicly.
21 That's not to say that we will report every
22 single measure, but any measure that's not in its

1 first year of use could be reported.

2 As far as payments, we look at the
3 benchmark for the measure and depending on
4 whether someone is above or below the benchmark
5 would determine whether or not they receive
6 actually an incentive versus a neutral adjustment
7 or a payment adjustment, based on that particular
8 measure. But, obviously, that's only one small
9 part in the whole MIPS program scoring.

10 MEMBER ROBINSON BEALE: So, thank you
11 for that explanation. So, just a question, in
12 the way that it was field tested, were providers,
13 did they know or was there an incentive or
14 disincentive attached to this process at the time
15 it was being tested?

16 MS. SOMPLASKY: No, we --

17 DR. GREEN: What year did we do that,
18 guys?

19 MS. SOMPLASKY: We tested it last year.
20 Providers did not receive compensation for
21 participating and they didn't know we were
22 collecting their data --

1 MEMBER ROBINSON BEALE: Okay.

2 MS. SOMPLASKY: -- for, obviously --
3 that was a claims data analysis that was done.
4 But those that did participate and provided us
5 with an interview and feedback were given a small
6 incentive for participation in that, because we
7 were onsite, we did work -- and that's as we get
8 to the eCQM, but that involved workflow analysis,
9 provider time, staff time.

10 MEMBER ROBINSON BEALE: Okay.

11 DR. GREEN: And there was potential
12 compensation from the PQRS and value modifier
13 program, but not specifically -- it wasn't
14 identified that this particular measure would get
15 you in the positive or negative adjustment. It
16 was just one of the measures as part of the
17 requirement that you could report as part of the
18 requirements for the programs.

19 MEMBER ROBINSON BEALE: And the
20 benchmarking that you mentioned, that was based
21 on your organization and those who were field
22 tested?

1 DR. GREEN: So, the benchmarking is
2 particularly important for the MIPS program and
3 it is based on historical data that we have for
4 the measure. Or if there are national standards,
5 I believe they will be factored in, but I'm not
6 100 percent on that.

7 MEMBER ROBINSON BEALE: Thank you.

8 DR. GREEN: They're certainly based on
9 our information.

10 CO-CHAIR BRISS: So, we're -- as
11 sometimes happens on the first one, we're a
12 little bit behind. I have three more cards up,
13 if we could go quickly through those three people
14 and then, let's try to move to a vote. So, Tami?

15 MEMBER MARK: Yes. Just to follow up
16 on David Einzig and Brooke Parish's point about
17 screening and the relationship to good treatment,
18 is there any thought about harmonizing this
19 measure with the PHQ-9 depression measure?

20 MS. SOMPLASKY: We've had discussions
21 with our expert work group about it, but right
22 now, they feel that our piece with the screen and

1 because we're not prescriptive about it being the
2 PHQ-9 that is used, we've not had any further
3 discussions about it. But it is part of the
4 discussions that we have with our expert work
5 group.

6 CO-CHAIR BRISS: Shane? Or maybe, no,
7 I'm sorry, Les?

8 MEMBER ZUN: So, I have one concern.
9 I think, conceptually I think this is a great
10 measure, but I'm reading the one denominator
11 exclusion that is problematic, patients in an
12 urgent or emergent situation where time is of the
13 essence, blah, blah, blah.

14 Well, emergency departments are quite
15 a unique place, where the patient may wait in the
16 waiting room for a long time, but this is a very
17 problematic burden, because if I identify someone
18 who is depressed, then what am I doing there? Do
19 I have the resources to provide that patient, if
20 they screened in? And there are so many other
21 screens that we have to do in emergency medicine,
22 that I --

1 MS. SOMPLASKY: This is not for
2 emergency medicine, this is outpatient codes
3 only.

4 MEMBER ZUN: Well --

5 MS. SOMPLASKY: So, we --

6 MEMBER ZUN: -- if it's an outpatient
7 code, that would be emergency medicine codes,
8 because they're all outpatient codes.

9 MS. SOMPLASKY: And they -- I'm sorry,
10 I should be clearer --

11 DR. GREEN: I think she means E/M
12 codes.

13 MS. SOMPLASKY: The evaluation and
14 management codes for emergency medicine are
15 excluded from this measure.

16 MEMBER ZUN: Okay. Thank you.

17 CO-CHAIR BRISS: You get the final
18 word.

19 MEMBER SHEA: Yes, thank you. I was
20 just wondering, in terms of, I know as people are
21 reporting in, that 7.5 percent of the eligible
22 professionals reported in, how does that compare

1 with other measures? Are they not choosing this
2 measure as much as others or -- just maybe as an
3 indicator of the usability of it.

4 MS. WELLS: I think it's in the top 20,
5 maybe, it's definitely not, like, in the top
6 five, but we're seeing it get reported a lot
7 more, I think because it aligns with a lot of
8 programs out there with ACOs and so forth.

9 CO-CHAIR BRISS: So, with that, let's
10 try to move to vote on usability and use.

11 MS. QUINNONEZ: Voting is now open for
12 the usability and use of measure 3148: Option 1,
13 high; option 2, moderate; option 3, low; and
14 option 4, insufficient information. We're voting
15 on usability and use of measure 3148: Option 1,
16 high; option 2, moderate; option 3, low; and
17 option 4, insufficient information.

18 Yes, it will capture your last vote.
19 Voting is now closed. For the usability and use
20 of measure 3148: 14 percent voted high, 77
21 percent voted moderate, nine percent voted for
22 low, and zero percent for insufficient

1 information. This passes with a moderate.

2 CO-CHAIR BRISS: All right. So, this
3 measure, we don't actually have to talk about
4 related and competing measures, so I think we've
5 successfully completed our first one.

6 DR. LUSTIG: Actually, the one that --

7 CO-CHAIR BRISS: But we have an overall
8 --

9 DR. LUSTIG: -- we had on the PA has
10 been withdrawn for consideration, so there's no
11 longer a related measure to discuss. Measure
12 0518.

13 CO-CHAIR BRISS: And do we have an
14 overall vote on it?

15 DR. LUSTIG: So, we have to do an
16 overall vote.

17 CO-CHAIR BRISS: Okay. So, one more
18 set. Anybody have final words before we do an
19 overall vote on the measure? So, let's vote one
20 more time.

21 CO-CHAIR PINCUS: Actually, I just had
22 one comment, just in terms of the related and

1 competing. At some point, we may want to look
2 over the range of depression measures and look at
3 the span of them and their interrelationship.
4 Not right now, but I think at some point, I think
5 it would be a good idea.

6 CO-CHAIR BRISS: David?

7 MEMBER PATING: I'm thinking
8 specifically the Minnesota Community Measurement,
9 NQF 0711 and 1884. Those are the ones that I was
10 referring to earlier with NCQA.

11 MEMBER GROSS: And, Charlie Gross, with
12 Anthem. Just to follow up, Harold, to your
13 point, in terms of how we vote yes/no, I mean,
14 I'm going to vote yes on this, it's useful, but
15 the competing measures from an operating
16 perspective and a provider prescriptive is
17 overwhelming.

18 So, while these things are very
19 useful, the reality is, if multiple measures are
20 out there for the same dimension, many providers,
21 sort of learned helplessness, wonder, which ones
22 should I use, and sometimes the default is, I

1 don't use any of them.

2 So, I think the, not the developers of
3 the measure, but I think NQF needs to wrestle
4 with that issue, because it's a huge one, both
5 from the provider perspective and the payer
6 perspective, when we go out and say, which of
7 these alternative measures should we be rolling
8 into our value-based purchasing agreements?

9 DR. GREEN: Peter, can I just comment
10 real quick on that?

11 CO-CHAIR BRISS: Yes, Dan.

12 DR. GREEN: Thank you. So, I think
13 that's an excellent point. And I'm sure as you
14 know, we are part of the AHIP group that is
15 looking to have a harmonized or adopt particular
16 measures that all the insurance companies can
17 agree on. So, I'm not sure that we've hit mental
18 health yet, but I think that's a great
19 suggestion. I'm sure it will be on one of the
20 panels in the future. Thank you.

21 CO-CHAIR BRISS: Anybody else have any
22 urgent things that they want to say before we do

1 an overall vote? Seeing no cards, so, this one
2 is simpler, yes or no.

3 MS. QUINNONEZ: Voting is now open for
4 the overall suitability for endorsement of
5 measure 3148: Option 1, yes; option 2, no. We
6 are voting on the overall suitability for
7 endorsement of measure 3148: Option 1, yes;
8 option 2, no.

9 All votes are in and voting is now
10 closed. For the overall suitability for
11 endorsement of measure 3148: 100 percent voted
12 Yes.

13 CO-CHAIR BRISS: I don't know that I've
14 ever been in a 100 percent.

15 DR. LUSTIG: So, earlier, people were
16 asking me how we need to consider the eMeasures
17 differently from the maintenance measure and so,
18 I'm glad that I don't have to give the talk, I
19 have my colleague Jason Goldwater here, who's
20 going to explain everything you need to know.

21 MR. GOLDWATER: No pressure at all,
22 Tracy, thank you. So, good morning, everybody.

1 Always enjoy this part of the meeting. So, the
2 wonderful world of eMeasures. I'm sure all of
3 you have been looking forward to this since the
4 moment you stepped in here this morning, because
5 nothing gets people's blood roiling than
6 electronic clinical quality measures.

7 So, I am not here to explain the
8 universe of this, I certainly could and if you
9 really want to get that geeky, I'm more than
10 happy to do so. But what I really want to do is
11 sort of talk about eMeasures from a larger, sort
12 of 50,000 foot view, of sort of what eMeasures
13 are, the different types of eMeasures that come
14 into NQF, what we look for when we see eMeasures,
15 and what you can expect.

16 And then, when that's done, I'll
17 happily answer whatever questions you might have.
18 I'm going to hope that this is going to work.
19 Oh, good, okay. So, eMeasures are not something
20 that's new. I think all of you who have been
21 doing this long enough probably know that.

22 eMeasures were first brought up by

1 CMS, back in the good old days when they were
2 HCFA, do we all remember that? Yes, that was the
3 long -- we're all aging ourselves here. And they
4 wanted to, in parallel with then George W. Bush's
5 Directive to have an EHR in every hospital and
6 physician office by 2014, and which that did not
7 actually happen, but we did come fairly close,
8 that if there was a way of electronically
9 recording information, there should be a way of
10 electronically reporting it.

11 Because the measure process at that
12 point was abstracting charts manually, which was
13 not the most efficient way of doing so. And so,
14 they began with the Doctors' Office Quality-
15 Information Technology Project, or DOQ-IT for
16 short, any of you remember that? Right.

17 So, I was the Project Manager for
18 that, which I rarely, if ever, admit to people.
19 But that was the first attempt. And DOQ-IT had
20 the greatest of intentions, but it did not
21 necessarily work, because EHR adoption at that
22 point was under 20 percent nationally.

1 So, now, we're sitting here in 2017,
2 where it's 80 percent, and so, there is a greater
3 ability now to be able to record data and report
4 it out electronically. And when measures come in
5 that are electronic to NQF, they usually come in
6 in one of four ways.

7 So, the first is a de novo measure,
8 which, as you know, is a brand new measure.
9 Rather than it be specified through a claims
10 extraction process, it is specified specifically
11 as an electronic measure and it has to adhere to
12 the same measure submission and testing process
13 that any NQF measure would have to submit to.

14 Then there are what we call
15 respecified eQMs. And so, those are measures,
16 and I believe that's what you're going to see,
17 so, that's a measure that was a chart-abstracted
18 measure and has been used, but now it's up for
19 maintenance and so they've respecified that.

20 So, they've taken the chart-abstracted
21 measure and they've made it into an electronic
22 one. And I'll tell you the components later

1 about what goes into that. And so, it must
2 adhere to NQF's measure submission and testing
3 process.

4 Then there are what we call legacy
5 electronic clinical quality measures. So, those
6 are chart-abstracted measures that are currently
7 used in national federal reporting programs, like
8 PQRS or the IQF program or maybe even be
9 recommended for MIPS.

10 But they are chart-abstracted and the
11 desire of CMS, and really of the federal
12 government, is to move those into an electronic
13 form. And so, a legacy measure, the only thing
14 that differentiates that between a respecified
15 measure is the way the measure is tested, because
16 they could use something called the Bonnie tool,
17 which is owned and operated by MITRE. Before any
18 of you ask, because I get this all the time, what
19 does Bonnie stand for? Nothing.

20 (Laughter.)

21 MR. GOLDWATER: I have no idea what it
22 stands for, if I had to say, it is probably the

1 name of the developer's pet or child. I mean, I
2 used to be a developer and we're not creative
3 folks, we name it after the first available thing
4 that we see.

5 (Laughter.)

6 MR. GOLDWATER: So, that's probably
7 what it was. We do not have -- there are no
8 legacy measures that are coming under
9 consideration to all of you. And we are slowly
10 sunseting that, because there were a lot of
11 legacy measures over the last couple of years,
12 but that is gradually winding down.

13 And then, lastly, there is what we
14 call the Trial Approval Program. You will not
15 have to worry about that, but just for your own
16 education, those are measures that are innovative
17 and new and there's clearly a need for, but it's
18 difficult for them to meet the NQF criteria for
19 endorsement, namely, in the testing side.

20 But the measure is deemed to be so
21 important, it would be a waste to not actually
22 put the measure forward if it could actually

1 benefit quality because of those testing
2 restrictions.

3 So, trial use is, the measure gets
4 through the same review as any NQF measure does,
5 but it doesn't get endorsed. What you're then
6 doing is, not endorsing it, but you're accepting
7 it into the trial use program and it actually
8 gets put into the field and it can be used and it
9 collects data while it's being used.

10 And once the developer feels they have
11 enough data, they pull the measure out of the
12 program, they analyze the results, and then, they
13 bring it to you again, this time for endorsement.
14 And we have roughly a dozen measures in the trial
15 use program at the moment.

16 But, again, that's not applicable
17 here. I almost said next slide, I really got to
18 get out of that. All right. So, what are the
19 specifications for an eMeasure? So, the first
20 one is what we call HQMF, or the Health Quality
21 Measure Format.

22 So, what on Earth is that? So, I'm

1 sure all of -- how many of you use the internet
2 for shopping? And don't be shy, right? All of
3 you do? Right. I mean, why do we go to the
4 store anymore? I mean, I found Boxed -- do you
5 know what Boxed is?

6 Boxed is like going to Costco without
7 actually having to go to Costco, you can order
8 all of these big items and they're shipped right
9 to your door and you don't have to deal with
10 Costco. It's the most wonderful thing in the
11 world, I will never go to Costco again.

12 (Laughter.)

13 MR. GOLDWATER: And the way -- it's
14 true, why would you want to stay at Costco? So -
15 -

16 DR. LUSTIG: They give out free
17 samples.

18 MR. GOLDWATER: What's that? They do.

19 (Laughter.)

20 MR. GOLDWATER: It's a great idea.
21 Anyway. The way that that works, the way any
22 online shopping works is, you input data and your

1 credit card number, any personally identifiable
2 information that's deemed necessary, and you send
3 it to the website that is going to be receiving
4 it for your order.

5 And the way that that is coded is
6 usually what we call the Extensible Markup
7 Language, which has been around really since the
8 early 1990s. And all that is is a very basic
9 common way of tagging and organizing the
10 information, so that it goes from your system to
11 the receiving system, the information is
12 interpreted, it's recorded, and your order is
13 placed correctly.

14 This is the same thing, because the
15 measure has to go from your system, has to be
16 inputted into a system, and it has to be able to
17 produce the result. So, HQMF is basically a
18 standard style way of organizing an electronic
19 measure.

20 It basically is the way it needs to be
21 laid out, what the tags need to be, what the
22 meaning of the information is, so that it can go

1 into any EHR system, regardless of what the
2 vendor is.

3 The way developers tend to create
4 electronic measures is the Measure Authoring
5 Tool. And in that, when you create a measure
6 from that, it comes out in the correct format.
7 The MAT is not required to do HQMF, you're
8 welcome to do it by hand, I don't know why you
9 would do that, but there are people that do.

10 But we do require that it has to be in
11 the Health Quality Measures Format, because it's
12 a very specified style and it ensures that it can
13 be used, then, in any EHR.

14 It also has to have value sets. So,
15 what are value sets? So, value sets are really
16 the way you represent clinical content. So,
17 major depressive disorder would be represented as
18 a value set and it would come from a controlled
19 clinical vocabulary.

20 And there are a variety of them.
21 There are ICD codes, which a lot of you are
22 probably very familiar with. There's SNOMED, are

1 people familiar with what SNOMED is? All right.
2 That's a very rich, very robust, clinical
3 vocabulary that covers numerous, numerous
4 clinical concepts.

5 There's LOINC, which is used for
6 laboratory orders and tests. There's RxNorm,
7 which is used for medications. And these are
8 standards that have been promulgated by the
9 Office of the National Coordinator and are really
10 commonly used throughout the community.

11 But value sets have to be part of a
12 measure. And value sets are maintained by the
13 National Library of Medicine in their Value Set
14 Authority Center. So, any eMeasure that comes to
15 us has to have value sets that are in the VSAC,
16 as we call it for short, and they have to be
17 published.

18 So, they cannot just be some random
19 value set that a developer created that nobody
20 else can see, it has to be a national value set
21 that is published in the VSAC. If the eMeasure
22 that comes in, and I look at all of these, it's a

1 joy, trust me, especially when you get 90 of
2 these, but the measure developer -- if I don't
3 find that there is a value set that's not
4 published, if I can't find it in the VSAC, then I
5 have to call the developer up and say, why did
6 you use this?

7 And they'll give me a reason and I'll
8 say, that's great, go into the VSAC and find the
9 code that matches what you have. If you cannot
10 find it, then we'll have to work on getting that,
11 what you've created, published. Which we can do,
12 but you have to have a nationally published value
13 set.

14 And the reason for that is, because
15 when you have a national one, it can be reused by
16 measure developers everywhere and it ensures
17 consistency. Because one of the problems when
18 eMeasures were first created is that everybody
19 was creating value sets and there was no
20 centralized way of keeping it.

21 So, that means ten developers could
22 create ten different value sets for generalized

1 anxiety disorder. It means the same thing -- I
2 mean, I'm not the expert, I'm just assuming that
3 it means the same thing, but everybody was coding
4 it differently.

5 So, to try to harmonize that, we just
6 want one value set for that particular condition.
7 If the published value set does not exist, the
8 measure developer must demonstrate that their
9 value set is in draft form and then they have to
10 wait to publish it to the VSAC.

11 So, the Value Set Authority Center,
12 which is like a library of value sets that the
13 National Library of Medicine has. And they can
14 go in there, submit it, and get it published.
15 It's not a difficult process whatsoever and we
16 usually do provide guidance, if necessary.

17 CO-CHAIR PINCUS: So, just to be clear,
18 so, for example, the generalized anxiety disorder
19 example, so, would ICD-10-CM be a value set?

20 MR. GOLDWATER: It could be,
21 absolutely. ICD, CPT, HCPCS, SNOMED, LOINC, we
22 can go on and on. There's a lot of them. What

1 we do try to do is keep it to very controlled
2 vocabularies that are widely used. Sir?
3 Microphone. Turn your microphone on.

4 MEMBER TRANGLE: Microphone. My name
5 --

6 (Laughter.)

7 MEMBER TRANGLE: My name is Mike, so I
8 thought you were just talking to me.

9 (Laughter.)

10 MR. GOLDWATER: My apologies.

11 MEMBER TRANGLE: But is there anything
12 to stop the Library of Congress subset that
13 you're talking about from publishing different
14 versions of the same thing so they compete and
15 that the definitions are not the same?

16 MR. GOLDWATER: So --

17 MEMBER TRANGLE: Because if you're
18 talking about CPT, for example, or just DSM-5 --

19 MR. GOLDWATER: Right.

20 MEMBER TRANGLE: -- and ICD-10, those
21 are not aligned.

22 MR. GOLDWATER: I agree. So, the

1 answer is, yes, they can. That's sort of part of
2 an issue. There's nothing on the VSAC right now
3 that -- so, if you were to create a generalized
4 anxiety disorder value set from DSM and there's
5 already one that exists from ICD and SNOMED, the
6 VSAC does not stop you from publishing that value
7 set. You can go ahead and publish it.

8 MEMBER TRANGLE: So, we probably
9 already have non-discrete value sets for
10 depression, then?

11 MR. GOLDWATER: That's correct. You
12 have many, many value sets --

13 MEMBER TRANGLE: And at --

14 MR. GOLDWATER: -- for depression.

15 MEMBER TRANGLE: And at some point, it
16 would be really important to harmonize, get rid
17 of duplication.

18 MR. GOLDWATER: So, we did take on that
19 project last year to do that. And without
20 actually getting into the nuts and bolts of that,
21 it's very difficult to do, because there are
22 really roughly over 55,000 value sets that are

1 currently published.

2 So, harmonizing what is already in
3 there is difficult. So, what we are trying to
4 do, then, is to create some sort of national way
5 of looking at it, to make sure that they are
6 national value sets that can be used. Yes?

7 MEMBER JENSEN: So, I work for the VA
8 and we have had electronic health record for 20
9 years.

10 MR. GOLDWATER: All right.

11 MEMBER JENSEN: And we do our own
12 performance measures. Do you think we use the
13 VSAC language? Or what -- value sets? Do you
14 know? I mean, I guess I should know the answer
15 to this, not you, but just curious if you know
16 that.

17 MR. GOLDWATER: I would imagine that
18 you would, yes, unless you have some other way of
19 clinically coding the information. But I know
20 VistA does use the VSAC value sets. So, I don't
21 know anyone that doesn't use those.

22 Sometimes they will create their own

1 and not publish them, and that's what we're
2 trying to stop. Because, then, if they're not
3 reusable, then we run into this problem where
4 everybody keeps creating duplicative value sets.
5 Yes, ma'am?

6 MEMBER MAZON JEFFERS: Maybe you're
7 going to answer this later, but can you just talk
8 a little bit about how this gets operationalized
9 if you're using a value set that comes from a
10 claims or billing information versus using a
11 value set that comes from diagnostic information
12 that might coming directly from an EHR?

13 MR. GOLDWATER: Right.

14 MEMBER MAZON JEFFERS: And how does
15 that play out?

16 MR. GOLDWATER: So, it's a good
17 question. And I think it's important to know
18 that value sets are not -- I mean, they're
19 primarily used in electronic measures, but
20 they're used in chart-abstracted measures too. I
21 mean, you have to represent the clinical content
22 one way or the other.

1 So, in some cases, there's alignment
2 between the value set that is used in the chart
3 and the value set in the EHR, which is what we
4 look for. If there isn't, then we have to try to
5 map to what's been nationally used in the VSAC.

6 And the reason, again, why I want to
7 reemphasize why we do this is, we're not -- we
8 wouldn't stop a measure if it doesn't do it, but
9 what we will do is, we will make the developer go
10 back and use national value sets that are
11 reusable.

12 It is -- in the committee that we had
13 to try to harmonize this, that was one of their
14 best strategies moving forward in trying to at
15 least attempt to get to some common denominator
16 of what value sets people will use.

17 Because if we continue on the path
18 that we were on -- again, in depression,
19 ironically, sitting here at the behavioral health
20 CDP, was one that we focused on during our
21 meeting and there are at least 300 variations of
22 depression, just as value sets.

1 There's depression, there's general
2 depression, there's major depressive disorder. I
3 don't know what the difference is between those
4 three, I'm sure there is, but if you're going to
5 use it in a measure, you have to be specific
6 about what clinical area you're focusing on and
7 make sure that if another developer's going to do
8 a measure like this, that they can use the same
9 exact value set.

10 CO-CHAIR BRISS: So, I'd like to fairly
11 quickly finish this --

12 MR. GOLDWATER: Right.

13 CO-CHAIR BRISS: -- and try to get on
14 to the next measure.

15 MR. GOLDWATER: Sure.

16 CO-CHAIR BRISS: And so, Harold, quick
17 comment, and then, let's see if we can finish
18 this up.

19 MR. GOLDWATER: Okay.

20 CO-CHAIR PINCUS: Yes. I just wanted
21 one very quick comment. Just, with regard to
22 value sets and developments in sort of diagnostic

1 taxonomies, that actually the World Health
2 Organization is in the final stages of developing
3 ICD-11, which people may not realize that the
4 rest of the world has been using ICD-10 for 25
5 years.

6 MR. GOLDWATER: Right.

7 CO-CHAIR PINCUS: And so, that -- and
8 in that, that's being harmonized with SNOMED and
9 being built off an informatics platform.
10 Actually, I co-chair the Quality and Patient
11 Safety Topic Advisory Group for WHO for ICD-11.
12 And so, some of this will, over the next --
13 depending upon when the United States actually
14 adopts ICD-11, is another issue. But --

15 (Laughter.)

16 CO-CHAIR PINCUS: -- that will -- but
17 it's being done in a way that it's actually
18 coordinated with the ICD-10-CM as well.

19 MR. GOLDWATER: Right.

20 CO-CHAIR PINCUS: But, anyway, I think
21 we do need to move on to thinking about, so, how
22 do -- what is the expectation for our review

1 today --

2 MR. GOLDWATER: Sure, right.

3 CO-CHAIR PINCUS: -- of this?

4 MR. GOLDWATER: So, and that sort of
5 leads right in to what we're going to talk about.
6 So, when you look at an eMeasure, it does have to
7 be tested for reliability and validity. So, the
8 requirement is that it has to be tested in at
9 least more than one vendor or two, at least two.

10 So, developers need to test on the
11 number of EHRs they feel is appropriate, it's
12 highly desirable that you test in multiple
13 systems. So, a question we often get asked is,
14 well, I know an Epic System in Cleveland Clinic
15 and I know an Epic System at, pick some hospital
16 in New York, Columbia, Weill Cornell Medical
17 College, and they both have Epic, is that one EHR
18 or is that two?

19 That would be two. And the reason is
20 is that every Epic installation is different.
21 There are variations on a theme, there's a lot of
22 similarities, but if you really study the

1 implementations of the system, there are
2 differences. So, that would be considered to be
3 more than one.

4 You have to indicate how the eMeasure
5 specifications were used to obtain the data.
6 Where did you get it from? What EHR? Did it
7 align with the specs of the measure? And, again,
8 you have to have it in the right format and that
9 the data that is in that format can be
10 implemented into that EHR system. Which, if
11 you've done everything correctly, that shouldn't
12 be a problem.

13 If the testing of an eMeasure occurs
14 on a small number of sites, it could best be
15 accomplished by focusing on patient-level data
16 validity. The testing of level data elements
17 require that all of them be tested.

18 At a minimum, the numerator, the
19 denominator, and exclusions must be assessed and
20 reported separately, which in the measure you're
21 going to look at, it was. We do have some
22 flexibility, understanding that not every

1 eMeasure is the same. We do have some standards
2 we do have to adhere to, but we also do
3 understand that, in certain cases, eMeasures are
4 going to have something different to them.

5 So, we do take them on a case-by-case
6 basis, I don't just look at them and say, well,
7 this is good or this is bad, it's really, what
8 are you trying to get at, can the measure be
9 computed, does it produce the most reliable
10 metric?

11 So, you should consult with NQF staff
12 if you think you have another reasonable approach
13 that will help you test for reliability and
14 validity to ensure that your measure is at least
15 getting a fair shake and representation at a CDP
16 meeting. Okay? Any questions? Yes?

17 DR. LUSTIG: I think you --

18 MEMBER LARDIERI: There you go. So,
19 it's -- I guess, for NQF in general, should NQF,
20 I guess the question is, should NQF even be
21 taking any measures in the future that are not
22 eMeasures? I think if we restricted only

1 eMeasures, we'd have significant savings in
2 administrative costs across the country.

3 And also, I think it would help to
4 spur providing technology, appropriate
5 technology, to those providers who don't have
6 technology now, because if you're going to
7 penalize or reward a provider, you need to make
8 sure that they have the appropriate technology.

9 If this HQMF format is available, can
10 be web-based, there's no reason why you should be
11 doing anything paper anymore, ever, I think. So,
12 I'm just wondering what NQF --

13 CO-CHAIR BRISS: So, thank you. I'd
14 like to parking lot that, which is a general
15 issue and not actually related to our committee
16 work. So, if I can go on to David?

17 MEMBER PATING: So, I think the issue
18 that affected our -- what will affect our rating
19 is the Bonnie testing. So, I'm wondering if you
20 can just explain that a little bit more? I saw
21 many measures were Bonnie tested and it looked to
22 me, there was either a thumbs up or a thumbs

1 down. Is there a score or a threshold value that
2 signifies adequate Bonnie testing?

3 DR. LUSTIG: So, Jason, just to also be
4 clear, the two eMeasures that this group will
5 look at are both legacy eMeasures.

6 MR. GOLDWATER: So, Bonnie testing, the
7 original design of Bonnie by MITRE was to test
8 the meaningful use measures for feasibility or
9 ensure that the measure logic calculated
10 correctly, before they were actually tested
11 within an actual EHR system.

12 So, the issue with legacy measures is
13 that, some of the testing data that would have
14 been available or the ability to test those
15 measures, which were at one point chart-
16 abstracted and then being moved into an EHR, was
17 proving to be somewhat difficult.

18 So, the compromise was to be able to
19 use Bonnie as a way to test the legacy measure to
20 ensure the fact that the numerator and
21 denominator could be populated appropriately, the
22 exclusions were being able to be taken out of the

1 measure as needed, and that the metric calculated
2 met the objective of the measure.

3 So, when we ask people to look at
4 Bonnie, what we ask is -- you have to realize
5 that Bonnie takes a synthetic test deck of
6 patients. In other words, it is patients that
7 you're creating, that you want the developer to
8 create the most realistic set of patients. So,
9 those individuals that would generally be in the
10 population.

11 You do not want -- one of the first
12 things is, did the developer just create a set of
13 patients that the measure will obviously pass?
14 If that's what they've done, and we usually catch
15 that when they do, and that did not happen here,
16 but when that happens, then we have to have them
17 go back and actually create a more diverse and
18 representative population, so that you can see
19 the exclusions, the exemptions, the numerator and
20 denominator being filled, and the calculation
21 being met.

22 So, we then asked, take into account

1 the synthetic test deck of patients, does it
2 represent the general population that would be
3 put into this measure if needed? Is the measure
4 calculating appropriately? Is it populating the
5 numerator and denominator as it should?

6 Is the metric that it's producing
7 mapping to the objective of the measure? And
8 does that measure, overall, when produced, is
9 that going to be an adequate representation of
10 quality performance, based on the original design
11 of the measure?

12 Because if it does, then the measure
13 generally is meeting feasibility, because they
14 will still have to have it in the appropriate
15 format, they'll still have to map to a data
16 model, it will still have value sets, all of
17 those elements and pieces will still be in place.

18 But when we look at Bonnie, it is
19 understandably, being a synthetic environment, is
20 it as close to being representative of the
21 population as it could be? In the particular
22 case of these measures, they also did test them

1 in EHRs, it wasn't just testing in Bonnie. So,
2 they did test in EHRs.

3 So, in addition to looking at the
4 Bonnie testing, you can also look at the way that
5 they were tested. And I think VistA was one of,
6 if I'm remembering correctly, was one of the
7 systems that was tested. So, you have the best
8 of both worlds, you have it tested in Bonnie and
9 you also have it tested in EHRs as well.

10 CO-CHAIR BRISS: Okay. So, one more
11 comment, Harold.

12 CO-CHAIR PINCUS: Just related to the
13 way in which we review these things today, your
14 comment about the fact that it has to be done in
15 two different EHRs, but that an Epic EHR in two
16 different places counts, does that -- I'm
17 concerned about that being sufficiently
18 generalizable. And also, what if the two places
19 are sort of, like, the sort of Jane Doe EHR
20 versus Joe Schmo EHR that are rarely, if ever,
21 used except in sort of idiosyncratic places?

22 MR. GOLDWATER: It's a good question.

1 The reason why we allow the different
2 implementations of similar EHRs is because the
3 evidence indicating the differences between
4 implementations is pretty significant. And while
5 it is highly desirable that they actually use two
6 or more different vendors, sometimes the
7 restrictions are going to be there that are not
8 going to allow that.

9 So, if they are able to find two
10 different EHR implementations that are the same
11 vendor, they can show what those differences are
12 and that they were adequately tested, then that
13 does prove feasibility, if it matches all of the
14 feasibility criteria.

15 Yes, in certain instances, it would be
16 preferable to go to more vendors, and
17 particularly in behavioral health, where there
18 are smaller EHR vendors and not the Epics that
19 you normally see in large hospitals. So, in that
20 particular case, some of the testing does
21 accompany that. In other cases, it does not.

22 But the requirement is, if they can

1 find two EHRs, get enough data to adequately test
2 the measure, show that it was implemented and has
3 produced the appropriate metric, then it has met
4 the feasibility criteria.

5 CO-CHAIR BRISS: So, we still have on
6 our plate to kind of do the eMeasure version of
7 the last one that we just did. We're a little
8 behind, I'd still like to see if I can move us
9 through before the break.

10 So, does anybody have questions that
11 are specifically related to the work we have
12 immediately in front of us in terms of evaluating
13 these eMeasures? And hearing none, let's try to
14 fairly quickly go through this.

15 I'm hoping that this can go fairly
16 quickly because many of the criteria are likely
17 to be pretty similar to the non-eMeasure that we
18 just went through. And maybe I'll start by
19 trying to make -- does the developer, want to tee
20 this up? Is there anything specific to the
21 eMeasure version that you need to tee up that we
22 didn't already talk about in the other version?

1 MS. SOMPLASKY: Not really, no. We're
2 prepared to speak to the sites and vendors that
3 were tested.

4 CO-CHAIR BRISS: So, I might like to
5 propose, it appears to me plausible that we might
6 be able to make the case that this is still
7 important to measure and report, sort of
8 regardless of whether it's an eMeasure version or
9 another one, and I'd like to skip that, unless
10 somebody has other ideas.

11 And I'd also like to skip that there's
12 a likely measure gap, right? And so, does
13 anybody want to object to that and talk further
14 about --

15 DR. LUSTIG: So, just to clarify, we
16 automatically assign the evidence rating that we
17 voted on last time, because those are identical.
18 There is a slight difference with gap, they do
19 present data based on the EHR data, and so, we
20 should technically have a vote on that.

21 CO-CHAIR BRISS: Okay.

22 DR. LUSTIG: But there doesn't need to

1 be discussion unless folks think there's a need
2 for it.

3 CO-CHAIR BRISS: So, can you scroll
4 down on the screen to the specific new data on
5 the -- that came from these -- so, that's the
6 data that we saw before? And this is the new EHR
7 data from two places, right? Is that right?

8 DR. LUSTIG: Yes.

9 CO-CHAIR BRISS: So, that's the only
10 new piece of information that we now have. So,
11 would anybody like to further discuss that or can
12 we move to a vote? I'm going to take silence as
13 assent and let's move to a vote.

14 MS. QUINNONEZ: Voting is now open for
15 the performance gap of Measure 3132: option 1,
16 high; option 2, moderate; option 3, low; and
17 option 4, insufficient.

18 We are now voting on performance gap
19 for Measure 3132. This is Preventative Care and
20 Screen: Screening for Clinical Depression and
21 Follow-Up Plan, the eMeasure. Option 1, high;
22 option 2, moderate; option 3, low; and option 4,

1 insufficient.

2 All votes are in and voting is now
3 closed. For the performance gap of Measure 3132:
4 57 percent voted high, 43 percent voted moderate,
5 zero percent voted low, and zero percent voted
6 for insufficient. Measure 3132 passes the
7 criterion of performance gap.

8 CO-CHAIR BRISS: So, we do need to talk
9 about reliability. Would one of the discussants
10 like to volunteer? Thank you, Lisa.

11 MEMBER JENSEN: You're welcome. The
12 group that looked at it determined that the
13 Reliability does seem to be good. Some question
14 about whether the varied EHR codes and ability to
15 extract that information are the same.

16 Data elements clearly defined.
17 Reliability was tested in two different
18 practices, primary care and peds, and was
19 determined to be good reliability. That's all
20 I'll say.

21 CO-CHAIR BRISS: Anybody else have
22 additions? Yes, Jeff?

1 MEMBER SUSMAN: I mean, just very
2 briefly, if I'm looking at the right data here,
3 they had four providers in MEDENT 22.0 and then a
4 bunch in Centricity, and you just have to ask
5 yourself, is that really strong enough data or
6 support for reliability?

7 So, I mean, I would not say it's high
8 by any means, just on the basis of that
9 particular level of testing. I guess I would
10 encourage CMS to be looking at trying to lure
11 more durable testing and more durable sample of
12 different EHRs when providing this to us.
13 Because I look at it and say, well, okay.

14 CO-CHAIR BRISS: Anybody else want to
15 speak to reliability? Yes, Shane?

16 MEMBER COLEMAN: I had a related
17 question. I'm just curious if there was a
18 rationale for why only those two EHRs and fairly
19 small, I think, representative sample?

20 MS. SOMPLASKY: This Measure was
21 initially supposed to be brought in front of NQF
22 in 2018, so we were given a very short period of

1 time to get this ready for presentation today.
2 It's voluntary for practices to participate in
3 testing.

4 We reached out to more than 50
5 practices that represented ten different vendors
6 and we actually had three sites immediately say
7 yes. We had to discount one of the sites because
8 they just weren't able to get the structured data
9 that we needed. So, what you see are the two
10 sites. And the Bonnie testing.

11 MEMBER COLEMAN: One other question is
12 just, I'm not -- in some ways, to evaluate this,
13 I kind of feel like I need some idea of what the
14 market share of EHRs would be across the country,
15 of sorts.

16 I mean, just because, like, looking at
17 these, I have no idea if these two together
18 represent one percent of the market share across
19 the U.S., in which case, that would be more
20 problematic then, I don't know, if it was 50
21 percent of EHRs, it would -- I would think it was
22 more generalizable. Do we have any idea?

1 MEMBER LARDIERI: Centricity is
2 probably about the third or fourth. You've got
3 Epic, then you've got Cerner, then MEDITECH, and
4 Centricity, and then a couple other ones fall in
5 that. So, they're at the top ten at least,
6 anyway.

7 CO-CHAIR BRISS: Raquel?

8 MEMBER MAZON JEFFERS: I just have a
9 question about whether we're supposed to be
10 thinking about reliability simply within the
11 confines of the eMeasure or are we also supposed
12 to be thinking about this in how much the Measure
13 measures a similar thing in a similar way as the
14 analog Measure, the non-eMeasure, so that there's
15 consistency from the non-eMeasure to the
16 eMeasure? Or are we just really thinking --
17 evaluating both those Measures to the question
18 of, does it measure what we want it to measure?

19 CO-CHAIR BRISS: Does the developer
20 want to comment on that?

21 CO-CHAIR PINCUS: I think it's also a
22 question that would be fair from NQF, about

1 whether -- because that's actually an important
2 issue.

3 DR. BURSTIN: It's actually a great
4 question. And I think one of the reasons we
5 wanted to make it clear that the eMeasure is
6 actually in some ways a very distinct beast is,
7 we've seen that rates of performance can be very,
8 very different. Now, it may be that rates of
9 performance are different because this is a
10 better data source and it's closer to truth.

11 And so, I think we want to be able to
12 not necessarily hold the eMeasure hostage to what
13 the rates of performance may have been on a data
14 source that may not have been as good, but at
15 times, we're also seeing the opposite, which is
16 that it is at times very difficult to get
17 standardized data in eMeasure fields and so, the
18 paper may actually have been closer to truth.

19 So, I think it's a great question, I
20 don't think we have a clear answer that says,
21 therefore, they have to be relatable. We're
22 trying to put them side-by-side.

1 I think an assessment from the
2 Committee about the quality of what you think
3 you're getting in terms of the reliability of the
4 Measure results on one versus another, as we
5 think to the earlier comment about
6 prioritization, would actually be very, very
7 useful.

8 CO-CHAIR PINCUS: Yes. I mean, I think
9 another reason might be that organizations and
10 practices that have the capacity to report
11 eMeasures may be higher performing. That may be
12 another sort of issue with that.

13 But I think, I mean, so one
14 recommendation to NQF is actually that -- if the
15 intention is that these be reported as -- is the
16 intention that these be reported, that is the
17 non-eMeasure and the eMeasure, be reported
18 combined or is two separate reports?

19 And so, it -- which kind of goes back
20 to Mike's larger issue is that, are we now going
21 to be having two different reports, one an
22 eMeasure and the other a non-eMeasure, for every

1 Measure?

2 DR. BURSTIN: Again, we'd love to move
3 away from having the older version of a Measure,
4 if we think the new version of the eMeasure is
5 truly best in class. I think we don't have
6 confidence at this point that you could take the
7 rates of performance on a Measure that's an
8 eMeasure and the prior rates of performance on
9 claims or paper and necessarily assume
10 comparability.

11 So, I think we've indicated in some of
12 our prior documents, you should not be comparing
13 performance across different versions of
14 Measures, since a lot of that could just be the
15 measurement differences inherent to the data
16 source.

17 CO-CHAIR PINCUS: So, Measures users
18 should --

19 DR. BURSTIN: With caution.

20 CO-CHAIR PINCUS: Essentially, you'd be
21 saying that, Measure users should be making a
22 choice about whether to use an eMeasure or the

1 non-eMeasure?

2 DR. BURSTIN: Correct. And hopefully,
3 moving to the eMeasure, if the eMeasure can meet
4 your needs.

5 CO-CHAIR BRISS: Anybody else have
6 comments about reliability? It looks to me like
7 we can move to a vote, please.

8 MS. QUINNONEZ: Voting is now open for
9 the reliability of Measure 3132: option 1, high;
10 option 2, moderate; option 3, low; and option 4,
11 insufficient. For the reliability of Measure
12 3132: option 1, high; option 2, moderate; option
13 3, low; and option 4, insufficient.

14 Okay, all votes are in and voting is
15 now closed. For the reliability of Measure 3132:
16 39 percent voted high, 57 percent voted moderate,
17 four percent voted low, and zero percent voted
18 insufficient. For the reliability of Measure
19 3132, this passes this criteria.

20 CO-CHAIR BRISS: So, would one of the
21 discussants like to talk about validity? Again,
22 I'd like to focus on the pieces of the validity

1 testing that are new to this Measure that we
2 haven't already discussed with the other version
3 of the Measure.

4 MEMBER COLEMAN: I'm happy to comment
5 on it. The Bonnie testing I think showed good
6 validity, I think it was 100 percent in both.
7 The face validity, I think was the same from last
8 time, so, the 12 experts, I believe. Otherwise,
9 a frequency question came up, but it came up last
10 time. It looks like that's mostly it.

11 MEMBER PINDOLIA: This is more for
12 education, for my part, but for the Bonnie test,
13 is 22 denominator adequate? It just seems so
14 low, but I don't know anything about it.

15 MS. JOHNSON: I'd love to hear what the
16 developer has to say, but when they're doing
17 testing using Bonnie, they want to make sure that
18 their Measure works. So, they want to make sure
19 that that logic works.

20 So, they have to have enough patients
21 in their deck, in their simulated data set, to be
22 able to hit all the different permutations, if

1 you will, of young people falling out, people
2 with this exclusion or that exclusion falling
3 out, and that sort of thing. So, as long as that
4 has been done, I think it is an appropriate data
5 set. And I would love to hear if the developers
6 look at it that way.

7 MS. WELLS: That's correct. That's my
8 understanding is, we want to have a sample of
9 patients that represent the different iterations
10 of possible performance, and that's kind of what
11 we're getting at with Bonnie testing.

12 MEMBER SUSMAN: So, it is essentially
13 looking at and reading the different pathways or
14 conditions and verifying that you've been
15 inclusive of those in setting up these synthetic
16 patients or synthetic charts?

17 MS. WELLS: Yes, I think so.

18 MEMBER SUSMAN: Okay.

19 MS. SOMPLASKY: Gary, Gary Rezek, are
20 you on the phone, because you created the test
21 deck for this, do you want to speak to how you
22 created it? Maybe Gary's not on the phone.

1 MR. REZEK: I created the original test
2 deck. We've also, in the process of the
3 meaningful use annual update, the test deck has
4 been subject to external review by MITRE and
5 Lantana, who have provided us feedback and we've
6 responded to that.

7 There are some required criteria for
8 the test deck, namely being that there is 100
9 percent coverage of all of the logic branches.
10 There's also -- we try to meet other requirements
11 to make sure we've tested, anywhere where age is
12 used, that we've tested boundary cases, boundary
13 cases with timing, test concepts with -- that
14 have ranges or units, such as lab results.

15 That every criteria is tested to be
16 met and unmet, so that if something's missing or
17 something is contrary to meeting the numerator,
18 that it's calculating the performance correctly.
19 And so, there is a level of subjectivity, but
20 there's also a pretty robust set of criteria that
21 we try to meet in the review process.

22 CO-CHAIR BRISS: Harold, and then

1 Shane.

2 CO-CHAIR PINCUS: So, for the previous
3 Measure, there was a validity testing of
4 comparing the claims to what was in the charts
5 with regard to follow-up. So, how would one do
6 an -- it's unclear to me how -- the Bonnie
7 testing isn't exactly the same thing.

8 What would be the equivalent of how to
9 do that with this eMeasure, to look at whether --
10 did what was sort of in the EHR, which could have
11 been a checkbox, whether the person actually did
12 it, the provider actually did what they said they
13 did?

14 MS. WELLS: So, we like to do data
15 element validity testing when we can and I think
16 that's what you're getting at, where we look at
17 the EHR data and then we compare it to the chart
18 with an actual manual review, so we might see
19 things in notes that didn't make it into the
20 Measure, that kind of thing. And, again,
21 unfortunately, we came up against our timeline
22 and weren't able to do that this time around.

1 CO-CHAIR PINCUS: I mean, one of the
2 concerns that I have, while eMeasures are a great
3 thing in terms of feasibility and efficiency, the
4 risk is that they're checkboxes that are
5 mindlessly checked. And so, I just would wonder
6 about the ability to have some way of testing
7 whether these events actually occurred in a
8 meaningful way.

9 MS. WELLS: For the specific testing
10 that we did, we go onsite and we do workflow
11 analysis. And then, we go through each of the
12 elements and we are looking in the EHR for how
13 that is documented and for follow-up plan, asking
14 them -- and I will readily admit that for the
15 electronic Measures, follow-up plan is very
16 difficult for vendors, whether you're talking
17 Epic, who we've talked to many times about
18 follow-up plans, or you're talking to GE.

19 MEDENT is actually one of the better
20 ones to work with, because they've actually
21 created structured fields in response to the
22 testing we've done. But it is part of what we

1 are walking through when we are there onsite and
2 looking at their cadre of patients that would
3 have been tested.

4 CO-CHAIR BRISS: And at the median, if
5 the worst thing we can say about this is that
6 it's a checkbox Measure, even the checkbox isn't
7 being checked a third of the time, right?

8 CO-CHAIR PINCUS: Yes.

9 DR. LUSTIG: And just as a reminder, in
10 terms of NQF criteria, face validity and Bonnie
11 testing are considered acceptable testing for
12 validity.

13 CO-CHAIR BRISS: So, anybody else with
14 things that haven't already been said? Let's try
15 to vote on validity, please.

16 MS. QUINNONEZ: Voting is now open for
17 the validity of Measure 3132: option 1, moderate;
18 option 2, low; and option 3, insufficient. For
19 the validity of Measure 3132: option 1 is
20 moderate; option 2, low; and option 3,
21 insufficient.

22 All votes are in and voting is now

1 closed. For the validity of Measure 3132: 78
2 percent voted moderate, 17 percent voted low, and
3 four percent voted insufficient. This passes the
4 validity criterion.

5 CO-CHAIR BRISS: So, would one of the
6 discussants like to tee up feasibility for us?

7 MEMBER JENSEN: I can go. I think that
8 we already kind of touched on that, in that the
9 difficulty of documenting the follow-up is what
10 the Committee identified as problematic.

11 CO-CHAIR BRISS: Anybody have other
12 comments? Let's move to a vote.

13 MS. QUINNONEZ: One second.

14 CO-CHAIR BRISS: We were too efficient
15 on that one for you, weren't we?

16 (Laughter.)

17 MS. QUINNONEZ: You were. All right.
18 Voting is now open for Measure 3132, we're voting
19 on the eMeasure approval for trial use for
20 specifications. Option 1 is high, option 2 --

21 DR. LUSTIG: No, we're -- sorry, we're
22 voting on feasibility.

1 CO-CHAIR BRISS: Feasibility.

2 MS. QUINNONEZ: We'll go back, sorry
3 about that. There we are, now we're reading.
4 Feasibility?

5 CO-CHAIR BRISS: Yes, feasibility.
6 It's feasibility.

7 MS. QUINNONEZ: Voting is now open for
8 the feasibility of Measure 3132: option 1, high;
9 option 2, moderate; option 3, low; and option 4,
10 insufficient. For the feasibility of Measure
11 3132: option 1, high; option 2, moderate; option
12 3, low; and option 4, insufficient.

13 All votes are in and voting is now
14 closed. For the feasibility of Measure 3132: 35
15 percent voted high, 61 percent voted moderate,
16 four percent voted low, and zero percent voted
17 for insufficient. This passes the feasibility
18 criterion.

19 CO-CHAIR BRISS: And usability and use
20 looks pretty similar to the other version that we
21 already voted. Would -- do any of the
22 discussants feel like there are specific things

1 to this version of the Measure that we need to
2 discuss under usability and use?

3 I'm getting heads shaking. Would
4 anybody else on the Committee want to add
5 anything about this version of the Measure?
6 Let's move right to a vote on usability and use.

7 MS. QUINNONEZ: Okay. Voting is now
8 open for the usability and use of Measure 3132:
9 option 1, high; option 2, moderate; option 3,
10 low; and option 4, insufficient information. For
11 the usability and use of Measure 3132: option 1,
12 high; option 2, moderate; option 3, low; and
13 option 4, insufficient information.

14 All votes are in and voting is now
15 closed. For the usability and use of Measure
16 3132: 30 percent voted high, 70 percent voted
17 moderate, zero percent voted low, and zero
18 percent voted for insufficient information. This
19 passes the usability and use criteria.

20 CO-CHAIR BRISS: And it does not appear
21 to me that we need to have a discussion on
22 related and competing, so I think we can move

1 straight to the overall vote on this one.

2 MS. QUINNONEZ: Voting is now open for
3 the overall suitability for eMeasure approval for
4 trial use.

5 DR. LUSTIG: It's not a trial use.

6 MS. QUINNONEZ: For endorsement.

7 CO-CHAIR BRISS: Yes.

8 MS. QUINNONEZ: Let's redo this vote.

9 We will now be voting for the overall suitability
10 for endorsement, for approval endorsement of
11 Measure 3132: option 1, yes; option 2, no. For
12 the overall suitability for eMeasure approval for
13 endorsement: option 1, yes; option 2, no.

14 All votes are in and voting is now
15 closed. For the overall suitability for
16 endorsement for eMeasure 3132: 100 percent voted
17 yes.

18 CO-CHAIR BRISS: All right. I have
19 failed in, my only role is to be a stern
20 timekeeper and I have failed in that.

21 (Laughter.)

22 CO-CHAIR BRISS: Let's slightly shorten

1 the --

2 CO-CHAIR PINCUS: You had a handicap
3 with the first one.

4 CO-CHAIR BRISS: We may be a little
5 behind for our first one, we're not hugely
6 behind. So, I'm going to give myself a partially
7 successful. Let's shorten the break a little and
8 we'll resume promptly at 20 after.

9 DR. LUSTIG: Thank you to our
10 developers. Thank you.

11 (Whereupon, the above-entitled matter
12 went off the record at 11:10 a.m. and resumed at
13 11:21 a.m.)

14 CO-CHAIR PINCUS: Okay. So, why don't
15 we get started? And let's hear from the -- so,
16 we're considering Measure 3207: Medication
17 Reconciliation on Admission.

18 DR. LUSTIG: No, 3205.

19 CO-CHAIR PINCUS: Oh, excuse me, 3205:
20 Medication Continuation Following Inpatient
21 Psychiatric Discharge. Number 3205. And let's
22 hear from the Measure developer.

1 DR. CAMPBELL: Thank you. Good
2 morning. My name is Kyle Campbell. I'm Vice
3 President of Pharmacy and Quality Measurement at
4 Health Services Advisory Group. This is my
5 colleague, Dr. Almut Winterstein, from the
6 University of Florida, who has collaborated with
7 us in the Measure development process for this
8 Measure.

9 The Measures that we're going to be
10 discussing today with you were developed for the
11 CMS Inpatient Psychiatric Facility Reporting
12 Program, which is a pay-for-reporting program
13 that includes about 1700 inpatient psychiatric
14 facilities nationally.

15 We developed the medication
16 continuation Measure to specifically address gaps
17 in treatment following inpatient psychiatric
18 admissions for frequently occurring diagnoses,
19 including schizophrenia, major depressive
20 disorder and bipolar disorder.

21 For these disorders, medications are
22 the primary mode of treatment. And furthermore

1 outcome data suggest that patients with these
2 diagnoses who are not adherent to their
3 prescribed medication regimens have a much
4 greater risk of relapse and also the potential to
5 either harm themselves or potentially someone
6 else.

7 We found intervention studies that
8 suggested that inpatient facilities could play an
9 important role in the care coordination process
10 for these patients and could impact med
11 continuation rates.

12 In our Measure development process, we
13 received input from a multi-disciplinary
14 technical expert panel and we also conducted in-
15 depth interviews with 20 diverse patients and
16 caregivers who had had recent experiences in the
17 inpatient psychiatric facility setting. Those
18 individuals suggested to us that medication
19 management was extremely important and that the
20 Measure would help them in their decision making,
21 where they sought care.

22 The Measure utilizes CMS

1 administrative data to calculate the percentage
2 of patients with schizophrenia, MDD and bipolar
3 who fill an evidence-based medication within two
4 days prior to discharge or 30 days post-
5 discharge.

6 It's important to note that, similar
7 to other CMS Measures based on administrative
8 data, the only patients that are included are
9 those that are Medicare fee-for-service patients
10 and in addition, those that have Part D coverage.
11 For this particular population, about 75 percent,
12 74 to 75 percent of the patients have Medicare
13 Part D, who are fee-for-service patients.

14 We did find a significant quality gap
15 and variation in performance rates nationally,
16 suggesting opportunity for improvement, and our
17 data suggests that the Measure is highly reliable
18 and valid and can be implemented with little to
19 no burden for inpatient facilities. So, we thank
20 you for your consideration of this Measure and
21 look forward to the discussion.

22 CO-CHAIR PINCUS: Okay. So, the first

1 criterion that we're going to be looking at is
2 evidence. So, does one of the lead reviewers
3 want to take a stab at discussing the evidence
4 issue? Tami?

5 MEMBER MARK: So, they develop a logic
6 model, pointing out evidence from guidelines and
7 structured reviews that support those guidelines
8 that lack of adherence to medication leads to
9 relapse and negative outcomes. And so, that
10 supports the evidence that people who get
11 discharged from a psychiatric hospitalization
12 should get a follow-up medication.

13 CO-CHAIR PINCUS: Other comments about
14 evidence? Anybody?

15 MEMBER PINDOLIA: So, one just comment,
16 but I definitely agree that I think the Measure -
17 -

18 CO-CHAIR PINCUS: Little closer to the
19 mic.

20 MEMBER PINDOLIA: Oh, sorry. I agree
21 that there is other data to support, but the
22 comment that I have is that, when I was trying to

1 look for studies to see if there is actual data
2 to show the timeliness directly results in
3 outcome differences, I couldn't find that.

4 However, from my own work with our
5 systems, psychiatric institution and the
6 discharge, I know that's an important part. So,
7 I don't think that question could be answered as
8 one thing that we were looking into, but I think
9 the data -- I think everyone understands that.

10 CO-CHAIR PINCUS: Okay. Les?

11 MEMBER ZUN: So, I had a couple of
12 questions, it's more a general understanding of
13 the Measure. So, first of all, how are we
14 measuring that they're taking the medicine? I
15 mean, it's writing the prescription, it's that
16 they picked up the prescription, right? And they
17 picked it up either two days before or 30 days
18 after the hospital stay, but how do we know that
19 -- how is it connected to actually compliance?

20 DR. CAMPBELL: Yes, that's a really
21 good question. So, it is a claim in Part D that
22 indicates that the patient purchased or paid for

1 the medication, right?

2 And there's ample data to suggest that
3 those adherence rates, meaning that if we monitor
4 or track adherence in accordance with claims data
5 and we look at things like medication possession
6 ratios or we look at proportion of days covered,
7 that those data are correlated directly to
8 outcomes. And so, we believe the same data or
9 evidence would apply here.

10 MEMBER ZUN: So, I understand that, but
11 I guess the gap is, but we don't know they took
12 it, they've just filled it. And --

13 DR. CAMPBELL: Yes, so those are
14 correlated, but to actually get at the question
15 of whether the patient took the medication or
16 not, obviously would be burdensome from
17 implementation from a facility perspective. So,
18 this is our best proxy that the patient in fact
19 took the medication.

20 MEMBER JENSEN: We also don't know if
21 they took it correctly. I mean, they may take
22 it, but then they don't take the right dose --

1 MEMBER ZUN: They gave it to the dog.

2 MEMBER JENSEN: -- they decided, oh,
3 it's too expensive, I'm just going to take half a
4 dose.

5 CO-CHAIR PINCUS: Rhonda?

6 MEMBER ROBINSON BEALE: I think you're
7 all making very good points. But one of the
8 things that's unique with behavioral health, and
9 particularly with a severe mental illness, is
10 that you have injectables. So, I'm wondering
11 whether or not there's a separate Measure for
12 injectables versus oral administered drugs.

13 DR. CAMPBELL: So, thank you for that
14 question. And, yes, we did consider long-acting
15 injectables as part of the Measure, so they
16 qualify for the numerator component.

17 And since most long-acting injectables
18 have a duration of action less than a month, it's
19 presumed that, even if that was administered
20 during the inpatient stay, that within the 30-day
21 follow-up period, that there would need to be
22 another administration.

1 Which is -- and that's captured,
2 actually, in the Measure, in Part D and Part B,
3 because some of the injections are given in the
4 physician office and billed to Part B, so that's
5 part of the Measure numerator.

6 CO-CHAIR PINCUS: Mike?

7 MEMBER TRANGLE: My understanding is
8 that this is limited to people with Medicare who
9 have Part D, is that correct?

10 DR. CAMPBELL: That's correct.

11 MEMBER TRANGLE: Which, I mean, it
12 seems like an important Measure, it's necessary
13 but not sufficient. But in many ways, I'm also
14 concerned about people that have other insurance
15 types and at least several of our hospitals, we
16 find that there are a lot of people being
17 discharged on MA pending. They don't have
18 medical assistance yet, but they've applied for
19 it, or no insurance.

20 And we also find that we have a lot of
21 patients that don't get their meds because of
22 prior authorization kinds of things, they're on a

1 certain formulary inpatient and the med has to be
2 changed to a different alternative, comparable
3 kind of thing.

4 And in some sense, I don't have a good
5 sense of if your sample is representative of the
6 real world and the complexities and the things
7 that get in the way. And if you could comment on
8 that?

9 DR. CAMPBELL: Sure. So, when we
10 evaluated the data, obviously being a Medicare
11 administrative data source, we're limited to
12 those patients with fee-for-service coverage.
13 But in terms of the prescription drug coverage,
14 about 74 percent of our patients in the cohort
15 have prescription drug coverage under Part D.

16 And Part D is actually really pretty
17 restrictive with plans in terms of the
18 formularies related to behavioral health and that
19 really substantially, in their language, in the
20 Part D Call Letter, substantially all medications
21 in the behavioral health class have to be
22 covered.

1 So, basically, we're looking at
2 patients in this Measure that have coverage and
3 if they were low-income patients, they would also
4 be eligible for a low-income subsidy. And, in
5 fact, when you look at the follow-up rates in
6 this Measure, the follow-up rates are, med
7 continuation rates, are actually higher in the
8 dual-eligible population.

9 And we hypothesize that's because they
10 have higher financial assistance related to the
11 medications being filled. So, we don't really
12 have anyone in this Measure at this point that
13 doesn't have coverage or would fall into those
14 gaps and that sort of thing.

15 CO-CHAIR PINCUS: Any other questions?

16 MEMBER SPERLING: Very briefly.

17 CO-CHAIR PINCUS: Yes?

18 MEMBER SPERLING: So, CMS asked for
19 this, correct? Or CMS was involved in
20 development of this?

21 DR. CAMPBELL: Yes, correct. We're
22 contracted by CMS.

1 MEMBER SPERLING: And the question is,
2 are they going to harmonize this or use this for
3 their Star Rating Systems for the Medicare
4 Advantage and Prescription Drug Plans? Do you
5 know?

6 DR. CAMPBELL: At this time, I'm not
7 aware. There's no plans or there haven't been
8 any discussions with the Star Rating program.

9 MEMBER SPERLING: Okay. Because the
10 reason I mention it, that's a very powerful tool
11 that CMS has, because if plans fall below the
12 Star Rating for a certain period of time, they're
13 actually booted out of the program. It's
14 something that really matters to the Prescription
15 Drug and Medicare Advantage Plans in Part D.

16 DR. CAMPBELL: Okay, thank you.

17 CO-CHAIR PINCUS: Tami?

18 MEMBER MARK: I just want to clarify,
19 the inclusion criteria is not only that they have
20 Part D, but they have to be enrolled in Part A,
21 B, and D at least 30 days post-discharge, is that
22 correct?

1 DR. CAMPBELL: That's correct.

2 MEMBER MARK: So, all of Part C is out?

3 DR. CAMPBELL: Correct.

4 MEMBER MARK: And the duals, would you
5 -- if the duals have a hospitalization, are they
6 going to be picked up? Because that'll be under
7 Medicaid?

8 DR. CAMPBELL: The duals, yes, the
9 duals are included in the data set, yes.

10 MEMBER MARK: But is their inpatient
11 admission going to be picked up, because that
12 part would be picked up under Medicaid, not
13 Medicare?

14 DR. CAMPBELL: It's picked up on
15 Medicare, I believe, because the Medicare is the
16 primary payer.

17 MEMBER MARK: Medicare is the primary
18 payer?

19 MEMBER PINDOLIA: And the Medicaid-only
20 population?

21 DR. CAMPBELL: We don't have the
22 Medicaid-only population in the Measure.

1 CO-CHAIR PINCUS: So, this is
2 essentially a Medicare Measure?

3 DR. CAMPBELL: Correct.

4 CO-CHAIR PINCUS: With --

5 MEMBER TRANGLE: I think the obvious
6 question that wasn't asked was, was there thought
7 given to including MA or other ones, to make it a
8 broader Measure and have more impact on overall
9 patient flow through hospitals?

10 DR. CAMPBELL: Yes, I think that's a
11 good question. Unfortunately, to limit the
12 Measure to the administrative data, we don't have
13 access to the administrative data for Part C, so
14 we don't have the ability to do that. So, that
15 was the limitation, yes, in the development.

16 CO-CHAIR PINCUS: Any other comments,
17 questions with regard to evidence? If not, we're
18 ready to vote.

19 MS. QUINNONEZ: Voting is now open for
20 the evidence of Measure 3205: Medication
21 Continuation Following Inpatient Psychiatric
22 Discharge: option 1, moderate; option 2, low; and

1 option 3, insufficient.

2 DR. LUSTIG: And just to clarify, high
3 is not an option here, because in the submission,
4 there wasn't a clear review of the quality,
5 quantity and consistency of the evidence.

6 MS. QUINNONEZ: All votes are in and
7 voting is now closed. For the evidence of
8 Measure 3205: 91 percent voted moderate, nine
9 percent voted low, and zero percent voted
10 insufficient. So, 21 out of 23 voted for
11 moderate, two people voted for low, and zero
12 voted for insufficient. This passes the evidence
13 criterion.

14 CO-CHAIR BRISS: Do we -- it's
15 interesting, do we have an opportunity to send
16 messages back to CMS? I thought I heard around
17 the table that there was a fair amount of support
18 for seeing if the denominator of this Measure
19 could be broadened to a broader population. Is
20 there -- did I hear enough of us saying something
21 like that, and if I did hear something like that,
22 do we have ways to send that back to CMS?

1 DR. LUSTIG: Yes. And also, when we
2 get to our criterion that have to do with
3 specifications, we can do that.

4 DR. BURSTIN: And it's broader than
5 mental health, obviously, this whole issues of
6 measures for fee-for-service versus measures for
7 MA is a problem and that the limited data source
8 for a developer like Kyle is just -- we just
9 don't have it. But, ideally, you would expect
10 those to be the same measures done in the same
11 way.

12 CO-CHAIR PINCUS: Just a question, are
13 there any -- is there precedent for any other, in
14 other areas of medicine, where there's a measure
15 for medication follow-up post-hospitalization?

16 DR. CAMPBELL: I don't believe so, I
17 think this is the first time for follow-up for
18 medication continuation.

19 CO-CHAIR PINCUS: So, for example, for
20 follow-up in terms of getting an additional
21 prescription for a beta blocker after an MI or
22 something, there's nothing like that?

1 DR. CAMPBELL: A beta blocker after MI,
2 there is, but that measure was retired after it
3 exceeded the --

4 CO-CHAIR PINCUS: Yes, but I thought
5 that was at discharge and not for the 30 days
6 after.

7 DR. BURSTIN: It was a HEDIS measure
8 that looked at six-month use --

9 CO-CHAIR PINCUS: Oh, it was six-month
10 use?

11 DR. BURSTIN: -- as well. But it's
12 also been retired for --

13 DR. CAMPBELL: Right. And there are
14 several that are -- look at long-term adherence
15 to medications, over a year period of time.

16 CO-CHAIR PINCUS: Okay. So, let's look
17 at the next issue of gap. Do one of the people
18 on the reviewer list want to comment on the gap
19 issue? Tami?

20 MEMBER MARK: I will, unless someone
21 else wants to. I think the gap relates to the
22 performance, is that right? And so --

1 CO-CHAIR PINCUS: Yes, performance gap.

2 MEMBER MARK: -- the distribution of
3 the scores, the median, meaning the percent that
4 got the medication post-discharge, was 80
5 percent. The bottom tenth percentile was 67
6 percent. The top ninetieth percentile was 88
7 percent.

8 CO-CHAIR PINCUS: Yes. I just, let me
9 take step away from being Chair to say, I was
10 actually surprised at how high it was.

11 MEMBER MARK: I was too.

12 CO-CHAIR PINCUS: Yes. That -- because
13 this measure, obviously, would be highly related
14 to measures of follow-up after hospitalization,
15 which have a much lower rate. And also, other
16 measures of treatment adherence over the course
17 of a longer period of time have a much lower
18 rate.

19 And so, I was just wondering whether,
20 in the testing, there was something that might
21 have skewed it, either because of the selection
22 of people that maybe have more access.

1 DR. CAMPBELL: Yes, I think that's a
2 good hypothesis. That, basically, we carefully
3 crafted the eligible population and we also paid
4 close attention to the exclusions. So, we're
5 excluding patients here that might be relatively
6 or absolutely contraindicated to a given
7 medication.

8 So, I think, we have just patients in
9 this population who probably don't have any
10 access issues. They have full prescription drug
11 coverage. If they're low-income, they also have
12 assistance. So, I think that's why you're seeing
13 higher rates than what you might see in the
14 general population.

15 MEMBER MARK: But that's the population
16 that's included in the measure. You're just
17 saying that you limited it to the people included
18 in the measure.

19 DR. CAMPBELL: I'm sorry?

20 MEMBER MARK: If I understand your
21 point, you tested it based on the criteria in the
22 measure, so you're not saying that when the

1 measure gets implemented, the rate is going to go
2 down?

3 DR. CAMPBELL: Right.

4 MEMBER MARK: This is -- because you
5 actually tested it on over 1,000 inpatient
6 facilities, it was a very large sample. So, I
7 don't think it's a weird, small sample.

8 CO-CHAIR PINCUS: Right. No, but it's
9 the way the denominator is defined.

10 MEMBER MARK: No --

11 CO-CHAIR PINCUS: The fact that you --

12 MEMBER MARK: Well, it's still many,
13 many, many -- most people with Part B coverage
14 who get admitted to an inpatient psychiatric
15 hospital are going to show this score. This is
16 not --

17 DR. CAMPBELL: Yes.

18 MEMBER MARK: -- an unusual score.
19 When this gets put out into the real world, we're
20 going to expect the same scores.

21 DR. CAMPBELL: Right. No, yes, I think
22 so, but it's not everybody who gets discharged

1 from a psychiatric hospital.

2 MEMBER MARK: It is pretty much -- they
3 tested it on over 1,000 --

4 CO-CHAIR PINCUS: No, but it's only
5 people with Medicare.

6 MEMBER MARK: Right. This measure is
7 only -- right.

8 CO-CHAIR PINCUS: Yes.

9 MEMBER MARK: That point is correct.

10 CO-CHAIR PINCUS: Yes, that's what --
11 that may be --

12 MEMBER MARK: But that's not this
13 measure, this measure is only people in Medicare.

14 CO-CHAIR PINCUS: Yes.

15 MEMBER MARK: I just -- I think the
16 point is, people have pretty good continuity of
17 care and access to medications. I mean, if you
18 look at the percent of the population taking
19 psychiatric medications, it's 15-20 percent, so
20 it actually doesn't really surprise me that it's
21 pretty high.

22 When you look at the percent of people

1 getting therapy or treatment outside of
2 medications, it's pretty low. So, to me, this
3 data is pretty consistent with all the other data
4 we see around psychiatric, maybe getting a little
5 away from our main point.

6 CO-CHAIR PINCUS: Okay. Rhonda? And
7 then, let's --

8 MEMBER ROBINSON BEALE: Yes. I was
9 just going to comment on your statement that this
10 is surprising since the post-discharge follow-up
11 measure is always so low. The problem with that
12 measure, very familiar with that, Harold, is that
13 the measure only measures follow-up with a
14 behavioral health provider.

15 And most geriatric patients go back to
16 their primary care physician or their medical
17 physician and that's generally the one who is
18 managing them. So, I would expect there to be a
19 great disparity between the two measures.

20 CO-CHAIR PINCUS: Vanita?

21 MEMBER PINDOLIA: So, I understand that
22 the range in the gap is only 66 to 88 and it's on

1 the high end, and that's good. But the concern I
2 have is, did you look further into see -- and
3 divide the population of -- if the gap was
4 different if they were discharged to a group home
5 versus individual home? I understand homeless
6 shelter probably is not a population with the
7 Part D, but we definitely see a difference when
8 they go to group home versus individual homes.

9 DR. CAMPBELL: Yes. So, that's also a
10 good question, and I saw that in the prior
11 comments, so I had somebody run it before we came
12 to the meeting. But not specifically to address
13 your question.

14 So, in the measure, we only include
15 those patients that are discharged to home or
16 home health. All the other discharge disposition
17 codes in the claims, of which there are many,
18 hospice, SNF, all those types of things, they're
19 excluded.

20 And I did look at a comparison between
21 home and home health, and home health has higher
22 rates of medication continuation, as you would

1 expect. But those discharged to home would be
2 more reflective of the mean in the measure.

3 CO-CHAIR PINCUS: Mike?

4 MEMBER TRANGLE: We've had sort of a
5 smoldering, I wouldn't say raging, controversy in
6 our system about whether many of these folks, we
7 should fill their scripts with the hospital
8 outpatient pharmacy, so they leave with the
9 pills, versus trusting them and their families to
10 get them in their local pharmacies. Did your
11 data answer that question? I didn't -- I wasn't
12 part of the Committee review of this, so you
13 wouldn't have pre-seen this.

14 DR. CAMPBELL: That's also another
15 great question. So, one of the reasons, when we
16 originally specified the measure, we were looking
17 at the time frame for the follow-up to be post-
18 discharge, right? So, 30 --

19 MEMBER TRANGLE: But we don't write
20 them before two days before discharge.

21 DR. CAMPBELL: Yes, yes, but what we
22 identified in the testing in some of the

1 facilities that we worked with were kind of those
2 innovative programs where there's medications at
3 the bedside, where they're delivered basically to
4 the facility.

5 And there was some concern that, if we
6 didn't back that date up a little bit, we --
7 those prescriptions might have been dispensed by
8 the pharmacy a day before discharge or two days
9 before discharge.

10 So, that's why we changed the window,
11 the follow-up window, to allow that. And just to
12 note, so, patients that have Part D, that's an
13 ambulatory benefit, so it has to come from the
14 ambulatory pharmacy.

15 MEMBER TRANGLE: The hospital
16 outpatient pharmacy?

17 DR. CAMPBELL: Right, correct.

18 MEMBER TRANGLE: That they get right
19 before discharge and they leave with?

20 DR. CAMPBELL: Yes.

21 MEMBER TRANGLE: But you don't -- you
22 didn't look at that to see if that was a bit more

1 successful approach?

2 DR. CAMPBELL: We didn't look at it in
3 terms of any data, we just had anecdotal reports
4 that it was occurring, that there was filling
5 prior to discharge. And so, that's why we
6 changed that window.

7 CO-CHAIR PINCUS: Yes. And they
8 wouldn't be able to tell whether it was more
9 effective, because that's included in the
10 measure. Other comments with regard to
11 performance gap?

12 MEMBER MARK: Well, I just, I had a
13 question about the testing of that. Because
14 under the data element validity testing, you say,
15 few discharges included provision of medication
16 at discharge. So, that sounds like you did do
17 some testing, although, I was wondering what the
18 percentage was.

19 DR. CAMPBELL: So, what we meant by the
20 provision of medications at discharge is, we had
21 our physician reviewers look to see if there were
22 any samples or anything that wouldn't be captured

1 in claims that were dispensed by the facility.
2 So, like a one- or two- or three-day supply. But
3 that wasn't the case, we didn't identify that.

4 CO-CHAIR PINCUS: What about, actually
5 related to that, what about patients who have had
6 longstanding conditions that may have a reserve
7 of medication at home, when they return home?

8 DR. CAMPBELL: That's a good question,
9 too. So, we did look at a distribution of the
10 day supply on the prior fills, prior to the
11 inpatient hospitalization. And, predominately,
12 they were a 30-day supply. So, we believe that
13 allowing a 30-day window post-discharge would
14 require that the patient --

15 CO-CHAIR PINCUS: Right. Although, if
16 they were hospitalized, it might have been
17 because they weren't taking that medication
18 before.

19 DR. CAMPBELL: True, yes. So, we
20 think, but we think the 30-day window is probably
21 the best approach, given that they may have some
22 stockpiled supply, which means they may not fill

1 it immediately post-discharge.

2 CO-CHAIR PINCUS: But it does sort of
3 -- if you consider that and also consider that
4 some proportion of people may have problems with
5 the medication once they leave the hospital and
6 may, in fact, come back to a provider, who might
7 change or eliminate the medication, that would
8 make the gap less --

9 DR. CAMPBELL: Right.

10 CO-CHAIR PINCUS: -- than what you
11 found. So, there might be somewhat less of a gap
12 than it might appear. Other items about the gap?

13 MEMBER JENSEN: I just had a question.
14 Are you looking at the clinical setting that the
15 person is receiving their prescription from? Is
16 it in the primary -- I think this is to Rhonda's
17 question, is it -- are they receiving it from a
18 primary care physician or a specialty care
19 physician?

20 DR. CAMPBELL: So, the idea here is
21 that these would be prescriptions that were
22 prescribed at discharge from the inpatient

1 psychiatric facility. Right, and it's whether
2 they filled it within 30 days post-discharge.

3 CO-CHAIR PINCUS: Well, what if they
4 went the next day to see a provider and that
5 person did, it would also be captured there too,
6 right?

7 DR. CAMPBELL: Right. Yes. It doesn't
8 have to be from a fill from the inpatient
9 facility. If they saw a provider and that
10 provider wrote a prescription and they filled an
11 evidence-based medicine within that drug class,
12 then the facility would get credit for it.

13 CO-CHAIR PINCUS: So, just, validity,
14 having to do with sort of the accountability and
15 the -- of the -- and this may be something that
16 comes up later in terms of usability, but in
17 terms of the control that the hospital has, from
18 the perspective of the developer, you're saying
19 that the hospital could basically have control of
20 this measure by virtue of providing the
21 prescription at the point of discharge?

22 DR. CAMPBELL: Yes. And other

1 practices, other interventions, like appropriate
2 discharge planning and patient/caregiver
3 relationship to establish the importance of the
4 use of the medication. So, we did find evidence
5 that there's several interventions that can
6 increase the adherence that the patient would
7 take the medication post-discharge.

8 CO-CHAIR PINCUS: Right. Although, if
9 they solve the problem by giving the
10 prescription, that could potentially undermine
11 the connection to an outpatient provider.

12 DR. CAMPBELL: Yes, but --

13 CO-CHAIR PINCUS: In terms of, the
14 patient would not necessarily have a need to go
15 see the outpatient provider, if they already have
16 the medication.

17 DR. CAMPBELL: I mean, I think that
18 would be part of the discharge planning, right,
19 and process from the inpatient facility. The
20 recommendation is, yes, here's the prescription
21 you should be taking, but you need to follow-up
22 with your PCP or your psychiatrist.

1 CO-CHAIR PINCUS: Right. Because of
2 the motivation of the individual, oh, I'm running
3 out of my prescription, I got to go see somebody.

4 DR. CAMPBELL: Yes.

5 CO-CHAIR PINCUS: Which might also
6 account for the differences between the two
7 measures, of the follow-up after hospitalization
8 measure. Any other comments about the gap?
9 Okay. We're ready to vote.

10 MS. QUINNONEZ: Voting is now open for
11 the performance gap of Measure 3205: option 1,
12 high; option 2, moderate; option 3, low; and
13 option 4, insufficient. For the performance gap
14 of Measure 3205: option 1, high; option 2,
15 moderate; option 3, low; and option 4,
16 insufficient.

17 All votes are in and voting is now
18 closed. For the performance gap of Measure 3205:
19 30 percent voted high, which is seven people, 70
20 percent voted moderate, which is 16 people, and
21 zero percent, zero individuals voted low, and
22 zero individuals voted insufficient. This

1 measure passes the criteria for performance gap.

2 CO-CHAIR PINCUS: Okay. Let's move on
3 to the next item, which is reliability. So, one
4 of the lead reviewers want to comment on that?

5 MEMBER JENSEN: The reliability, the
6 group looked at, was that it was acceptable,
7 adequate. I don't think there were any
8 particular questions about it.

9 CO-CHAIR PINCUS: Any other discussion
10 with regard to reliability?

11 MEMBER MARK: I'll just point out that
12 they used the signal-to-noise ratio and if I
13 understand this right, they found that you have
14 to have at least 75 discharges in order to be
15 able to participate, to get a reliable measure.

16 DR. CAMPBELL: Yes, that's correct.

17 CO-CHAIR PINCUS: And that's -- and
18 most of these facilities have that.

19 DR. CAMPBELL: Yes, about 1200 out of
20 about 1700 had at least 75 discharges. And we
21 did use a two-year measurement period to increase
22 the number of facilities that could report, or

1 could be reported on.

2 CO-CHAIR PINCUS: Vanita?

3 MEMBER PINDOLIA: So, my question was
4 more based on the type of drugs that we're
5 looking at for the numerator to qualify. So,
6 like the SSRIs, which are heavily, all generic
7 and part of many \$4 program, did you look at how
8 many patients are getting their prescriptions
9 that aren't using their prescription card and the
10 claims processor because of that?

11 And that can vary from region to
12 region. Just in Henry Ford Health System, I did
13 that analysis and five years ago, it was already
14 at 12 percent would not show and it's been
15 growing steadily since then. And especially as
16 now Meijer is also supplying it, Walmart, Costco,
17 there's multiple.

18 DR. CAMPBELL: Yes. I think that's a
19 good question. And we have developed other
20 measures of adherence, NQF-endorsed measures of
21 adherence for behavioral health.

22 My understanding, though, is under

1 Part D, that Medicare has been actively working
2 with the folks that administer these programs and
3 that there's some, I guess, capture, additional
4 capture of the data. But I don't know to what
5 extent that's occurring at this point.

6 MEMBER PINDOLIA: I helped lead for the
7 Part D metrics at the plan in Henry Ford Health.
8 And there's been no boost effect, there's been
9 nothing, even if the data's been submitted, that
10 12 percent of our population did not show their
11 cards. And now, it's growing to 18 percent.

12 So, I have not seen that and I'm just
13 concerned as we keep having more and more drug
14 adherence-related measures and we're continuously
15 having more drugs that go into that program, so I
16 just want to -- as we add more, I think there
17 should be a further discussion or dissection of
18 the data to understand that.

19 DR. CAMPBELL: Yes, I think that's a
20 really good suggestion and something that we'd
21 definitely take back to CMS.

22 CO-CHAIR PINCUS: Any other comments

1 about reliability? Okay. I guess we're ready to
2 vote on reliability.

3 MS. QUINNONEZ: Voting is now open for
4 the reliability of Measure 3205: option 1, high;
5 option 2, moderate; option 3, low; option 4,
6 insufficient. For the reliability of Measure
7 3205: option 1, high; option 2, moderate; option
8 3, low; and option 4, insufficient.

9 All votes are in and voting is now
10 closed. For the reliability of Measure 3205: 26
11 percent voted high, six individuals, 74 percent
12 voted moderate, 17 individuals, zero percent
13 voted low, and zero percent for insufficient.
14 This measure passes the reliability criterion.

15 CO-CHAIR PINCUS: Okay. Let's now move
16 to validity.

17 MEMBER JENSEN: So, with validity, I
18 think we're back to that question of, patients
19 may be picking up their prescriptions, but are
20 they in fact taking them, and are they taking
21 them appropriately as prescribed?

22 CO-CHAIR PINCUS: Other comments with

1 regards to validity?

2 MEMBER PARISH: I had one question in
3 terms of, if somebody didn't really get their
4 meds changed, that they're on a mail-in order
5 plan that they already have four months of med at
6 home, they wouldn't be picking up another med.

7 DR. CAMPBELL: Yes. So, we did an
8 analysis of the frequency of days' supply for the
9 patients in the cohort and the overwhelming
10 majority of patients' prior fill to an inpatient
11 hospitalization was 30 days.

12 CO-CHAIR PINCUS: And even if they were
13 on a regular supply, that would have popped up
14 anyway. But what if their medication was
15 changed?

16 DR. CAMPBELL: If their medication was
17 changed, then obviously they would have to fill -
18 -

19 CO-CHAIR PINCUS: Right.

20 DR. CAMPBELL: -- whatever was
21 prescribed at discharge, which means that they
22 would need to have a fill within the 30 days.

1 CO-CHAIR PINCUS: Right, but what if
2 they kept on taking the old one or they got --
3 yes, I'm just sort of -- that's sort of -- people
4 do automatic refills. If they got changed to a
5 different medication, but they're getting the
6 continuing refill is from the old medication.

7 DR. CAMPBELL: Oh, I see. So, if under
8 their mail-order system, they went ahead and
9 refilled from their prior medication, yes, I
10 don't think that there would be any way to
11 address that or capture that within the data,
12 because we do allow any evidence-based medication
13 within the specific drug classes related to the
14 indications.

15 CO-CHAIR PINCUS: David?

16 MEMBER PATING: This is a really basic
17 question. So, in terms of this validity
18 question, is the validity question, did they get
19 the prescription filled or are they taking the
20 medicine, which was related to the gap?

21 So, it wasn't quite clear to me. Are
22 we -- filling and taking the medicine is not the

1 same and I just wanted to make sure I understand
2 the actual validity question that we're trying to
3 resolve.

4 CO-CHAIR PINCUS: So, the validity goes
5 on, obviously, at several different levels. One
6 is the validity of the measure itself in actually
7 measuring what it purports to measure.

8 And then there's the validity of the
9 concept as it's being applied, in terms of,
10 really, are people actually ingesting the
11 medication, because that's where the evidence is
12 that suggests the measure actually results in
13 better outcomes?

14 MEMBER PATING: So, could you speak to
15 that second linkage issue? Did you have data on
16 that?

17 DR. CAMPBELL: So most of the data,
18 because most studies use a proxy for adherence,
19 which is the filling of the prescription, which
20 is what we use, so most of the outcomes data
21 related to whether the patient had an adverse
22 outcome, if they weren't filling the medication,

1 is not related to a patient-reported measure,
2 let's say, that, I took the pill every day for 30
3 days.

4 It's actually claims data that's
5 utilized to figure out if they actually filled
6 the medication. So most of the data, that's the
7 way most of the evidence is characterized.

8 CO-CHAIR BRISS: So just on that point,
9 it seems to me that filling a prescription sort
10 of may or may not relate to taking the
11 prescription, but if you're not filling the
12 prescription, then you know that the person is
13 not taking it, right? And so --

14 DR. CAMPBELL: Yes.

15 CO-CHAIR BRISS: -- there's a fair
16 amount of gap in even filling the prescription.
17 So you always have this tension about what can be
18 measured and how good of a proxy it is. But I
19 think this does tell us something important about
20 continuity of care.

21 CO-CHAIR PINCUS: At some point, there
22 may be an eMeasure that actually is using

1 wearables to determine, but we're not there yet.
2 Rhonda? And then Vanita and Tami.

3 MEMBER ROBINSON BEALE: I may have
4 jumped too far ahead, I was going to threats to
5 validity, would that be --

6 CO-CHAIR PINCUS: Oh, okay. Vanita?

7 MEMBER PINDOLIA: I had a question on
8 validity test reporting. So, I see the data
9 element validity testing, and I understood that
10 makes sense; you're trying to validate what this
11 measure was doing.

12 But the measure score validity test,
13 I just had concerns on that, because when that
14 correlation was done, there was a large effect
15 for the 30-day follow-up, but definitely not for
16 the seven-day or the all-cause readmission.

17 What is -- if your measure is just,
18 they filled a script or not, what is the jump to
19 saying, did this decrease all-cause readmission?

20 I'm trying to understand the need for
21 that validity test and where does that -- is this
22 going to be used as measure, eventually. I'm

1 always concerned -- it's going to eventually
2 become a 5-Star, and is it then going to become 3
3 point, because it's an outcome measure all of a
4 sudden, instead of a process measure, which would
5 be a 1. And so that's why my question.

6 DR. CAMPBELL: Okay, thank you for the
7 question. So we actually developed and the
8 measure received endorsement, the IPF All-Cause
9 Readmission Measure, and our hypothesis was that
10 if patients didn't fill their medication
11 immediately post-discharge, that they'd be more
12 likely to have a readmission within the 30-day
13 window.

14 And, in fact, that's what we found,
15 when we looked at the Spearman's rank
16 correlation. I mean, granted, the correlation
17 isn't large, but it's in the direction that we
18 expect and supports the hypothesis.

19 And then if you look at the follow-up
20 after hospitalization, the correlation gets
21 stronger between seven-day and 30-day, which in
22 our mind, if we're trying to show that this is a

1 measure of quality of care, it does correlate
2 well to the existing endorsed measures related to
3 the same construct, which is coordination of
4 care.

5 And it's really, actually, exciting to
6 be able to do this, because a lot of times we
7 don't have the data, or we don't have the right
8 measure to compare it to, but in this case, we
9 feel that these measures do, in fact -- if you
10 follow up with your outpatient provider, you're
11 more likely to fill a prescription.

12 MEMBER PINDOLIA: So it's looking at
13 correlation to coordination of care?

14 DR. CAMPBELL: Yes.

15 MEMBER PINDOLIA: Okay.

16 CO-CHAIR PINCUS: Okay. David?

17 MEMBER EINZIG: So, just for
18 clarification, when we vote on validity, are we,
19 I understand what we're measuring, but are we
20 voting on the validity that simply the
21 medications are getting filled, or the spirit of
22 the measure of: are the patients taking the

1 medication?

2 CO-CHAIR PINCUS: Howard, you want to
3 -- yes. I mean, my sense is that it's both.

4 DR. LUSTIG: It's both, yes.

5 CO-CHAIR PINCUS: Yes, it's both. Yes,
6 it's both, obviously, but in many cases, we're
7 looking at data that are sort of surrogates to
8 actual endpoints, that are intermediate
9 endpoints. That's the reality in terms of the
10 feasibility of this.

11 CO-CHAIR BRISS: So David, I would say,
12 so the way I would frame that up is that it's
13 both -- are you actually able to measure what it
14 purports to measure? So is it validly measuring
15 whether people filled scripts on the one hand?
16 And then is that measure an acceptable proxy for
17 actually taking the med? It's both.

18 CO-CHAIR PINCUS: Okay. Raquel?

19 MEMBER MAZON JEFFERS: And then, I just
20 would go one step further, and then, is that
21 measure a measure of continuity of care? Because
22 that's where I'm falling off the edge, because I

1 don't see it as a continuity measure. Because
2 you are saying the majority of the prescriptions
3 that are being filled were written by the
4 inpatient hospital, not by a community provider.

5 DR. CAMPBELL: Right. So in order to
6 ensure, particularly in this population, that
7 patients fill their medications post-discharge,
8 it's sort of that first step in continuity. And
9 so I think -- and it's also the step that we feel
10 like, since the IPFs most likely wrote the
11 prescription, that we can hold them accountable
12 for it, right?

13 We're not asking them to stay
14 accountable for what happens six months from now.
15 We're asking them, for the prescription you
16 wrote, did your patient go and fill that
17 medication?

18 CO-CHAIR PINCUS: It's not a measure of
19 coordination of care. Yes, Rhonda?

20 MEMBER ROBINSON BEALE: I'm saying,
21 it's more a measure of transference, if the
22 patient had a positive transference to the

1 treatment and therefore wanted to fill their
2 prescription because they understand the
3 importance of it. It's kind of like that.

4 CO-CHAIR PINCUS: Or whether the
5 hospital just gave them the medication as they
6 were going out the door. I mean, that's -- it
7 may not be the patient went out and filled it in
8 the case of this medication.

9 One question I had related to validity
10 is the issue of sociodemographic risk adjustment.
11 I saw that African American patients performed
12 worse on this, and whether there's a need -- and
13 I can imagine that safety-net hospitals may have
14 more of a problem in, for -- those patients that
15 are being discharged to other facilities, may
16 have more of a problem in getting follow-up for
17 those patients and patients having sort of the
18 organizational capacity and other sort of
19 socioeconomic supports to go get their
20 prescriptions. How might that be impacted?

21 DR. CAMPBELL: So it's generally a
22 process measure. So for NQF, we generally don't

1 risk-adjust process measures.

2 CO-CHAIR PINCUS: Well, I thought that
3 there's a period of time in which we're looking
4 at that.

5 DR. BURSTIN: Right. So during our
6 trial period, we are looking at all measures to
7 see if there's a conceptual basis for adjustment
8 and thinking about whether that makes sense in
9 this particular measure. We don't usually look
10 at process measures, I think, as Kyle correctly
11 points out.

12 I will say, though, that adherence is
13 sort of a funny process/outcome, it's not clearly
14 a process. I think many would think of it
15 probably as an intermediate outcome, which
16 certainly would be eligible for this.

17 I will also say that the Pharmacy
18 Quality Alliance has a series of adherence
19 measures that they are actively in the process of
20 adjusting for SES, so there is some work already
21 happening here.

22 CO-CHAIR PINCUS: So if we endorse

1 this, does that mean we endorse it even though
2 there's not a specific sociodemographic
3 adjustment built into it, or are we encouraging
4 that one be built in?

5 DR. BURSTIN: I think it would be
6 reasonable to hear from the developers to see if
7 they've thought about it. Do they believe
8 there's a conceptual basis and whether there
9 could even be data to look at whether it's
10 possible? It's difficult to -- I mean, again,
11 there's no current risk adjustment for the
12 measure.

13 CO-CHAIR PINCUS: Right.

14 DR. BURSTIN: So it's a little hard to
15 conceive of throwing in additional variables for
16 a risk model that does not yet exist. That being
17 said, you may suggest this measure be stratified
18 for the populations most at risk to ensure we're
19 understanding what those differences are.

20 DR. CAMPBELL: Yes. In general -- and
21 we participated in the sociodemographic pilot
22 related to the IPF All-Cause Readmission Measure.

1 In general, we don't look to risk-adjust for
2 race/ethnicity, because we don't want to risk-
3 adjust away any potential disparities in care.

4 CO-CHAIR PINCUS: Right, but what about
5 sociodemographics more broadly?

6 DR. CAMPBELL: Sociodemographics, we
7 actually didn't find in the IPF All-Cause
8 Readmission Measure that they were more
9 explanatory than the clinical comorbidities that
10 we used, so we didn't recommend an SDS
11 adjustment.

12 CO-CHAIR PINCUS: Right, but we're
13 talking about --

14 DR. CAMPBELL: This measure, yes, I'm
15 getting to that. So for this measure, as I
16 mentioned, because it's a population of patients
17 that have prescription drug coverage, and because
18 those patients also would be eligible for low-
19 income subsidy, I don't think there's really any
20 barriers to access there that would necessitate
21 us doing any types of adjustment.

22 And in fact, when we looked at the

1 data, the dual-eligible population, which is
2 generally a good marker in claims of lower
3 socioeconomic status, they have higher rates of
4 med continuation, rather than lower. So I don't
5 think there's anything other than the disparity
6 we noted for race/ethnicity where we might
7 consider stratification.

8 CO-CHAIR PINCUS: Rhonda?

9 MEMBER ROBINSON BEALE: So with that
10 being said, I have a question about the exclusion
11 of patients with delirium secondary diagnosis and
12 dementia secondary diagnosis, because I'm not
13 quite clear I understand why.

14 DR. CAMPBELL: So one of the things we
15 did as part of our exclusion analysis was to look
16 and say, is there any reason why a patient would
17 not have an indication for a given medication in
18 the class?

19 And for patients with schizophrenia
20 and dementia, there is a black box warning, as
21 many of you are probably aware of, and I think
22 the APA has come out with a recent statement

1 about how to handle that, and it's a patient-by-
2 patient sort of risk/benefit tradeoff.

3 And for that reason, our technical
4 expert panel said we should probably just take
5 those out because we can't ascertain that
6 risk/benefit in claims. And delirium is a
7 similar thing; some of the medications in the
8 measure are contraindicated for delirium.

9 CO-CHAIR PINCUS: Okay. Vanita?

10 MEMBER PINDOLIA: I'd like to further
11 challenge the sociodemographic question that was
12 raised by Harold, because when you compare the
13 dual-eligibles, they have pretty much co-pay.
14 For Part D, when they're in the donut hole, and
15 if they do need one of the second or third
16 generation atypicals, that 40 percent of the
17 brand that they have to pay is almost impossible
18 for many, and they don't qualify for the low-
19 income subsidy.

20 So I know from our experience with
21 COPD, that's a huge problem we have, because of
22 the cost of inhalers, and they're not generic at

1 all; there's no generic available. And if they
2 have a 20 percent on their nebs, we cannot do an
3 alternative, other than give it away free. So I
4 don't think you can extrapolate your dual-
5 eligible population data to this because this is
6 more pure Part D where they won't have that.

7 DR. CAMPBELL: Do you -- I mean, I
8 think if we were to explore this in the future,
9 do you have a variable that would be available in
10 claims data that would allow us to do that that
11 is not the dual-eligible variable for Part D? I
12 think that really is -- that's really the
13 question is, in the claims data, what data do we
14 have as a proxy for sociodemographic status?

15 MEMBER PINDOLIA: Well, we do a lot of
16 heat maps based on ZIP Code analysis. And so
17 that would definitely be available.

18 DR. BURSTIN: And certainly, in our
19 experience in the SDS trial, a number of measures
20 have come forward, including those supported from
21 CMS, that looked at SDS by ZIP Code, income, or
22 even nine-digit ZIP, linked to the current

1 population survey at CPS. So, I think there are
2 options that may get closer to the income issue,
3 I think which is what Vanita's raising. It's
4 really more income that might be broader than the
5 duals.

6 MEMBER PINDOLIA: Yes.

7 DR. WINTERSTEIN: I think there's also
8 something said to, in the discharge planning
9 process, to think about affordability for
10 patients.

11 To discharge a patient on a drug that
12 clearly cannot be afforded may not really be the
13 best course of action for that facility, and it
14 might be better to find a lower-tier
15 antipsychotic that would be affordable. So, I
16 think there's also this -- there's a certain
17 component that's in the control of the IPF, I
18 would think.

19 CO-CHAIR PINCUS: Provide some
20 incentive for them to consider the patient's
21 particular situation. Okay. Andrew and then,
22 Peter. And Les, is yours up? Oh, okay. Andrew

1 and then Les and then Peter.

2 MEMBER SPERLING: Okay. So --

3 CO-CHAIR PINCUS: You've got to make
4 sure it faces us.

5 MEMBER SPERLING: My understanding, and
6 I've worked in the Part D program for a long
7 time, is the diagnosis for which the prescription
8 is being written, or the indication is actually
9 not part of the Part D claims data. So, the
10 pharmacist doesn't actually know what the
11 diagnosis is or even the reason the prescriber
12 has written the prescription, right?

13 DR. CAMPBELL: Yes, that's correct. In
14 our case, we've integrated the A and B and D
15 data, so the diagnosis comes from the A and B
16 data --

17 MEMBER SPERLING: Okay.

18 DR. CAMPBELL: -- for Medicare fee-for-
19 service patients.

20 MEMBER SPERLING: And then another
21 reason for the exclusion of dementia and these
22 other indications is, because on the other side

1 of this, the Part D plans and the Medicare
2 Advantage plans are all being held to account by
3 CMS for off-label prescribing for dementia, and
4 they are actually under obligation to lower that
5 rate, and they've done so dramatically.

6 So you have to understand that CMS is
7 using this for different purposes, for the Star
8 Ratings, for these plans to make sure that
9 they're -- and for the facilities to make sure
10 that they are trying to reduce off-label
11 prescribing of antipsychotics.

12 CO-CHAIR PINCUS: Les, and then Peter.

13 MEMBER ZUN: I'm always concerned about
14 using face validity as your tool to measure
15 validity. And when I look back at who assessed
16 it, they were TEP, technical expert panel, but it
17 doesn't say who was on the panel, whether they're
18 physicians, what their background is.

19 CO-CHAIR PINCUS: No, it's --

20 MEMBER ZUN: It's really hard for me to
21 understand who validated it if I don't know who
22 the ten people were.

1 CO-CHAIR PINCUS: Yes, it's actually,
2 if you get to the bottom of the --

3 MEMBER ZUN: Is it?

4 CO-CHAIR PINCUS: -- report, it
5 actually lists the people. Yes, it's at the
6 very, really, actually the very end almost.

7 DR. CAMPBELL: Yes, so, just to answer
8 your question broadly, our technical expert
9 panels are usually very diverse in terms of
10 stakeholders. So we have folks that are
11 clinicians. We have folks that represent
12 hospital systems, folks that are methodologists,
13 and also, importantly, patient and caregiver
14 representatives on our panel.

15 CO-CHAIR PINCUS: Okay.

16 CO-CHAIR BRISS: I was going to say on
17 the question of whether or not you should adjust,
18 so at this point, I don't see good evidence that
19 this should be an adjusted measure. I would call
20 it significantly under the control of the
21 provider. That if the provider does the right
22 thing, that you can likely get a reasonable score

1 on this measure.

2 And I think we're way upstream about
3 worrying about how and whether this might impact
4 somebody's 5-Star rating, and I'm more -- at this
5 point, you don't tell us anything, at least that
6 I saw, about -- you saw a statistically
7 significant difference between black patients and
8 other patients, but we don't actually know how
9 big that effect is. And so for a variety of
10 reasons, I think it's way premature, actually, to
11 be talking about adjusting this measure.

12 CO-CHAIR PINCUS: Other comments with
13 regard to validity? So seeing none, let's vote.

14 MS. QUINNONEZ: Voting is now open for
15 the validity of Measure 3205: option 1, high;
16 option 2, moderate; option 3, low; and option 4,
17 insufficient. For the validity of Measure 3205:
18 option 1, high; option 2, moderate; option 3,
19 low; and option 4, insufficient.

20 Looking for one more vote, if you
21 could just submit your votes one more time,
22 please? There we are, we captured it. All votes

1 are in and voting is now closed.

2 For the validity of Measure 3205: 9
3 percent voted high, 2 individuals; 78 percent
4 voted moderate, 18 individuals; 3 individuals,
5 which would be 13 percent, voted low; and 0
6 percent insufficient. So for validity of Measure
7 3205, this passes the validity criterion.

8 CO-CHAIR PINCUS: Okay. Let's move on
9 to feasibility. One of the lead reviewers want
10 to comment on feasibility?

11 MEMBER PINDOLIA: I think this one's an
12 easy one. All the data is claims-based, and so
13 it's easy to gather.

14 CO-CHAIR PINCUS: Any other comments
15 about feasibility? Okay. Ready to vote on
16 feasibility.

17 MS. QUINNONEZ: Voting is now open for
18 the feasibility of Measure 3205: option 1, high;
19 option 2, moderate; option 3, low; and option 4,
20 insufficient. For the feasibility of Measure
21 3205: option 1, high; option 2, moderate; option
22 3, low; and option 4, insufficient.

1 Looking for one more vote. There we
2 are. All votes are in and voting is now closed.
3 For the feasibility of Measure 3205: 61 percent
4 voted high, 14 individual votes; 39 percent voted
5 moderate, 9 individual votes; 0 percent voted for
6 low; and 0 percent insufficient. For the
7 feasibility of Measure 3205, this passes the
8 feasibility criterion.

9 CO-CHAIR PINCUS: Okay. And now let's
10 move on to usability and use. One of the
11 reviewers want to comment on usability and use?
12 David?

13 MEMBER PATING: I'm not going to
14 comment, but I'd like to raise a question. I'm
15 not sure who the target of this measure is. Is
16 this a measure that looks at integrated health
17 plans, or is it measuring --

18 CO-CHAIR PINCUS: It's hospitals.

19 MEMBER PATING: Hospitals?

20 CO-CHAIR PINCUS: Hospitals, it's part
21 of -- that's --

22 MEMBER PATING: It's a hospital

1 measure?

2 CO-CHAIR PINCUS: It's a hospital
3 measure.

4 MEMBER PATING: So on that basis, I
5 actually have concerns about the usability of
6 this measure. I think any measure that sort of
7 measures the after-hospital performance, even if
8 the prescription is given at the time of
9 discharge, really discriminates against public
10 hospitals with very transient populations that
11 come in and out, are not identified, have no
12 medical home, and most of the care is done in the
13 hospital or sometimes even in a jail psych
14 setting and then discharged.

15 So I'm really concerned about that.
16 Even though the data is there, and it's easy to
17 capture, these may not be linked patients, and so
18 again, public sector hospitals, I would imagine
19 will do poorly on this. VA hospitals, for that
20 matter, maybe.

21 MEMBER JENSEN: VA hospitals, we would
22 do great because we provide medications to our

1 patients. So it would be no problem for us.

2 CO-CHAIR PINCUS: And would the
3 medications you dispense be captured?

4 MEMBER JENSEN: In this measure? No,
5 because they're not measuring veterans. But I
6 mean --

7 CO-CHAIR PINCUS: Right.

8 MEMBER JENSEN: -- we collect data
9 about this all the time, about whether or not our
10 patients pick up their prescriptions. And when
11 they're discharged, we make sure they do, because
12 the pharmacy is right there, and so the nurse
13 goes down and gets it and sends the patient home
14 with it.

15 MEMBER PATING: That would be for the
16 two-day, right, and the seven-day. Just the 30-
17 day, with homeless vets, I know sometimes are
18 lost to follow-up. So that's -- anyway, the
19 veterans system is not on -- because I don't
20 think the Medicare is applying to that
21 population.

22 CO-CHAIR PINCUS: But anyway, Rhonda

1 and Mike.

2 MEMBER ROBINSON BEALE: I would agree
3 with David. I have some concerns for hospitals,
4 not just public hospitals but hospitals that are
5 not involved in some type of accountable care
6 organization, because there's not necessarily
7 those resources built in or those processes being
8 built in.

9 So, if this would include populations
10 that are not in ACOs, I think it's going to be
11 problematic. Or Stars, if this is going to be a
12 star and something that has to do with a rating
13 in that regard, it will be problematic.

14 CO-CHAIR PINCUS: Okay. Mike, and then
15 Peter.

16 MEMBER LARDIERI: Yes, I was just going
17 to echo the same thing. I mean, I think, on a
18 system level, I think this would be good, but
19 just putting that on the hospital, when the
20 hospital loses the patient, I mean, in our
21 system, we don't have all our patients staying
22 in-system -- they go to other systems -- how do

1 we do that follow-up with them?

2 I think at a system-level, you can
3 hand-off from your inpatient to your outpatient
4 provider within your system. They can reach out
5 and have a push/pull type thing to make sure the
6 patient takes their medication. I think that
7 would be a better view of it than just on the
8 hospital.

9 CO-CHAIR PINCUS: Peter?

10 CO-CHAIR BRISS: I'd like to speak for
11 it, actually. So I think there's little --
12 everybody knows that there's a lot of losing
13 people between hospital discharge and community
14 care, but if we're not measuring it and paying
15 attention to it and trying to do better, we're
16 never going to do better, right?

17 And I work at a safety-net hospital;
18 my clinical work's at a safety-net hospital. So
19 I actually think this kind of measurement is
20 essential to do.

21 CO-CHAIR PINCUS: Just for me to step
22 out of the role of the chair for a minute, I

1 agree very much with Peter, because in some ways
2 this is a lot more controllable than, for
3 example, follow-up after hospitalization --

4 CO-CHAIR BRISS: Yes.

5 CO-CHAIR PINCUS: -- in seven and 30
6 days. Because the hospital can actually
7 prescribe it, so it is a more controllable
8 measure. Mike?

9 MEMBER TRANGLE: I mean, I agree, too.
10 I mean, to some extent, what it's doing is, it's
11 driving, even if it doesn't directly mandate,
12 hospitals to use their outpatient pharmacy to
13 have the patient leave with the script. That's
14 the way you can control it.

15 So in some sense, I think it's kind of
16 driving a practice change in a way that's not
17 necessarily clearly articulated, but for you to
18 do well at that, you need to take control and
19 control what you can and make it happen.

20 Some people could argue that it's a
21 cost-shifting for hospitals that are safety-net
22 hospitals. Some of our hospitals are safety-net

1 hospitals. We've sort of bitten that bullet and
2 sort of said, yes, we're going to do that. But I
3 think that's sort of calling a nickel a nickel or
4 whatever.

5 CO-CHAIR PINCUS: Okay. Lisa?

6 MEMBER JENSEN: Well, I think the other
7 thing it's measuring is the organization's
8 ability to be educating the patients about taking
9 their medications. Is that happening during the
10 -- at the beginning of their hospital stay right
11 through to discharge.

12 CO-CHAIR PINCUS: Mike?

13 MEMBER TRANGLE: I'm really sort of
14 probably getting ahead of ourselves for
15 usability, but I do think the one caveat we sort
16 of keeping come back to is it's a small slice of
17 the population.

18 And I think, when we come to -- in
19 some sense, when we come to voting for the
20 overall thing, I'd like us to see if there's a
21 consensus when we're doing that to vote with a
22 recommendation to broaden the pool to include MA

1 patients or other ones that we could.

2 CO-CHAIR PINCUS: Okay. Other
3 comments? So, let's vote on usability and use.

4 MS. QUINNONEZ: Voting is now open for
5 the usability and use of Measure 3205: option 1,
6 high; option 2, moderate; option 3, low; option
7 4, insufficient information.

8 All votes are in and voting is now
9 closed. For the usability and use of Measure
10 3205: 22 percent, 5 individuals voted high; 65
11 percent voted moderate, 15 individual votes; and
12 3 individual votes, which would be 13 percent,
13 voted low. 0 for insufficient information. For
14 usability and use, Measure 3205 passes this
15 criterion.

16 CO-CHAIR PINCUS: Okay. So now we are
17 voting -- are there any -- there are no related
18 or competing measures. So, now, we're voting for
19 endorsement. Any final comments with regard to
20 endorsement?

21 CO-CHAIR BRISS: I think, related to
22 Mike's comment, that we'd already committed to

1 give that advice to CMS about we'd love to see a
2 broader measure. So it --

3 CO-CHAIR PINCUS: Right.

4 CO-CHAIR BRISS: -- seems to me that
5 it's okay to vote on.

6 CO-CHAIR PINCUS: That advice is thus
7 given, Ellen. Yes. Okay. Seeing no further
8 comments, let's vote.

9 MS. QUINNONEZ: Voting is now open for
10 overall suitability for endorsement of Measure
11 3205: option 1, yes; option 2, no. Looking for
12 one more vote. All votes are in and voting is
13 now closed.

14 For the overall suitability for
15 endorsement of Measure 3205: 87 percent voted
16 yes, 20 individuals; 13 percent voted no, 3
17 individual votes. For the overall suitability
18 for endorsement of Measure 3205, this passes this
19 criterion. This is a recommendation.

20 CO-CHAIR PINCUS: So thank you. So,
21 before we take a relatively short break for
22 lunch, do we just want to hear from any NQF

1 member or public responses or comments to our
2 morning's work? Anybody in the room? Anybody on
3 the phone?

4 OPERATOR: To make a public comment,
5 please press star-1. And we have no comments.

6 CO-CHAIR PINCUS: Okay. So why don't
7 we take a break for lunch and let's return at a
8 quarter of. And --

9 DR. LUSTIG: Yes, so we'll try to get
10 your lunches quickly and we'll get right back to
11 your second measure, if that's all right. Thank
12 you.

13 (Whereupon, the above-entitled matter
14 went off the record at 12:26 p.m. and resumed at
15 12:47 p.m.)

16 DR. CAMPBELL: Okay, so this measure,
17 the medication reconciliation at admission was
18 also developed for use in the same program, the
19 inpatient psychiatric facility reporting program.

20 We know that inaccurate medication
21 reconciliation is a significant patient safety
22 issue that's been recognized by the Joint

1 Commission, Institute of Medicine, and other
2 national organizations that have been focused on
3 patient safety.

4 We also know that medication errors or
5 discrepancies can lead to adverse drug events for
6 patients and that a medication reconciliation
7 process can reduce both the risk of errors and
8 also harm to the patient through adverse drug
9 events.

10 The medication reconciliation measures
11 currently endorsed by NQF do not really assess
12 the quality of the process, and they also do not
13 focus on medication reconciliation at admission.

14 And in our review of the literature,
15 medication reconciliation at admission was
16 identified as a critical point in the care
17 transition and also the point at which many
18 errors could be introduced into a patient's
19 medication regimen.

20 In our patient and caregiver
21 interviews that we conducted, we had several
22 patients indicate that a comprehensive

1 information gathering process was critical
2 because they may not always be able to reliably
3 report all of their information at admission when
4 they're in crisis.

5 And they noted that they would prefer
6 to go to facilities with overall good medication
7 management practices, obviously including
8 medication reconciliation process. And
9 importantly, they felt that this measure was
10 understandable to them and would be of benefit.

11 The measure addresses the quality of
12 the medication reconciliation process by a
13 establishing a minimum standard for the
14 collection and documentation of information on
15 medications that patients were taking prior to
16 the inpatient admission.

17 It's specified as a composite measure
18 to improve interpretation and has three
19 components. The first is an information
20 gathering component. The second is the
21 completeness of critical prior-to-admission
22 medication information, and the third is the

1 actual reconciliation step by a licensed
2 prescriber meaning that you should continue,
3 discontinue, or adjust.

4 We identified very wide variation in
5 performance on this measure, suggesting ample
6 opportunity for improvement. And it is a chart-
7 abstracted measure. We did attempt to estimate
8 burden, which we identified as a median time of
9 approximately ten minutes per admission.

10 And we validated the measure with a
11 random sample of approximately 100 admissions per
12 facility. So we thank you for your consideration
13 of this measure and look forward to your
14 questions and comments.

15 DR. LUSTIG: If I could just jump in,
16 I also wanted to give one word on why we're
17 considering this as a composite measure. And I
18 know different people often have different
19 definitions.

20 According to NQF's definition, we
21 consider this to be a composite measure because
22 there are three components to the measure that

1 are aggregated for each component and then
2 aggregated again for the final score.

3 And so for that reason, we did discuss
4 with the developers classifying this as a
5 composite measure. It actually required them to
6 provide even more information than if it was
7 classified as a process measure.

8 So we just wanted to clarify that in
9 case anyone had questions.

10 CO-CHAIR BRISS: So with that, would
11 any of the discussants like to tee up the
12 importance to measure and report?

13 MEMBER PINDOLIA: Before we do that,
14 I have one question, and I had emailed it to the
15 NQF, and we wanted to have clarification. The
16 measure is right now very general to say average
17 completeness of med rec, processed within 48
18 hours of admission to an inpatient facility.

19 But everything inside, whether that's
20 a gap survey, the reliability to everything, was
21 based off nine psychiatric facilities only. So
22 is this for just psychiatric hospitals, or is

1 this for all hospitals?

2 DR. CAMPBELL: Yes, it's for just
3 inpatient psychiatric facilities.

4 MEMBER PINDOLIA: Okay, thank you.

5 MEMBER SUSMAN: It would help if you
6 just briefly discuss the three components. And
7 having not been one of the people who reviewed
8 this in depth, I'm trying to get my mind around
9 how you exactly compute these.

10 DR. WINTERSTEIN: Yes, thank you for
11 this question. And that was quite a challenge
12 because we really wanted to capture, via quality,
13 medication reconciliation process rather than
14 just presence of one.

15 So there's three components. One
16 essentially looks at the sources that are
17 considered in establishing a comprehensive
18 medication, prior to admission medication list,
19 because we are focusing on the admission process,
20 so the key part is to find out what the patient
21 took before he or she was admitted to the
22 facility.

1 So we are looking in the first
2 component at the sources that were considered, so
3 the measure requires two sources. One that would
4 be related to the patient. So that could be the
5 patient him or herself as well as caregivers,
6 pill bottles that were brought, or a medication
7 list, and then a healthcare-related source which
8 could be an outpatient prescriber, an outpatient
9 pharmacy, the PDMP, so the Prescription Drug
10 Monitoring Program, or any other healthcare
11 provider that was contacted in order to get
12 additional information.

13 In component 1, we also require that
14 the medication -- this prior-to-admission
15 medication list is in the designated place in the
16 charts for easy reference and that the
17 information that is on the PTA medication list is
18 consistent with the information that might be
19 dictated on the HMP by the admitting prescriber.

20 And when I say consistent, we're
21 requiring that the PTA medication list includes,
22 at a minimum, the medications that were also

1 dictated on the HMP. So that's the first
2 component.

3 MEMBER SUSMAN: So this is all under
4 one component, or is this --

5 DR. WINTERSTEIN: So each of the
6 components, the subcomponents that I just
7 mentioned would be scored, and that would be
8 averaged across record. So basically there is a
9 maximum of four subcomponents that would be met,
10 and that would be your average per record.

11 A second component looks at the
12 medications that are actually documented on the
13 PTA medication list, and it requires that the
14 name, the dose, the route, the frequency, and the
15 last time taken is documented for each
16 medication.

17 For the last time taken, there is
18 permission to document that the patient cannot
19 remember it because the patient is the only
20 source that can reliably produce this
21 information.

22 For the other four sources, there

1 would be a requirement that there's adequate
2 documentation so that the reconciling physician
3 actually knows what he or she is actually
4 reconciling. That's the second component.

5 And that is again scored for each
6 medication that is listed on the PTA medication
7 list and then averaged across all medications
8 that were recorded for the number of patents that
9 were, for the number of records that were
10 reviewed.

11 And then the third component is a
12 single item, and that looks at whether the
13 medications on the PTA medication list were
14 reconciled by a prescriber within 48 hours. And
15 the reconciliation is operationalized with either
16 documentation that the medication was to be
17 discontinued, discontinued, or modified.

18 So there should be a prescribing
19 decision that specifies what is to be done with
20 this medication, and that should happen within 48
21 hours. And that's again average for all
22 medications that are extracted across all

1 records.

2 MEMBER JENSEN: Okay, so one of our
3 first comments from the folks that reviewed this
4 was that the literature is weak on supporting
5 this. And so I'm wondering if you can talk a bit
6 more about the literature and what kind of
7 support you all found in developing this.

8 DR. WINTERSTEIN: Yes, so the
9 literature is, and I think we all are familiar
10 with the IOM report in 1999 that came out on
11 medication errors and medical error in general
12 and the prevalence of preventable adverse drug
13 events in both institutional and non-
14 institutional settings.

15 So we know that as a whole,
16 preventable adverse drug events are quite common
17 and are considered a very massive threat to
18 appropriate healthcare and optimal healthcare
19 outcomes.

20 That said, and I actually personally
21 have done a lot of research in this area, there's
22 also a huge challenge in measuring this because

1 preventable adverse drug events come in many
2 flavors and forms.

3 And so to measure them really requires
4 systematic chart reviews by very astute people
5 who are actually able to identify preventable
6 adverse drug events as such. So it's not so easy
7 to measure this, and that I think explains the
8 major limitations for most studies that have been
9 published in this area.

10 There are a lot of studies that have
11 been published with respect to medication errors
12 on admission. Usually these are studies that
13 have been conducted by pharmacists that look very
14 specifically on medications that were ordered on
15 admission and compare those against what patients
16 were admitted on.

17 And the range of problems, ranges,
18 depending on the definition really from 10, 30
19 percent up to 80 percent per patient who is
20 affected by at least one error that could have
21 been avoided.

22 But are those errors then really

1 relate to sincere outcomes, as I said, is a very
2 different question. I think in most studies,
3 there's an estimate that about 10 to 25 percent
4 of those would be considered clinically-relevant
5 in one way or the other.

6 In many instances it's omission errors
7 and admission errors so that essentially,
8 essential medications were forgotten and not
9 continued on admission. But there also are, you
10 know, confusions, different doses, and so on.

11 CO-CHAIR BRISS: Other comments on, or
12 questions on importance of the measure?

13 CO-CHAIR PINCUS: Just one question.
14 Sorry.

15 CO-CHAIR BRISS: Andrew.

16 MEMBER SPERLING: Thank you. So my
17 question, or really comments relate to the
18 accuracy of the data that's going to come out of
19 this. I'm specifically concerned about instances
20 of acute psychosis, suicidality, really the
21 extreme symptoms.

22 And that's really the cohort of people

1 we're dealing with, right? People that are
2 adhering to their treatment and are doing fine
3 aren't admitted to psychiatric hospitals, because
4 we know there's aggressive utilization management
5 on the front end in many healthcare plans.

6 And the question is, the ability of
7 someone who's in the midst of an episode of acute
8 psychosis to render an accurate list of all the
9 medications they have, not just the psychotropic
10 medication, but if they have comorbid diabetes or
11 asthma, a whole long list, to be able to come
12 forth with the names of the medications, the
13 dosage, the frequency, all of that. So we're
14 collecting data that clinicians are going to rely
15 on that may not be entirely accurate.

16 And so that's one of the concerns that
17 many of us have of making sure that, if we're
18 collecting data, let's make sure it's accurate so
19 it's used in the right way.

20 And I know you've made some effort to
21 look at when a patient being admitted simply
22 can't deliver that list of medications and how --

1 can you talk a little bit more about how you sort
2 of accommodate for those emergent circumstances,
3 which is, quite frankly, more prevalent in the
4 case of an inpatient admission.

5 DR. WINTERSTEIN: Yes. And we did
6 alpha test this measure when we started to really
7 define those specifications in our own two
8 inpatient psych facilities. And we got a lot of
9 feedback from those providers there.

10 So if the patient is unable to provide
11 information that can be documented, and if that
12 documentation is there, that would be counted as
13 an appropriate patient source. So actually the
14 facility would score favorably if -- as long as
15 the facility documents this patient was not in a
16 condition that he or she could provide any useful
17 information.

18 So that's absolutely accepted as a
19 patient source. In order to address the issue
20 that this is a really very special circumstance
21 where many patients may really not be able to
22 provide their accurate PTA medication, this was

1 the exact reason why we require a health system
2 source as well.

3 And that's what we consider the
4 minimum standard, that there's at least an
5 attempt made to try to get a more comprehensive
6 view on the prior-to-admission medication list.

7 MEMBER SPERLING: And what would those
8 be if there isn't a family member there? I mean,
9 they have to randomly call pharmacies, or what?

10 DR. WINTERSTEIN: Yes, so the health
11 system sources would be an outpatient provider.
12 So any kind of PCP who could be identified,
13 outpatient pharmacies, the Prescription Drug
14 Monitoring Program that is accessible to all
15 providers in 49 states.

16 Prior to admission, prior admission
17 records or records that would be available within
18 the health system that the patient was admitted
19 to. All of those would be acceptable.

20 MEMBER SPERLING: You mentioned --

21 DR. WINTERSTEIN: Just one of those.

22 MEMBER SPERLING: And this covers

1 psych units and general hospitals as well?

2 DR. WINTERSTEIN: The measure is only
3 constructed for inpatient psychiatric facilities.
4 It was only tested there. But if those have an
5 integrated electronic health record system and
6 can look at the affiliated hospitals or
7 affiliated clinics, they could use that
8 information as well.

9 CO-CHAIR BRISS: I think I have Jeff,
10 Harold, Michael. Jeff?

11 MEMBER SUSMAN: So I'm interested in
12 the evidence. I mean, so IOM, whoever comes out
13 and says, yes, we should do medicine
14 reconciliation, but this measure strikes me as
15 very complicated and taking a lot of things
16 together in a composite where I'm not sure that
17 any element is equal.

18 I mean, is it really just as important
19 to do A as the third component, composite 3? I'm
20 not clear that there's good evidence that doing
21 this in the way that it's constructed and
22 measured here leads to improved outcomes

1 although, yes, you can say it feels good.

2 But does it really make a difference?

3 And I guess I'm somewhat skeptical. We can talk
4 about other matters which I'm concerned about,
5 but let's just start with evidence.

6 DR. WINTERSTEIN: Yes, I think that
7 was one of the major points to reading arguments
8 to really submit this as a composite measure to
9 give you the opportunity to look at the
10 contribution of each component to the overall
11 score at the ends and to make it very transparent
12 that there are three components.

13 And we had a lot of discussions, and
14 you will see in the sensitivity testing that was
15 done that there's actually various ways of
16 summarizing the components.

17 There was one way that we present
18 where we ignore them altogether and just take all
19 the elements for the measure and summarize
20 everything up. What we ended up presenting here,
21 and you will see the data on how this compares
22 for each of the various versions, is that there

1 was a 30/30/30.

2 So component 1 is the information
3 gathering process. Component 2 is here's the
4 meds, and here's the information on the
5 medications. And number 3 is the medication
6 reconciliation.

7 Number 3 is just one single item, but
8 that's the action step that is the finite really
9 trigger for an outcome, right? So if the
10 physician doesn't reconcile whatever is on this
11 medication list, nothing is going to happen.

12 So that last component is obviously
13 very critical. However, this last component also
14 just only works when there is actually
15 information that is valid that an action can be
16 based on.

17 So as we were discussing this, to us
18 and to the -- we actually had two groups. One
19 was an internal workgroup of providers in our own
20 facilities, and then we had a larger technical
21 expert panel that is again in the materials
22 listed.

1 To us, it felt -- to that whole group,
2 it felt that the way we had assigned value or
3 rate makes most sense thinking about how each
4 process contributes to the overall effect at the
5 end, which would be hopefully we have a
6 medication reconciliation process that ends up in
7 the right medications.

8 MEMBER SUSMAN: So just to briefly
9 follow up, are there studies which would link
10 each of these components, or the elements that go
11 into the components, with enhanced outcomes. And
12 that's what I'm trying to get my head around.

13 DR. WINTERSTEIN: Yes. So those
14 studies that have -- well there's two things.
15 One is the components that we mention are aligned
16 with the process that the Joint Commission
17 defines as an appropriate medication
18 reconciliation process. So they are consistent
19 with that.

20 MEMBER SUSMAN: So it's not an
21 evidence-based recommendation?

22 DR. WINTERSTEIN: Right. No, that's

1 just a best practice. Those studies that have
2 been published, that have looked at a medication
3 reconciliation process, use that process. In
4 most instances, they are pharmacists, and most
5 studies have been conducted in acute care
6 facilities and not in IPFs.

7 In most instances, they are
8 pharmacists that use an information gathering
9 process that is two-pronged, similar to what we
10 are proposing, that ensures that the medications
11 are properly recorded. And then there is a
12 physician reconciliation process at the front
13 end.

14 So that is kind of a standard process
15 that we were trying to capture, yes.

16 CO-CHAIR BRISS: Harold and then
17 Michael.

18 CO-CHAIR PINCUS: So I had several
19 questions to clarify exactly what the measure is
20 in terms of its operationalization. And then I
21 had some concerns.

22 One is, how are you defining attempt

1 to reach? Because it doesn't say that they
2 necessarily reach a source. So if you could talk
3 a little bit about that.

4 And also to clarify, this includes all
5 medications, not just psychiatric medications?

6 DR. WINTERSTEIN: Yes, so we define as
7 an attempt, as a documentation in the chart, that
8 an attempt was made to contact the provider.

9 CO-CHAIR PINCUS: So what does
10 documentation of an attempt mean?

11 DR. WINTERSTEIN: I called the
12 pharmacy, and the pharmacy was closed, or I
13 called the provider, and the provider was closed,
14 something along these lines.

15 CO-CHAIR PINCUS: What if there is no
16 known provider or no known pharmacy?

17 DR. WINTERSTEIN: There would still be
18 a PDMP that could be contacted at the minimum, as
19 long as there was a patient name.

20 CO-CHAIR PINCUS: What if there was no
21 PDMP, if the patient has no insurance?

22 DR. WINTERSTEIN: Well, there would

1 still be a PDMP. The PDMP is not linked to
2 insurance. The PDMP would capture everything
3 that a pharmacy dispensed for this patient that
4 is a controlled substance. It's not linked.

5 CO-CHAIR PINCUS: As a controlled
6 substance?

7 DR. WINTERSTEIN: Yes. Yes. PDMP is
8 Prescription Drug Monitoring Program.

9 CO-CHAIR PINCUS: Right, right. But
10 that's only for a controlled substances.

11 DR. WINTERSTEIN: Yes, that's correct.

12 CO-CHAIR PINCUS: So it's not for
13 anything else.

14 DR. WINTERSTEIN: Yes, yes.

15 CO-CHAIR PINCUS: So --

16 DR. WINTERSTEIN: So that was the
17 first question. Remind me --

18 CO-CHAIR PINCUS: And the other is --
19 but this is medication reconciliation for all
20 medications?

21 DR. WINTERSTEIN: Yes. Yes, and
22 there's two reasons for this. Number one, a lot

1 of psychiatric patients have certainly a lot of
2 non-psychiatric medications. There is certainly
3 an increased risk for non-mental morbidity in
4 those populations.

5 CO-CHAIR PINCUS: I know. I mean, I
6 think it should be obviously for all medications.
7 Yes, I'm not asking for justification for it. I
8 just want to be clear that that is in fact --

9 DR. WINTERSTEIN: Yes.

10 CO-CHAIR PINCUS: Although for one of
11 the sources, it's only for a single class of
12 medications.

13 DR. WINTERSTEIN: Yes, that's correct.

14 CO-CHAIR PINCUS: So that you could
15 actually meet that criterion just by looking just
16 at a single class of medications.

17 DR. CAMPBELL: Yes. And I think it's
18 important to note with the measure that we're
19 attempting to establish a minimum standard of
20 what might be necessary for a provider to do, and
21 not necessarily what might be required every
22 single time for a provider to do.

1 So while that might be sufficient in
2 one case, in other cases, the provider may need
3 to contact two or three different health systems
4 to identify that, correct?

5 CO-CHAIR PINCUS: So here's my
6 concern, is that this is very minimal. It's
7 really very limited in terms of both the nature
8 of the data collection, but also, it's just about
9 documentation.

10 It doesn't look at all about the
11 accuracy of the medication reconciliation, either
12 accuracy in terms of whether the documentation is
13 in fact accurate to what the patient actually has
14 been receiving, nor does it look at the quality
15 of the judgment about reconciliation.

16 So it's very minimal, and it's heavily
17 burdensome. And so it raises the question of
18 whether the juice is worth the squeeze here.

19 DR. CAMPBELL: So if you look at the
20 -- I mean, I think if we go back to the
21 discussion that we had on the prior measure, if
22 you look at the data, there's a huge quality gap

1 here to suggest that the facilities aren't even
2 yet doing the minimum.

3 And while we can't guarantee that what
4 comes out of this process is 100 percent accurate
5 medication list, what we can guarantee is that if
6 they don't go through this process, there's
7 evidence to suggest that discrepancies are going
8 to occur.

9 So if the dose, the name of the
10 medication, the frequency, all those types of
11 things aren't documented in the medical record,
12 and there isn't documentation in the medical
13 record of an action step occurring, it's highly
14 likely that there's going to be an error which
15 then will lead to ADE.

16 I don't think at this point there's
17 any feasible way to measure, that wouldn't be
18 incredibly burdensome, the overall validity of a
19 medication list at the end of the day. But I
20 think the process that we're suggesting here
21 would greatly reduce the chance that a
22 discrepancy would occur.

1 MEMBER TRANGLE: I think this measure
2 was so complicated it's hard to know where to
3 start to make a comment. And maybe I'll start,
4 as most people do, from sort of the ones that are
5 sort of engaging your emotions more than your
6 intellect, you know?

7 In our system, we've been working on
8 this for a while, in Minnesota, and we have an
9 integrated system even though 13, only 13 percent
10 of our safety net hospital admissions are on our
11 health plan. But we can directly see it. And a
12 slightly higher percent are on our EMR, which we
13 share with our 1,800 outpatient docs.

14 And we've been working on this, and it
15 just feels like we're torturing ourselves to some
16 extent. I mean, I think all of us buy into the
17 concept that if you know what somebody's taking,
18 you can coherently make decisions which you have
19 to make, and it's much, much better for safety
20 and quality of care.

21 So the concept, the need, that the
22 importance of it is sort of, and at least in our

1 system, is totally a given. How we've struggled
2 to operationalize it has been sort of quite
3 variable. And I think our results have been very
4 variable.

5 Theoretically, we have pharmacists in
6 our ED some of the time, and they'll try to do
7 it. But it seems like more than half the time
8 they'll say: tried to connect with something and
9 couldn't do it, which if you're the attending the
10 next day, figuring out, well, what am I going to
11 order, is totally useless. You know?

12 At the same time, we'll try to get a
13 hold of the pharmacy or a person or someone else,
14 and we try to do all this stuff, but it's -- and
15 we have an EMR that drives us to either sort of
16 continue, modify, or discontinue the med.

17 But in a lot of ways, documenting
18 that, the documentation by itself has been quite
19 onerous and hasn't necessarily helped us. What I
20 really care about is what were they taking,
21 what's our best guess, and how do I use that data
22 to make coherent decisions and decide what to

1 start them on and what not.

2 And the documentation part doesn't
3 really help, especially if it's documenting that
4 we tried and didn't learn anything. But it's
5 quite onerous.

6 And I guess where I'm coming from is
7 sort of like I totally think it's a really
8 important measure to figure out how to make it
9 work and how to do it. But it needs to be
10 simpler, more operational, and less time-
11 consuming.

12 And that's my own personal, but I also
13 know it's my system's experience. Did you get
14 much feedback when you asked other places or
15 people for feedback? Did you hear similar
16 things, or what were the recommendations here?

17 DR. CAMPBELL: Yes, so I know this is
18 getting more into usability. So we have heard
19 public comment about the potential burden. And,
20 one of the things we believe is that, given that
21 the measure was validated in a limited sample of
22 100 cases, we believe that that burden could

1 potentially be limited if the measure were
2 implemented.

3 The other thing that we've planned to
4 do is to provide an electronic tool to facilities
5 that don't have electronic health records that
6 would allow them to calculate the measure
7 directly.

8 DR. WINTERSTEIN: I think your
9 question was more about doing what the measure
10 requires rather than extracting the measure,
11 right?

12 MEMBER TRANGLE: We could see the
13 burden, maybe more -- we have -- I think I'm on
14 now. We have an EMR. But looking at the EMR
15 doesn't give us any guarantee that it's accurate.
16 You know? A lot of meds are on there, and
17 they're on there forever. And unless someone is
18 sort of updating it and culling it, it's not
19 necessarily reliable either.

20 DR. WINTERSTEIN: We have the same
21 issue in our facility, yes. I think there is --
22 you're coming from a level that is already

1 somewhere here on the ceiling. Just based on our
2 sample of field testing hospitals, we have some
3 facilities that are pretty much on the street,
4 just in terms of --

5 Yes, I mean, and paper is not
6 necessarily bad for a good PTA medication list.
7 But we have facilities who don't have even a
8 paper form. We have facilities where there is no
9 designated form of any PTA medication list
10 whatsoever.

11 MEMBER TRANGLE: I didn't really mean
12 on paper. I meant someone, a pharmacist said:
13 tried to contract somebody. Or: tried to update
14 this and couldn't.

15 DR. WINTERSTEIN: Yes. So let me
16 explain why we required in this measure this
17 documentation of two sources. And that really
18 goes back to what was mentioned earlier about the
19 lack of this measure to evaluate whether the
20 medication, whether the PTA med list was right.

21 And the main reason why this is very
22 difficult to do is because there's no gold

1 standard of what is right. Right? I mean, even
2 if you call the outpatient PCP, he knows half of
3 the pie, and any specialist will know the other
4 half of the pie, and the pharmacy will know a
5 certain piece. And the patient is the only one
6 who can tell us whether he's actually taking what
7 he even filled.

8 So there is no gold standard. It is
9 a process, and there is no outcome. There is no
10 accurate PTA medication list. So what we were
11 trying to do is to essentially define a process
12 that would increase the likelihood that there's
13 actually a workable PTA medication list that a
14 physician could use.

15 Will that be the optimal and perfect
16 and accurate list? Absolutely not. But really
17 it would be better than what is currently
18 available, which in many of those facilities is
19 zero. I would argue yes.

20 And I completely agree with you that
21 to get this process absolutely right, it is
22 extremely difficult. We have the same thing in

1 our facility. But from here to there, there's a
2 lot of other things that can be done.

3 CO-CHAIR BRISS: So we may be jumping
4 around a little between criteria. So we've been
5 back and forth a little from importance to
6 feasibility to usefulness. So we might want to
7 try to do one criterion at a time.

8 I agree that it's, on this one it's a
9 little hard. And so I want to take off my
10 chair's hat for a second and make a couple of
11 comments, and then we'll just go the rest of the
12 way around the table.

13 So I think I also have some concerns
14 about this one. It's specified in a way that's
15 complicated. It's hard to understand. I won't
16 talk too specifically about burden here, but it's
17 a little hard to know how much upside I'm going
18 to, I'm likely to get from implementing this
19 measure relative to what it costs me to implement
20 it.

21 And so, and the systematic review
22 doesn't help me much with that. It mostly reads:

1 we looked at 25 or 30 studies; most of them were
2 not any good. The ones that were any good mostly
3 showed improvement in charting and not actually
4 improvements for patients.

5 And so it's a little hard to know
6 whether this very complicated burdensome measure
7 is giving me a meaningful upside that makes up
8 for those things. And so I think I have some
9 concerns.

10 And then having said that, it's
11 inarguable that this is an important problem.
12 But it's -- whether this specific measure is the
13 right way to solve it, I'm not sure.

14 And so with that, my chair's hat comes
15 back on. I would like to move us relatively
16 quickly to a vote. And so I may have contributed
17 to the problem that I'm about to identify.

18 But I think that we're doing some
19 degree of repeating each other. And so try to be
20 relatively brief, and try to, if you feel the
21 need to agree with what's already been said,
22 maybe note that. But let's try to get through

1 the rest of the comments and get to a vote on
2 this criteria, please?

3 MEMBER PINDOLIA: So I'll be really
4 brief. I guess I'm saying that I agree with the
5 comments that have been made. And the work we've
6 been doing at Henry Ford Health System with
7 trying to improve the med rec upon admission I
8 feel would go backwards if we added another
9 burden of here's a checkbox, because it's going
10 to be another checkbox that we'll get sidelined
11 from the work we're already doing to try to
12 improve that with our limited resources.

13 MEMBER ROBINSON BEALE: Yes, I agree
14 it's very complex, but I also agree it's very,
15 very important. So I'm wondering whether or not
16 the focus of this being on the hospital may be an
17 area that is later in the process.

18 And maybe what it needs to be is a
19 focus on the health plan who has the utilization
20 data. The hospital generally calls to let -- to
21 find out if a patient is someone with insurance.
22 The hospital's got to call to find out if the

1 person is eligible or their insurance is active.

2 So they notify the health plan of this
3 admission. The health plan in most cases will
4 have access to pharmacy data, at least the fill
5 rate. And so I would see this, and I will deny
6 this outside of this room even though this is
7 going on record, but the process should be on the
8 health plan to make sure that information is
9 available to the hospitals for any acute
10 admission.

11 I think you would have a better bang
12 for your buck if it was placed there and not on
13 the hospital. So I'll stop right there.

14 CO-CHAIR BRISS: We can get to a vote.

15 MEMBER MAZON JEFFERS: I was going to
16 say something similar, that it's almost as if the
17 three steps are additive to the final step. As
18 you've said yourself, you can't do the
19 reconciliation if the information isn't good.

20 But maybe how you go about doing that
21 is less of a concern than actually achieving the,
22 maybe, and it's not perfect but if there's a way

1 to focus a little bit more energy on the
2 reconciliation piece as the actual measure and
3 not all three steps, and allow systems to figure
4 out what they need to do in order to achieve the
5 reconciliation piece which really you have to do
6 those steps anyway in order to get there.

7 MEMBER LARDIERI: Yes, and so thank
8 you. My question is how is this different than
9 under meaningful use for hospital, have to do
10 medication reconciliation, or you just figuring
11 them no psychiatric hospitals have EHRs, some do
12 and they would already have to have this
13 incorporated in. So how is this different than
14 that?

15 DR. CAMPBELL: I'm sorry, so how is it
16 different than the meaningful use type measures
17 for electronic health record medication?

18 MEMBER LARDIERI: For the medication
19 reconciliation. There's a measure specifically
20 that they have to meet for medication
21 reconciliation.

22 DR. CAMPBELL: But those types of

1 measures are more type of attestation which again
2 when we talk about checkbox type things, that's
3 what we're trying to get away from. And so what
4 we were trying to do with this measure is to
5 operationalize something that's meaningful in
6 terms of understanding the quality and the
7 completeness of the process.

8 So I think there's a balance here that
9 if you don't try to accurately measure the
10 process itself and you just simply say the
11 process was done, then it could become a checkbox
12 measure, right, that everybody just said yes, the
13 process was done but we have no idea what the
14 quality of it is.

15 And I think what we're trying to
16 achieve with this measure is that at a minimum,
17 if you don't have, like, dose frequency and that
18 sort of thing about the medications for the
19 patient, and you don't know whether the patient
20 should be continued or discontinued on a
21 medication within 48 hours, that's not a hospital
22 that I would want to personally go to. Right?

1 (Simultaneous speaking.)

2 MEMBER LARDIERI: The measure under
3 meaningful use is at, you have to identify dose,
4 frequency, the same thing. So it's not any
5 different. It's not just a checkbox, you have to
6 identify the dose and everything.

7 DR. CAMPBELL: Okay. So I mean, my
8 understanding of the measure was that it was more
9 an at a station measure. So I guess that's
10 something we need to look into.

11 MEMBER LARDIERI: I want to review it
12 because that's not what it says. The other piece
13 is, and I heard that you're going to give a free
14 web-based platform for organizations that don't
15 have an EHR. But if they do have an EHR, have
16 you estimated the cost to make this form because
17 you're requesting a for in the EHR.

18 So that means development time, that
19 means a cost to the provider to pay for my vendor
20 to do that. So what's that overall cost across
21 the country?

22 DR. CAMPBELL: Yes, so we haven't

1 looked specifically because so few inpatient
2 psychiatric facilities have implemented
3 electronic health records at this point. And at
4 this point, the measure is intended only for
5 inpatient psychiatric facilities. So it hasn't
6 been specified as an EHR measure.

7 MEMBER LARDIERI: Yes. And you know,
8 I like the idea of the web-based platform, but if
9 we're going to do a web-based platform, give it
10 to them for everything they need to measure, not
11 just for this one thing would be helpful.

12 CO-CHAIR BRISS: So we need to vote on
13 importance of the measure and reporting. So this
14 one's a bit of a tough one. So we're trying to
15 reframe the question, right? This is supposed to
16 be just on the evidence, right?

17 But I let the conversation go a little
18 broader because I think that you can't answer the
19 evidence question without knowing sort of what
20 the quality measure is and what the intervention
21 is.

22 And you may not be able to vote on the

1 evidence question without making some judgment in
2 your head of, does the upside, is the upside
3 worth the potential downside in terms of costs or
4 harms or other things.

5 And so I let it go. But the question
6 on the table is is there evidence about that if
7 we do this, essentially if we do this measure,
8 that it's going to be a measurable upside.

9 CO-CHAIR PINCUS: You just summarized
10 what I was going to ask. So that was fine.

11 CO-CHAIR BRISS: We've done this
12 together a lot. We can probably channel each
13 other. We're like an old married couple. And so
14 with that, can we vote on the importance? It's
15 measure and report.

16 MS. QUINNONEZ: We are now voting on
17 the evidence of Measure 3207, Medication
18 Reconciliation on Admission. Option number one,
19 high. Option number two, moderate. Option
20 number three, low. And option number four,
21 insufficient.

22 CO-CHAIR BRISS: And just in case this

1 comes up, can somebody remind the panel the
2 difference between low and insufficient?

3 DR. LUSTIG: Insufficient really means
4 you don't have enough information to make a
5 decision.

6 MEMBER MAZON JEFFERS: Can we just be
7 clear then that if you don't, if people vote low
8 then the measure won't pass and it's a must pass
9 criteria.

10 MS. QUINNONEZ: Voting is still open
11 for Measure 3207 for evidence. Option one, high.
12 Option two, moderate. Option three, low. And
13 option four, insufficient. All votes are in,
14 voting is now closed.

15 For evidence of Measure 3207, 4
16 percent voted high, one individual, 26 percent
17 voted for moderate, 6 individual votes, 65
18 percent voted low which is 15 individual votes,
19 and one voted for insufficient.

20 CO-CHAIR BRISS: Okay. And I just
21 want to emphasize to the developer that we know
22 that this is a lot of work, right, and nobody

1 doubts the importance of the topic. But there
2 may be some, I hope you find something to,
3 compensation to be constructed and moving this
4 work forward.

5 DR. CAMPBELL: Yes, absolutely. We
6 appreciate --

7 (Simultaneous speaking.)

8 DR. LUSTIG: We actually should have
9 just a little bit of feedback on specifically
10 what type of evidence the Committee would want to
11 see going forward and --

12 MS. JOHNSON: And I think it would
13 help us when we write the report to understand
14 since there was a lot of discussion about the
15 quality construct and how it was created and
16 feasibility and all that kind of stuff kind of
17 got meshed into your vote.

18 We want to make sure that your vote
19 was actually about evidence. So you, we want to
20 make sure that you really felt like there's not
21 enough evidence to show that medication req leads
22 to good outcomes.

1 CO-CHAIR PINCUS: Yes. I think it was
2 basically the point that Peter made at the very
3 end. It was the link between the evidence that
4 the documentation of this construct would
5 actually have an impact on patient outcomes.

6 CO-CHAIR BRISS: He's channeled me
7 again. Raquel?

8 MEMBER PATING: For giving comments
9 for future suggestions, if you bring this back, I
10 would not bring this back as a paper measure. I
11 would try to move with a measure as complicated
12 as this strictly into eMeasures. I think that
13 the burden, the systems would be really hard.

14 And it wasn't quite clear to me,
15 because I saw some notes saying this was a paper,
16 I guess one of the National Hospital Association
17 or Public Hospitals recommended eMeasure and I
18 would recommend if you came back you look at only
19 that format.

20 CO-CHAIR BRISS: All right, and one
21 more thing. One of the things that I found hard
22 in the materials is getting your head around what

1 the measure is exactly measuring and what the
2 scores mean is really hard if you're coming to
3 this cold.

4 And so it's sort of translating from
5 that to if we do that, will you have better
6 outcomes was very hard for me. And so maybe the
7 staff has been giving me funny looks about aren't
8 you creeping into reliability or validity or
9 other things.

10 But I said already that it's hard to
11 answer the, even the evidence question without
12 being able to answer what are you measuring and
13 how does it improve things. And I think you
14 would be better off with a simpler measure, if
15 you could do that.

16 DR. LUSTIG: Thank you.

17 MEMBER TRANGLE: I mean, it could be
18 very concrete. If somehow, even if we started
19 out with, like, .001 percent, if we were
20 documenting these were the meds somebody was
21 truly taking before, or what they were, you know,
22 versus I made an attempt to find out, it would be

1 much more meaningful to me and I think that grade
2 of evidence would be higher.

3 It means something to me and the rest
4 would flow from that, the feasibility, the
5 usability, and you know, versus we asked and
6 documented that we asked but couldn't find out.

7 MEMBER SUSMAN: And to make sure that
8 your lives are doubly complicated or triply
9 complicated, the issue of it being a composite
10 measure for me and tying it back to evidence was
11 very difficult, and the reason I chose in part to
12 vote for insufficient evidence or low evidence.

13 I think, you know, maybe the advice
14 you had from NQF staff or the approach that you
15 decided to take around making this a composite
16 might have complicated this discussion and
17 particularly just focusing on evidence.

18 CO-CHAIR BRISS: All right, thank you.
19 We are really close to back on time.

20 CO-CHAIR PINCUS: Let's move to the
21 next measure which is prevention, care, and
22 screening, tobacco use screening, and cessation

1 intervention, 3225.

2 DR. LUSTIG: And so I've actually been
3 remiss at announcing when there are people who
4 have recused themselves from measures. So Dr.
5 Briss is actually recused from this measure, the
6 e-version and the prevalence measure that are
7 coming up. So he won't participate in any of the
8 discussions.

9 And once again, to add to your
10 confusion, this is another one of those that this
11 is the previous 0028 but has been renumbered
12 because there is also the e-version that we will
13 look at.

14 CO-CHAIR PINCUS: So if the measure
15 developers might introduce themselves and present
16 some preliminary information.

17 MS. TIERNEY: Yes, thank you. Hi,
18 everyone. I'm Sam Tierney, I'm the Director of
19 Measure Development Operations at the PCPI and
20 I'm joined by my colleagues Jamie Jouza who is
21 with our specifications team, and Eduardo Segovia
22 who is with our testing team.

1 We appreciate the opportunity to be
2 here today and to present this measure and the
3 versions of it, the various versions of it for
4 consideration for continued endorsement.

5 So just a little bit of background
6 about the measure. The measures if you will.
7 They are intended to promote adult screening for
8 tobacco use and the provision of cessation,
9 intervention for those who screen positive.

10 Although the impact and public health
11 importance of tobacco screening and intervention
12 is well founded and I'm sure very well known to
13 the Committee, since our measure, the first
14 tobacco measure to be reviewed, I thought I would
15 provide just a little bit of highlights about the
16 importance of this topic area.

17 Tobacco use is the leading preventable
18 cause of disease, disability, and death in the
19 United States, cigarette smoking results in close
20 to half a million of premature deaths each year
21 and accounts for one in every five deaths.

22 There is good evidence that tobacco

1 screening and brief interventions are successful
2 in helping tobacco users quit, and that if people
3 quit, that can lower their risk for heart
4 disease, lung disease, and stroke.

5 The measure was developed originally
6 many years ago. It has continued to be updated
7 by us on an annual basis and a more rigorous
8 update every three to four years.

9 The measure was developed by a multi-
10 disciplinary cross-specialty workgroup. And it
11 has undergone some important milestones in the
12 measurement process. We have a rigorous process
13 we follow including a public comment period, and
14 we previously would submit our measures to vote
15 by our membership.

16 The measure was developed to align
17 with the USPSTF recommendations around tobacco
18 screening and cessation intervention. And as a
19 result it is focused on adults. I know there was
20 a comment about potentially expanding the measure
21 to adolescents.

22 There is a corresponding

1 recommendation statement from the USPSTF around
2 screening or adolescents. And there are some
3 unique needs for that patient population which
4 are addressed by another measure that NCQA
5 stewards that particularly deals with that
6 patient population.

7 The measure certainly addresses a gap
8 in care, and as you probably noted from looking
9 at the forms in the PQS program, there's still a
10 demonstrated opportunity for improvement.

11 Although the rates seem relatively
12 stable over time, the adoption of the measure is
13 fairly low with about 21 percent of providers
14 reporting.

15 More data that's probably more
16 nationally representative although probably a bit
17 dated comes from a medical literature and we
18 included it in our submission that indicates that
19 rates of screening are around 65 percent and then
20 rates for intervention for tobacco users are even
21 lower, around 30 percent.

22 There's also data that indicates that

1 there's disparities in screening and intervention
2 based on age, ethnicity, and insurance status.

3 The measure is in widespread use in
4 various federal programs including the new MIPS
5 programs including the new MIPS program, the
6 former PQS program, and the EHR incentive
7 program.

8 And we believe that continued
9 endorsement will only continue to encourage its
10 adoption, and continue to impact the lower rates
11 that we've seen, the suboptimal rates of tobacco
12 screening and cessation intervention. Thank you.

13 CO-CHAIR PINCUS: Do we want to move
14 to the initial criterion? Connie?

15 MEMBER HORGAN: Just a comment, in
16 your list of disparities was the standard
17 sociodemographics. I just wanted to ask a
18 question about disparities related to individuals
19 who have mental health, alcohol, and drug
20 problems in the literature in that area.

21 MS. TIERNEY: You know, that's a great
22 question. I do know that it's, you know, it is

1 an important special population to look at as it
2 relates to tobacco use screening and
3 intervention.

4 I know actually Dr. Pincus, you
5 authored an article where you talked about
6 separating that category of patients out as sort
7 of its own disparity element and identifying how
8 the rates compare with that patient population as
9 compared to others.

10 We did not provide that in the
11 submission form. I would be certainly happy to,
12 you know, review the literature and provide that,
13 but I do know there is a version of this measure
14 was adapted by the, by NCQA for use in patients
15 with that sub-population, with serious mental
16 illness.

17 So it is an NQF endorsed measure
18 focused just on that, that more narrow
19 population. Although this measure, because it's
20 very broad in nature, does include that
21 population, we don't stratify the information out
22 by that variable.

1 CO-CHAIR PINCUS: Just so why don't we
2 move ahead to actually looking at issues around
3 sort of evidence. Do we need to look at that
4 since this is a maintenance measure?

5 DR. LUSTIG: I think that there was
6 some new evidence provided. Was there updated
7 evidence?

8 MS. TIERNEY: Yes. USPSTF had done an
9 updated recommendation statement from 2015, and
10 they had an additional evidence review that
11 supported the recommendation statement was all
12 still favorable and in support of the measure
13 focus, but it was updated since the last time it
14 was reviewed.

15 CO-CHAIR PINCUS: So it sounds as if
16 unless people have specific comments, we don't
17 need to vote on that, correct?

18 DR. LUSTIG: Yes, because even though
19 it's new evidence, it's directionally the same as
20 what we had before. So unless there was
21 objection, we don't need to re-vote on evidence.

22 CO-CHAIR PINCUS: Mike, are you

1 concerned?

2 MEMBER LARDIERI: I just had a
3 question. Why 24 months? It seems if somebody
4 starts smoking, and maybe I don't know the
5 evidence around addiction with smoking. If I
6 start smoking this year, does it take 24 months
7 before I get addicted?

8 So I'm just wondering why 24 months.
9 We found that not useful in our system, so we do
10 at least once a year. So that's one question.

11 The other piece was around kids, and
12 I guess it's around folding adolescents into this
13 as opposed to having two separate measures
14 because that's just more of a burden. But first
15 on the 24 months.

16 MS. TIERNEY: Yes, that's a good
17 question. So initially when the measure was
18 developed, we sought the input of an expert
19 workgroup in trying to determine sort of the
20 periodicity of the requirement for the numerator.

21 And at that time, the group felt that
22 24 months was appropriate. I know that we did

1 look at the literature, and I don't believe
2 there's any particular evidence that indicates an
3 appropriate timeframe, whether that be six
4 months, a year, 24 months. So I think that was
5 what our expert workgroup agreed to.

6 And with the lack of particular
7 literature that recommends how routine the
8 assessment should be, that's what the measure
9 includes.

10 I will say that the measure does
11 include language about at least once every 24
12 months, and what we've heard from implementers is
13 that oftentimes they do do it more often. Some
14 do it at every visit, and some do it more on the
15 annual basis.

16 So the measure doesn't prohibit
17 someone from doing it more regularly, but the
18 base requirement is that it be done once every 24
19 months.

20 CO-CHAIR PINCUS: Raquel?

21 MEMBER MAZON JEFFERS: I think I might
22 be skipping out of order of the discussion, but

1 this measure is a lot like 0027 which is the
2 next, not the next measure but it's, like, three
3 measures away that we're going to be, I mean, a
4 lot like it.

5 DR. LUSTIG: There are different
6 levels of analysis, and 0027 is based on patient
7 reported data.

8 CO-CHAIR PINCUS: Mike, anything
9 specific about the evidence?

10 MEMBER TRANGLE: I think so. It's
11 really to some -- there was an article that came
12 out by Mike McKusick maybe three, four months ago
13 talking about the best value of doing sort of
14 interventions in terms of impact for what you
15 invest in doing it.

16 And that article basically said the
17 three, the top three things of anything, this is
18 medical not just psych stuff, is smoking
19 cessation work with adults, smoking cessation or
20 prevention and cessation with adolescents, and
21 then doing vaccinations.

22 So to the point that was made earlier

1 about the age range and, you know, is somebody
2 looking at the adolescent group. And if it
3 isn't, it might be something we might consider
4 recommending this group work on in the future.

5 MS. TIERNEY: Yes, I think it's a
6 great point. I do think the age cutoff is
7 somewhat arbitrary. I think it results from the
8 fact that when we were developing the measure, we
9 were focused on preventative services and
10 screenings for adults.

11 There is another measure that, so this
12 notion is certainly covered within the NQF
13 portfolio because there is another measure that
14 includes patients between the age of 12 to 20 and
15 includes, you know, is a very similar focusing on
16 tobacco cessation and intervention.

17 I will say the one challenge, you
18 know, with sort of combining it within the one
19 measure is that there may be specific concerns or
20 considerations for the pediatric population such
21 as, for example, no pharmacotherapy or maybe
22 focusing more on a second hand smoke exposure.

1 There may be particular
2 recommendations for that population that if we
3 were just to consider adding them to our measure,
4 that sort of the nuance of that may be lost a
5 little bit.

6 So I do know that there is, again,
7 there is that other measure. But that's, but
8 currently yes, our measure is just focused on the
9 adult patient population.

10 It's certainly something we could take
11 back to consider when we update the measure. But
12 of course at that time we would have to look at
13 again sort of those unique needs of that patient
14 population as well as the measurement landscape
15 in trying to not, you know, to avoid duplication
16 and think about harmonization and that sort of
17 thing.

18 But it's certainly something we could
19 consider for the future.

20 CO-CHAIR PINCUS: Let me just say
21 that, you know, what we've decided to do because
22 we were getting sort of delayed is that time

1 permitting, to have a discussion about alignment
2 across all the tobacco measures tomorrow after
3 we've been through this.

4 And, you know, the staff at NQF had
5 actually done, put together a nice table sort of
6 looking at the different tobacco measures. But
7 our thinking was let's go measure by measure and
8 get through. Okay?

9 So is there any objection to moving
10 beyond the evidence and now going to gap? Okay.
11 So with regard to gap, do any of the people that
12 have been involved in the initial review want to
13 comment about the gap issue? You know, is the
14 gap that was present when this measure was
15 initially developed, is there still a gap.

16 MS. JOUZA: Yes, so performance gap
17 was the comments by the group that looked at this
18 was more focused on disparities and disparities
19 from the public data, and that that seemed to not
20 be directly addressed in the measure but there.

21 And I was, I myself was particularly,
22 I don't think we have time to discuss it, but

1 interested in the -- that cessation assistance is
2 higher in the Medicaid population by some
3 published data, and those in high poverty areas
4 as compared to the private and Medicare
5 population which surprised me, and those in low
6 poverty areas.

7 By age was still disparity. And in
8 terms of the performance gap, in terms of
9 reporting, I think the biggest gap, perceived gap
10 is that even though there's good performance for
11 those who report, only 21.7 percent are actually
12 reporting. So there's still a lot of room for
13 improvement there, at least as in measure and
14 PQRS.

15 I don't know if someone else from the
16 group wants to comment.

17 CO-CHAIR PINCUS: Any other comments
18 about the performance gap?

19 MEMBER PINDOLIA: Couple questions.
20 So looking at the 2015 PQRS, I mean, there was a
21 tremendous improvement in, so the claims is it's
22 at 96.24 percent. And I understand we're saying

1 only 22 percent are reporting.

2 So the comment that I have, there's
3 been a huge movement with many employer groups
4 and to do health risk assessments and for their
5 employees.

6 So the patient comes in for a visit
7 but the doctor's not documenting that this was a
8 smoking cessation, but it gets documented on the
9 MQF or on these other forms that are submitted.
10 Could that be where we're missing so much that is
11 going on, because there are so many employer
12 groups that want that record.

13 And so for health plans, we have a lot
14 of that data. But there is nothing that comes in
15 that there was a coding for smoking cessation
16 discussion or that because they filled out what
17 they called an MQF form or other forms like that.

18 MS. JOUZA: So with respect to the way
19 that this measure, and I know we're talking about
20 the claims registry piece, the denominator coding
21 that we would require in order to pull a patient
22 in isn't such that it would require that it

1 states that there's any sort of smoking
2 cessation, there are two CPT codes that are
3 included right now, 99406 and 99407 which are
4 specific to that cessation, but again, not
5 required.

6 And the way that it's captured in the
7 claims registry world right now for PQRS is is
8 sort of that attestation with the CPT2 40 or 4F
9 that says I screened my patient for tobacco use,
10 and if they were a tobacco user, I intervened.

11 MEMBER PINDOLIA: Well, I can tell you
12 from my experience at least just within Henry
13 Ford Medical Group because when they have to do
14 this, let's say for Ford Motor Company that's in
15 our backyard and these large employer groups, it
16 causes such a huge unevenness in their patient
17 workload.

18 I mean, the documentation has been
19 very streamlined. It's just this form, and this
20 is what you're doing and this is what it is. So
21 I don't believe they document that.

22 And I could be wrong if that's not

1 true across many other employer group based
2 provider programs like that.

3 MS. JOUZA: And I'm not sure, and that
4 may be, it may be a difference because if that's
5 from a, you know, more of like that plan side
6 too, we are focused on the specific provider side
7 for this measure, or these measure versions. So
8 that may impact kind of where or how that's
9 documented.

10 But again, at some point, in order to
11 report on this program, there is the
12 acknowledgment and the acceptance by the eligible
13 provider, eligible clinician to actually put
14 through the actual coding in order to capture the
15 numerator.

16 Similar for the EHR version utilizing
17 the LOINC, SNOMED concepts, CPT if those are used
18 for the actual interventions themselves.

19 MS. TIERNEY: Yes, I was just going to
20 also add to what Jamie said. I mean, I think
21 given that this measure's in the federal
22 reporting programs and there's a penalty for not

1 reporting, I think there's an incentive for
2 providers when they've done this to report that
3 they've done this.

4 So I think that if it is done at the
5 provider level, they probably would very likely
6 report that they've done it. I understand what
7 you're saying that it might be captured in other
8 ways, but I imagine that they would plan,
9 identify some sort of a work around so they could
10 still get credit if you will on the measure
11 because there is this penalty for not reporting.

12 MEMBER PINDOLIA: Right. And that's
13 where I guess where I'm kind of in conflict with
14 the gap results because it's only 22 percent
15 you're saying are reporting. But then there's
16 this penalty.

17 And the ones that report, there's
18 really no gap. So that's where I'm trying to
19 figure out there's no gap because we're missing
20 data that's already captured in other ways, or
21 there really is no gap.

22 CO-CHAIR PINCUS: Yes. Well, I think

1 one of the issues is, just to be clear, we're not
2 looking at that gap based upon the program of
3 reporting. We're looking at the gap in terms of
4 this measure.

5 So that's, you know, and we may be
6 looking under the lamp post with regard to this
7 program. But it would be useful to have broader
8 information about the overall on a population
9 based level.

10 So Mike, Jeff, and David.

11 MEMBER TRANGLE: I want to speak to
12 the gap for people who have mental health and CD
13 services. I'm part of a collaborative in
14 Minnesota that's with the Lung Association and
15 DHS. And we mirrored something that I think was
16 going on in North Carolina.

17 So there were two states that
18 essentially over the last at least ten, maybe
19 fifteen years have shown, look, with our data
20 that the rates of folks smoking have gone down
21 for every subgroup except people that have mental
22 illness and CD problems where it's been totally

1 flat and there's been no progress.

2 And maybe you have some similar data
3 that you were talking about. We, too, have been
4 recommending that in the broad based measures
5 that we do look at folks with mental illness and
6 CD as a disparate group so that it could be
7 tracked in a whole host of different measures,
8 lifespan, other kinds of things, not just tobacco
9 cessation which was one of the key drivers for
10 lifespan.

11 But there is data saying there, for
12 the group that we're attempting to look at,
13 behavioral health patients, there is a real
14 performance gap, but it gets lost in the shuffle
15 if you're not subdividing out our population.

16 CO-CHAIR PINCUS: Jeff?

17 MEMBER SUSMAN: Briefly. When do we
18 eliminate a measure? Do we need it to be 95
19 percent within, 99 percent? My sense is that
20 this data isn't representative of the population
21 as a whole and that the 21 percent or 22 percent
22 that actually are reporting are perhaps different

1 than the other approximately 80 percent.

2 But without that data, we're sort of
3 left in this well this feels like we should still
4 be measuring it, there's certainly some
5 disparities, some populations where we're not
6 doing as well. At this rate, we'll never get rid
7 of a measure.

8 CO-CHAIR PINCUS: David?

9 MEMBER PATING: Well, given that the
10 USPTF just moved the measure up from number three
11 to number two and three, I think it's -- moved
12 down or something like that. But anyway, yes.
13 It's, I think the need is growing greater.

14 I wanted to make sure that this
15 measure, that we put in comments the issue of
16 tobacco screening versus nicotine screening with
17 the e-cigarette craze. I think we really need to
18 look at whether this is the time and place to
19 expand the definition to catch the next wave of
20 the epidemic.

21 The second thing would be I would also
22 just verify that I think public sector we still

1 have high rates of smoking. Now the veterans, I
2 know you guys have high smoking in the vets, and
3 mental health population.

4 So while health plans and primary care
5 is probably doing well overall, there's the
6 subsegments. And that's the way organizations
7 should re-look at it. They should be segmenting
8 their overall measures because as the difference
9 in the total measure gets narrower, the
10 separating yourself really depends on your
11 margins.

12 So health plans are going to have to
13 look at those anyway. But I think your comment
14 is around the nicotine and e-cigarettes and
15 expanding the definition.

16 CO-CHAIR PINCUS: Okay, so we're going
17 to be dealing with the measure as it is, and
18 obviously we can make recommendations going
19 forward. But so Raquel and Mike, are there
20 additional comments on gaps that have not been
21 made before?

22 MEMBER PATING: I don't think it has

1 to do with gaps.

2 CO-CHAIR PINCUS: Okay. Connie.

3 MEMBER HORGAN: Well, I just want to
4 add on the e-cigarette and the nicotine issue and
5 make the point of the intersection with age and
6 the phenomenal growth with adolescents so that if
7 that does get considered in the future that that
8 be taken into account.

9 MS. TIERNEY: Just to I think
10 emphasize something you said earlier, I think
11 there's different sources of data for the gap.
12 You know, ideally you would have data from the
13 measure, and we do have some data from the
14 measure.

15 But I would argue it's not nationally
16 representative because it's only 21.5 percent of
17 eligible providers who could have reported on the
18 measure.

19 We did also include in the submission
20 form data from the medical literature around the
21 provision of cessation interventions and the
22 screening. And the rates there are not great,

1 you know, around 65 percent.

2 It's somewhat dated, you know, but it
3 is around 65 percent were getting screened, and
4 then about 30 percent were getting the
5 intervention.

6 And additionally, you know, on top of
7 that there's also the disparities that I think
8 you know are additional --

9 CO-CHAIR PINCUS: No, I think your
10 point is well made. And I think also you could
11 add with, you know, moving from PQRS to MIPS,
12 that's going to, intended to expand from the 22
13 percent to a much larger proportion. So that
14 gives a view.

15 So why don't we move to vote with
16 regard to gaps.

17 MS. QUINNONEZ: Voting is now open for
18 performance gap of Measure 3225. Option number
19 one, high. Option number two, moderate. Option
20 number three, low. And option number four,
21 insufficient.

22 Performance gap of Measure 3225.

1 Option one, high. Option two, moderate. Option
2 three, low. And option four, insufficient.
3 Thank you, all votes are in and voting is now
4 closed.

5 For the performance gap of Measure
6 3225, 26 percent voted high, 6 individual votes.
7 Sixty one percent voted moderate, fourteen
8 individual votes. Nine percent voted for low,
9 two individual votes. And four percent voted for
10 insufficient, one individual vote.

11 For performance gap of Measure 3225,
12 this passes the measure criteria.

13 CO-CHAIR PINCUS: Okay, so let's move
14 on to reliability. Do one of the members of the
15 group that were reviewers want to comment on
16 reliability? Anyone? I'll have to call on
17 somebody. Mike?

18 MEMBER LARDIERI: I'll go ahead, but
19 it seems reliable. Reliability is not my
20 specialty, Harold, I think you know that. So --

21 But from what I'm reading here, yes it
22 does seem reliable. It's been around for a

1 while. So I think it's safe to say that it's
2 still reliable.

3 CO-CHAIR PINCUS: Okay, Dodi?

4 MEMBER KELLEHER: And I think again
5 this is a maintenance measure where they did do,
6 show the 2015 and sampling as well as the testing
7 for 2017 evaluation. So, and in I think it -- to
8 echo, it seems reliable. Meets the algorithm,
9 and so I think that's pretty much it. And a nice
10 big sample.

11 CO-CHAIR PINCUS: Any further comments
12 about reliability? Okay, so why don't we vote on
13 reliability?

14 MS. QUINNONEZ: Voting is now open for
15 the reliability of Measure 3225. Option number
16 one, high. Option number two, moderate. Option
17 number three, low. And option number four,
18 insufficient.

19 We are voting on the reliability of
20 Measure 3225. Thank you, all votes are in and
21 voting is now closed.

22 For the reliability of Measure 3225,

1 48 percent voted high, that's 11 individual
2 votes. Fifty two percent voted moderate, twelve
3 individual votes. Zero percent voted for low,
4 and zero percent voted for insufficient.

5 For the Measure 3225, reliability,
6 this passes the measure's criteria.

7 CO-CHAIR PINCUS: Okay, let's move on
8 to validity. Comments from the reviewers with
9 regard to validity? Dodi?

10 MEMBER KELLEHER: So there was the
11 2017 evaluation was again face validity. And
12 though I don't think anything I have to say makes
13 it not valid or a lot less valid, I was concerned
14 about the ten and the more importantly that there
15 seemed to be more disagreement about the level of
16 agreement. And I wondered if you wanted to make
17 any comment about that.

18 MR. SEGOVIA: Yes, I can speak to
19 that. So it's unfortunate we only were able to
20 get ten responses since the submission, but we
21 actually have added additional responses. So we
22 actually got responses from 29 folks since the

1 submission and raised the validity score to 76
2 percent, strongly agree to agree.

3 We can also strongly agree as well as
4 agree that the measure was valid.

5 (Off-microphone comments.)

6 MR. SEGOVIA: I'm sorry? 76 percent.
7 Yes, and I would be happy to add that to the
8 forms.

9 MEMBER KELLEHER: I have one more
10 comment. The other comment I want to make is
11 about threats to validity. And my, I sort of
12 have a question or an issue about what would
13 constitute a reason, a medical reason not to
14 screen, even if one's life expectancy is short,
15 one was terminal, one had heart disease and
16 likely a short lifespan.

17 Why would you not want to screen and
18 offer intervention if the screening were positive
19 for someone who, you know, was certainly not
20 going to get better being allowed to smoke, or at
21 least being offered the opportunity.

22 I say this because in my own

1 experience I've seen, because it's an addiction,
2 I've seen people who were outside hospitals
3 having their last smoke before they got, you
4 know, angioplasty.

5 So I was just curious as to why that
6 exclusion. I don't think it's a big threat, but
7 I don't see why.

8 MS. TIERNEY: Yes, that's a good
9 question. I do think the greatest example that
10 we discussed with our expert workgroup and more
11 recently our technical expert panel, it really
12 does relate to the limited life expectancy issue.

13 I think there's, you know, a comfort
14 in knowing that if there's a valid reason that as
15 a physician you felt that you didn't want to
16 screen someone, that you could do that.

17 And so I think that's the largest
18 reason it's there. And I think that we heard
19 from, you know, the palliative and hospice
20 medicine community that this is an appropriate
21 exception for us to have.

22 I do think that the rates of the

1 exceptions as we've, you know, from our analysis
2 are still pretty low so that they're I think
3 across the different modalities they're all less
4 than one percent.

5 So I don't think that people are using
6 it inappropriately, but I do think it gives the
7 option, and our expert workgroups felt that it
8 was, you know, more comfortable with it being
9 there if there was a good reason that you chose
10 not to screen someone.

11 MEMBER PATING: So I just have a
12 question regarding 2B5, meaningful difference,
13 and then also comparing this to the chart above
14 that under reliability.

15 So under reliability, you show that
16 you're able to show that 25 percent of claims
17 providers did not meet threshold. I guess
18 meaning that they didn't either screen or they
19 didn't provide treatment.

20 And to me that seems like significant
21 difference and that gap that I would want to
22 close. And then down here on your meaningful

1 difference, however, your 25th percentile on
2 claims is .97 and your 75th is 1.

3 So at one level you're looking at
4 individual providers, and another level you're
5 looking at claims. I guess how do you recommend
6 this measure be used and which meaningful
7 differences are more meaningful.

8 MS. TIERNEY: So can you point me to
9 what you're talking about in regards to the --

10 MEMBER PATING: So 2B5.

11 MS. TIERNEY: 2B5.

12 MEMBER PATING: 2B5 under validity
13 which is threats to validity you see claims data
14 with a standard deviation of .1, and the 25th
15 percentile is 97 percent. And the 75th
16 percentile is 100, right, or 1.0.

17 And then if you go up to the
18 reliability section, you'll see claims where you
19 had 190 events, 53,000 providers. And you said
20 25 percent of the providers didn't meet
21 thresholds which means they didn't do something.

22 MS. TIERNEY: Right, so the threshold

1 there, just thank you for showing me where it
2 was. I'm sorry, I think I'm looking at the wrong
3 document. But the threshold there refers to the
4 threshold that was determined to conduct the
5 signal to noise analysis.

6 So anyone with less than ten events
7 was excluded. So 25 percent of providers in
8 claims did not have in the claims sample that we
9 provided did not have ten events.

10 The measure is intended to be used at
11 the individual clinician level. And so all the
12 data, even though it may be the source of the
13 data is claims, it's all physician level data.

14 MEMBER PATING: Okay.

15 MS. TIERNEY: Does that help a little
16 bit?

17 MEMBER PATING: Well then you still
18 have the meaningful difference problem which is
19 can you really separate low performers from high
20 performers either at the individual or the plan
21 level. And it just, I think it's something that
22 needs to be addressed, whether retired or

1 expanded to a broader definition set.

2 MS. TIERNEY: So I think the challenge
3 with the meaningful differences in performance
4 with our data sample here is that the mean
5 performance rate especially in claims was very
6 high because as we've discussed there were, you
7 know, not that many physicians reporting on the
8 measure, or not as much as we would like.

9 So I think that's why the meaningful
10 differences are less, I guess, noteworthy within
11 the claims sample because of the high performance
12 rate. I think if we had something that was, you
13 know, more representative, and I think in the
14 sample above with the registry where the
15 performance rate is lower, the meaningful
16 difference is more significant.

17 And I think similarly, you would see
18 the same thing in the EHR data we have because of
19 the data from that, the mean performance rate is
20 even lower. So I think it's a function of the
21 data that we received and the fact that the
22 claims performers, the limited sample of people

1 who were reporting in claims, are reporting very
2 well.

3 CO-CHAIR PINCUS: Again, I think one
4 of the issues is that it's unfortunate that the
5 data's so limited to the groups that have agreed
6 to participate in a program which means that they
7 probably chose this because they do well on it.

8 And so that's part of the issue.
9 Mady, you still have a question?

10 I had one other question about
11 validity which goes back to the origination of
12 this which is how do we know that the, for those
13 who are identified as needing cessation
14 interventions are actually getting evidence based
15 interventions?

16 MS. TIERNEY: SO that's a great
17 question. The eMeasure requires either
18 pharmacotherapy, and we define that as, well our
19 eMeasure defines that but our claims registry
20 version doesn't define that. It's through
21 attestation which Jamie can speak to.

22 The way we define counseling is brief

1 counseling, three minutes or less. Of course
2 someone could do more.

3 I realize from the evidence that, you
4 know, the greater the intensity of the
5 counseling, the greater impact on tobacco
6 cessation. So ideally yes, we would want them to
7 do more.

8 But given the focus of the measure,
9 you know, its national impact in trying to be
10 something that could be easily done within
11 primary care.

12 You know, we elected to define
13 counseling as three months or less because that
14 does have an impact based on the data from the
15 guidelines, but albeit not as significant as if
16 it was longer or if it was in several different
17 instances, you know, multiple times.

18 CO-CHAIR PINCUS: In an ideal world,
19 you would want this measure to number one, be
20 validated by even in this 22 percent of
21 physicians participating in the program to see
22 whether or not for those patients, even those

1 clinicians, whether there was actually a higher
2 rate of smoking cessation.

3 And in fact, actually, you probably
4 would want to move toward a measure that actually
5 includes actual smoking cessation.

6 But, and that may be aspirational at
7 this point, but it's something that, you know, at
8 least my point of view, should this measure come
9 up again for maintenance, that that would be an
10 expectation.

11 MS. TIERNEY: I definitely think your
12 point's well taken. I think that's something we
13 would certainly want to move to and certainly a
14 topic that we can discuss with our TEP as we
15 review the measure annually and just determine
16 sort of future directions with it.

17 CO-CHAIR PINCUS: Any discussion about
18 validity? Okay, let's --

19 MEMBER MARK: I had one point. The US
20 Preventative Services Task Force gives smoking
21 cessation an A rating, right? So isn't that
22 enough validity to suggest that smoking --

1 CO-CHAIR PINCUS: I couldn't hear the
2 last part --

3 MEMBER MARK: I was saying that it
4 seems like enough validity to suggest that
5 smoking advice works if the US Preventative Task
6 Force reviewed all the materials --

7 (Simultaneous speaking.)

8 CO-CHAIR PINCUS: Well, we're talking
9 about the validity of this measure, not just --

10 MEMBER MARK: I know, but this measure
11 is basically just measuring whether the provider
12 gave advice to someone who is smoking. And the
13 US Preventative Services Task Force says that
14 giving advice is highly effective.

15 So it seems that it's a direct, you
16 know, it's tautological this measure can't be
17 sound even then. But maybe I'm missing
18 something.

19 CO-CHAIR PINCUS: No, I'm saying but
20 the measure itself says evidence based. That's
21 in the description.

22 MEMBER MARK: Well, I guess the other

1 point is, you know, I think it's interesting that
2 this measure is, if I look at the claims data,
3 I'm kind of surprised how high the rate of
4 compliance is because if you look at the
5 screening and brief intervention for alcohol use
6 which is also a claims based measure, it's teeny.

7 And so I'm wondering what the
8 difference is. And maybe the difference is
9 because you only have to provide three minutes
10 for this measure, and for the SPI measure it has
11 to be at least 15 minutes.

12 So I wonder if, I mean, I think that
13 it would be interesting to look at whether it has
14 to be effective, if it can be effective at three
15 minutes. You know, but I don't think that
16 actually negates this measure, I just think it
17 would be an important way to decide.

18 CO-CHAIR PINCUS: Mady?

19 MEMBER CHALK: This is just a brief
20 comment that takes us a little backwards. But
21 the US Preventative Services Task Force
22 definition of not only the smoking cessation

1 interventions that it got an A rating, but also
2 that the question about the exclusions earlier.

3 All of it rests on what the USPTF has
4 said. The issues that arise about how can a
5 measure be constructed such that -- I lost my
6 train of thought. Skip it, I'll go back to it
7 later. I lost my train of thought.

8 CO-CHAIR PINCUS: Let's move to voting
9 on, oh Tammy, you still? Let's move on voting on
10 validity.

11 MS. QUINNONEZ: Voting is now open for
12 validity of Measure 3225. Option one, moderate.
13 Option two, low. Option three, insufficient.

14 For the validity of Measure 3225,
15 Option one, moderate. Option two, low. Option
16 three, insufficient.

17 DR. LUSTIG: And again, just a
18 reminder, the highest rating is moderate because
19 the validity is based on face validity testing.

20 MS. QUINNONEZ: Looking for one more
21 vote. Thank you, all votes are in and voting is
22 now closed. For the validity of Measure 3225, 87

1 percent voted moderate, that's 20 individual
2 votes. Nine percent voted low, that's two
3 individual votes. And four percent voted
4 insufficient, one individual vote.

5 So for the validity of Measure 3225,
6 it passes the criteria.

7 CO-CHAIR PINCUS: So moving right now
8 moving to feasibility. Any comments on
9 feasibility? Anita?

10 MEMBER PINDOLIA: Just one quick
11 comment. For, and I was trying to quickly
12 identify this, the numerator, you get counted if
13 you screened and then the intervention could be
14 either the three minute discussion or use of a
15 smoking cessation pharmacotherapy product? Does
16 that include OTC nicotine products?

17 MS. JOUZA: I'm trying to recall from
18 our RxNorm for the eMeasures. I do believe that
19 it does because we do offer kind of like a
20 plethora. There's a patch, there's a pill, et
21 cetera, etc.

22 MEMBER PINDOLIA: So then the second

1 question for the feasibility, how does that get
2 captured, because we don't capture that in Rx
3 claims.

4 MS. JOUZA: How does it get captured
5 in the claims registry? Again, unfortunately it
6 is that attestation for it. It's going to be
7 documented somewhere in that patient's record.

8 MEMBER PINDOLIA: Oh, just that the
9 doctor said --

10 CO-CHAIR PINCUS: An attestation.

11 MEMBER PINDOLIA: Okay, thanks.

12 MS. JOUZA: Exactly. And it could be
13 --

14 (Off microphone comments.)

15 MS. JOUZA: Yes. And it could be
16 either/or or a combination of both.

17 CO-CHAIR PINCUS: Any other comments
18 about feasibility? Okay, ready to vote on
19 feasibility.

20 MS. QUINNONEZ: Voting is now open for
21 the feasibility of Measure 3225. Option one,
22 high. Option two, moderate. Option three, low.

1 And option four, insufficient.

2 Looking for one more vote. Thank you,
3 all votes are in and voting is now closed. For
4 the feasibility of Measure 3225, 52 percent voted
5 high, 12 individual votes. Forty eight percent
6 voted moderate, eleven individual votes. Zero
7 percent voted for low, and zero percent voted for
8 insufficient.

9 This passes the criteria of
10 feasibility for Measure 3225.

11 CO-CHAIR PINCUS: Okay, now use and
12 usability. Any comments on use and usability?
13 Mike?

14 MEMBER LARDIERI: Yes, I'm not sure if
15 it comes up here or not, but I think it would be
16 more useful if we were able to put another
17 question at the end that gets to the smoking on
18 the panel question which is one of the other
19 measures.

20 So if you would identify the
21 percentage of the patients who are actually no
22 longer smoking as well as those other three

1 questions, I think that would, me as a provider,
2 make that much more useful because then I know
3 what percentage of my population is smokers and
4 not smokers.

5 And if I've done anything, I can just
6 look and see how I've brought that number down.

7 MEMBER KELLEHER: And just to pound
8 the nail in all the way, I think all the tobacco
9 related measures need to think about changing
10 their titles and including nicotine delivery
11 rather than tobacco to incorporate, keep up with
12 the times here, especially as it relates also
13 down to the pediatric level.

14 CO-CHAIR PINCUS: So if the staff
15 could keep a record of, like, all these comments
16 that we're making in terms of future improvements
17 to this and to the other tobacco measures,
18 nicotine measures.

19 Any other comments about usability and
20 use?

21 (Off microphone comments.)

22 CO-CHAIR BRISS: So on the last point,

1 on the last point you think about the pros and
2 cons of that. So one of the reasons that a lot
3 of measures get specified for just inhaled
4 tobacco use is first that inhaled tobacco use is
5 the public health most important one.

6 And if you want to measure all the
7 other tobacco things, you greatly increase the
8 measurement burden because then people have to
9 ask about hookahs and there's a whole long list
10 of other things that you might make people ask
11 about.

12 And so think about the trade-offs of
13 what you ask for. At this point, I'm not voting.
14 My tobacco people at CDC would prefer to have the
15 whole long list, truth is. But there are a lot
16 of healthcare systems that don't agree with that.

17 CO-CHAIR PINCUS: So maybe our
18 recommendation is figuring out how to solve that
19 problem. Any other comments about usability and
20 use? Okay, let's vote.

21 MS. QUINNONEZ: Voting is now open for
22 usability and use of Measure 3225. Option number

1 one, high. Option number two, moderate. Option
2 number three, low. And option number four,
3 insufficient information.

4 Thank you, all votes are in and voting
5 is now closed. For the usability and use of
6 Measure 3225, 50 percent voted for high, which is
7 12 individual votes. Forty two percent voted
8 moderate, that is ten individual votes. Eight
9 percent voted low which is two individual votes.
10 And zero percent for insufficient information.

11 For usability and use of Measure 3225,
12 this passes the measure criteria.

13 CO-CHAIR PINCUS: So are there, do we
14 have to deal with any kind of competing?

15 DR. LUSTIG: There's nothing
16 competing. And so as we said before, we're going
17 to talk about this in the scope of our overall
18 portfolio tomorrow.

19 CO-CHAIR PINCUS: Okay. So let's vote
20 on endorsement, but before we do so, are there
21 any final comments with regard to endorsement
22 issues? Mike?

1 MEMBER TRANGLE: Question as much as
2 a comment or recommendation or wishful thinking,
3 I don't know what the right title is. But could
4 we either pass it with a recommendation or in
5 suspense that's my wishful thinking, that it is
6 analyzed so that we can look at the results with
7 the BH subset and look for improvements so it
8 doesn't remain lost in the shuffle and we wonder
9 whether there's even a gap or that kind of thing.

10 CO-CHAIR PINCUS: So when did this
11 come up for renewal of their maintenance?

12 DR. BURSTIN: I will point out, and
13 Harold knows as well, and NCQA will be up shortly
14 that there are a whole set of CD risk production
15 measures specifically for the behavioral health
16 population.

17 There's no reason you couldn't suggest
18 to the developer that they add, that they begin
19 to explore adding the strata. It doesn't have to
20 wait three years, that could be part of our
21 annual review process that we recognize the
22 importance of this and we would like to see them

1 begin to include a stratum for serious mental
2 illness.

3 CO-CHAIR PINCUS: Yes, in a sense
4 creating expectations about other measures that
5 are looking at this kind of thing, you know,
6 these phenomena that they sort of move to the
7 sort of next level of expectation in terms of
8 being able to measure things that are more
9 meaningful.

10 MEMBER TRANGLE: It's really not just
11 a intellectual thing because what we're finding
12 when we're trying to do the work is that the
13 general approaches that have good evidence that
14 they've improved things for the general
15 population don't work for the behavioral health
16 population.

17 And if it gets shown for the general
18 population, then there will be more funding and
19 more recognition that something different needs
20 to happen for our sub-population.

21 It drives money, it drives attention,
22 and potentially resources. So it's really not

1 just an esoteric kind of thing.

2 CO-CHAIR PINCUS: Okay, any further
3 comments before we vote on endorsement? Okay,
4 why don't we vote.

5 MS. QUINNONEZ: Voting is now open for
6 the overall suitability for endorsement of
7 Measure 3225. Option number one, yes. Option
8 number two, no. Thank you, all votes are in and
9 voting is now closed.

10 For the overall suitability for
11 endorsement of Measure 3225, 100 percent voted
12 yes, that's 24 votes.

13 CO-CHAIR PINCUS: Okay, so why don't
14 we move on to the next one which is the eMeasure
15 version of this. Okay, take it away.

16 MS. TIERNEY: You know, I don't think
17 we have anything additional to add. In my
18 earlier discussion we sort of described the
19 overall importance of the measure and --

20 CO-CHAIR PINCUS: Right, but if you
21 say something about how, what you've done to
22 specifically adapt this for the measure.

1 MS. TIERNEY: All right, Jamie, would
2 you speak to that?

3 MS. JOUZA: Sure. So this measure is
4 kind of broad in nature in that we don't have
5 those targeted populations as we've been
6 discussing. And so our denominator essentially
7 captures all of those patients who are 18 years
8 or older.

9 In terms of that numerator though, in
10 order to adapt it for the eMeasure, we have had
11 to codify and use some of those recommended
12 clinical vocabulary LOINC to capture our
13 screening tool, or screening questions. RxNorm to
14 capture the pharmacotherapy agents as well as CBT
15 and SNOMED to capture the actual procedure of the
16 cessation intervention.

17 And so in order to kind of take it
18 from that attestation piece with the CPT2 code as
19 has been included in the PQRS program since the
20 measure was introduced, which we just said was
21 back in, like, 2009, in some form.

22 And so that has been kind of expanded

1 and able to kind of capture and really look at
2 what is being required for the measure. And so
3 there's no longer that attestation you have to
4 show that you've done, you've screened, you have
5 a tobacco user status, tobacco non-user status.

6 And so that's been adapted and used as
7 different coding terminologies.

8 CO-CHAIR PINCUS: Just, I might have
9 missed this but how do you capture OTC?

10 MS. JOUZA: Those are going to be
11 through RxNorm codes. And I think there would be
12 a prescription. So we allow for a medication
13 order or a medication active.

14 And so if the physician were to give,
15 you know, they recommend that you go pick this
16 up, then they could do that. That would still be
17 documented kind of in that.

18 CO-CHAIR PINCUS: So that would be
19 documented in the --

20 MS. JOUZA: Yes, we do allow, like I
21 said, if a patient is actively taking the
22 cessation pharmacotherapy or is ordered to do so

1 at that particular screening, that counts as the
2 intervention.

3 CO-CHAIR PINCUS: Any questions on the
4 clarification here? So is there any objection to
5 having further discussion with regard to
6 evidence? Any? Okay, so we can move on beyond
7 evidence to gaps. And here the gaps are become
8 relevant to the particular groups that are being
9 evaluated. And is there data about that?

10 MS. TIERNEY: We do have data from the
11 sample that we received from CMS that we
12 conducted our testing analysis on that, chose
13 lower rates of performance for this measure, come
14 here to the claims and registry versions of the
15 measure.

16 CO-CHAIR PINCUS: What there was lower
17 rates?

18 MS. TIERNEY: Lower rates, yes.

19 CO-CHAIR PINCUS: What magnitude?

20 MS. TIERNEY: I don't have it right at
21 my fingertips.

22 (Off microphone comments.)

1 MS. TIERNEY: Thank you. 76.83.

2 CO-CHAIR PINCUS: Any comments about
3 gaps on this measure from any of the reviewers?

4 MEMBER HORGAN: I think the only issue
5 is that it performs slightly less well.

6 CO-CHAIR PINCUS: What was that?

7 MEMBER HORGAN: I think the only gap
8 is that performance is less, and we just listened
9 to those numbers. But everything else seemed
10 similar to the extent of the study.

11 CO-CHAIR PINCUS: Okay.

12 MEMBER MAZON JEFFERS: Will it
13 attribute that lower performance to the fact that
14 you've eliminated the attestation aspect of the
15 measure, and you are looking more at verifiable
16 evidence?

17 MS. JOUZA: Yes, I think, and also
18 kind of the adoption of the EHR in moving to that
19 comfortable, you know, claims registry to kind of
20 requiring, again these are different coding
21 terminologies than many are comfortable with or
22 used to.

1 And so that could also contribute to
2 I think the lower performance. While they
3 understand, you know, how to report and which
4 codes are applicable to the measure.

5 But again, because you can capture and
6 the way that the measure is structured, the
7 eMeasure is structured, we have our screening and
8 non-user, and then we have our screening and user
9 and intervention.

10 And so with that, CPT2 in the claims
11 registry version 3225, that kind of lumps it all
12 together. And so now we are actually making that
13 computer requirement that you have to have this
14 and this and this.

15 CO-CHAIR PINCUS: So just a question.
16 So I think, I can understand why the rationale
17 why it might be a lower measure. But does that
18 also suggest that during this phase it's also
19 created unreliability if part of the problem is
20 sort of the, you know, the application of the
21 methodology for capturing the data?

22 MS. JOUZA: I think that there are

1 oftentimes questions that we received that
2 implementers, vendors themselves are kind of
3 unsure how to kind of pull things together and
4 want to really ensure that they are meeting their
5 requirements of the measure.

6 So there might be a misunderstanding
7 and potentially lower reliability. But again,
8 this measure have been a part of, and there are
9 other tobacco related measures that are included
10 in the program, including the smoking objective
11 that was part of meaningful use.

12 And so I think that there is better
13 appreciation for what those requirements are,
14 again for EHR specific reporting too.

15 CO-CHAIR PINCUS: Okay. Any further
16 discussion about gaps?

17 MEMBER MAZON JEFFERS: I'm sorry, I
18 remembered my question. Is this for use only in
19 primary care settings? I'm sorry, I didn't do
20 the in depth review on this one.

21 MS. JOUZA: It is not. This measure
22 actually includes a variety of settings, a

1 variety of encounter, different types of
2 encounters. And so we do have the office primary
3 care physician settings. We do have
4 ophthalmological visits, occupational therapy,
5 speech hearing evaluation encounters.

6 And that was all based on, as Sam had
7 mentioned before, when we developed the measure
8 initially, we had a multi-disciplinary workgroup.
9 And so we had a lot of those specialties kind of
10 at the table and subsequently received some
11 requests from CMS and we received some requests
12 from specialties in particular who requested that
13 they have their encounters added.

14 MEMBER MAZON JEFFERS: But it doesn't
15 include behavioral health settings?

16 MS. JOUZA: It does.

17 MEMBER MAZON JEFFERS: It does?

18 MS. JOUZA: Yes.

19 CO-CHAIR PINCUS: To vote on the gap
20 issue.

21 MS. QUINNONEZ: Voting is now open for
22 Measure 3185, preventative care and screening

1 tobacco use screening and cessation intervention
2 eMeasure. We're voting on performance gap.

3 Option number one is high, option
4 number two is moderate, option number three is
5 low, and option number four, insufficient. For
6 the performance gap of Measure 3185, option one
7 high, option two moderate, option three low, and
8 option four insufficient.

9 Thank you, all votes are in and voting
10 is now closed. For the performance Measure 3185,
11 performance gap, 33 percent voted high which is
12 eight individual votes, 67 percent voted
13 moderately which is 16 individual votes, zero
14 percent voted for low and zero percent voted for
15 insufficient.

16 So performance gap passes the criteria
17 for this measure.

18 CO-CHAIR PINCUS: Okay, let's move on
19 to reliability. Any of the reviewers who
20 reviewed it want to comment on reliability?
21 Connie?

22 MEMBER HORGAN: The reliability scores

1 were similar to the previous measure which makes
2 this very easy to do. The reliability at the
3 minimum number of events was 181, and it was .99
4 at the average number.

5 CO-CHAIR PINCUS: Any additional
6 comments with regard to reliability? Mike?

7 MEMBER LARDIERI: Yes, I just have
8 one. Where does dental fit in? Does that fit in
9 under clinician, office clinic? I missed that on
10 the other one too. It doesn't look like dental
11 is involved.

12 MS. JOUZA: We don't specifically
13 address the dental community within the measure
14 itself.

15 MEMBER LARDIERI: Is there a reason
16 why not or are you going to include that? I
17 mean, dentist is a great place to do that.

18 MS. TIERNEY: Yes, I mean, I think
19 it's something we could consider in future
20 updates. As Jamie said, we've had, you know, we
21 had this broad workgroup. It did not include
22 dentists when we developed the measure. So some

1 of the people who were on that workgroup
2 certainly felt that, you know, it was appropriate
3 for their setting of care. So they, you know,
4 encouraged us to have that setting included
5 within the measure specifications.

6 We have received subsequent requests
7 from other professionals that have also allowed
8 those codes to be added once we've added those
9 through a process that we follow. But we've
10 never had a request from the dental community.
11 But I think it's something we could certainly
12 pursue.

13 You know, of course the
14 appropriateness of it with our technical expert
15 panel and then also involving the dentists, the
16 dental community to see if this is something that
17 they would want to report on.

18 DR. BURSTIN: I'll just mention NQF
19 did a report several years ago specifically on
20 the future for dental measurement and this whole
21 area of screening for oral cancers is so
22 prominent. Anyone who's been to the dentist at

1 8:00 a.m. this morning, it was a good full five
2 minutes of my exam. It seems like such a logical
3 place to put smoking as well. So I would be
4 happy to share that report with you guys.

5 CO-CHAIR BRISS: So a couple of
6 comments on the specs that I would like to see
7 improved over time, actually doesn't reflect,
8 doesn't deal with the stuff for today.

9 But I would like, I would love to see
10 you move toward a less restrictive denominator.
11 So the at least two visits, the people who are
12 seeing you pretty routinely aren't the people
13 that I'm most worried about actually.

14 So I would like to see the denominator
15 be less restrictive than that in terms of how
16 many visits are required. I would also like to
17 see as tobacco prevalence in the population goes
18 down, your performance on this measure is more
19 and more about screening people for tobacco use
20 who aren't smokers.

21 So hypothetically, if you were to
22 encounter a population that had a national

1 average tobacco use that was 15 percent, you did
2 a perfect job screening and a zero job of actual
3 treating the actual smokers, you could score 85
4 percent on this measure as it's currently
5 specified.

6 And so the gap is increasingly not on
7 the screening side, it's on the treatment side.
8 And I would much like to see you separate the
9 screening from the treatment and give us separate
10 scores for the two pieces.

11 MS. JOUZA: So that's a great point,
12 and just to jump in, that is actually something
13 that we are kind of modeled and put forward to
14 consideration for, by CMS.

15 And so they're actually reviewing that
16 proposal to kind of split it out so that we can
17 actually see those rates for the actual
18 screening, and then of the screening, of those
19 who were screened and were tobacco users in our
20 denominator, who got the intervention so that we
21 can get that and actually see overall where the
22 gap is.

1 CO-CHAIR PINCUS: I think, just a
2 question for Helen. You know, I think that makes
3 a lot of sense. But it's important to at least
4 in my mind that it be combined as a single
5 measure but with two different so that it's not
6 like people can pull measures out of the arm room
7 and carry them and say oh, we're just going to do
8 screening.

9 MS. JOUZA: And that's exactly what
10 we're trying to do.

11 CO-CHAIR PINCUS: Any other comments
12 about reliability? Okay, we're ready to vote on
13 reliability.

14 MS. QUINNONEZ: Voting is now open for
15 the reliability of Measure 3185. Option one,
16 high. Option two, moderate. Option three, low.
17 And option four, insufficient.

18 Thank you, all votes are in and voting
19 is now closed. For the reliability of Measure
20 3185, 21 percent voted high, 5 individual votes.
21 Seventy nine percent voted moderate, nineteen
22 individual votes. Zero percent voted for low,

1 and zero percent voted insufficient.

2 Reliability of Measure 3185 passes
3 this criteria.

4 CO-CHAIR PINCUS: Let's move on to
5 validity. Comments on validity? Dodi?

6 MEMBER KELLEHER: I just wanted to
7 note that the Bonnie testing was 100 percent.

8 CO-CHAIR PINCUS: Connie?

9 MEMBER HORGAN: And I was thrilled to
10 find out that the name Bonnie meant nothing.

11 My comment relates to something that
12 we've discussed before on the previous measure
13 that's allowing medical reasons. And the comment
14 that was given is that there have been concerns
15 expressed about this being gamed.

16 The explanation that was given is that
17 it's so low it's not worth worrying about. I
18 just want to point out that as we move forward,
19 and we're only dealing with a relatively small
20 proportion of physicians who aren't using this
21 measure as it becomes more widely used, I don't
22 know that you can assume that it's immune from

1 gaming.

2 And that is something that I think we
3 should continue to look at because it is
4 extremely vague in terms of the, right?

5 CO-CHAIR PINCUS: Is there another
6 medical reason other than limited life expectancy
7 that anybody had in mind?

8 MS. TIERNEY: We have had this
9 discussion with our expert panel just recently in
10 fact. And there was general agreement that there
11 are some situations that you may not find it
12 appropriate at that visit to perform the
13 screening.

14 We didn't get specific examples to add
15 to the measure. We asked are there, you know,
16 some that happen frequently enough that we could
17 add to the measure just because we do get asked
18 this question, are there other examples.

19 We didn't get specific examples, but
20 the general consensus of the test was that there
21 are situations and, you know, maybe somewhat rare
22 but there are situations apart from limited life

1 expectancy where you might not want to screen.

2 And I think it was more focused on at
3 that visit maybe because at that visit you would
4 be focused on other things.

5 CO-CHAIR PINCUS: Connie?

6 MEMBER HORGAN: Just following up on
7 that, and I am not a clinician so I defer to the
8 clinicians in the room. But I have heard that
9 argument used specifically for behavioral health
10 and that you would not want to screen, or mental
11 health and other addictions because of certain
12 situations. So I just want to loop that back.

13 CO-CHAIR PINCUS: Peter?

14 DR. SAXON: Hi, this is Andrew Saxon,
15 I'm with the American Psychiatric Association and
16 work with the PCPI. And so I just want to very
17 strongly argue against that point of view.

18 Most of the remaining tobacco users
19 are mental health patients. That is the place
20 where we need to be screening the most. And
21 there really is no reason why that cannot be
22 included in a mental health visit.

1 Even if a person is suicidal, tobacco,
2 smoking doubles the risk for suicidal behavior,
3 so it should be inquired about as a potential
4 risk factor for suicide.

5 MEMBER HORGAN: I would like to
6 clarify that I'm agreeing with you. The only
7 point was that if it's left vague as a medical
8 condition, it opens it up to gaming. So one
9 should protect against that happening.

10 DR. SAXON: I'm sorry if I
11 misunderstood your comment.

12 MEMBER HORGAN: Important to clarify
13 it.

14 CO-CHAIR BRISS: I just wanted to
15 endorse the idea of less exclusions. Generally,
16 I think less exclusions are better. And if that
17 means that we're not always going to score 100
18 percent all of the time, I'm fine with that.
19 Especially if the exceptions are rare.

20 CO-CHAIR PINCUS: Yes, it's only .4
21 percent. Okay, I think then we're ready to vote
22 on validity.

1 MS. QUINNONEZ: Voting is now open for
2 validity of Measure 3185. Option one, moderate.
3 Option two, low. Option three, insufficient.
4 All votes are in, voting is now closed.

5 For validity of Measure 3185, 79
6 percent voted moderate, 19 individual votes.
7 Twenty one percent voted low, five individual
8 votes. And zero percent voted for insufficient.

9 For measure 3185, this measure passes
10 the validity criteria.

11 CO-CHAIR PINCUS: Okay, let's move on
12 to feasibility. Any comments about feasibility?
13 Connie?

14 MEMBER HORGAN: I would like to ask if
15 you could offer more explanation about the
16 testing you did in two different systems and then
17 you said in one system, the data elements, only
18 17 of the 26 elements were currently feasible.
19 And then it was a statement about they were
20 judged to be feasible in the next three to five
21 years. Could you expand on that?

22 MR. SEGOVIA: Sure, I can expand on

1 that. So in terms of the feasibility in some
2 EHRs, we noted that some providers don't use
3 particular encounter counts.

4 So if your internal medicine provider,
5 you may not be able to use behavioral health
6 codes. So that contributed to some of the not
7 being able to use some of the encounter codes for
8 that.

9 Also I want to note that some of the
10 exclusions were unable to be captured in
11 structured fields. So most folks use free text
12 to document those.

13 MEMBER HORGAN: I was more commenting
14 on how do you know it's going to be better in
15 three to five years? It's just, like, a random
16 number, everything gets better in three to five
17 years.

18 MR. SEGOVIA: Which system was --
19 (Off microphone comments.)

20 MR. SEGOVIA: It was what?

21 PARTICIPANT: It was an Epic --

22 MR. SEGOVIA: Implementation?

1 CO-CHAIR PINCUS: Epic was -- so the
2 VA was able to --

3 MR. SEGOVIA: The VA was, okay.

4 CO-CHAIR PINCUS: Other comments with
5 regard to feasibility? I guess, you know, I
6 don't know. Mike, you would probably know in
7 terms of market penetration. But, you know, Epic
8 I think is the largest. And it would take them
9 three to five years, does this have any
10 implications for other vendors?

11 MEMBER LARDIERI: Some other vendors
12 can probably do it faster. Epic has a certain
13 way of implementing changes. They come out,
14 like, once every six months, and they do the
15 whole world of Epic at once, and then they move
16 on.

17 And if you're in the queue at that
18 point, it comes on. If you're not, you have to
19 wait again. So a lot of it has to do with that.
20 But other vendors could do it sooner. I think
21 three to five years, this could happen sooner
22 than three to five years if organizations wanted

1 it.

2 Again, it gets to the issue of there's
3 another issue. I mean, do the vendors have to
4 pay in order to make this happen, and then those
5 costs then go down to the provider. And maybe I
6 don't want to pay for that. So you know, that
7 also is implied with these things.

8 CO-CHAIR PINCUS: Any other comments
9 about feasibility? Okay, I think we're ready to
10 vote.

11 MS. QUINNONEZ: Voting is now open for
12 the feasibility of Measure 3185. Option one,
13 high. Option two, moderate. Option three, low.
14 Option four, insufficient.

15 Looking for two more votes. Thank
16 you, all votes are in, voting is now closed. For
17 the feasibility of Measure 3185, 29 percent voted
18 high to 7 individual votes, 71 percent voted
19 moderate to 17 individual votes, zero percent
20 voted for low and zero percent voted for
21 insufficient.

22 For the feasibility of Measure 3185,

1 it passes this criteria.

2 CO-CHAIR PINCUS: Okay. Let's move on
3 to use and usability. Any comments about use and
4 usability? Connie?

5 MEMBER HORGAN: I know Peter spoke
6 about everyone at the CDC wants everything in
7 this measure, but I think the fact that the
8 implementers of this measure were asking for more
9 information and addressing the issue of
10 electronic, a continuing delivery system should
11 be taken, given a high priority of this
12 particular mechanism that's not being included.

13 So as we get into the future I think
14 it might distinguish it more from some of the
15 others.

16 CO-CHAIR PINCUS: Okay, any other
17 comments with regards to usability? David?

18 MEMBER PATING: Since Peter got to
19 make a speech I'm going to make a little bit as
20 well.

21 So as pain as the fifth vital sign
22 falls out, I would be hopeful that tobacco can

1 move in. I think tobacco should be every visit,
2 every time, and it's like the suicide question
3 for mental health and it's such a major public
4 issue.

5 So with regards to that I think the
6 issue because measures, we're showing really high
7 screening rates, but as moving into treatment as
8 Peter is mentioning is a really good goal, but
9 absolutely realizing this is a relapse in disease
10 we may even need to look at six- and two-year
11 outcomes.

12 There's Doug Ziedonis and several
13 national speakers that are moving towards the
14 idea of tobacco registries that we really need to
15 be thinking longer term with tobacco cessation,
16 probably more relapse than not, and everyone
17 knows it takes seven times to quit smoking or
18 before you're effective.

19 So as you look to this development of
20 this measure, broadening it, including more
21 things, thinking farther out, it's still our
22 number one killer. So thanks.

1 CO-CHAIR PINCUS: Thank you. Other
2 comments on usability and use?

3 So I think we're ready to vote on
4 usability and use.

5 MS. QUINNONEZ: Voting is now open for
6 usability and use of Measure 3185. Option 1
7 high, option 2 moderate, option 3 low and option
8 4 insufficient information.

9 Thank you, all votes are in and voting
10 is now closed. For the usability and use of
11 Measure 3185, 42 percent voted high, ten
12 individual votes, 58 percent voted for moderate,
13 14 individual votes, zero percent voted for low,
14 and zero percent voted for insufficient
15 information.

16 So for usability and use of Measure
17 3185, this passes the measure criteria.

18 CO-CHAIR PINCUS: So before we get to
19 the voting of endorsement any final comments with
20 regard to endorsement? Mike?

21 MEMBER TRANGLE: In my attempt to win
22 the broken record award could we make sure we

1 stratify this?

2 CO-CHAIR PINCUS: I think there may be
3 a lot of candidates for that so --

4 MEMBER TRANGLE: But I would just want
5 to make sure that we really see how well this
6 sub-population of behavioral health patients fare
7 as this plays out over time. Just like I was
8 saying it for the non-electronic version.

9 CO-CHAIR PINCUS: Thank you.

10 Other comments before we vote on
11 endorsement? Okay, so let's proceed to vote on
12 endorsement.

13 MS. QUINNONEZ: We are now voting for
14 the overall suitability for endorsement of
15 Measure 3185. Option 1 yes, option 2 no.

16 Looking for -- thank you. All votes
17 are in, voting is now closed. For the overall
18 suitability for endorsement of Measure 3185, 100
19 percent voted yes.

20 CO-CHAIR PINCUS: Nice work. We've
21 gone through a lot of these in a row. So now
22 we're going to consider Measure 3229. And I

1 guess, Peter, you're recused?

2 CO-CHAIR BRISS: I'm re-recused.

3 CO-CHAIR PINCUS: Re-recused.

4 DR. LUSTIG: My apologies about the
5 earlier one, but Dr. Briss is definitely recused
6 from this measure.

7 CO-CHAIR PINCUS: Okay. So if the
8 measure developers can introduce themselves and
9 give us a summary?

10 DR. MCNAIR: Good afternoon, everyone.
11 My name is Tiffany McNair and I'm a division
12 director at the CMS Innovation Center's
13 Prevention and Population Health Group.

14 I'm joined by my colleague and the
15 lead of our measure's portfolio, Dr. Katherine
16 Sapra. We're very excited to be here today and
17 really appreciate the opportunity to share our
18 measure with NQF and also with the committee.

19 I'd like to start out just by saying
20 that as a practicing OB/GYN myself, I really am
21 very much encouraged by the promise offered by
22 population based outcome measures such as the one

1 that we are seeking endorsement from you all
2 today.

3 And we recognize that while our
4 measure is relatively simple, the constant
5 undergirding it is not. As we shift from volume
6 to value and increasingly focus on enhancing
7 quality within our health care system an emphasis
8 on outcomes is logical and yet at times it seems
9 as if moving in this direction is a Herculean
10 feat.

11 And what we're offering today for
12 consideration is really, as one of the committee
13 members put in their preliminary analysis, a
14 first step. And I think as many of you know, a
15 journey of a thousand miles begins with that
16 first step.

17 And we hope that we can provide
18 clarity for you all in the technical merit of the
19 measure and also have a fruitful discussion on
20 its promise, not in isolation but in harmony with
21 other related process measures such as the one
22 that we just talked about.

1 We hope that this will help to advance
2 quality population health, and of course a system
3 in which disease is not only prevented but really
4 health is promoted.

5 So the evidence for our measure is
6 well supported that smoking and cessation
7 activities are clear. We thank our predecessors
8 for the prior measure for really articulating
9 that well and really helping to clarify the
10 ongoing performance gap.

11 What I will say in addition to that is
12 that beyond the kind of in-office counseling and
13 the provision on behavioral and pharmacol
14 therapies as well as the linkages that are
15 created to community based services, we also know
16 that the evidence supports really increased care
17 coordination and case management to strengthen
18 that.

19 So for instance, a patient that's seen
20 in your office ensuring that they have not only
21 referral but strong connection and linkage to
22 quit lines, for example, with additional phone

1 calls and follow-up not only from the outpatient
2 setting but even upon discharge. We know that
3 this increases uptake of successful interventions
4 and therefore potentiates the patient's ability
5 to stop smoking.

6 And yet despite all of these available
7 tools as well as the fact that there are existing
8 process measures, we know that smoking prevalence
9 continues to persist and is a really widely
10 variable across practices, and as many of you
11 have mentioned already is higher among certain
12 subgroups as well and we're not necessarily
13 capturing that in the current milieu.

14 So given the strong evidence base and
15 the performance gap, we're proposing what is
16 relatively simple but a far-reaching measure to
17 capture the intermediate outcome of smoking
18 prevalence. We just want to provide a few
19 clarifications for you to our submission package
20 and then we're looking forward to the discussion.

21 3229 is collected via electronic
22 health records and it captures the percent of

1 adult patients, specifically those that are age
2 18 or older, who are current smokers among those
3 patients who are screened for smoking.

4 Now the timing for collection is in
5 line with the existing measure NQF 0028 which is
6 now 3225. The measurement period is one year, so
7 basically a patient must have had as you all know
8 a qualifying encounter within that measurement
9 year. However, their smoking status could have
10 been ascertained within the 24 month prior, so
11 either in the measurement year or 12 months
12 before that.

13 In terms of exclusions, as with NQF
14 0028 one could have been excluded from this if
15 for medical reasons if they weren't screened,
16 such as limited life expectancy as we also heard.
17 But in our case you could have also been excluded
18 simply because a provider did not employ
19 universal screening, and we'll talk some more
20 about that.

21 Regarding the numerator and
22 denominator, all patients within the denominator

1 must have been screened, right, and all patients
2 in the numerator must have had a positive screen.
3 This is an important distinction from 0028, so
4 with the denominator in 0028 it includes the
5 entire patient panel. Ours just includes those
6 patients who were screened and therefore you know
7 that they're either a smoker or a nonsmoker.
8 That's the denominator.

9 In the numerator with our measure we
10 stop at whether or not that person is a smoker.
11 So you screen positively, you're in the
12 numerator. With NQF it goes on to further query
13 as to whether or not that person received
14 counseling or interventions.

15 Now the data for the proposed measure
16 also was obtained via the Medicare PQRS reporting
17 mechanism and a sample was drawn from over 70,000
18 patients from nearly 400,000 eligible providers
19 and across all regions of the U.S.

20 One point that may not have been fully
21 articulated in our submission was that testing
22 was conducting on eligible providers with at

1 least ten patients and among those who reported
2 smoking status on at least 50 percent of their
3 patients.

4 Findings from the testing demonstrate
5 that our measure is highly reliable -- we hope
6 that you are in agreement -- regardless of region
7 or practice geography and regardless of patient
8 panel size.

9 Specifically among those eligible
10 providers who did see at least ten patients, the
11 mean reliability was 0.89 and was even higher
12 among those with at least 100 patients.

13 Another piece of late-breaking news
14 that we'd like to provide for you on face
15 validity because we were also encouraged on this
16 piece was that our technical expert panels did
17 weigh in on whether or not this would be a good
18 measure of quality, so to distinguish between
19 poor and good quality of health care.

20 And within our TEP, seven of the
21 members of our technical expert panel had a
22 smoking focus and among those seven five did

1 agree, either strongly agree or agree that this
2 would be a good measure of quality.

3 Additionally, as you may have also
4 read in our empirical validity testing, we found
5 that smoking prevalence decreased by an estimated
6 two percentage points for every ten percentage
7 point increase in screening and intervention.

8 And so essentially when one does
9 screen appropriately in one year we can see in
10 the subsequent year that smoking prevalence does
11 in fact decline, so there was an association
12 there.

13 And the providers who performed well
14 on the process whatever those processes are, in
15 this case screening and intervention, they also
16 performed well in the intermediate outcomes
17 smoking prevalence, our measure.

18 One other point of this as an
19 intermediate outcome measure we know that the
20 measure is not required to be risk adjusted.
21 That said, members of our TEP and our team firmly
22 believe an unadjusted version of this measure is

1 the right path forward at this time.

2 First, we do not want to mask the
3 underlying disparities that many of you have
4 already articulated today that may exist within a
5 provider's practice in terms of smoking behavior
6 and among specific subgroups within their
7 population.

8 Second, in support of broader
9 population health improvement efforts we really
10 do see this measure as an internal quality check
11 essentially to say, assuming that you're
12 utilizing the full scope or menu of options
13 available to you whatever they might be, we can
14 then determine and quantify the reach of those
15 interventions by actually seeing whether or not
16 your smoking prevalence has decreased as a result
17 of employing those different options.

18 So we are still exploring the
19 possibilities for the use of this proposed
20 measure in our quality programs, but we are
21 confident that it does offer critical linkage
22 between discrete processes, so clinical

1 interventions, care coordination strategies and
2 the like, and the downstream health impacts of
3 smoking.

4 And we do also believe that it offers
5 an opportunity, a very critical one, to
6 potentiate the impacts of related process
7 measures and to really provide additional
8 flexibility to physicians as opposed to checking
9 off just boxes around different processes to
10 really be able to move us down to the outcome, or
11 this intermediate outcome of interest and then
12 eventually to our true outcome of interest which
13 is reducing smoking related morbidity and
14 mortality.

15 And so again just to echo what I said
16 earlier, we believe that our measure's promise is
17 really realized in first taking this initial
18 critical step in focusing on population based
19 outcome measures. We hope that it offers
20 feedback to providers not only on the outcomes of
21 the screening and intervention strategies, but
22 also incentivizes them to leverage additional

1 approaches that are multimodal, that are evidence
2 based, that are cross-sector, and most
3 importantly that are patient centered.

4 I will stop there. I speak fast, but
5 I wanted to make sure we had enough time for you
6 all to weigh in, and we thank you again for this
7 opportunity to have a discussion.

8 CO-CHAIR PINCUS: So initially are
9 there questions about clarification of this
10 measure that people had? So Jeff, Lisa.

11 MEMBER SUSMAN: I wonder what your
12 response is to the fact that this potentially at
13 least seems like it could be gamed. You're a
14 smoker, I'm not going to bother screening you.
15 You don't smoke, I'll make sure that you get in
16 the sample and whether you have data.

17 I thought there was a fair amount of
18 missing data, like a quarter or so in the
19 population. I'm just trying to get a handle on
20 that issue and I don't have any concerns about
21 the validity or usability and so on.

22 DR. MCNAIR: I think it's a really

1 good question and I'll let Kate speak
2 specifically to some of the data around the
3 missing data. And what I will say is that's one
4 of the reasons why we have talked about this
5 being a really good opportunity to use in tandem.
6 So assuming that with the other measure that
7 someone has screened and is reporting on their
8 screening practices, then this is a measure that
9 could be used kind of harmoniously with that so
10 that you could kind of get around to some degree.

11 It's a slight mitigation strategy
12 around the potential gaming that could occur in
13 that regard.

14 DR. SAPRA: Yes, thank you for that
15 question. You're right about the missing data.
16 And there's a couple of pieces that I wanted to
17 highlight.

18 One is that when we looked at the full
19 sample, so the testing was primarily done on
20 those providers that had at least ten patients
21 and screened at least 50 percent of all their
22 patients, and then when we expanded it to all of

1 the eligible providers without those minimum
2 criteria, the smoking prevalence was slightly
3 higher.

4 So that does suggest that perhaps
5 those people that are meeting the minimum
6 reporting, do have minimum reporting for our
7 testing did have somewhat lower prevalence. So
8 that's something that we are open to talking
9 about is whether or not there needs to be any
10 kind of minimum reporting with this measure.

11 And then again as Dr. McNair said we
12 would propose using this in harmony with the
13 other process measures because if you don't
14 screen someone you would not have them, because
15 they are a smoker you would not have them in our
16 measure and they wouldn't be in the denominator,
17 but then for a process measure on screening they
18 wouldn't be in the numerator.

19 So you would perform, let's say this
20 is true of all your smokers you don't record
21 anything on smokers but you record everything on
22 the nonsmokers, you would perform really poorly

1 on a process measure around screening and you
2 would perform great on our outcome measure. So
3 it does provide a little bit of a check.

4 MEMBER SUSMAN: Yes, I'm not sure this
5 is a feasible solution, but if you defaulted on
6 the screened it means you're a smoker, there
7 would be a high incentive in one measure to have
8 everybody screened and to determine what their
9 status was.

10 DR. MCNAIR: Precisely.

11 CO-CHAIR PINCUS: So Lisa and then
12 Tami and then I have a question. Oh, and then
13 Charles.

14 MEMBER JENSEN: I don't know if this
15 comment fits in necessarily here and it's
16 probably global for all of these tools that we're
17 talking about tobacco, but I'm thinking about the
18 legalization of marijuana in several states or a
19 few states or however many states, where does
20 that fit in, in our screening? Are we screening
21 folks for use of marijuana?

22 DR. MCNAIR: I assume that, you know,

1 for most people that are taking adequate social
2 history that they're including that. You're
3 asking about tobacco, you're asking about
4 illicits and you're asking about alcohol use.

5 But we don't have that directly
6 included within our measure as is specified, but
7 yes --

8 CO-CHAIR PINCUS: Sounds like that's
9 another point too.

10 DR. MCNAIR: I think that's an
11 important, I think that's a very important point
12 to make, but I would hope that that's kind of how
13 people are actually asking these questions.

14 MEMBER JENSEN: Well, it's not illicit
15 in some states. So, you know, are you smoking
16 tobacco? Yeah, no. But I smoke marijuana. I
17 mean are they going to volunteer that? So just a
18 thought.

19 CO-CHAIR PINCUS: So does tobacco.
20 It's not a middle ground. Raquel.

21 MEMBER MAZON JEFFERS: Yes, I just had
22 a question also about the care setting and it

1 relates to this issue about the preponderance of
2 the smoking population being kind of in the
3 behavioral health population.

4 So from what I can tell it doesn't
5 look like the measure -- I'm with you. It
6 doesn't look like the measure can be implemented
7 in a behavioral health setting, or you don't
8 specify that as a care setting for its use.

9 DR. MCNAIR: Right. Thank you for
10 that question. And we do agree with all the
11 points that were made and at the prior discussion
12 about the importance of having this be a measure
13 where we're able to focus on those populations
14 that are most vulnerable, in particular those
15 that are suffering from mental illness.

16 We actually don't explicitly say that
17 but we do hope that it can be utilized in a
18 behavioral health setting, outpatient as well as
19 inpatient.

20 MEMBER MAZON JEFFERS: So just to be
21 clear, it's people with mental illness and people
22 with substance use disorders. And the amazing

1 thing about treating people for their tobacco
2 addiction in a substance use disorder setting is
3 that it's an addiction, so the people that are
4 treating the other substance use disorders are
5 very well equipped to be able to treat the
6 tobacco use disorder as well.

7 CO-CHAIR PINCUS: So just to clarify,
8 this measure would apply to all providers?

9 DR. MCNAIR: Are you talking
10 specifically in terms of operationalization in
11 the future?

12 CO-CHAIR PINCUS: Yes.

13 DR. MCNAIR: We're still determining
14 that, but yes, I would say yes, our interest
15 right now is for it to apply to all providers and
16 I will tell you that we are thinking --

17 DR. BURSTIN: I'm sorry, I don't think
18 Hal is asking about how you'd actually implement
19 it but is the measure specified to be for all
20 providers.

21 CO-CHAIR PINCUS: Yes, the measure is
22 specified. That's my point. Yes, it's not how

1 you're going to ultimately use it, not how CMS is
2 using, CMS is proposing this measure for
3 endorsement, which means it's open for anybody to
4 use for anybody.

5 So the specifications, you know, do
6 not limit providers in any way, so potentially
7 dentists, others.

8 MS. MARINELARENA: Hi, this is
9 Melissa. Sorry, this is Melissa Marinelarena and
10 I'm senior director here at NQF and I did help
11 write the preliminary analysis and worked with
12 CMMI.

13 There is in the specifications it does
14 list the type of providers in there, so you have
15 to look at the measure as the way it's presented
16 to you right now. I believe there was, and
17 Tracy, if you can help me. I think it was a
18 psychiatrist, ophthalmologist, but it does, it's
19 within the Excel spreadsheet.

20 But so right now it's only been,
21 what's presented to you is the type of providers
22 that are presented to you in the documentation.

1 CO-CHAIR PINCUS: So that's my
2 question is what are those providers.

3 MS. MARINELARENA: And if you give me
4 a second I'll, while you keep the conversation
5 going I will pull it up for you.

6 CO-CHAIR PINCUS: Okay. I just want
7 to clarify Raquel's question.

8 DR. MCNAIR: We were specifically
9 saying that it is specified for behavioral health
10 settings, but if you could pull up that list that
11 would be helpful to us as well. Thank you.

12 CO-CHAIR PINCUS: Okay, so in the
13 meantime, Tami?

14 MEMBER MARK: I thought I read that
15 there's an existing measure parallel to this that
16 applies at the state level, but you did think
17 about applying this to the health plan level or
18 why or why not?

19 DR. MCNAIR: NQF, yes, 2020 is at both
20 the state and national level based on the CDC's
21 behavioral risk factor surveillance system. And
22 yes, this is something that could certainly be

1 applied at the health plan setting, at the health
2 plan level, excuse me.

3 CO-CHAIR PINCUS: Okay, Charles.

4 MEMBER GROSS: A couple of questions
5 to clarify. Medicare data only was used in the
6 analysis?

7 DR. SAPRA: So I'll go ahead and take
8 that one. It does use PQRS, but the EHR system
9 which is actually all-payer, so for physicians
10 who choose to report in PQRS EHR they have to
11 report for their patients regardless of payer.

12 MEMBER GROSS: Thank you. And a
13 second follow-up question, is the data captured
14 here in some ways a subset of 3225 or should we
15 hold, and if it is maybe we'll hold that for
16 tomorrow?

17 DR. SAPRA: So our measure is very
18 well harmonized with 3225 aka 0028, in fact
19 that's where we took our measure from so it
20 aligns very well. The big difference as Dr.
21 McNair said at the beginning was that we are
22 really concerned with the intermediate outcome of

1 smoking behavior.

2 So whereas our colleagues move on to,
3 say, if you're a smoker then you need to go on
4 and get either counseling or some other type of
5 cessation intervention, we say we really just
6 care whether you smoke or not and that allows
7 providers, as Dr. McNair said in her
8 introduction, to really use a whole suite of
9 tools that are available to them that might not
10 fit discretely within that particular process
11 measure, or I believe we have another process
12 measure coming up after ours.

13 So this one really works in tandem
14 with all process measures, but it is extremely
15 well harmonized and so hopefully this will come
16 up when we talk about feasibility, usability, I
17 can't remember which one. But it's coming right
18 from 0028. Sorry, 3225.

19 MEMBER GROSS: Thank you.

20 CO-CHAIR PINCUS: Mike.

21 MEMBER TRANGLE: The focus of my
22 question really is quite similar to yours in that

1 whether it's a subset or not it seems like this,
2 if you're looking at the focus of the evidence,
3 which I think is the section we're talking about
4 here, it's not quite a standalone measure. You
5 know, it's like if you only had this alone and it
6 wasn't side by side with something else it
7 wouldn't quite be meaningful and the focus would
8 sort of be too narrow to be totally useful.

9 And to some extent I think I'm sharing
10 your bias that is there a way of connecting or
11 somehow mooshing together two measures into
12 making one simplifying.

13 I know we like harmony, but even
14 simplifying and combining as sort of a general
15 principle for us to think about that and one that
16 could really make it easier for the users and
17 maybe less expensive. This is a prime measure to
18 think about it.

19 CO-CHAIR PINCUS: Yeah, let me, also
20 my question. Because when I first looked at
21 this, I was one of the reviewers initially but I
22 sort of looked through all of them. And I

1 initially thought it was something and the more I
2 read it I realized it wasn't what I thought it
3 was.

4 And so the relationship between a
5 qualifying encounter and the relationship to this
6 screening assessment, are they both one and the
7 same thing in terms, you know, in terms of the
8 time relationship between those two things?

9 So my initial thinking in terms of how
10 I read it in a superficial way was that there was
11 the creation of a denominator, meaning a
12 denominator that was in that practice meaning
13 somebody that you would be seeing, you know, on
14 some potentially, you know, has had some contact
15 with, and then at some later point to look at
16 whether that person had remained, you know, had
17 stopped smoking or remained a smoker.

18 But it looks like now it's simply,
19 essentially a period prevalence of smoking, which
20 means that if I, you know, if I'm a psychiatrist
21 I'm going to have a much higher, you know, period
22 prevalence than, you know, somebody who's an

1 ophthalmologist.

2 DR. MCNAIR: That's correct. I'll
3 take this and then I'll see if Dr. Sapra has
4 anything additional to add. You're correct that
5 it is a kind of point in time estimate.

6 And just to go back to the definitions
7 that essentially one would have to have had the
8 qualifying encounter within the measurement
9 period which is one year, but the ascertainment
10 of this smoking status did not have to occur
11 within that measurement year. Does that make
12 sense?

13 So you would have had to have seen the
14 patient within the measurement year, but the
15 smoking status may have been obtained a year
16 before that.

17 CO-CHAIR PINCUS: So I guess my point
18 is that makes an attribution to me, so you're
19 creating the attribution through the qualifying
20 encounter.

21 DR. MCNAIR: Right.

22 CO-CHAIR PINCUS: But it does nothing

1 to say that, you know, that I did anything to
2 improve things.

3 DR. MCNAIR: Right, I think that one
4 of the, and you're right. One of the challenges
5 is that this is a measure that will be very
6 helpful over time, right, to essentially be able
7 to trend over time and we recognize that. And we
8 certainly thought about other opportunities to
9 even refine the measure beyond what it is
10 currently as a point estimate.

11 But that's why as we're proposing it
12 today, we do think that it doesn't stand alone as
13 well as when it is in tandem with another measure
14 to be able to determine whether or not the things
15 that you're doing at a practice level with your
16 patients in terms of the different types of
17 evidence based interventions and tools, whether
18 or not they are having an impact.

19 CO-CHAIR PINCUS: So I guess I'm
20 confused as to why you didn't propose this as a
21 tandem measure, you know, because if it's not,
22 don't all the endorsed measures have to be

1 standalone measures?

2 Well, Jeff, and well, actually, David
3 was next.

4 MEMBER PATING: Well, my question's
5 really along the same line because it all comes
6 down to I'd rather do one measure than, why do
7 two measures when one will work?

8 And I would be interested more that
9 you would, I think that I'm not understanding the
10 gap or the evidence for this particular measure
11 which would make me want to stop you early, have
12 you go work with PCPI and see whether you should
13 be a component measure or a submeasure of their
14 measure.

15 And I think with all the same kind of
16 recommendations that Dr. Briss gave earlier,
17 there's no doubt that looking at a panel based
18 level or a population it may add something, but
19 it doesn't seem like we should have a whole
20 definition set to do that when we might already
21 have data and can sub it out in various ways.

22 DR. MCNAIR: The one point that I'll

1 just make is that I think what becomes
2 challenging about the proposition that you've
3 made is that as what we're trying to achieve with
4 our measure is that the breadth out of this
5 process measure, I mean the menu, the suite
6 what's available that can constantly evolve,
7 right?

8 So what we don't want to propose is
9 that you should always screen or intervene in
10 this way. What we're saying ultimately is what
11 we care about is the outcome or the intermediate
12 outcome which is whether or not smoking
13 prevalence has been reduced.

14 We're relatively agnostic as to how
15 you get there, but I think the best way to get
16 there is to utilize evidence based approaches.

17 MEMBER PATING: There's by taking
18 smokers out of my practice, and I think we were
19 also asking PCPI to evolve their measure as well.
20 And so maybe these could be coevolved at the same
21 time.

22 So rather than doing tandem to a

1 measure with a PCPI measure, which may need to be
2 retired because it's not broad enough or not
3 inclusive enough, maybe the two of you could work
4 together to satisfy both these needs and evolve
5 together.

6 CO-CHAIR PINCUS: So anyway let's
7 continue. We have Mady, Racquel, and Tami, are
8 you still, have your thing up? Okay, so Mady,
9 Racquel, Tami, Jeff and Lisa.

10 MEMBER CHALK: So my comment is that
11 this for me is a contextual measure. I don't
12 know that we've ever talked in this group about
13 contextual measures, but I know other groups have
14 where you want to know what the prevalence is of
15 something and then you set the other measures in
16 that prevalence.

17 I don't know if this group has ever
18 considered those as measures. Do you understand
19 what I'm saying?

20 CO-CHAIR PINCUS: Yes, I understand.
21 The question is whether that meets the sort of
22 NQF expectations around --

1 MEMBER CHALK: That's my question.

2 CO-CHAIR PINCUS: -- measures that can
3 be used for accountability purposes.

4 MEMBER CHALK: That's my question.

5 DR. BURSTIN: I mean in many ways this
6 is essentially an outcome of smoking prevalence.
7 So we do have, I know somebody's here from
8 HealthPartners.

9 We do have an endorsed optimal
10 cardiovascular risk measure for example that has
11 four components, one of which is the percentage
12 of nonsmokers in your practice. So I think in
13 and of itself this is an outcome.

14 I'm not sure it's a component measure.
15 It could be used as a component measure, but if
16 you are going to look annually or compare
17 practices to practices to see the prevalence of
18 smoking.

19 Now that being said it certainly
20 raises the risk adjustment concerns that many of
21 you have brought up already.

22 CO-CHAIR PINCUS: Okay, Racquel.

1 MEMBER MAZON JEFFERS: So I really
2 like the idea that you are moving towards an
3 outcome based population measure and that, you
4 know, essentially you're saying I don't really
5 care how you get there, I just want to see your
6 rate of population go down. I think there's real
7 value in that and I support that you're moving in
8 that way.

9 I think some of the concerns around
10 the potential for gaming which sort of led into
11 the discussion about trying to combine this with
12 a process measure are important, right. So you
13 said that practices were excluded from this study
14 if they only, were only included if they screened
15 50 percent of their patient population.

16 Well, is it possible to really only
17 include this measure for practices that are
18 practicing universal screening in their practice
19 so that then you have a different group of
20 practices that you're looking at and you're
21 avoiding some of the gaming issues that I think
22 people are trying to, I think that's the

1 motivation behind trying to combine this with a
2 process measure is trying to avoid this gaming
3 issue.

4 But there might be a way within the
5 measure itself to change the way you define the
6 measure so that you can avoid the gaming within
7 the measure so it stands more on its own two
8 feet.

9 DR. MCNAIR: Thank you. That's an
10 excellent point and echoes the sentiment that Dr.
11 Sapra made earlier around trying to have a
12 minimum kind of reporting threshold or burden
13 that we would have to determine moving forward.

14 CO-CHAIR PINCUS: Tami, and then Lisa,
15 Jeff.

16 MEMBER MARK: Hopefully this falls
17 into the category of expanding and not beating a
18 dead horse. So I think what maybe Harold is
19 saying is it would be more helpful if you had a
20 change measure.

21 So rather than just saying, because if
22 you look at the numbers the range is, the 30th

1 percentile has six percent smoking and the 90th
2 percentile has, let's see, 28 percent smoking, so
3 if I'm in the middle why should I bother? I'm
4 already doing fine.

5 But if the measure is based on change,
6 then you're going to encourage everybody to do
7 something not just people, not detail or, so I
8 don't --

9 CO-CHAIR PINCUS: Lisa.

10 MEMBER MARK: I guess, yeah, like you
11 had a response to --

12 DR. MCNAIR: Is it okay for me to
13 respond?

14 CO-CHAIR PINCUS: Sure.

15 DR. MCNAIR: First of all, excellent
16 point and I do think that a delta measure or
17 something along those lines is certainly
18 something to consider moving forward.

19 At this time we propose this, one,
20 because we think that it again irrespective it
21 does allow for this, again, quality check as we
22 talked about as we think about it being used in

1 tandem with process measures.

2 But I do agree with you that a delta
3 measure is also a direction that we could head in
4 the future.

5 MEMBER SHEA: I just had a question
6 and it might be in all of this about the
7 attribution, because as an inpatient psychiatrist
8 I might be the person who saw them in the
9 hospital and they haven't seen anyone else and
10 then they'd be attributed to me.

11 But I don't, other than the time I
12 have them I don't have a chance to make any other
13 impact. So I was just wondering, you know, we
14 come into this too in terms of, you know, when
15 you attribute who's the primary provider or how
16 that works. So I was just wondering how you make
17 that attribution.

18 DR. SAPRA: Thanks for the question.
19 It's something that we have been talking about a
20 lot with our partners across CMS, because I think
21 actually this issue of attribution also gets a
22 little bit into the operationalization piece of

1 it because this is specified as the patient panel
2 prevalence measure.

3 So it could be used for an inpatient
4 setting, it could be used in outpatient settings
5 right now, and I know that Melissa and others
6 were checking on this.

7 I believe that we have specified this
8 as really for outpatient settings rather than an
9 inpatient setting, but that's something that
10 we're considering as we think about what is the
11 appropriate venue to deploy the measure.

12 So that's, you know, we're trying not
13 to bleed too much between the NQF endorsement
14 and, you know, where this could potentially be
15 used in CMS programs, but we are thinking a lot
16 about these issues around attribution.

17 CO-CHAIR PINCUS: Jeff.

18 DR. LUSTIG: And just saying I, so
19 under the care setting it says outpatient
20 clinician office/clinic and then other, and then
21 under other it says PQRS providers may include
22 additional settings such as speech and hearing

1 evaluation, occupational therapy evaluation and
2 ophthalmological visits.

3 MEMBER MAZON JEFFERS: And then also
4 if you actually click on the setting, because I
5 read that first and thought it excluded
6 behavioral health. But then I found in the other
7 document further, way, way, further down it
8 actually specifies behavioral health settings.

9 MEMBER SUSMAN: So I think this is a
10 great measure if, if we deal with the gaming.
11 And we've already gone through two or three
12 options to do that.

13 I think it's sort of like doing a
14 clinical trial, a drug study where you have
15 intent to treat and we measure actually what
16 happens. And some people don't take the
17 medicine, drop out, whatever, and we assign an
18 outcome to them. We could do the same, you're a
19 smoker until proven otherwise.

20 That's one option, whether that would
21 be very acceptable, probably not. But the others
22 that you proposed are also, but right now I'm not

1 going to pass this on validity because of that
2 particular issue.

3 So I think as I'm thinking through
4 this I see absolutely why you're doing this and
5 where you're going. And ultimately the end game
6 will be, we'll be responsible for populations,
7 we'll be responsible for assuming that we are
8 doing what we're supposed to be doing and held
9 accountable for that. Great.

10 CO-CHAIR PINCUS: Mady, did you have
11 yours up? Okay, Tami, yours up? Mike?

12 MEMBER TRANGLE: Just a quick comment
13 or concern. And I think the concern, I mean this
14 is like you said, sort of a point prevalence
15 about how much people are smoking, but it's a
16 point prevalence that has a two-year delay,
17 window or delay potentially involved in that. And
18 I don't know if your methodology is such it's the
19 last one taken if you've have three or whatever
20 it is, and I can kind of get a two-year delay if
21 you're talking about screening, but if I think
22 you're talking about prevalence it strikes me as

1 a little bit more concerning.

2 DR. SAPRA: So it is the most recent
3 encounter. And the two-year is really to
4 harmonize with our friends and really to reduce,
5 I mean because we're very sensitive to burden and
6 we did not want to be increasing provider burden
7 with this measure. That's why we wanted to be
8 fully harmonious with 3225 so that's the reason
9 for the 24 months.

10 Now the last encounter that you have
11 that's your smoking status. So if you were a
12 smoker 20 months ago and then I saw you last
13 month and you were a nonsmoker, that's wonderful
14 for all of us and you would be counted as a
15 nonsmoker in our measure.

16 CO-CHAIR PINCUS: So Rhonda and then
17 Brooke, are you putting yours up?

18 MEMBER PARISH: Yes.

19 CO-CHAIR PINCUS: Rhonda then Brooke,
20 and then let's stop and vote on evidence.

21 MEMBER ROBINSON BEALE: So I just
22 needed some clarification with the 24 months

1 being there from the first encounter to the last
2 encounter within that 24 months. However, are
3 you requiring continuous enrollment or
4 attribution to that particular provider for the
5 24 months?

6 DR. MCNAIR: Thank you. Are we
7 requiring, so it's at the provider level but not
8 from patient to patient. I'm not sure if I'm
9 answering your question. Can you articulate it
10 for me again?

11 MEMBER ROBINSON BEALE: Sure.

12 DR. MCNAIR: Thank you.

13 MEMBER ROBINSON BEALE: So if you're
14 measuring me on a provider level, my population,
15 and let's say, I don't know how you're going to
16 do this with 24 months, but let's just say you
17 have a measurement at the end of 2015, okay, and
18 I have a 24 percent rate of smoking.

19 Then the next year I have a 55 percent
20 smoking rate but I may have new patients that
21 are attributed into my practice at this time in
22 the next year, and I'm trying to understand how

1 that works in your measurement. And how do you
2 account for that?

3 DR. MCNAIR: How do we account for
4 like the turn --

5 MEMBER ROBINSON BEALE: Yes.

6 DR. MCNAIR: -- is that what you're
7 asking? It's a very good question. Again
8 because this is at the provider level, the idea
9 is that you're going to have turn.

10 And so ultimately it's not that we're
11 looking from patient to patient, we're looking at
12 the level of the provider and of their panel. So
13 that's, yes, that's my answer to your question.

14 MEMBER ROBINSON BEALE: But their
15 panel can change.

16 DR. MCNAIR: Yes.

17 MEMBER ROBINSON BEALE: Unless you
18 have continuous enrollment during that
19 measurement period.

20 DR. MCNAIR: That's correct.

21 MEMBER ROBINSON BEALE: Okay, all
22 right. You understand what I --

1 CO-CHAIR PINCUS: Okay, so Brooke, and
2 then let's vote. Brooke, put on your microphone.

3 MEMBER PARISH: I just had a really
4 quick comment that I noticed that this was
5 smokers and nonsmokers, but a lot of the evidence
6 was actually tobacco cessation which is also
7 something different, and of course now we have
8 nicotine cessation. Are we just looking at
9 smoking and are we defining, is there any
10 definition of smoking? Because I know that there
11 are people who will say they're not a smoker and
12 they have a cigar monthly.

13 DR. SAPRA: Yes, there we have
14 specified what constitutes a smoker from the
15 SNOMED CT codes and it is smoked tobacco, so it
16 would include your monthly cigar. Or not you,
17 maybe a partner or friend.

18 CO-CHAIR PINCUS: So are we ready to
19 vote with regard to evidence?

20 MEMBER GROSS: Hal, could you clarify,
21 because we've been talking about a lot of
22 different, what are we voting on exactly when it

1 comes to evidence?

2 CO-CHAIR PINCUS: So my understanding,
3 and correct me if I'm wrong, whether the concept
4 as presented is likely to be, is dealing with an
5 important issue and is likely to have some impact
6 on outcomes.

7 DR. LUSTIG: Right. Does the evidence
8 base show that the measure is linked to outcomes.

9 DR. BURSTIN: This is an outcome so
10 that's not quite right. So all we require for an
11 outcome measure is that the developer has
12 presented a rationale for the outcome and offers
13 some information on potential evidence based
14 processes or structures that could be utilized to
15 try to impact that outcome.

16 So again different bar --

17 CO-CHAIR PINCUS: Now my
18 interpretation is this is not an outcome measure,
19 this is a prevalence measure. Outcome implies
20 that there's a longitudinal context, to me.

21 DR. MCNAIR: It is an intermediate
22 outcome measure. That's how it was submitted and

1 how it's specified.

2 MEMBER SUSMAN: A plan that does five
3 percent versus 25 percent assuming we get the
4 data issues would be better. Wouldn't you say
5 that the smoking prevalence of you versus I if --

6 CO-CHAIR PINCUS: If it's a managed
7 behavioral health plan as compared to an MCO I
8 would think it was, you know.

9 MEMBER SUSMAN: That's what I'm
10 saying, the level, but --

11 CO-CHAIR PINCUS: Yes, where at
12 provider level you're comparing a community
13 mental health clinic to a primary care clinic
14 because it's --

15 MEMBER SUSMAN: And we always have
16 those sorts of differences in these measures.
17 There's always going to be different
18 organizational structures.

19 CO-CHAIR PINCUS: It's not
20 organizational, it's patient population.

21 DR. BURSTIN: Well, this is why I
22 think this came back to them. We haven't gotten

1 to it, so again I want to try to separate out
2 evidence from what will follow in terms of
3 talking about validity and I think that's where
4 issues like this of different patient populations
5 and risks may come forward.

6 But I think for evidence again, if you
7 think about this as an intermediate outcome
8 measure the expectation is that there's a
9 rationale for how potential processes for
10 structures could impact this intermediate outcome
11 or outcome.

12 MEMBER MARK: So what's the difference
13 between evidence and validity? I'm getting a
14 little confused.

15 DR. BURSTIN: Go ahead.

16 MS. JOHNSON: They are related, which
17 is good, right? They should be related. When
18 you think about evidence we usually ask you to
19 think about the clinical side of things.

20 So for this particular one, do you
21 feel like that there is evidence to show that if
22 you basically stop smoking does that improve

1 patient outcomes? I think that's probably what
2 we're looking at for this one.

3 You will talk about or could talk
4 about evidence again later on when you talk about
5 validity and that's where you think about how the
6 specifications align with the evidence, if
7 there's anything particular in terms of how the
8 measure is constructed.

9 So I'm not sure if that answered your
10 question but I can try again if that didn't do
11 it.

12 CO-CHAIR PINCUS: So is everybody
13 clear?

14 DR. BURSTIN: We're voting on whether
15 stopping smoking is a good thing or not.

16 CO-CHAIR PINCUS: So it's not related
17 to the measure, per se.

18 DR. BURSTIN: It's related to the
19 measure focus. That's what evidence is. It's
20 the evidence and the measure focus.

21 CO-CHAIR PINCUS: It's related to the
22 intent of the measure.

1 DR. BURSTIN: Right, right.

2 MS. QUINNONEZ: Voting is now open for
3 Measure 3229, patient panel adult smoking
4 prevalence. Option, we are voting on the
5 evidence. Option is number 1 is high. Option
6 number 2 is moderate. Option number 3 is low.
7 And option number 4 insufficient.

8 Voting for the evidence of Measure
9 3229. Option 1 high, option 2 moderate, option 3
10 low, and option 4 insufficient.

11 Thank you, all votes are in. Voting
12 is now closed. For the evidence of Measure 3229,
13 39 percent voted for high, nine individual votes,
14 43 percent voted for moderate, ten individual
15 votes, 13 percent voted for low, three individual
16 votes, and four percent voted for insufficient,
17 one individual vote. This passes the criteria
18 for evidence.

19 CO-CHAIR PINCUS: Okay, so now let's
20 talk about gaps. Any comments from the primary
21 reviewers with regard to gaps? Jeff.

22 MEMBER SUSMAN: There is a nice table

1 demonstrating that there's a wide distribution of
2 prevalences and that seems to me would, I'd
3 dearly like to have zero percent and there are
4 people in the 20s and so I think there's a gap.

5 CO-CHAIR PINCUS: Any other comments?

6 Okay, I think we're ready to vote on
7 gaps.

8 MS. QUINNONEZ: We're now voting for
9 performance gap of Measure 3229. Option 1 high,
10 option 2 moderate, option 3 low, and option 4
11 insufficient.

12 Thank you, all votes are in and voting
13 is now closed. For the performance gap of
14 Measure 3229, 57 percent voted high. That's 13
15 individual votes, 39 percent voted moderate, nine
16 individual votes, zero percent voted for low, and
17 four percent voted insufficient. So for
18 performance gap of Measure 3229 this meets the
19 criteria.

20 CO-CHAIR PINCUS: Okay, now let's
21 discuss reliability. Comments from the primary
22 reviewers with regard to reliability?

1 MEMBER KNUDSEN: The liability was
2 reported was pretty high, 0.89, I believe.

3 CO-CHAIR PINCUS: Other comments with
4 regard to reliability, Jeff.

5 MEMBER SUSMAN: It's hard to separate
6 out reliability from validity if the validity of
7 the measure itself might be impugned, so that
8 honestly you don't know what the prevalence might
9 be if there's 25 percent missing data, which
10 means that your measurement and my measurement
11 might have a lot of unreliability in it or
12 differences that are important to account for.
13 So I think it sort of goes into both categories.

14 CO-CHAIR PINCUS: Okay, Shane, then
15 Mike, then Racquel. Oh, Andrew, Shane. Shane,
16 then Andrew, then Mike.

17 MEMBER SPERLING: All right, so just
18 very briefly because I may have missed it
19 earlier. This is self-attestation, right, are
20 you smoking or not? Because I know the Safeway
21 employee wellness program, they got a lot of
22 attention in recent years.

1 Actually in order to qualify for that
2 discount on your premium, you know, for your
3 employer, your health insurance, they actually
4 swab the inside of your cheek because there's
5 some sort of test that actually tells you whether
6 or not you've been ingesting tobacco or smoking
7 tobacco.

8 DR. MCNAIR: Right, this would be upon
9 screening and as reported by the patient.

10 MEMBER SPERLING: So self report by
11 the patient.

12 DR. MCNAIR: That's correct.

13 CO-CHAIR PINCUS: Well, it's reported
14 by the patient as reported by the provider.

15 DR. MCNAIR: Right, and there may be
16 providers that are practicing other methods in
17 which case they would also endorse that the
18 person is a smoker.

19 CO-CHAIR PINCUS: Okay, Shane.

20 MEMBER COLEMAN: This might be related
21 kind of to the gaming, I think it fits in this
22 area. But and I'm curious if it's the necessary

1 sample size of the patients or the at least 50
2 percent screening I think was trying to get.

3 Are you guys just trying to get to
4 make sure it's randomization? Because that's
5 going to be one of the key things, right, to
6 either validity or reliability is making sure
7 that the screening that's occurring that you're
8 grabbing are kind of a true random sampling of
9 the population.

10 DR. SAPRA: Yes, these are, you guys
11 are really hitting on really important aspects of
12 the measure. And I do want to highlight that the
13 reliability testing was done among those who had
14 at least 50 percent of the patients screened and
15 we don't know if it was a simple random sample of
16 their patient population or not. We just simply
17 don't have that information.

18 So I think this is one of the things
19 that we've been talking about in terms of, you
20 know, should this measure only be done for
21 providers who are screening at least 50, or, you
22 know, that's the way it was tested, at least 50

1 percent of their patients.

2 And when we apply that cutoff in a
3 minimum of ten patients per provider we do get
4 very high reliability. And so the reliability
5 portion is really, you know, can we discriminate
6 poor performers from high performers, and then
7 validity is a little bit different, you know, are
8 we measuring what we think we're measuring.

9 Are we measuring good and poor quality
10 of health care that's delivered when we look at a
11 very important predictor of morbidity and
12 mortality which is the smoking behavior of the
13 patient.

14 CO-CHAIR PINCUS: Okay, Mike and then
15 Racquel.

16 MEMBER LARDIERI: Oh, yes. And I just
17 have the same comment as with the other smoking
18 measure and the reliability specifications to
19 look at other settings, so I'll look at dental
20 and include dental in there.

21 CO-CHAIR PINCUS: Racquel.

22 MEMBER MAZON JEFFERS: So to a point

1 that David raised earlier about the relapsing
2 nature of the tobacco as an addiction is that,
3 you know, if it takes on average seven times to
4 quit and there's a provider who's working
5 diligently with a patient who might be relapsing,
6 it really does penalize that provider if that
7 point in time happens to catch the patient when
8 they have relapsed even if they've made several
9 concerted attempts to quit.

10 DR. MCNAIR: I think that is a great
11 point and I know that there was a comment from
12 one of the reviewers around potentially adjusting
13 for kind of the stage of change that providers --
14 oh, excellent -- that your patients are in.

15 I think again just going back to our
16 earlier comment around the importance of just
17 really unveiling kind of what you're working
18 with, I mean that's really the spirit of this
19 measure and we don't want to make assumptions and
20 mask what we think is going on that may not be
21 going on.

22 So that's really where we're coming

1 from with this measure.

2 CO-CHAIR PINCUS: I had a question
3 about reliability also in terms of looking over a
4 24-month period. And you're making an
5 attribution across that full 24-month period,
6 would the sort of periodicity of different
7 providers sort of create unreliability?

8 So if, you know, if some providers had
9 sort of, you know, were more likely to do their
10 screening at certain points in time and there was
11 a sort of variation could that introduce
12 reliability problems?

13 DR. MCNAIR: I'll turn to Dr. Sapra.
14 We didn't find that in our testing but --

15 CO-CHAIR PINCUS: Because you're
16 trying, I guess when you're trying to
17 characterize the practice as a whole, but it's
18 not really a point prevalence. It's a point
19 prevalence at different periods of time over two
20 years.

21 DR. SAPRA: It's the prevalence at the
22 most recent encounter, so whatever the smoking

1 status is at that most recent encounter.

2 Now if you're someone who likes to
3 screen your patients every two years because
4 that's what the process measure, let's say you've
5 been reporting on 0028 all along and so you
6 screen every two years. That's the frequency
7 with, and as long as you've seen a patient during
8 our one year measurement period that's your
9 periodicity.

10 Whereas, someone else down the road,
11 maybe they're screening at every visit, and as
12 long as they've also seen someone during the
13 measurement year, both of you at the most recent
14 encounter, wherever that status, whenever you
15 ascertain that as long as it's within 24 months
16 that is the smoking prevalence.

17 I don't know that there's a way for us
18 to get around that periodicity because that's
19 simply the way that it's specified and I'm not
20 actually sure that it would affect the
21 reliability.

22 I actually can't, maybe other people

1 can think through it with me, but from a
2 measurement standpoint I'm not sure that it
3 actually would affect the reliability of this
4 measure.

5 CO-CHAIR PINCUS: Well, it might if
6 you made changes to how you practice at different
7 points in times it might, so anyway just
8 something to think about. Yes, within that 24
9 months because you're not comparing people
10 contemporaneously.

11 Okay, any other comments on
12 reliability? Mike.

13 MEMBER TRANGLE: Just a quick question
14 because I thought I heard this two different
15 ways. When I look at the committee pre-
16 evaluation comments I saw one of the comments was
17 it does not include patients in a substance use
18 disorder setting. But I thought I heard that it
19 did.

20 So just, I'm a little confused about
21 does it or not, and you might ask the same
22 question if somebody's on a psych unit or in a

1 mental health setting too.

2 DR. SAPRA: Yes, it does include
3 outpatient behavioral health.

4 CO-CHAIR PINCUS: So let's move to
5 voting on reliability.

6 MS. QUINNONEZ: Voting is now open on
7 reliability of Measure 3229. Option number 1
8 high, option number 2 moderate, option number 3
9 low, and option 4 insufficient.

10 Looking for one more vote. Thank you.
11 All votes are in and voting is now closed.

12 For the reliability of Measure 3229,
13 13 percent voted high, three individual votes, 43
14 percent voted for moderate, ten individual votes,
15 43 percent voted for low, ten individual votes,
16 and zero percent voted for insufficient.

17 DR. LUSTIG: This ends up being
18 consensus not reached for Measure 3229 for
19 reliability, so we'll still continue.

20 CO-CHAIR PINCUS: So let's move to
21 validity, 60 percent, so let's move to validity.

22 Jeff.

1 MEMBER SUSMAN: Yes, I think this is
2 where this measure really falls down. We've
3 talked about all the different concerns and I
4 just don't think it's a valid measure as
5 currently specified with all the issues that
6 we've noted which I won't elaborate on.

7 CO-CHAIR PINCUS: Other comments of a
8 different sort? Any comments supporting
9 validity? Okay, I guess we're ready to vote.

10 MS. QUINNONEZ: Voting is now open for
11 the validity of Measure 3229. Option 1 high,
12 option 2 moderate, option 3 low, and option 4
13 insufficient.

14 Thank you. All votes are in and
15 voting is now closed. For the validity of
16 Measure 3229, four percent voted high, one
17 individual vote, nine percent voted for moderate,
18 two individual votes, 78 percent voted for low,
19 18 individual votes, and nine percent voted for
20 insufficient which is two individual votes.

21 This does not pass the criteria for
22 validity.

1 DR. LUSTIG: Now this is a must-pass
2 criterion so our discussion on this measure
3 stops.

4 DR. SAPRA: Can we ask for, I know we
5 have discussed, but I just thought the precedent
6 was that if don't pass that we can have some
7 feedback specifically. Thank you.

8 CO-CHAIR PINCUS: People are, there
9 are the particulars or recommendations in terms
10 of feedback that people would like to make?

11 DR. MCNAIR: And we definitely welcome
12 to the problems we've identified any potential
13 solutions.

14 CO-CHAIR PINCUS: So I think, okay, I
15 think two comments have been made so far that I
16 think are probably the most significant and there
17 may be others as well. One was to think about
18 how this can be converted to a change measure.

19 Number two is to think about how this
20 can be added to one of the previous measures that
21 we've discussed that, you know, leaves it sort of
22 over time to both screening intervention and

1 smoking outcome.

2 So that if it was sort of a combined
3 nested measure it would, you know, be a more
4 effective and potentially valid approach. And I
5 don't know if everybody agrees with that or if
6 there's other comments that people wanted to
7 make.

8 So Racquel, Rhonda, other people?

9 MEMBER ROBINSON BEALE: Well, I would
10 just say that there were two big concerns from my
11 perspective. One was this gaming issue, so if
12 there's a way to avoid, you know, providers
13 performing favorably even if they're not
14 screening their patients so, or because they're
15 kicking all of their smokers out of their
16 practice. So you really want to try to figure
17 out how to control for that.

18 And then the other would be kind of
19 the sequential nature of it. I think what people
20 were trying to get out with the conversation
21 around the window of time is that you want to see
22 that the provider saw the patient, had an

1 opportunity to have an intervention with the
2 patient before they're getting measured as to
3 whether the patient is smoking or not.

4 So if there's a way to structure the
5 measure so that it's more sequential in nature,
6 which might get solved if you're looking at the
7 change measure that Tami had suggested as well,
8 the change in the performance, but so that the
9 provider definitely had contact with the patient
10 prior to being measured for whether the patient
11 has changed their behavior or not.

12 CO-CHAIR PINCUS: Rhonda.

13 MEMBER ROBINSON BEALE: Yes, I just
14 want to add to that. I think it's real important
15 to look at your attribution methodology because
16 it's real important. And I think you also have
17 to have continuous and how do you say that the
18 members continuously attributed to that provider
19 during that time period. That is real important.

20 Otherwise, like if the provider gets
21 a whole new set of patients in it's going to
22 invalidate your measure over time or to show

1 improvement. So I think those are the pieces
2 added to all the other comments would help to
3 clean that one up.

4 CO-CHAIR PINCUS: Okay, anybody else?

5 Okay, well, thank you.

6 DR. MCNAIR: Just want to say thank
7 you all. We really appreciate this as we try to
8 kind of push forward in this direction of
9 outcomes. It's very helpful to have your
10 expertise and to just hear your candid feedback.
11 So we appreciate that. Thank you.

12 CO-CHAIR PINCUS: And so let's take a
13 break for ten minutes. Promptly at 4 o'clock get
14 back.

15 (Whereupon, the above-entitled matter
16 went off the record at 3:51 p.m. and resumed at
17 4:02 p.m.)

18 MS. WILLIAMS-BADER: Hi, my name is
19 Jenna Williams-Bader. I am director of
20 Performance Measurement at NCQA. And I am joined
21 by Mary Barton, who is vice-president of
22 Performance Measurement at NCQA.

1 Today we are presenting the Medical
2 Assistance for Smoking and Tobacco Use Cessation
3 Measure. This is a long-standing health plan
4 level measure that uses patient reported data
5 from the CAHPS survey to assess if patients have
6 received assistance to quit smoking and tobacco
7 use from a doctor or other health provider.

8 It aligns with the Grade A
9 recommendation from the United States Preventive
10 Services Task Force, which I think the PCPI has
11 done a good job. Are you describing?

12 The performance rates continue to
13 demonstrate room for improvement, and we also
14 have evidence that there are meaningful
15 differences in these performance rates.

16 The measure has demonstrated validity.
17 The questions undergo cognitive testing, and we
18 also have case validity and construct validity.
19 The measure also demonstrates reliability. And
20 we've used the data binomial to analyze
21 reliability of the measure.

22 And then the measure is used in

1 several programs, including the quality rating
2 system, health plan ratings and accreditation,
3 and the Medicaid adult core sets.

4 CO-CHAIR BRISS: That was mercifully
5 brief. Thank you for that. So I think I'd like
6 to suggest, we've talked a lot about a boatload
7 of tobacco measures already. And we've generally
8 decided, I think, that tobacco is bad. But there
9 are things that can be done about it and that
10 there's a remaining gap, right?

11 And so I think, unless somebody is
12 dying to add stuff on the tobacco is still bad
13 and things can still be done, that we could skip
14 that criteria. And is there anybody around the
15 table that wants to object to that?

16 And then can we -- and I think we have
17 to -- we still have vote the remaining gap. But
18 does anybody want to say anything further on the
19 gap before we -- on minding the gap before we
20 just move sort to a vote?

21 MEMBER SPERLING: And I promise -- I'm
22 sorry, I promise to be very brief. I just want

1 to note for the record that, at least on the
2 medication assisted on tobacco cessation, just in
3 the last few months we've had some advancement.
4 Because there was black box warning on one of the
5 major products for people with psychiatric
6 disorders.

7 An FDA advisory panel and the FDA
8 itself voted to lift that black box warning, so a
9 major, you know, evidence based and FDA approved
10 intervention for smoking cessation is now going
11 to be available to people with psychiatric
12 disorders.

13 And I think it's something that would
14 be important for us to try and get our hands
15 around in terms of measuring how people with
16 mental illness were able to access that FDA
17 approved therapy.

18 CO-CHAIR BRISS: Congratulations.
19 Anybody else have comments on performance gap
20 before we vote?

21 (Off microphone comments.)

22 CO-CHAIR BRISS: Yes. We're done with

1 it. I skipped us right over the first hurdle.
2 I've cleverly skipped that one and moved us
3 straight to the performance gap.

4 DR. LUSTIG: But as a reminder, it's
5 a maintenance measure, so since the evidence is
6 in the same direction, we don't need to vote.

7 CO-CHAIR BRISS: And if you want to
8 object on the evidence --

9 DR. LUSTIG: No, no, no.

10 MEMBER PINDOLIA: I just had a
11 question. If you don't mind, could you just
12 reword the CAHPS survey question for me. Like,
13 word for word, I just can't remember it
14 specifically. It's because of what's on the
15 performance data. So that's why.

16 (Off-microphone comments.)

17 MS. WILLIAMS-BADER: Oh, I'm sorry.
18 I didn't turn mine -- oh, okay. So you can hear
19 me now. All right, so this is based, actually,
20 on several questions. And I'm just pulling it up
21 here.

22 Yes, if you actually look at, starting

1 on Page 101, it shows the questions that are used
2 to determine the enumerator. And Page 102 shows
3 the questions that determine the denominator. So
4 for the numerator, as I said, there are three
5 different rates.

6 So it's based on three different
7 questions. "In the last 12 months, how often
8 were you advised to quit smoking or using tobacco
9 by a doctor or other health provider in your
10 plan? In the last 12 months, how often was
11 medication recommended or discussed by a doctor
12 or health provider to assist you with quitting
13 smoking or using tobacco? Examples of medication
14 are nicotine gum, patch, nasal spray, inhaler, or
15 prescription medications."

16 And the third question is, "In the
17 last 12 months, how often did your doctor or
18 health provider discuss or provide methods and
19 strategies other than medication to assist you
20 with quitting smoking or using tobacco? Examples
21 of methods and strategies are a telephone help
22 line, individual or group counseling, or a

1 cessation program."

2 CO-CHAIR BRISS: And the staff's
3 getting real irate at both me and Harold for
4 mixing up the criteria, right. And so I would
5 say that how the measure is --

6 PARTICIPANT: What was that?

7 (Laughter)

8 CO-CHAIR BRISS: I'm sorry, sir.
9 You're recused and don't get the rebuttal. We'll
10 be here for the next three measure discussions.
11 So I think the details of how it's specified is
12 really a reliability thing. So first we should
13 discuss, if needed, and then vote on whether
14 there's a performance gap.

15 I would call specifications details a
16 reliability thing. So anybody else want to
17 comment? If not, let's vote.

18 MS. QUINNONEZ: Voting is now open for
19 Measure 0027, Medical Assistance With Smoking and
20 Tobacco Use Cessation. We are voting on
21 performance gap, Action Number 1, high, Action
22 Number 2, moderate, Action Number 3, low, and

1 Action Number 4, insufficient.

2 A performance gap of Measure 0027,
3 looking for one more vote. Okay, voting is now
4 closed. For performance gap of Measure 0027, 50
5 percent voted high, 50 percent voted moderate,
6 zero percent voted low, and zero percent voted
7 for insufficient. This passes the criteria for
8 performance gap.

9 CO-CHAIR BRISS: So now we can move to
10 reliability. So we've teed up how the measure
11 was specified earlier. Would one of the lead
12 discussants like to comment on reliability?

13 MEMBER MAZON JEFFERS: I just had a
14 question, because the denominator is defined
15 slightly differently in two different places in
16 the PA. So at one point it says it's patients 18
17 years and older who answered the CAHPS survey in
18 Medicaid and Medicare. And then another
19 reliability specification, the denominator
20 details are for Medicaid, Medicare, and
21 commercial plans. So can you just clarify what
22 the denominator is?

1 MS. WILLIAMS-BADER: Sure. You might
2 have -- I don't know exactly what you've been
3 looking at. But one of the things to note is
4 that the advising smokers, smokers and tobacco
5 users, the quit rate is only reported for -- it's
6 only rate-reported for Medicare. Medicare does
7 not include the discussing cessation medications
8 and discussing cessation strategies.

9 The advising smokers and tobacco users
10 who quit is reported for all three kinds. And
11 then Medicaid and commercial also report the two
12 discussing rates.

13 CO-CHAIR BRISS: Yes, ma'am?

14 MEMBER PINDOLIA: So my question is
15 more to do with the wording of the questions
16 themselves. And I know this is part of CAHPS.

17 Being one of the people that have to
18 look at how we're improving our CAHPS scores and
19 HOS surveys, one of the areas that I keep coming
20 and running into, and then looking at the gap
21 scores that I saw from 2014 to 2016, they're just
22 pretty much always the same.

1 The concern I have is is the
2 population really understanding what that means
3 in the differentiation between all three of those
4 questions? Because when we're doing our random
5 samples, and then the feedback we're getting, I
6 don't know if they really do.

7 So, like, when we have strategy or,
8 like, could we make the language sixth grand
9 level? I mean, could we do something so that, to
10 make sure that it's not because of not
11 understanding the question and that's why the
12 results are coming this way?

13 Are we repeating it in so many
14 different ways that they're kind of, like, I
15 already answered this. Something to take back of
16 understanding why is our measure continuously,
17 year after year, not changing.

18 MS. WILLIAMS-BADER: Yes. So we do,
19 all the questions do undergo commuted testing.
20 So to your point, as much as we can, we use that
21 commuted testing to help us determine whether or
22 not individuals really are interpreting the

1 questions the way we intend them to.

2 I can't speak for certain as to why
3 the rates haven't changed, but I will say I did
4 go back and try to find if there's any other
5 indications or other data that might align or not
6 align with ours to show whether or not there are
7 -- whether or not it's changing using other
8 sources.

9 And there's data coming from the
10 National Health Interview Survey, just related to
11 the advice, that demonstrates that there has not
12 been much change since 2005. So the rear deck
13 where it actually got lower in 2010, but the 2015
14 rate for that is very similar to what it was in
15 2005. So we're demonstrating that there might
16 actually not be much movement on this at the
17 moment.

18 And that might be because patients are
19 quitting, and so patients who are quitting are
20 not in the measure. So we do know that
21 individuals are -- fewer individuals are smoking
22 now or using tobacco than they used to. So that

1 might be part of the issue and why the rates are
2 staying stable.

3 CO-CHAIR BRISS: The other thing --

4 MEMBER PINDOLIA: That was my point,
5 is that in the previous measures we're seeing
6 some demographic data that shows, especially for
7 Medicare, there's a continuous decline,
8 especially as they get older. It's, like 1.8
9 percent, right?

10 So in our health plan, we just
11 continue to keep getting -- keeping the same
12 people. And they're just aging with us, right.
13 So is our score -- because unfortunately, there's
14 a lot of dollars tied to this, right, for 5-Stars
15 and things like that.

16 So it does become, you know -- so then
17 there's all this effort, like, why aren't we
18 improving? And it's, like, well, I think we are.
19 And so I just want to make sure we're not trying
20 to say we don't have a higher quality when really
21 we're not measuring the right people or the right
22 way. And I understand it's a random sample, and

1 I get that, but something to really think about
2 of what that means downstream effect.

3 MS. WILLIAMS-BADER: Sure. It think
4 that's a good point and something for us to think
5 about.

6 CO-CHAIR BRISS: The other thing that
7 I would say on that point is that they say later
8 that, when they do construct validity testing,
9 that the different pieces of the three sort of
10 things correlate with other.

11 And you would expect that, if some
12 systems do better than other systems, which I
13 find to be plausible, that people that reported
14 more screening are also reporting more
15 intervention. And that's actually what they show
16 in their data. So that makes me feel a little
17 bit better, that they're not just confusing
18 people with the questions.

19 Comments on non-reliability? If not,
20 why don't we vote?

21 MS. QUINNONEZ: The voting is now open
22 for reliability of Measure 0027. Option 1, high,

1 Option 2, moderate, Option 3, low, and Option 4,
2 insufficient.

3 Looking for one more vote. Thank you.

4 All votes are in, and voting is now closed. On
5 the reliability of Measure 0027, 23 percent voted
6 high, five individual votes, 68 percent voted
7 moderate, 15 individual votes, nine percent voted
8 for low, which is two individual votes, and zero
9 percent voted for insufficient. For the
10 reliability of Measure 0027, this passes this
11 criteria.

12 CO-CHAIR BRISS: Anybody like to
13 volunteer to tee up validity, please?

14 (No audible response)

15 CO-CHAIR BRISS: I can do validity.
16 They've done face validity testing with ten out
17 of 12 supporting. They've done cognitive
18 testing, as you've heard, and they've done
19 construct validity testing, which surely you've
20 also heard. So anybody want to really comment
21 more before we vote on validity?

22 (No audible response)

1 CO-CHAIR BRISS: Let's vote.

2 MS. QUINNONEZ: Voting is now open for
3 validity of Measure 0027. Option 1, high, Option
4 2, moderate, Option 3, low, and Option 4,
5 insufficient.

6 Thank you, all votes are in. Voting
7 is now closed. On the validity of Measure 0027,
8 41 percent voted high, nine individual votes, 55
9 percent voted moderate, 12 individual votes, five
10 percent voted low, one individual vote, and zero
11 percent voted for insufficient. For the validity
12 of Measure 0027, this passes this criteria.

13 CO-CHAIR BRISS: Is there any further
14 comment on validity before we move to
15 feasibility?

16 (No audible response)

17 CO-CHAIR BRISS: Hearing none,
18 somebody what to tee up feasibility rather?

19 MEMBER MAZON JEFFERS: The data is
20 collected in a CAHPS survey which is feasible.

21 CO-CHAIR BRISS: Seems feasible on its
22 face, doesn't it? Anybody want to add to that?

1 MEMBER SHEA: Well, just as a reviewer
2 and NCQ report for the membership about confusion
3 about it either.

4 CO-CHAIR BRISS: Okay. Any further
5 comments before we vote? All right, let's vote.

6 MS. QUINNONEZ: Voting is now open for
7 feasibility of Measure 0027. Option 1 is high,
8 Option 2, moderate, Option 3, low, and Option 4,
9 insufficient.

10 CO-CHAIR BRISS: And usability and
11 use?

12 MS. QUINNONEZ: Looking for one more
13 vote, actually. Here we go. Thank you. Voting
14 is now closed for feasibility of Measure 0027.
15 Fifty-nine percent voted high, 13 individual
16 votes, 41 percent voted moderately, that is nine
17 individual votes, zero percent voted for low, and
18 zero percent voted for insufficient. So for
19 feasibility of Measure 0027, this passes this
20 criteria.

21 CO-CHAIR BRISS: All right, usability
22 and use, anybody want to tee this up? Yes,

1 ma'am?

2 MEMBER MAZON JEFFERS: So I'm going
3 for second place for the broken record club. So
4 it's not clear whether this measure can be used
5 in a behavioral health setting. And as we said
6 before, tobacco use and the substance use in
7 mental illness population is very high. So if
8 you could just comment as to whether it can be
9 used in a behavioral health setting.

10 MS. WILLIAMS-BADER: So again, it's
11 not necessarily used in a setting as the other
12 measures would be at the provider level. Because
13 it is a health plan level measure.

14 The way that the question is phrased
15 and the way the health provider is defined in the
16 CAHPS survey is it can be a general doctor, a
17 specialist doctor, a nurse practitioner, a
18 physician assistant, nurse, or anyone else you
19 would see for healthcare. So I think that
20 depends on how the person taking the survey
21 interprets that particular definition.

22 MEMBER MAZON JEFFERS: So I think it's

1 about 50 percent of states that still have a
2 carve-out for their behavioral health program.
3 It's not included in their managed care plans.
4 And I believe, therefore, they're not required to
5 complete the CAHPS survey.

6 I could be wrong. But I think it's a,
7 you know, you're going to leave out -- you're
8 potentially leaving out behavioral health
9 providers.

10 DR. BARTON: So you're suggesting that
11 this measure should be used in more places. And
12 we could not agree more.

13 (Laughter.)

14 DR. BARTON: Unfortunately, NCQA does
15 not have any pathway into measuring non-plan
16 populations yet. But, you know, I think it would
17 be -- a lot of this has to do with the sampling
18 of per caps.

19 And of course that -- so that if there
20 was a state that saw that its responsibility was
21 to take care of these vulnerable patients whom
22 they had not moved into managed care, they could

1 absolutely institute a survey of that population.
2 I don't know of any states that have done that,
3 nor does NCQA really have a lever to make states
4 do that.

5 CO-CHAIR BRISS: Yes?

6 MEMBER SPERLING: While states may not
7 have a direct lever to do that, they can. MBHOs
8 are, in many cases, are compliant with NCQA
9 standards, right? But while states -- while you
10 don't have the leverage to do it, state can
11 insist, in a Medicaid managed care contract, that
12 you're caught up and will comply with all
13 relevant NCQA standards, right?

14 CO-CHAIR BRISS: Yes. And Michael?

15 MEMBER TRANGLE: One, I agree with
16 him. That's one of my two comments. But I won't
17 repeat it. And the other is sort of the issue
18 that in my efforts to keep first place, a program
19 record amongst the population that is in your
20 denominator, to be able to stratify it by
21 behavioral health patients would be very, very
22 important and helpful to do. So we could look

1 for improvement in that sub-population.

2 MS. WILLIAMS-BADER: So I would just
3 say that would require, I think -- Mary and I
4 were talking about this earlier -- that would
5 require that they sample in a particular
6 population. Because right now, the data that's
7 captured through CAHPS would not allow us to
8 stratify.

9 But actually, we see that the future
10 of this measure is not a survey-based measure
11 necessarily. But it might be a measure that uses
12 electronic clinical data systems. So in the
13 future, that might be something that we're able
14 to consider. It's just not feasible with what we
15 have from the CAHPS data right now.

16 CO-CHAIR BRISS: And Dr. Zun?

17 MEMBER ZUN: So one thing that I'm a
18 little confused about is this is all contingent
19 on the patient actually understanding that this
20 is what they're getting, right, that they're
21 getting this counseling or some intervention.
22 Have we tested, in fact, that they know when

1 they're getting that intervention?

2 MS. WILLIAMS-BADER: So I think two
3 things are not -- I mean, I can jump into it.
4 One is, like I said, the measure, the questions
5 you undergo on cognitive testing. But the second
6 is that one reason to collect this from the
7 patient is that the patient should understand
8 that that's what happens.

9 And if they actually are saying no,
10 this didn't happen, but the physician thinks that
11 it did, that might actually be a major problem.
12 So I think in this case, if the patient isn't
13 understanding that's what's happened, then that
14 might actually indicate a problem.

15 MEMBER PINDOLIA: I'll just add a
16 comment of clarification on that. Les, I'm not
17 sure if you're aware, but the survey is done,
18 like, April through June, like, in 2017, for them
19 to remember what happened in 2016, right.

20 And so I don't know if you can really
21 say that for many of our Medicare patients.
22 They're 80 years old. They're on many different

1 medications. And sometimes they don't even
2 remember what happened a month ago, much less a
3 year ago.

4 MEMBER ZUN: Well, that was one of my
5 concerns, will they know about it.

6 MEMBER SHEA: So meanwhile, I mean,
7 and I don't know whether you could do this, is if
8 you could bring claims on your own for the people
9 that indicated that they had or didn't have
10 smoking cessation with medicine, or if you bring
11 a sample to see if they filled it or didn't fill
12 it.

13 DR. BARTON: We have not done that in
14 the past. A survey, you know, one of the
15 downsides of doing a survey measure is you don't
16 know who the people are. CAHPS closely guards
17 the anonymity of their sampling.

18 But as we think about a future measure
19 that Jenna referred to, I think we would
20 absolutely be interested in looking at something
21 that triangulates data from prescriptions, from
22 claims for counseling, or claims in places where

1 this is done, you know, things like quit lines,
2 in order to assess, really, what's been provided
3 to patients who still smoke.

4 CO-CHAIR BRISS: And I wanted to make
5 two quick comments. So one on that point,
6 neither of your options for this are perfect, so
7 there is -- you can either -- your realistic
8 choices are a provider checkbox measure that
9 isn't accurate all the time, or the patient's
10 report of whether I actually got the service.

11 And the truth is if I had to choose
12 between these, I would pick the patient report
13 which I think is closer to outcomes, right. And
14 so -- and then the other thing that I wanted to
15 say that nobody has said yet is that these
16 measures are, in terms of usability and use,
17 there isn't a whole lot of programs. Anybody
18 else? Mike, are you still --

19 MEMBER LARDIERI: Well, yes. I just
20 want to back up a little bit. But there are 41
21 states that recognize NCQA health plan
22 accreditation. So it's only nine states where

1 you wouldn't have that.

2 PARTICIPANT: D.C. is one of them.

3 (Laughter.)

4 MEMBER LARDIERI: D.C. is one of them.

5 Sorry, DC. But it covers most of them.

6 CO-CHAIR BRISS: So can I move us to
7 a vote?

8 MS. QUINNONEZ: Voting is now open for
9 usability and use of Measure 0027. Option Number
10 1 is high, Option Number 2 is moderate, Option
11 Number 3, low, and Option Number 4, insufficient
12 information.

13 Looking for one more vote. Thank you.
14 All votes are in. The voting is now closed. For
15 usability and use of Measure 0027, 45 percent
16 voted high, that's ten individual votes, 50
17 percent voted moderate, that's 11 individual
18 votes, five percent voted low, that's one
19 individual vote, and zero percent voted for
20 insufficient information. So this actually --
21 usability and use criteria is passed for Measure
22 0027.

1 CO-CHAIR BRISS: We'll talk about the
2 whole portfolio of tobacco measures tomorrow, so
3 we don't have to do this today which, I think,
4 gets us to the overall suitability vote. And
5 anybody have final comments before we vote?

6 (No audible response)

7 CO-CHAIR BRISS: Hearing none --

8 MS. QUINNONEZ: Voting is now open for
9 overall suitability for endorsement of Measure
10 0027. Option Number 1 is yes, Option Number 2 is
11 no.

12 Looking for one more vote. Thank you.
13 All votes are in. Voting is now closed. For the
14 overall suitability for endorsement of Measure
15 0027, 100 percent voted yes.

16 CO-CHAIR BRISS: All right. So as I
17 discussed, we're going to move the discussion of
18 the portfolio of tobacco measures to tomorrow
19 which makes us back some time. And so two more
20 measures for the afternoon that we're going to
21 try to get through. So without further ado --

22 (Off-microphone comments)

1 CO-CHAIR BRISS: That's right, 108.

2 DR. LUSTIG: So we were conferring
3 here before we move on to the next measure, NQF
4 has a new designation for measures that exceed
5 our expectations for the criteria. And so
6 Measure 0027 appears to qualify for us to
7 consider whether it should get what we call
8 endorsement plus designation.

9 And this is the first time we're
10 actually going through this process which is why
11 we wanted to confer about this. And so you'll
12 notice it does say, toward the end of our measure
13 evaluation form, that this measure is a candidate
14 for endorsement plus designation if the committee
15 determines that it meets the evidence for measure
16 focus without an exception, which this did, is
17 reliable as is demonstrated by score level
18 testing, is valid as demonstrated by score level
19 testing, and has been vetted by those being
20 measured or other users. And so our initial
21 analysis was that the measure did meet all of
22 these criteria.

1 So really, it's a discussion of the
2 group whether we think that this should be
3 conferred this endorsement plus designation.

4 MS. JOHNSON: And, Tracy, you may want
5 to just remind everybody about the vetting and
6 what we're looking for for vetting. And
7 actually, Mary, you may want to talk a little bit
8 about what data comes in to you guys. Because
9 the first piece has to do with giving data back
10 to plans. And you guys might not give it back,
11 they might give it to you. So you might just
12 need to describe that for us.

13 CO-CHAIR BRISS: And can I ask a
14 question of the staff too? So what are the
15 implications of endorsement plus? So if I'm a
16 user, and I'm trying to make some sense out of
17 the population of 600 or so NQF fit endorsed
18 measures, how am I supposed to use this
19 information?

20 DR. BURSTIN: So some of it was the
21 idea that these would be measures that exceeded
22 our criteria. And in particular, we added a new

1 criterion for this particular designation which
2 is that you seek input from those who are using
3 your measure to actually improve upon your
4 measure.

5 And so some of this was trying to get
6 more of that usability into the development
7 process. And so wanted to reward those measures
8 and developers that were actually, in fact, doing
9 that. And it would give an indication to others
10 out there that this is potentially a measure
11 that, you know, achieves the highest rating from
12 NQF.

13 MEMBER TRANGLE: I have a question,
14 and I hope it doesn't sound too metaphysical.
15 But it really gets to if we're a behavioral
16 health measurement standing committee, what does
17 that mean?

18 And I think it kind of gets to are we
19 looking at the -- is our domain sort of
20 behavioral health patients wherever, whenever
21 they come up? Is it broader, is it all humanity?
22 And we just -- some of the measures may apply

1 more to us. You know what I mean.

2 Because if we take it that we're
3 really sort of stewards of how well quality of
4 care, and satisfaction, and other things are
5 going on with behavioral health patients, it
6 might play out differently where we can't really
7 subdivide them here. And do we want to give a
8 special endorsement versus our domain is larger
9 than that? So I'd just like us to at least think
10 about that?

11 CO-CHAIR BRISS: Raquel?

12 MEMBER MAZON JEFFERS: Yes. So it's
13 hard for me to endorse plus something when I'm
14 still struggling with this harmonization issue.
15 Because this measure feels -- I know you said
16 that it's different from the measure, whatever it
17 was, 3225. Because it's not a provider checkbox,
18 it's a -- I get the difference.

19 But they're really measuring the same
20 thing. Did patients receive tobacco screening
21 and cessation advice? And so it's hard for me to
22 vote to endorse plus something in a -- maybe I'm

1 not thinking about the process correctly. But
2 it's hard for me to think about endorsing plus
3 something without taking into account the other
4 similar measures.

5 CO-CHAIR BRISS: So, Helen, is there
6 an answer to why this is really different from
7 the 3225? It sounds like the answer might be
8 that NCQA has gone through additional effort to
9 get input from users. Is that the short answer?

10 DR. BURSTIN: That would be my sense
11 of it. But again, I will also admit to Rachel's
12 point that we didn't specifically think about
13 whether the absence of a competing measure would
14 preclude you from this plus designation either.
15 So you've raised a really good point. Again,
16 these are different data sources. But it's still
17 a fair point.

18 CO-CHAIR BRISS: Mady?

19 MEMBER CHALK: Yes. So, Raquel, so to
20 me the difference between the two measures is one
21 is collected by providers or plans and the other
22 is a patient survey. To me, one is more patient

1 centered, and the other is not.

2 I'd love to see somebody, some
3 researcher, get those into a relational database
4 and be able to take a look at how responses
5 differ and how that matters. But that's a
6 separate issue. That's a separate issue from the
7 measure itself. And the fact that you're getting
8 feedback and asking for it is very important to
9 me, from patients.

10 CO-CHAIR BRISS: Helen, has NQF
11 endorsed -- done endorsement plus before this
12 committee, or are we guinea pigs again?

13 DR. BURSTIN: No, actually, I wasn't
14 aware we were actually rolling it out yet. It
15 was mainly rolling out the new criterion that
16 says did you get feedback, are you iteratively
17 improving the measure, which was really our
18 action for now.

19 But, you know, I don't know that we
20 have to spend a lot of time on this. And we can
21 return to the plus designation after we've had
22 more time to deliberate. But nonetheless, just

1 so pleased to hear that, on the surface, you guys
2 read that. So that's great.

3 CO-CHAIR BRISS: I'd like to table
4 this discussion, because I'm afraid it's going to
5 hang us up. And the thing that I'd like to have
6 you guys really work out is how to handle the
7 plus designation in the context of a family of
8 measures down the road. I'm a little worried
9 about unintended consequences for some measures
10 of the family and not others. So with that --

11 DR. LUSTIG: So I think we're moving
12 onto Measure 0108. And we do have two committee
13 members that are recused. Connie and Harold are
14 both recused from discussing this measure.

15 DR. BARTON: And if it's okay, Dan
16 Roman will introduce the measure.

17 MR. ROMAN: Hi, I'm Dan Roman. I'm a
18 senior research associate at NCQA. I'm going to
19 be discussing our follow-up care for children
20 prescribed ADHD medication, so switching gears a
21 little bit from smoking.

22 There's a long-standing plan level

1 process measure that uses medical and pharmacy
2 claims data as its data source. Our intent here
3 is to ensure appropriate follow-up care occurs
4 once children are prescribed ADHD medications to
5 allow for assessment of medication effectiveness
6 and adherence, and to monitor for potential side
7 effects.

8 The measure applies to children six to
9 12 years of age who are prescribed ADHD
10 medications during a 12 month intake period.

11 There are two rates. The first, the initiation
12 fees, assesses follow-up within 30 days after the
13 first dispensing event.

14 And then the second is our
15 continuation maintenance phase which assesses, of
16 those who are compliant for Rate 1, how many then
17 have two additional follow-up visits in the 31 to
18 300 days after the first dispensing event.

19 Since the measure was first introduced
20 in HEDIS set in 2006, on average, across
21 commercial and Medicaid plans, performance rates
22 have increased six to ten percent for the

1 initiation phase rate and ten to 16 percent for
2 the continuation and maintenance phase.

3 We also see a wide variation in
4 performance across the percentiles overall. So
5 we believe there is still an opportunity for
6 quality improvement. And as far as changes, we
7 have not made any since the measure went through
8 its last maintenance update in 2015. That's all.

9 MEMBER PINDOLIA: So I'm going to read
10 my comment, because I put a lot of thought into
11 this one on the details.

12 So regarding the maintenance measure
13 and the new information, there's been a large
14 shift in patient provider interaction to follow
15 more technology-based methods, whether it's
16 either EMRs, the chats that go along with that,
17 Apps, direct emails to physicians, telemedicine.

18 This measure limits the initial
19 follow-up visit as face-to-face within 30 days of
20 starting the ADHD medication.

21 The second change in patient care
22 that's really growing rapidly is the high amount

1 of high deductible plans that are rolling out.
2 So this has a direct impact on the patient's out
3 of pocket spend that has increased the
4 physician's desire to find alternative methods to
5 have patient communication, and especially for
6 the young adults, which is the six to 12 year-old
7 parents, where if their child is fine, and they
8 did that first visit, they're really reluctant to
9 come back within 30 days and pay another office
10 visit, which is out of pocket for many of them
11 with their high deductible plans.

12 So with that, I'm asking for evidence
13 on the first initial phase of the 30 days. I
14 understand it comes from the 2011 AAP guidelines.
15 So I've actually contacted AAP, because there is
16 no literature to support that statement. AAP has
17 responded that they agree, there is no literature
18 to support that statement, but the body of
19 individuals in 2011 felt it was appropriate.

20 And I said in 2011 it probably was.
21 But healthcare has evolved so much. And now,
22 five, six years later, that is not the way we're

1 practicing. In fact, we're telling our providers
2 you've got to find different ways to engage with
3 your patients. This whole coming back in the
4 clinic is not working.

5 So then, I also went and did some
6 guidelines of lines of my own. And in January of
7 2017, there was actually a study published in
8 American Journal of Managed Care. And it was
9 actually assessing this actual measure. And it
10 was done through the Medicaid population in
11 Alabama in 1999 to 2012, 61,251 patients on
12 average per year.

13 And their findings also really help
14 share the concerns that I have that the low
15 performance that we're seeing in that first 30
16 days, because there was a stark difference
17 between the two follow-ups, the 30 percent goes
18 to 60, 70 percent, their study showed that
19 actually the ones who were the poor performers
20 for the 30 days, within 30 days, had higher --
21 no, had lower ER use and hospitalization.

22 Because the patients who have those

1 biggest concerns, the parents are willing to
2 bring them in. So the ones who did have their
3 follow-up within 30 days, they actually had
4 higher ER and hospitalization use. They had
5 higher total cost of care compared to those who
6 were not compliant.

7 When they went and expanded that day
8 period, 30 to by just 20 days, you see a 20
9 percent increase, and improvement, and compliance
10 to that measure. But, you know, so at this
11 point, I don't know what that initial phase is
12 really telling me, that that's poor quality
13 within 30 days.

14 The heart rate and the blood pressure
15 increase that, you know, people are worried
16 about, I think, from talking to AAP, that's why
17 they had this, the parents bring the children in
18 after -- in the late evening. The peak effect of
19 the drug has worn out. So to catch that, you're
20 missing it.

21 So I've actually reached out to the
22 Henry Ford Medical Group chair of Pediatric

1 Psychology, Psychiatry, and the chair of
2 Pediatrics for their input on this measure. And
3 they said exactly, that is their concern.

4 And this has become a checkbox for
5 them and to just have them come in and have a
6 nurse check it, meaning nothing. Their biggest
7 concern is one to two months later, when they're
8 down to one percent BMI, and that's like, their
9 biggest issue they're having with the startup of
10 the ADHD drugs.

11 And they are all being given
12 titrations, right, for the first month anyway.
13 So we're overburdening these parents with so many
14 outreaches and then telling them to come back,
15 but they're not doing so. So I have a lot of
16 concerns of the evidence to support that first
17 30-day visit of being face-to-face and within 30
18 days.

19 MR. ROMAN: As far as it being face-
20 to-face, you're correct. It is based off of the
21 language in the 2011 guideline which suggested
22 that there should be a face-to-face.

1 That said, NCQA is evaluating the use
2 of telemedicine and telehealth in general across
3 all of our measures. For this particular
4 measure, we have out for public comment a
5 recommendation to include, I believe it's video
6 conferencing for this measure.

7 It already does include telehealth for
8 the other two visits, so we are evaluating that
9 and looking into it to try to make sure that
10 we're counting, exactly, everything you just
11 said.

12 It's kind of in process though, right
13 now. So the change is not implemented in the
14 measure under the version that you're seeing.
15 But it is something that we have out for public
16 comment right now.

17 MEMBER PINDOLIA: Yes, when would that
18 change occur if -- because it has a great
19 implication on the providers. Because it goes
20 right into so many provider fee incentive
21 payments.

22 MR. ROMAN: It would -- I believe it

1 would be implemented for HEDIS 2018. So that's
2 published in July if it goes through public
3 comment, and our CPM, our Clinical Performance
4 Measurement, approves the change, and it goes
5 through our Board, and all that.

6 But July is when we come out with the
7 next version of the measure. So it would be
8 another way for qualifying for the measure beyond
9 the face-to-face.

10 CO-CHAIR BRISS: Presumably, that
11 would be a substantive change that would require,
12 for it to maintain endorsement, it would come
13 back through us again, right? Is that right?

14 DR. BARTON: Of course we would update
15 the specification. And that's actually a
16 decision about whether ---

17 (Simultaneous speaking.)

18 DR. BARTON: We would share the updated
19 specification with NQF. And I believe they would
20 decide whether or not it merit a separate review.

21 MEMBER MARK: On the point of
22 evidence, the summary document says that the

1 developer states numerous, "More than 100 studies
2 related to the care of patients with ADHD have
3 been published since the publication of this
4 guideline. None of which contradict the need for
5 appropriate follow-up once treatment with
6 medication begins."

7 But it wasn't clear if you did any
8 kind of systematic review, or how you reviewed
9 the evidence, or what went into that. I mean, my
10 little, you know, simple review came up with some
11 interesting articles, you know.

12 And things continue to change, as was
13 pointed out, in this field, like, if there was
14 any study on how consumers felt about having to
15 come back in, if they felt burdened. That might
16 be helpful.

17 The rate of prescribing of ADHD drugs
18 has increased greatly. So it'd be helpful to
19 have more information about exactly what was done
20 in terms of the updated literature review.

21 MR. ROMAN: Sure. I would say it
22 would not rise to the level of a systematic

1 review. For a maintenance update like this, we
2 do look at the studies available and do kind of a
3 cursory review of is there anything that is
4 saying this measure is outdated, or is no longer
5 effective, or doing harm as follow-up.

6 And so as far as follow-up goes, we
7 were not able to find anything that says that
8 there's -- definitely you shouldn't be doing
9 follow-up in an appropriate timeframe. I mean,
10 that's really kind of the level of things we look
11 at for a maintenance update.

12 If there's a guideline change, for
13 example, we start there. In this case, there
14 aren't any guidelines. Even the AAP, though they
15 said that they, you know, that they don't really
16 think that face-to-face visit's necessary,
17 there's no new guideline out.

18 So we start at the guidelines, and
19 then we kind of work our way down into the other
20 literature. And there is plenty about care for
21 ADHD on children. As far as anything
22 contradicting the need or the appropriateness of

1 the measure, we were not able to find anything.

2 MEMBER EINZIG: So a few points.

3 First point is I'm really impressed you actually
4 got in touch with the American Academy of
5 Pediatrics.

6 And just to emphasize, you know,
7 guidelines are not evidence. And so if it was
8 just a bunch of people around a table saying this
9 is what we think is right, that's not evidence,
10 not strong evidence. So I want to emphasize
11 that.

12 Second thing, if you pull up the AACAP
13 practice parameters, they don't give timeline. I
14 don't know if you're able to put it up on the big
15 screen. Can you put up the link for that AACAP
16 practice parameter?

17 I'll just read it off here. "The
18 frequency and duration of follow-up sessions
19 should be individualized for each family and
20 patient, depending on the severity of ADHD
21 symptoms, the degree of comorbidity of other
22 psychiatric illness, the response to treatment,

1 and the degree of impairment in home, school,
2 work or peer-related activities.

3 "The clinician should establish an
4 effective mechanism of receiving feedback from
5 the family and other important informants in the
6 patient's environment to be sure symptoms are
7 well controlled." And it goes on.

8 They suggest two to four follow-up
9 visits in a year. But nowhere in it does it say
10 a one-month timeframe in the first month. So
11 that's the second point.

12 The third point, just from a clinical
13 perspective, from seeing a lot of patients, I can
14 come up with a lot of examples when it is not in
15 the patient's or family's best interest to come
16 back in within a month.

17 The first example would be prescribe
18 in July, school doesn't start late August or
19 September. It might not be the most fruitful
20 time to come back before school starts. You
21 won't get optimal feedback.

22 Another example is you've got a kid

1 with autism who also has ADHD symptoms. And that
2 can be a huge burden for an emotionally
3 disregulated kid to have to come in for a follow-
4 up within that timeframe. So I can go on, but
5 I'll stop there.

6 CO-CHAIR BRISS: So it sounds to me
7 like several people have expressed concerns about
8 the level of evidence supporting the one-month
9 timeframe. So -- and the truth is the last time
10 the committee met we had some of these concerns
11 even then.

12 And as has been said already, our
13 tools for interacting with families have only
14 gotten greatly better since the last time we
15 revisited this measure.

16 So let's -- I'd like to suggest that
17 we call that issue sufficiently aired, unless
18 somebody has new points to make on that. And
19 then we'll go the rest of the way around the
20 table. Please, Mike, you're next.

21 MEMBER LARDIERI: My question is more
22 about how you're going to implement the video

1 conferencing. And not all plans pay for it. If
2 you're in a Medicaid environment, some states
3 don't allow you to do that. So you're sort of
4 stuck, for awhile anyway.

5 MR. ROMAN: I can say a little bit.
6 And let me see if Mary or Junqing, who is also
7 here, Liu from our NCQA, can add more. There is
8 a coding system structure that's out there that
9 is going to be implemented. And we put that into
10 our specs.

11 As far as state by state, I'm not
12 sure, you know, how much control that NCQA has
13 over what is allowed. But there are codes
14 available that can be used for video conferencing
15 and, for Pela Health, and modifiers to existing
16 codes that capture this sort of thing, the kind
17 of the more electronic exchange.

18 MEMBER LARDIERI: Yes, I'm aware of
19 the codes, but how do you get providers paid? I
20 mean, it's great to have the code, but you're not
21 going to get paid for it. So you're not going to
22 -- I don't know a lot of them are going to do it.

1 MEMBER ZIMA: I just have two
2 additional, unique points. One was, you know,
3 this measure's been around for ten years. And I
4 kind of disagree that there's been a lot of
5 change. So, I mean, I think it really raises the
6 question of really, you know, how valuable has
7 this measure been stimulating change over the
8 last ten years?

9 And I think it's particularly
10 important, because in the CMM phase there's
11 always that potential overestimation of
12 adherence. Because there's a very high attrition
13 rate, right. So what, 70, 80 percent of kids
14 don't make it into the CMM phase. Is that right?

15 (Off microphone comments.)

16 MEMBER ZIMA: Sixty-five percent. And
17 I think the other issue is I think we have to be
18 mindful that these are Schedule 2 drugs required
19 in triplicate, except for atomoxetine.

20 And, you know, both AAP and AACAP
21 guidelines really emphasize that, in monitoring
22 medication safety in these children, you have to

1 look at the child clinically. You have to look
2 at the side effects, you have to look at the
3 parent preference, you have to look at things
4 like school time, and school schedule, and things
5 like that.

6 And, you know, when you look at the
7 fine print in that CMM, it appears that two of
8 the follow-up visits, one is allowed to be just a
9 telephone contact. And, you know, to me I don't
10 think a telephone contact with a parent who wants
11 a refill of a stimulant in a hyperactive kid,
12 and I haven't been able to see that child, check
13 the pulse, check the blood pressure, check the
14 weight, I don't think that's safe practice. And
15 so I think those are two of my main concerns.

16 And, you know, I think the other issue
17 is it gets back to, you know, over 100
18 publications supporting continuity of care.
19 Maybe it's continuity of care when you could set
20 Rx persistence that should be measured as well
21 during the CMM, not just the number of contacts.

22 MEMBER TRANGLE: I think these are

1 related, but somewhat unique points. When we
2 talked about this last time, I think we also
3 talked a fair amount about what is the literature
4 showing about starting and somehow adjusting
5 stimulants as to whether true outcomes,
6 functional abilities to do well, and adapt in
7 various social and academic settings, what's the
8 evidence for that versus just that we got them
9 relying on a pill, you know?

10 We said that was sort of -- we talked
11 about it last time and said it wouldn't hurt to
12 see that burnished and just make sure there's
13 good correlation there.

14 And the other thing, my other comment
15 is, at least in my system, we're doing a lot of
16 communication in other vehicles that you didn't
17 mention. And I'd hate for us to modify it to
18 televideo only so that we can stay behind where
19 things truly are at by the time it gets
20 implemented.

21 So we're doing a lot of sort of just
22 online, going through My Chart, you know, kind of

1 directly into the EMR kind of communication.
2 We're doing mobile apps. We're doing other kinds
3 of vehicles that you did not mention but are
4 becoming more prominent, you know. And, you
5 know, I just don't want to always stay behind the
6 curve.

7 MEMBER PATING: Yes, my comments are
8 actually to the same. And I want to nominate
9 Vanita for next Senator or President.

10 (Laughter)

11 MEMBER PATING: Also for going the
12 extra mile when I was trying to even just to get
13 the first 100 feet.

14 You know, NCQA has done a really great
15 job with moving the field in a lot of different
16 ways with these initiation continuation formats.
17 I think you've done it with this. You've done it
18 -- I believe with depression. I know that you've
19 done it with alcohol and drug screening.

20 But the problem is is that the field
21 is evolving faster than you all. So the measures
22 are supposed to drive performance. But I

1 actually feel in my system, which is a large
2 networked system, NCQA has actually inhibited,
3 through its auditing process, the ability to
4 innovate.

5 I mean, one is televisits. There were
6 video visits. Another one is apps, another one
7 is even just various kinds of things, including
8 education which is not considered billable
9 appointments, because of this data structure that
10 you've created.

11 And to have another two years of this,
12 you are putting institutions out of product
13 cycles. That is a whole product cycle in the
14 technology world, in terms of being able to use
15 IT hand-held technology to monitor people that
16 can give you very good outcomes.

17 So organizations are not willing to
18 take the risk, because NCQA auditors in the field
19 will not, you know, modify specifications, you're
20 telling us that it really starts from the top.
21 And so I'm just really asking you to hear the
22 comments around the table. And it's not that

1 you're not moving the field in a good way, you
2 have moved the field. But the field needs to
3 move you, and it needs to be reciprocal, right.

4 So you just need to hear that in a
5 very active way. Because I think you've put my
6 organization two or three years behind by not
7 willing to innovate the measure. And it's shut
8 down innovation in very important ways.

9 CO-CHAIR BRISS: Okay. So we've heard
10 a lot of kind of similar comments around the
11 table. I think we may be at a point where we can
12 vote on evidence unless somebody else would like
13 to have a last word. And the question on the
14 table is essentially do you believe that the
15 measure, as currently specified, has evidence to
16 suggest that it importantly drives better
17 outcomes.

18 MEMBER MARK: Well, I think -- that's
19 the validity measure. This is the generic
20 question of whether this is an important -- if
21 there's evidence to support that, in general,
22 right, following up after ADHD treatment is

1 important.

2 MEMBER PINDOLIA: Is it that, or is it
3 the evidence of what we're trying to measure with
4 this?

5 MEMBER MARK: I think that's the
6 validity. Again, it gets complicated and
7 confusing several times --

8 CO-CHAIR BRISS: Yes. We've been a
9 little back and forth. And I'm not sure that
10 there's an easy answer to that.

11 MEMBER MARK: Yes.

12 CO-CHAIR BRISS: I think this is the
13 key question. I think you could make it an
14 evidence question. And I think you could make it
15 a validity question. I heard from you, it would
16 have been an evidence question. But I'm okay if
17 we limit our conversation about evidence to is
18 ADHD important. And, you know, is continuity of
19 care important?

20 MEMBER MARK: Yes. So the only other
21 thing I would say is that the recent report from
22 SAMHSA reports that the number ED visits

1 involving ADHD stimulant medications tripled from
2 -- I'm trying to get things updated here --
3 tripled over the last ten years. So in 2011 it
4 was 31,000 visits. So seems like there are a lot
5 of increasing harms being done by ADHD
6 medications which might argue that this is more
7 evidence for this than there was before.

8 MEMBER PINDOLIA: If I could just add
9 a caveat, I think you have to look at that per
10 thousand. Because the number of children that
11 are added on for ADHD over the last ten years has
12 increased so much. So the increase in ER isn't
13 just as proportional as the increase in the
14 number of people using the drugs.

15 MEMBER MARK: No, you're right.
16 That's my point. There're so many more people
17 using the drugs. We're having a tripling of the
18 adverse effects. So that would argue that we
19 need to have post to start follow-up even more
20 now than we did before, not post to start, you
21 know, post-prescription follow-up.

22 CO-CHAIR BRISS: All right. So I

1 don't actually think it's worth voting on your
2 ADHD. It is important in whether follow-up
3 conceptually is also important. So I'd actually
4 like to vote on the evidence question about do
5 you think that this measure, as currently
6 specified, is likely to result in meaningful
7 improvements for affected kids and families.

8 MS. QUINNONEZ: Voting is now open for
9 measure 0108, Follow-up Care for Children
10 Prescribed ADHD Medication. We're voting on the
11 evidence. Option Number 1 is high, Option Number
12 2 is moderate, Option Number 3 is low, and Option
13 Number 4 is insufficient.

14 Thank you. All votes are in. Voting
15 is now closed. For the evidence of Measure 0108,
16 five percent voted high, so one individual, 40
17 percent voted moderate, eight individual votes,
18 35 percent voted low, seven individual votes, and
19 20 percent voted for insufficient, four
20 individual votes.

21 DR. LUSTIG: So that's consensus not
22 reached, and we'll continue to discuss the

1 measure.

2 CO-CHAIR BRISS: So we move to
3 reliability. Any other reviewers like to comment
4 on performance gap? Anybody like to comment on
5 performance gap?

6 (No audible response)

7 MEMBER ZIMA: I think it's been said,
8 little change.

9 CO-CHAIR BRISS: And then having said
10 that, it is little change, and there are probably
11 important differences, at least as the measure is
12 currently specifying, between bottom performers
13 and top performers.

14 MEMBER ZIMA: Yes. So the bottom 10th
15 quartile is 29 percent, and the 90th top quartile
16 is 50 percent for commercial insurance. And for
17 Medicaid it's 29 percent and 56 percent. So
18 there's a big gap in performance.

19 CO-CHAIR BRISS: So anybody want to
20 talk about that further before we vote on that
21 criteria?

22 (No audible response)

1 CO-CHAIR BRISS: All right, let's
2 vote.

3 MS. QUINNONEZ: The voting is now open
4 for performance gap of Measure 0108. Option 1 is
5 high, Option 2, moderate, Option 3, low, and
6 Option 4 insufficient.

7 CO-CHAIR BRISS: But if it's a hung
8 jury, you keep going. We had a hung jury.

9 MS. QUINNONEZ: All votes are in.
10 Voting is now closed. For performance gap of
11 Measure 0108, 33 percent voted high, six
12 individual votes, 50 percent voted moderate, nine
13 individual votes, 11 percent voted low, two
14 individual votes, and six percent voted
15 insufficient, one individual vote. For
16 performance gap of Measure 0108, this passes this
17 criteria.

18 CO-CHAIR BRISS: So we're done. We
19 move to reliability. Comments?

20 (No audible response)

21 CO-CHAIR BRISS: We've clearly worn
22 out the panel. So they've done a signal to noise

1 analysis. It meets usual standards, it looks
2 like. Anybody want to comment further?

3 (No audible response)

4 CO-CHAIR BRISS: Why don't we vote.

5 MS. QUINNONEZ: Voting is now open for
6 reliability of Measure 0108. Option 1, high,
7 Option 2, moderate, Option 3, low, and Option 4,
8 insufficient.

9 Thank you. All votes are in. Voting
10 is now closed. For the reliability of Measure
11 0108, 35 percent voted high, seven individual
12 votes, 40 percent voted moderate, eight
13 individual votes, 25 percent voted low, five
14 individual votes, and zero percent voted for
15 insufficient. For reliability of Measure 0108,
16 this passes this criteria.

17 CO-CHAIR BRISS: And then we're to
18 validity. And so it's both components of that.
19 Does it measure what it purports to measure and,
20 if you do the right things that people will be
21 better off, right? So, Bonnie, you're up.

22 MEMBER ZIMA: I think, again, this

1 gets to David's point about the NCQA approach. I
2 mean, this will be based on the face validity,
3 you know. And you look at the technical expert
4 panel, only three of the panel members were MDs
5 or prescribers of medication. And of those three
6 MDs, only one was a child psychiatrist. One was
7 an internist, and one was a family medicine
8 person specializing in geriatrics. There was no
9 pediatrician on the initial TEP. So I think that
10 should be called out.

11 And then the other thing, looking at
12 construct validity, you pulled up another HEDIS
13 measure related to any contact with a primary
14 care provider. And I guess that makes sense,
15 because you're really looking at them at a
16 follow-up visit.

17 But again, I think the more important
18 issue is the continuity of care for children on
19 stimulant medication. And so I think you kind of
20 missed the mark a little bit in thinking about
21 construct validity there.

22 CO-CHAIR BRISS: Anybody else have

1 points they want to make that haven't already
2 been made?

3 (No audible response)

4 CO-CHAIR BRISS: Let's try voting this
5 criteria then.

6 MS. QUINNONEZ: Voting is now open for
7 validity of Measure 0108. Option 1, high, Option
8 2, moderate, Option 3, low, and Option 4,
9 insufficient.

10 Thank you. All votes are in. Voting
11 is now closed. For the validity of Measure 0108,
12 ten percent voted high, two individual votes, 25
13 percent voted moderate, five individual votes, 55
14 percent voted low, 11 individual votes, and ten
15 percent voted insufficient with two individual
16 votes. This is consensus not reached.

17 CO-CHAIR BRISS: No, it's --

18 MS. QUINNONEZ: Not passed?

19 CO-CHAIR BRISS: Not passed, right.

20 MS. QUINNONEZ: No pass. For the
21 validity of Measure 0108, this is a no pass for
22 validity.

1 CO-CHAIR BRISS: Thank you.

2 DR. LUSTIG: And so we do stop our
3 discussion on this measure at this point. We do
4 have a post-meeting comment period which, if you
5 want to submit any other information, you can for
6 that.

7 CO-CHAIR BRISS: I think we were
8 pretty clear about what the issues were. We've
9 given other developers a chance to ask any
10 follow-up questions. Do you have left-over
11 questions about what the issues were?

12 DR. LUSTIG: No.

13 CO-CHAIR BRISS: Thank you. So 0576,
14 we are in the home stretch.

15 MEMBER TRANGLE: May I just ask you
16 a question? I mean, whether it's now an effort,
17 what happens now. I'm not familiar with what
18 happens if you choose to deconstruct or not have
19 a -- is there a lag of time period that it just
20 continues to happen, do you see what I'm asking?

21 DR. BARTON: NCQA's not dependent on
22 NQF endorsement. We use our measures. We're

1 delighted, overjoyed to have the input from the
2 fields that this process gives us. We think
3 there's a super-high value to the consensus
4 development process.

5 Don't let me -- big mistake is not
6 respecting the CDP process. It's wonderful, it's
7 terrific. But just as CMS, sometimes uses
8 measures that are not NQF endorsed, sometimes
9 NCQA uses measures that are not NQF endorsed.

10 CO-CHAIR BRISS: But it does seem
11 likely that the feedback I'll get, you'll get it
12 incorporated into your ongoing discussions,
13 right?

14 DR. BARTON: Yes, absolutely.

15 MEMBER COLEMAN: Can I just check in
16 real quick? The summary of each of those actions
17 doesn't come up for me. I'm just curious if any
18 others have noticed that too and make sure
19 there's not a technical challenge on my behalf
20 that I need to fix or something.

21 (Off microphone comments)

22 MEMBER COLEMAN: Correct. Yes, I've

1 noticed they haven't been on other ones, but now
2 that it's mine, I just want to make sure that I
3 don't need to do something different.

4 CO-CHAIR BRISS: All right. So we are
5 on 0576. Do you guys want to tee that up for us,
6 please?

7 DR. LIU: Sure. This is Junqing Liu,
8 research scientist at NCQA, delighted to be here
9 to talk about the Follow-up After Hospitalization
10 for Mental Illness Measure. This is a long-
11 standing claim-based measure. The measure
12 addresses follow-up care for a vulnerable
13 population who is hospitalized for mental illness.

14 Evidence shows that follow-up care
15 reduces suicide attempts, re-admissions, and
16 improves functioning. Clinical practice
17 guidelines also support follow-up after
18 hospitalization.

19 The measure has demonstrated
20 performance gap in a variation across health
21 plans. About 30 to 40 percent people across
22 private lines do not have follow-up care within 30

1 days after discharge from hospitals. Even
2 evidence supports it is important to receive
3 follow-up care.

4 The measure has high reliability as
5 demonstrated by the beta-binomial reliability
6 scores. The measure is used in seven national
7 reporting programs such as Medicaid, a coreset,
8 hospital compare data in 70 programs, in-patient
9 psychiatric facility quality reporting programs.
10 And the measure is also used in NCQA's
11 accreditation of commercial, Medicaid, and
12 Medicare plans. Thank you.

13 CO-CHAIR BRISS: Thank you. Anybody
14 like to go first and talk about the evidence for
15 this one?

16 MEMBER COLEMAN: I'm happy to start us
17 out. Again, I only have my comments here, but I'm
18 happy to share them and others can chime in with
19 me.

20 I think the biggest question for me
21 came up around the seven and 30 days. Again,
22 that's kind of the time period. I wasn't sure how

1 much evidence there was specifically for those two
2 time points. So I was curious why they were
3 chosen.

4 Otherwise, I wanted to make sure it was
5 psychiatric hospitalization. You mentioned that,
6 hospitalization for mental illness. It actually,
7 I thought I saw it in two different applications,
8 or two different parts of the application it reads
9 just a little bit differently. So I just wanted
10 to clarify that. And I think that's mostly it.

11 CO-CHAIR BRISS: We'll go around this
12 way. Raquel?

13 MEMBER MAZON JEFFERS: I just had a
14 question that with our efforts to really try and
15 develop more and more integrated models of care,
16 even for people who might be slightly more
17 moderate even to acutely mentally ill, it looks
18 like the follow-up visit can only occur with a
19 mental health specialist, mental health
20 practitioner.

21 But more and more people are receiving
22 their mental health services in primary care

1 settings as well. And I'm just wondering if you
2 thought about that as an alternative option for
3 people.

4 MEMBER MAZON JEFFERS: She's waiting
5 for more questions?

6 CO-CHAIR BRISS: I think you can go
7 ahead and answer that one.

8 DR. LIU: Thanks for the comments. So
9 the seven-day and 30-day, those are consensus
10 based. We developed this measure with our
11 Behavioral Health Measurement Advisory Panel. The
12 panel considered that if someone is sick enough to
13 be hospitalized, it's important for them to
14 receive timely follow-up care.

15 So we felt that it will be great if
16 someone can receive follow-up care within seven
17 days. If not, at least they should receive
18 follow-up care within 30 days. So that's the
19 rationale behind those timeframes.

20 And I think studies have started to
21 emerge using this measure. It is the -- and
22 started to show that follow-up within these

1 timeframes are contributing to reduced re-
2 admissions.

3 In the psychiatric hospital measure you
4 mentioned, actually this measure is about
5 hospitalization in any hospitals. It could be
6 psychiatric hospitals or other general hospitals.

7 And your comments about integration of
8 primary healthcare and considering other types of
9 providers, we thought about that. And actually we
10 think the integration was not contraindicated with
11 this measure. Because most of the integrated
12 models, first you need mental providers either
13 available remotely or being part of the team.

14 And we also, consulting some research
15 conducted, such as by the World Health
16 Organization research, is showing that still in
17 primary care half of the time in the mental health
18 program conditions are not recognized.

19 Even when they are recognized, half of
20 the time they're not treated. For those who are
21 treated, in the majority of time they are not the
22 state of art first line treatment provided by

1 other type of providers.

2 So we discussed with our Measurement
3 Advisory Panel in great detail. They felt that,
4 again, someone who is sick enough to be
5 hospitalized, they should see a mental health
6 provider.

7 MEMBER MAZON JEFFERS: I don't disagree
8 that there are many models of primary care
9 behavioral health integration that utilizes part
10 of their workforce mental health professionals to
11 do a lot of the mental health interventions.

12 But there's a prescribing component.
13 Would you -- I guess my question is do you
14 consider a physician who might be a prescribing
15 physician who's prescribing a psychopharmaceutical
16 for someone with a mental health disorder, do you
17 consider that a follow-up visit?

18 DR. LIU: Yes. If someone has a
19 prescribing authority, yes.

20 MEMBER MAZON JEFFERS: And that's a
21 mental health professional.

22 CO-CHAIR BRISS: So let's keep going

1 around. Tammy, I think you're next.

2 MEMBER MARK: Yes. Again, I think the
3 -- well, if you can talk about how you updated the
4 literature, so I'm thinking back to that last
5 discussion. You know, it seemed like the way it
6 went was, if there was nothing contradicting this,
7 our prior evidence was still good. And mainly
8 they relied on guidance, you know, looking at
9 practice guidelines.

10 And if there were studies that they had
11 cited, that showed that ADHD follow-up led to
12 improved outcomes, that might have changed the
13 conclusion of that last discussion. So I'm
14 wondering if you found any, or you looked for any
15 articles that had looked at the correlation
16 between this HEDIS measure and some outcomes, like
17 re-admissions. Because I think that would be
18 helpful.

19 Because we do seem to be really
20 thinking about the validity again. And so if
21 there's newer evidence in support of the validity,
22 it would be helpful to also hear about that.

1 DR. LIU: Yes. About the process of
2 evidence review for this measure, we actually
3 tried to be very comprehensive when we do those
4 runs. And we also listened to internal work
5 looking at this measure.

6 So we tried to be as comprehensive as
7 we can. You can notice that we have several
8 updates in the form about practice guidelines and
9 evidence since last endorsement. We had a study
10 cited after that last endorsement.

11 And we at NCQ are thinking hard about
12 how to correlate our measures. I think that's a
13 discussion about how we can correlate this measure
14 with our Plan All-Cause Readmission measure.

15 At this time, that measure does not
16 stratify the condition. But we can look into it.
17 And as I mentioned, there are published studies
18 conducted outside of NCQ, is using this measure
19 demonstrating the measure can reduce re-admission.

20 CO-CHAIR BRISS: Another thing that
21 might be at least subtly different from the last
22 one, as I hear it, is for the last one there were

1 lots of other proposals that were made about other
2 ways that could assure adequate follow-up that
3 weren't actually captured by the measure, right.

4 And we did that in both directions
5 There were ways that people proposed that weren't
6 captured by the measure that might have been less
7 face-to-face. And there were times when, later in
8 the course of the telephone visit, might not be
9 enough.

10 And so the other thing that, at least
11 ever since the discussion at this point in this
12 measure, is that we haven't had the same kind of
13 discussion about there are better alternatives to
14 assuring follow-up.

15 MEMBER MARK: Yes. I mean, I published
16 a study showing that post-discharge follow-up
17 reduces re-admissions. And it wasn't cited, so I
18 know there's literature out there wasn't cited.
19 So my point is that it could be helpful to, you
20 know, bring that forward more clearly.

21 (Laughter)

22 MEMBER LARDIERI: Yes, thanks. I see

1 the, you know, the list of providers. But how are
2 you picking that up in the claim on the primary
3 care side, like, that it's a social worker, or
4 that it's a masters or doctoral degree
5 professional? How are you picking that up on the
6 claim?

7 DR. LIU: We received questions from
8 the field through HEDIS medical reporting. People
9 ask us how they should identify the right type of
10 providers. We heard that there's NPI and other
11 providers, emergency providers indicated.

12 Our claims and our HEDIS management
13 specification also provide definitions about
14 mental health practitioners. So there's other
15 ways to help plans' providers to identify the
16 mental health practitioners.

17 MEMBER ZIMA: Yes. You know, I think
18 I had a question and a comment. One was this
19 measure goes down to age six. But why didn't you
20 report any evidence supporting it for children and
21 teens?

22 DR. LIU: So I think this measure we

1 were talking about in children and adults. We
2 actually are looking into evidence, and there is
3 evidence supporting the prevalence of this
4 condition. I think this panel can all agree that
5 mental health conditions is also prevalent in
6 children, adolescents, and adults.

7 I think we can -- if that's, you know,
8 something we need to add, we can definitely add
9 more. Because we are looking into that. It is
10 important for that population as well.

11 MEMBER ZIMA: Yes, I thought it was an
12 important omission, because the evidence was
13 basically from NICE and then APA by target
14 disorder, schizophrenia, bipolar, and major
15 depression. So that, I thought, was an important
16 omission.

17 The other issue is really this
18 conundrum that we talked about that, you know,
19 we're taking measures where the unit of analysis
20 is the health plan. But when it gets NQF
21 endorsed, then we're putting hospitals in a
22 position of being accountable for this measure.

1 And, you know, NCQA can argue, well,
2 you know, when we had a health plan level measure,
3 the health plan is accountable to find follow-up
4 for their patients. But as I can imagine, using
5 this measure for a hospital, they're going to face
6 the challenge of coordinating follow-up mental
7 health care in a system that's fragmented, or
8 their contract to the commercial insurer that
9 doesn't have the capacity to accept all of their
10 referred patients. So I think that, in using it
11 prime time, it kind of shifts who we find is
12 accountable.

13 DR. BARTON: So I would absolutely take
14 that up with someone who proposed this measure for
15 the IPF population, for IPFs. And that's not what
16 we're proposing here. We're proposing this as a
17 measure for health plans.

18 MEMBER KELLEHER: And it has been used
19 by at least the, we know from the carve-out
20 managed behavioral health organizations, it's been
21 sort of gold standard that they themselves do.
22 They don't rely on the provider network, including

1 the facilities, to follow-up, the seven and 30 has
2 been pretty standard stuff for a very long time.

3 CO-CHAIR BRISS: Absolutely.

4 MEMBER KELLEHER: And very useful for
5 reducing re-admission.

6 CO-CHAIR BRISS: Just before I continue
7 around, it seemed like people were coming out of
8 the woodwork to want to comment on this specific
9 thing. So anybody have further comments on this
10 specific issue? It's sort of about the level for
11 which its specified, right? At least --

12 MEMBER SHEA: So I can tell you that
13 what the health plans do is they use this as a
14 quality metric for the hospitals and they take
15 money away from us if we're not performing, if our
16 discharges aren't performing. So that is
17 definitely happening now.

18 CO-CHAIR BRISS: Okay, Rhonda.

19 MEMBER ROBINSON BEALE: I can testify
20 to that.

21 (Laughter)

22 MEMBER ROBINSON BEALE: To the fact

1 that we use it for both hospitals and the
2 outpatient facilities, generally the IOPs, because
3 it does bring a joint accountability. So I think
4 limiting this to the health plan is really not as
5 effective as it is beginning to apply it to the
6 delivery system itself.

7 But one of the things that's been
8 inherently problematic with this particular
9 measure, and behavioral health has adopted
10 telemedicine quite extensively in some areas, and
11 you're still not allowing that to be part of the
12 follow-up which I think is still problematic at
13 this point. A visual, audio visual contact with
14 the patient can be very, very sufficient in
15 behavioral health.

16 CO-CHAIR BRISS: So Lisa wanted to get
17 back in that one.

18 MEMBER SHEA: Yes. I have another --
19 it's kind of like a flip, but sometimes plans want
20 the hospital to, like, set up an appointment that
21 very day. So they leave the room, and they walk
22 across the hall. So they're outpatients now. So

1 I didn't know if you have data about same-day
2 visits of discharge versus after that. Because
3 that's a strategy that has been used.

4 CO-CHAIR BRISS: Hang on, hold on a
5 second. You guys want to answer that question?

6 DR. LIU: Sure. So I think this kind
7 of is very well acknowledged that this kind of
8 measure is challenging, right. We always write
9 accountable entity hospital outpatient health
10 plans.

11 Our thinking is health plans are paying
12 for the services, they are responsible for the
13 network accuracy across inpatient and outpatient.
14 So we see health plans that involve accountability
15 entity.

16 But we know these measures are being
17 used for hospitals. We think this is encouraging
18 care coordination. Because all the entities are
19 in the same loop. We need -- I think, I know
20 places are working together to improve the
21 performance.

22 But the Powerhouse issue, we are

1 evaluating Powerhouse for all HEDIS measures. For
2 this measure, we are adding video conferencing for
3 the follow-up visits. And if that is approved, we
4 will have our annual updates for NQF process. We
5 update our measures all the time, any changes, you
6 know, specification, we want to make sure we are
7 aligning the version that's available for use,
8 that's endorsed by NQF.

9 About the same-day visit, we heard of
10 that. And we're trying to understand the
11 magnitude. We think that's a small portion. We
12 actually had a discussion with our Behavioral
13 Health Measurement Advisor Panel on that very
14 issue.

15 And the recommendation came out of that
16 panel is that that's great quality improvement
17 effort, that places are trying to catch people
18 while they are still in your care to, you know,
19 make that appointment.

20 But that's not equating the clinical
21 care of a follow-up visit. So for that we made a
22 decision to balance the challenge of reporting and

1 the quality of true clinical interventions. We
2 decided to remove the same-day visit. This is a,
3 you know, another recent decision. We wanted to
4 make sure next round of annual update of this
5 measure, we want to make sure that's clear.

6 CO-CHAIR BRISS: Mike, are you still on
7 this point?

8 MEMBER TRANGLE: You know, we have the
9 same-day sort of gig going on by a number of
10 health plans in our area. And when I talk to them
11 about this, and sometimes it felt like there was
12 confusion running rampant about is this a
13 continuity of care measure where the ideal is
14 you're getting to see your provider you're going
15 to continue to see on a routine basis, and you've
16 made a transition, versus I'm hooking you up with
17 someone who you're going to see just as an interim
18 kind of thing, tide you over while you're waiting
19 a couple of months to get in to see somebody else.

20 And they both meet your measure. But
21 I think the things you're really trying to incense
22 are quite different, you know. And some of that

1 depends on how much access, in general, you have
2 in your area.

3 CO-CHAIR BRISS: So generally speaking,
4 panels wear out as the day goes on. You guys are
5 getting more riled up as the day goes on. Shane,
6 were you --

7 (Laughter)

8 CO-CHAIR BRISS: Shane, were you trying
9 to get in?

10 MEMBER COLEMAN: No, I'm --

11 CO-CHAIR BRISS: Les, you're next.

12 MEMBER ZUN: I'm really concerned that
13 we're giving the wrong message here. If 50
14 percent of psychiatric patients have a medical
15 illness, and between 20 and 80 percent have a
16 substance use disorder as well, and we're sending
17 them back just to a mental health professional, I
18 think that's the wrong message.

19 I really think we -- and your issue
20 about integrative health is much more important.
21 I don't know if I can say any philosophical or
22 ethical kind of comments here today, but I think

1 this is -- you know, although I don't have a
2 problem with the measure and what we're trying to
3 do, but we're going in the wrong direction here.
4 As a national organization that's trying to be on
5 the forefront of quality, this is not where we
6 need to be.

7 Okay, I'm off my soapbox. Thank you.

8 MEMBER ROBINSON BEALE: Okay, last
9 statements, you need to include substance use
10 disorders in this. I'm not sure why that's
11 continued to be excluded. That's a huge part, and
12 it's also an area that is exceptionally important
13 that you have follow-up.

14 FEMALE PARTICIPANT: Besides, it's a
15 mental illness.

16 MEMBER ROBINSON BEALE: And it's a
17 mental illness, according to S05.

18 (Laughter)

19 MEMBER ROBINSON BEALE: Maybe. But the
20 last point is this measure would be far more
21 effective if you also had a composite measure that
22 measured engagement post-discharge. Someone who's

1 been in the hospital is going to need to be seen
2 more than once and probably three times in the
3 next 30 days or so.

4 So a composite measure will help stop
5 the gaming of the same appointment, the same-day
6 appointment by the hospital. Because a person is
7 going to have to see the next level of provider
8 and demonstrate some engagement.

9 CO-CHAIR BRISS: So, Mike, I'm going to
10 give you the last word before we vote this
11 criteria.

12 MEMBER LARDIERI: Okay. I was going to
13 echo what Les was saying, because there's a lot of
14 that going on out there where the plans will pay
15 just for someone to meet the patient in the
16 community someplace for a visit to get their
17 seven-day visit. And then they shuffle them off
18 to who their real provider is. And they may not
19 get to that provider for awhile. So they met that
20 30-day.

21 And then I have the same comment on the
22 video conferencing. I'm all for video

1 conferencing. But if you're going to approve it,
2 you need to get the plans to pay for it and work
3 it out in the states so that in the Medicaid plans
4 -- so that you can actually do it and get paid for
5 it. Because that's not happening now across the
6 states. It's not a code, the codes are there.
7 It's state laws and some plans are not paying for
8 it.

9 CO-CHAIR BRISS: So Bonnie wants to
10 edit me and get the actual last word.

11 MEMBER ZIMA: Sorry, last minute. But,
12 yes, I'm a little concerned because of the
13 severity of the illness of the patients that are
14 being hospitalized for mental illness and the
15 breadth of the mental health providers spanning
16 people that aren't able to prescribe.

17 I would anticipate that a substantial
18 proportion of the patients being discharged are
19 going to be on some type of psychotropic
20 medication. And so somebody could pass and get a
21 counselor, which is good, but a big reason for re-
22 admission is that they're not compliant with their

1 medication.

2 DR. BURSTIN: This has been an
3 incredibly interesting discussion. It's gone way
4 beyond evidence. So I get it. And you'll have,
5 you know, if you continue it, other opportunities
6 to bring that in and other points along validity,
7 or usefulness of the measure, or feasibility. But
8 again, this is truly just about did they provide
9 sufficient evidence for the measure focus. I just
10 want to keep us back oriented to the task at hand.

11 CO-CHAIR BRISS: So with that, yes?

12 MEMBER ZIMA: Just for clarification,
13 so our mental health participant is being defined
14 as a psychiatrist, a psychologist, a social
15 worker, not the primary care provider, if that's
16 who's been the continuous provider for that
17 patient?

18 DR. BURSTIN: It specifies mental
19 health provider also include social worker,
20 registered nurse, marriage and family counselor,
21 professional counselor.

22 DR. LIU: Yes, that's the definition.

1 It does not include primary care physicians.

2 MEMBER MAZON JEFFERS: Like you said,
3 you're going to be reconsidering video contact,
4 and you're looking at some other updates to the
5 measure. Is this a consideration for -- are you
6 considering updating the measure with a new
7 definition of provider, community provider?

8 DR. BARTON: I'll say the most
9 immediate changes are to the codes for telehealth,
10 and types of telehealth, and the same-day visit
11 exclusion. The question of the provider, the way
12 that we specify who the person should meet with,
13 is a longer term question that we're continuing to
14 engage with our panels.

15 I think, you know, Bonnie's raised the
16 point that the very sick population who are
17 discharged from mental health hospitalizations,
18 and our advisory panels have continued to hue to
19 the sense that it should be a mental health
20 professional, maybe not a prescribing professional
21 but at least a mental health professional who can
22 understand the reason why they were hospitalized

1 the issues that are likely to come up as a result
2 of their discharge.

3 And so that's, really, the advice that
4 we've taken in terms of specifying this as being
5 a visit with a mental health professional.

6 CO-CHAIR BRISS: So I'd like to move us
7 to the vote. And is there -- so now we're talking
8 about the evidence for the measure concept, as
9 it's currently written.

10 MS. QUINNONEZ: We are now voting on
11 Measure 0576, Follow-up After Hospitalization for
12 Mental Illness. We are voting on the evidence.
13 Option Number 1, moderate, Option Number 2, low,
14 Option Number 3, insufficient.

15 Thank you. All votes are in. The
16 voting is now closed. For the evidence of Measure
17 0576, 75 percent voted moderate, 15 individual
18 votes, 20 percent voted low, four individual
19 votes, and five percent voted insufficient, one
20 individual vote. So for evidence of Measure 0576,
21 this passes the first criteria.

22 CO-CHAIR BRISS: Anybody want to

1 comment on gap in care?

2 MEMBER COLEMAN: I'm happy to keep us
3 moving. You know, it suggests basically that
4 there is a gap in, you know, looking at coverage
5 for Medicaid and Medicare to commercial coverage.
6 The average rates basically, like, with this
7 measure, where anywhere from 30 to 50ish percent,
8 90th quartile went from -- or looking at ten to
9 90th, you're looking at anywhere from, you know,
10 30s to 80s as far as one of the largest spans, it
11 looks like.

12 And then there's, you know, there were
13 remarked to be differences, you know, disparities
14 among the usual things, such as age, SCS, I think
15 we said, social functioning, minority status, et
16 cetera.

17 CO-CHAIR BRISS: And for the record,
18 there is not such a thing as -- there are, like,
19 four quartiles. There's not such a thing a the
20 90th quartile. I think there is a 90th percentile.

21 All right. So anybody else want to
22 comment on gap? Yes?

1 MEMBER MAZON JEFFERS: I just had one
2 question for the gap. Do you do analysis to see
3 if there's a difference between rural and suburban
4 areas or inner city?

5 And it goes back to the conversation we
6 had earlier identifying other individuals that
7 could possibly help with the health plan being
8 responsible. We really are trying to find other
9 ways to help our providers, especially in the
10 areas where they can't reach. And so it may be
11 even telemedicine might not be an option. Because
12 we have patients that just don't even have a
13 computer, you know, in the home and things like
14 that.

15 So could a health plan behavioral
16 health person help satisfy, and connect to that,
17 and do things? So just to think about it from a
18 different perspective.

19 CO-CHAIR BRISS: So, Bonnie, were you
20 trying to get back in on this point, or is your
21 card -- okay. So it looks to me like we can vote
22 on performance gap.

1 MS. QUINNONEZ: Voting is now open for
2 performance gap of Measure 0576. Option 1, high,
3 Option 2, moderate, Option 3, low, and Option 4,
4 insufficient.

5 Thank you. All votes are in. For the
6 performance gap of Measure 0576, 40 percent voted
7 high, eight individual votes, 60 percent voted
8 moderate, 12 individual votes, zero percent voted
9 for low, and zero percent voted for insufficient.
10 For performance gap of Measure 0576, this passes
11 the performance gap criteria.

12 CO-CHAIR BRISS: So on the reliability
13 front, I think we've talked about the details of
14 the specifications in some detail already. So
15 let's not re-litigate a lot of the specs
16 discussion that we've already had. Would anybody
17 like to tee up the reliability testing or new
18 things about specs that we haven't talked about
19 already?

20 (No audible response)

21 CO-CHAIR BRISS: Are we ready to vote?

22 MS. QUINNONEZ: Voting is now open for

1 the reliability of Measure 0576. Option 1, high,
2 Option 2, moderate, Option 3, low, and Option 4,
3 insufficient.

4 Thank you. Voting is now closed. For
5 the reliability of Measure 0576 we have 30 percent
6 voted high, six individual votes, 55 percent voted
7 moderate, 11 individual votes, 15 percent voted
8 low, three individual votes, and zero percent for
9 insufficient. For reliability of Measure 0576,
10 this passes this criteria.

11 CO-CHAIR BRISS: So that takes us to
12 validity. Anybody have additional comments that
13 haven't been made? Bonnie?

14 MEMBER ZIMA: Just to give -- face
15 validity is based on the NCQA measure life cycle.
16 And advisory panel's meaningful difference is
17 determined by statistical differences between the
18 25th and 75th percentile ranking.

19 CO-CHAIR BRISS: David? David?

20 MEMBER EINZIG: So this is just going
21 back to defining mental health providers. So
22 places that have collaborative care models, the

1 first question is if the psychiatrist gives advice
2 to the pediatrician, but that's not accounted for
3 in the billing or captured in some way, that
4 person will get dinged. So that's Question Number
5 1.

6 And then Question Number 2, for
7 pediatricians or folks in primary care who get
8 extra training in mental health, their pediatric
9 portals -- I don't remember what it's called --
10 but there's extra training that people can get for
11 a year to get more mental health expertise or
12 ongoing six-month with follow-ups with a child
13 psychiatrist or a mental health professional.
14 Will those folks be counted, or do they get
15 captured in some way?

16 DR. LIU: So the provider type, I
17 understand we have a recovery care model is that
18 the primary care and then the psychiatrist or the
19 mental health providers, they can both bill the
20 services. So therefore, that service will come
21 through our measure if one of the mental health
22 providers' service is captured.

1 The other part about the pediatricians
2 who have extra training about mental health, I
3 think that's moving in the right direction.
4 Because there is a shortage of mental health
5 providers, especially child psychiatrists.

6 So we -- our measure, we can see how
7 much advantage, and research is demonstrating, and
8 how the states' definitions of the mental health
9 providers will evolve. We will definitely want to
10 make sure our measures keep pace with those
11 developments.

12 CO-CHAIR BRISS: So, Dave --

13 DR. BARTON: I would just add to that
14 that the additional training for pediatricians is
15 absolutely in the spirit of our list of providers
16 that are accepted. And so that's, you know, I
17 think -- and what Junqing said is absolutely
18 right. So we need to work on figuring out how we
19 can word things in order to make sure that we're
20 sorting the right people in.

21 But to your first question, I think,
22 really, the truth of the matter is that claims

1 data is certain on the one hand, because everybody
2 wants to get paid for the thing that they do, but
3 on the other hand, practice is moving very fast in
4 ways that suggest that claims data is not going to
5 be the best way to determine the truth.

6 And we're very actively working on
7 measures, including a set that is not coming to
8 this panel, about monitoring for depression, that
9 use electronic clinical data that is completely
10 unrelated to claims. And I think that that's among
11 the ways in which the future is going to look.

12 CO-CHAIR BRISS: David, Michael, Shane.

13 MEMBER PATING: I would just like to,
14 again, reiterate that the expansion of the type of
15 providers that can be providing services with
16 behavioral health homes and medical homes, I think
17 the likelihood of primary care providers being the
18 medicater or the point of contact is very
19 significant, as well as in many states Medicaid
20 only allows one visit type per day.

21 So you're either going to see your
22 internist, or you're going to see your therapist.

1 And if I have a heart failure, I am going to see
2 my internist. And it's not going to fall in. So
3 it should really be any provider, any contact with
4 anyone can improve the initiation and engagement,
5 including unlicensed substance abuse counselors.

6 CO-CHAIR BRISS: Michael, Shane

7 MEMBER TRANGLE: My comments are along
8 the same lines in that there's great variability
9 in terms of whether PAs are covered by health
10 plans. And there are collaborative care codes.
11 I don't know when they take effect. But I don't
12 think they specify which patients are talked
13 about, you know, so that I could, whenever it
14 takes effect, I could say I had a discussion with
15 primary care, but you won't know what patient it's
16 about, you know.

17 So I think ultimately you're looking at
18 EMRs and trying to figure out -- it would be in
19 the chart in the progress note that talked to Dr.
20 Trangle about so-and-so. So I think that's a good
21 way to go.

22 CO-CHAIR BRISS: So it's pretty clear

1 at this point, I think, that we've established
2 that there are -- there's an ever-broadening range
3 of providers that you guys might consider. So,
4 Shane, I'll give you what I think will be the last
5 word on this one.

6 MEMBER COLEMAN: Yes. So I guess I'll
7 keep it short. The care codes, they came back in
8 January, they tie in to the PCP visit. But you
9 can find, like, a G-code that says the
10 psychiatrist was consulted.

11 States haven't activated the Net, but
12 they exist in seamless code. So definitely
13 there's a -- and then otherwise, I'll just -- I
14 want to give a little bit of what we call impose
15 in my organization.

16 And I totally agree with the spirit of
17 everything everybody's saying. But if we have any
18 primary care docs here, I think we have, like,
19 one, right, maybe? Yes. They freak out sometimes
20 if you send schizophrenics to them out of the
21 hospital unsupported.

22 We're in a really innovated system. So

1 I just want to say, yes, I actually agree. I
2 totally agree with the spirit. And, I don't know,
3 just be aware that, you know, you start to be a
4 little bit -- when folks have severe and
5 persistent mental illness, you absolutely freak
6 primary care out if you start, you know,
7 discharging them out of a psychiatric hospital
8 straight to primary care without any sort of help.

9 CO-CHAIR BRISS: So it looks like all
10 the cards are down. I'd like to try to vote
11 validity please.

12 MS. QUINNONEZ: We are now voting on
13 validity of Measure 0576. Option 1, moderate,
14 Option 2, low, Option 3, insufficient.

15 All votes are in, voting is now closed.
16 For the validity of Measure 0576, 63 percent voted
17 moderate, 12 individual votes, 37 percent voted,
18 low, seven individual votes, zero percent voted
19 insufficient. So for Measure 0576, validity, this
20 passes the validity criteria.

21 CO-CHAIR BRISS: So that takes us to
22 feasibility. Anybody want to tee this up? This

1 --

2 (Laughter)

3 CO-CHAIR BRISS: Yes, this one's
4 already in play, right. It seems feasible.
5 Anybody want to comment on it further before we
6 vote? Let's hear it please.

7 MEMBER KELLEHER: Oh, okay.

8 CO-CHAIR BRISS: Oh, sorry. Did I jump
9 the gun?

10 MEMBER KELLEHER: I just wanted to say
11 that, being from one of the nine states where the
12 behavioral health system is entirely not
13 integrated with the physical health system, it is
14 still challenging in many places to have someone
15 discharged from a hospital setting and caught in
16 the community, and to have those data systems talk
17 to each other sufficiently to gather this measure.

18 CO-CHAIR BRISS: Anybody else have
19 comments?

20 (No audible response)

21 CO-CHAIR BRISS: And if not, let's vote
22 feasibility please.

1 MS. QUINNONEZ: Voting is now open for
2 feasibility of Measure 0576. Option Number 1,
3 high, Option Number 2, moderate, Option Number 3,
4 low, and Option Number 4, insufficient.

5 All votes are in. And voting is now
6 closed. The voting for feasibility of Measure
7 0576, 30 percent voted high, six individual votes,
8 60 percent voted moderate, 12 individual votes,
9 ten percent voted low, two individual votes, and
10 zero percent voted for insufficient. So for the
11 feasibility of Measure 0576, this passes the
12 criteria.

13 CO-CHAIR BRISS: So that moves us to
14 usability and use. It's used in a variety of
15 places. Anybody have additional comments that
16 they'd like to make?

17 (No audible response)

18 MS. QUINNONEZ: Voting is now open for
19 usability and use of Measure 0576. Option Number
20 1, high, Option Number 2, moderate, Option Number
21 3, low, Option Number 4, insufficient information.

22 Voting is now closed. For usability

1 and use of Measure 0576, 32 percent voted high,
2 six individual votes, 53 percent voted moderate,
3 ten individual votes, 16 percent voted low, three
4 individual votes, and zero percent voted for
5 insufficient information. For usability and use
6 of Measure 0576, this passes this criteria.

7 CO-CHAIR BRISS: So with that, overall
8 suitability. Anybody want to make closing
9 arguments before we do the final vote? Hearing
10 none -- I'm sorry, Rhonda.

11 MEMBER ROBINSON BEALE: We're voting on
12 this based on how it is right now, not the planned
13 changes that NCQA will be making, is that correct?

14 CO-CHAIR BRISS: Yes.

15 DR. BURSTIN: Although they did
16 indicate several changes they were willing to make
17 by annual update, I think, as you heard. So I
18 think, you know, you could factor that in. But we
19 are voting on the measure as it is now.

20 CO-CHAIR BRISS: Yes. We're always
21 voting on the measure as it stands. So with that,
22 yes or no?

1 MS. QUINNONEZ: If there are no more
2 comments, we'll be voting on overall suitability
3 for endorsement of Measure 0576. Option Number,
4 yes, Option Number 2 is no.

5 Voting is now closed. For the overall
6 suitability for endorsement of Measure 0576, 80
7 percent voted yes, 16 individual votes, and 20
8 percent voted no, four individual votes for the
9 overall suitability for endorsement.
10 Recommendation, this passes.

11 CO-CHAIR BRISS: So thanks to NCQA for
12 hanging with us as we discuss the rapidly evolving
13 landscape of behavioral health integration and how
14 you communicate with patients.

15 (Off microphone comments)

16 CO-CHAIR BRISS: Not today. It's too
17 late to talk about measure harmonization today.
18 We can table it until tomorrow. If you we need
19 public comment --

20 DR. LUSTIG: We do need public --

21 CO-CHAIR BRISS: So really, would any
22 of you long-suffering people in the back like to

1 make you public comments? Would anybody from the
2 phone like to make a comment?

3 OPERATOR: If you'd like to make a
4 public comment, please press star one. Press star
5 one to make a public comment. And there are no
6 public comments.

7 CO-CHAIR BRISS: So thanks to everybody
8 for hanging with us. This was quite a day.

9 DR. LUSTIG: For the committee members
10 that are coming to dinner with us, it's really
11 just down the street. So for anyone who's joining
12 the dinner, it's literally down the street from
13 here, so five minute or less walk. It's called
14 Siroc, S-I-R-O-C. And everyone should have a --
15 the committee members, you should have a menu and
16 address in your folder, actually.

17 I promise you tomorrow will be easier.
18 And we start, I think it's at 8:30. And if you
19 guys beat us there, the reservation's under
20 National Quality Forum.

21 (Whereupon, the above-entitled matter
22 went off the record at 5:53 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Behavioral Health Standing Committee

Before: NQF

Date: 02-28-17

Place: Washington, DC

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NATIONAL QUALITY FORUM

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BEHAVIORAL HEALTH STANDING COMMITTEE

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WEDNESDAY
MARCH 1, 2017

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The Standing Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:40 a.m., Peter Briss and Harold Pincus, Co-Chairs, presiding.

PRESENT:

PETER BRISS, MD, MPH, Co-Chair
HAROLD PINCUS, MD, Co-Chair
MADY CHALK, PhD, MSW, Treatment Research
Institute
SHANE COLEMAN, MD, MPH, Behavioral Health
Division Southcentral Foundation
DAVID EINZIG, MD, Children's Hospital and Clinics
of Minnesota
CHARLIE GROSS, PhD, Anthem, Inc.
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FNAP, FAAN, Ohio State University*

BROOKE PARISH, MD, Blue Cross Blue Shield of New Mexico
DAVID PATING, MD, Kaiser Permanente
VANITA PINDOLIA, PharmD, Henry Ford Health System (HFHS)/Health Alliance Plan (HAP)
RHONDA ROBINSON BEALE, MD, Blue Cross of Idaho
LISA SHEA, MD, DFAPA, Butler Hospital, Care New England Health System
ANDREW SPERLING, JD, National Alliance on Mental Illness
MICHAEL TRANGLE, MD, HealthPartners Medical Group
BONNIE ZIMA, MD, MPH, UCLA Semel Institute for Neuroscience and Human Behavior
LESLIE ZUN, MD, MBA, Sinai Health System

NQF STAFF:

KAREN JOHNSON, Senior Director
TRACY LUSTIG, DPM, MPH, Senior Director
ELISA MUNTHALI, MPH, Vice President, Quality Measurement
ERIN O'ROURKE, Senior Director
DESMIRRA QUINNONEZ, Project Analyst
KIRSTEN REED, Project Manager

ALSO PRESENT:

PAUL CLEARY, PhD, Yale School of Public Health*
SOEREN MATTKE, Dsc, MPH, MD, RAND Corporation
ELIZABETH SLOSS, PhD, RAND Corporation
KATE WATKINS, MD, MSHS, RAND Corporation*

* present by teleconference

A-G-E-N-D-A

Welcome, Recap of Day 1 4

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

8:40 a.m.

CO-CHAIR BRISS: So maybe I will start.

Welcome back. Thank you all for coming back after all the punishment yesterday. We got through a lot of measures yesterday. So we finished ten of them, several of them hard, and approved seven out of ten and still got out in time for dinner. So congratulations.

Today looks like an easier day. We will try to successfully get through our three today and have some additional time to discuss. It is kind of -- we should have some time to discuss what the portfolio looks like as a whole in the afternoon today. So, that should be kind of an interesting discussion that we don't always get to have. So, I have no further preamble.

Harold?

CO-CHAIR PINCUS: Just I think it is important to emphasize that discussion because part of our role is getting kind of a guidance to the field about what sort of measures are needed,

1 how have measures evolved, what are the sort of
2 expectations for measures that get submitted in
3 the future. And I think certainly that
4 discussion will be informed by our discussions
5 yesterday in terms of what were the criteria we
6 really thought about in terms of looking at the
7 measures that were approved and those that were
8 not. And so we are the evolving sort of state-
9 of-the-art of measurement in this area is going.

10 So, start thinking about that and sort
11 of jotting down ideas. And we will be able to
12 look at some of the alignment issues, like
13 especially for example tobacco, where we had some
14 discussions yesterday about the varying types of
15 measures that are applied in different context
16 and how to sort of make them more aligned.

17 Any questions? Mike.

18 MEMBER LARDIERI: Could we talk or maybe
19 have someone explain a little better the
20 economics of measures? Because a lot the
21 developers, some of them do them because like CMS
22 they want to do them because they need to do them

1 to move things forward but some of the other
2 measure developers, don't they get paid for this?
3 What I read in going through some of the
4 materials and I knew it but it never really
5 dawned on me that when they develop a measure,
6 they are going to push it to an EHR, that EHR
7 vendor needs to pay them a license in order to
8 access it. So, I am wondering if that has
9 something to do with why we have so many
10 different measures that are like with tobacco.
11 They are doing the same thing, different
12 developers doing a little different something but
13 then everybody pays downstream. And I don't know
14 if I am right or wrong on that but I would like
15 to know the economics of it a little better.

16 CO-CHAIR PINCUS: Okay, so you are
17 talking about both the economics of how measures
18 get developed and the economics of how measures
19 get implemented?

20 MEMBER LARDIERI: And how they get --
21 who pays for that. Because as a provider, I'm
22 paying for it at some level. If a measure

1 developer is charging an EHR company a licensing
2 fee, that licensing fee is passed down to me. So
3 that area of how it works.

4 CO-CHAIR PINCUS: Okay. Mady.

5 MEMBER CHALK: Yes, the other part of
6 that, which is bedeviling, some organizations
7 that are not sending measures forward, despite
8 our best efforts, is the whole cost of stewarding
9 a measure. It is quite costly but essential.
10 Otherwise, measures can't be brought forward.

11 But there are several organizations that
12 I am talking to about bringing measures forward
13 that simply can't do it. And there is no obvious
14 source of funds for that and the cost is
15 substantial.

16 So maybe when you --

17 CO-CHAIR PINCUS: No, I think that is an
18 important issue in terms of as we identify gaps,
19 how exactly do those gaps get filled in a
20 practical way.

21 MEMBER CHALK: I was hoping that at some
22 point in our open time of discussion we could

1 begin talking about the whole question of
2 proximal outcome measures and what happened with
3 the tobacco measure yesterday. That is a
4 proximal outcome measure but couldn't get through
5 for specification issues.

6 There are lots of instruments that are
7 being used standardly in the field, both in
8 mental health and addictions treatment and that
9 could yield proximal outcomes. The ASI -- well
10 PDQ-9 we know about and the ASAM criteria, those
11 are not coming forward and there is a reason --
12 because they don't think they can get through.
13 And I am hoping we can at least talk about what
14 it is going to take to get those to change that
15 view, I guess, of the NQF process and think
16 through how we can encourage those kinds of
17 measures.

18 MEMBER GROSS: The second and third Mike
19 and Mandy's point and I think it is another facet
20 of the same issue, maybe at some point we can
21 discuss what is NQF's role, what position do they
22 want to take relative to being the thought leader

1 with regard to multiple measures and narrowing
2 around proximal outcomes and also encouraging
3 potentially new ones because I think there is a
4 real opportunity. There are so many measures out
5 there that are costly. The costs go somewhere.
6 So people are either paying multiple times for
7 similar measures or choose not to do any of them.
8 So I think there is an opportunity for some
9 organization to be the leader in this area. And
10 I wonder NQF's role in that. So, maybe we can
11 have a fruitful discussion about that sort of
12 thing.

13 CO-CHAIR PINCUS: So, I don't know. Is
14 Shantanu or Helen going to be here later?

15 MS. MUNTHALI: Helen will not. I'm not
16 sure about Shantanu. But with regards to what
17 Mady was saying and I think everyone else around
18 the table, measure development is very costly.
19 So by the time measures come to us, it really is
20 too late. There has been quite a bit of
21 investment that has been made in putting these
22 measures together. So our focus and priority has

1 been on how we can affect the upstream.

2 What you will be doing in terms of
3 identifying the right gaps, the right measures
4 will help us to communicate that to developers
5 through our Measure Incubator and developers that
6 come to us.

7 But then, as Mady said, our process is
8 another challenge. We do have a scientific
9 rigorous process. We are hoping, again, that we
10 can get to measure developers through technical
11 assistance. This is something that, in the last
12 year or two, we have been pushing to hear from
13 measure developers earlier than we have because
14 we do know, when they are around the table, they
15 haven't really gotten the input that they need to
16 be more successful through our process. But I
17 think we can talk about it a little further when
18 we talk about gaps.

19 CO-CHAIR PINCUS: Yes, I think it would
20 be good to give a little bit of an update to
21 people about the Measure Incubator and how that
22 works or how it has been working and what the

1 plans are for that.

2 Mike?

3 MEMBER TRANGLE: Two years ago as part
4 of his plenary at IHI, Institute for Healthcare
5 Improvement, it was two or maybe three years ago,
6 Don Berwick's keynote speech talked about how
7 there were too many measures and how we need to
8 sort of figure out how to simplify and reduce the
9 number.

10 And I think if we are thinking about the
11 role of NQF, I don't see an equal emphasis on how
12 do we synthesize three measures down into one.
13 How do we sort of like -- you know, it is all
14 about new ones coming up and then when they
15 happen to come up again, you talk about them and
16 we sort, in a half-assed -- excuse my language --
17 fashion, without that much time or real scrutiny
18 or effort to talk about harmony. But I don't
19 think we really harmonize. We just talk about
20 it.

21 We probably need to have equal effort
22 and equal pre-work about synthesizing measures as

1 we do in creating new ones.

2 CO-CHAIR PINCUS: I'm a little bit
3 worried about having the discussion we are going
4 to have later now. Because I think when we look
5 at what is -- and I think the discussion of the
6 three, the two and a half measures this morning
7 will also I think add to the discussion later on
8 because they bring up exactly some of the issues
9 that you guys are talking about.

10 CO-CHAIR BRISS: And clearly, we will
11 have to think about the agenda because it is
12 clear that nobody is going to have anything to
13 say about the portfolio overall. It is kind of
14 disappointing but we will try to do the best we
15 can this afternoon.

16 CO-CHAIR PINCUS: But any -- Rhonda and
17 Tami.

18 MEMBER ROBINSON BEALE: I shouldn't bite
19 into a bagel.

20 I just want to bring up an issue I think
21 is parallel to what has just been discussed and
22 that is I know that there is a lot of easier

1 measure development when we are looking at
2 structure and process. Outcomes is a whole
3 different story.

4 In behavioral health, probably even more
5 so than other fields, there is a tremendous need
6 for outcomes and being able to measure the
7 outcomes.

8 I know there has been attempts in the
9 past to bring forward a measure that is a
10 technique that is used to determine whether or
11 not treatment has been effective. And that is
12 looking at the effect size. It is looking at the
13 amount of change that has occurred over a period
14 of time. It doesn't fit into a nice denominator
15 and numerator type format but it has a lot of
16 validity in terms of really being able to
17 determine whether or not there has been an effect
18 based on the intervention and it is a methodology
19 that can be used across many different types of
20 outcome measures.

21 And I guess when Mady was talking about
22 the fear of coming back again, when I talk to

1 those who are in this type of -- doing this type
2 of work, they don't even think about the NQF
3 because they feel as though they are not, this
4 format is not going to be accepted. And I am
5 wondering if times have changed now because I
6 think the last time was about six years ago,
7 whether or not thinking has changed or whether or
8 not there is more thought around this type of
9 approach.

10 CO-CHAIR PINCUS: So, let's move ahead
11 with the discussion of -- now it is not actually
12 -- we are not considering this as for endorsement
13 but as something that we want to have some
14 discussion about. And, hopefully, it will also
15 pertain to our discussion later because this is a
16 perception of care, a kind of an outcomes sort of
17 measure that has come up for maintenance. And
18 also one of the issues is is that there has been
19 little attention to this in terms of new
20 information about its use. It is a much older
21 measure.

22 Is Paul Cleary on the phone?

1 Are we connected to the phone? How do
2 you call the operator?

3 MS. REED: Operator, is Paul's line
4 currently open? Because he is saying that he can
5 hear us but we are not able to hear him.

6 OPERATOR: Yes, his line is open.

7 DR. CLEARY: Hello? Operator?
8 Operator, can you hear me?

9 OPERATOR: Yes.

10 MS. REED: We can hear you.

11 DR. CLEARY: Can you tell the committee
12 that you can hear me?

13 CO-CHAIR PINCUS: Yes. Hi, Paul, this
14 is Harold Pincus. We can hear you.

15 DR. CLEARY: Oh, okay, great. Hi,
16 Harold. Hi, Peter. Hi, committee members.

17 CO-CHAIR PINCUS: Good. So we are just
18 starting a discussion about the ECHO measure.
19 And as I think Helen spoke with you earlier, and
20 said that because there is so little further
21 information on it, that it is difficult for us to
22 formally consider this for endorsement but it is

1 something that we want -- because of the
2 importance of perceptions of patients is so
3 important, we wanted to get an understanding of
4 where this measure stands in terms of its
5 updating, in terms of its use, in terms of what
6 additional data there is with regard to both this
7 measure specifically and how it fits in with any
8 measures that might be in development.

9 DR. CLEARY: Okay, do you want a three-
10 minute summary and then I will open it up to
11 questions?

12 CO-CHAIR PINCUS: Sure.

13 DR. CLEARY: Okay, so the first point I
14 will make, this may be obvious to everyone, but
15 perhaps not, it is part of what call the CAHPS
16 family. And CAHPS stands for Consumer
17 Assessments of Healthcare Providers and Systems,
18 so a group of surveys that are stewarded by AHRQ
19 to basically assess patients' experiences with
20 care.

21 As someone alluded, I think Peter
22 mentioned quite a while ago, it was back in the

1 late '90s, actually, Ken Manderscheid as SAMHSA
2 came to us and was very interested in expanding
3 to behavior health and there was a tremendous
4 amount of interest in the field in general. And
5 at the time, a survey called MHSIP, which
6 actually is still used, was the most widely used
7 one. There was some questions about it whether
8 it was the best survey and/or could we have a
9 measure that was part of the CAHPS family. A
10 detailed -- there was quite an elaborate process
11 with different professional and advocacy groups
12 to try and take the best of the MHSIP and some
13 current CAHPS surveys. And we came up with ECHO
14 to be sort of politically neutral but it is
15 really a CAHPS survey.

16 And regarding the recent discussion I
17 just heard, I consider CAHPS measures process
18 measures; that is, what did or did not happen
19 when you saw your behavioral health specialist.

20 During the development process, there
21 was a tremendous amount of interest in and really
22 quite adamant support for some assessment of

1 outcomes. Now, there is no delusion that this is
2 an outcomes measure but there are some measures
3 in there about perception of improvement. I was
4 not in favor of those because I don't think this
5 kind of measure is the best way. You know there
6 are symptom scales for depression and anxiety and
7 so on and those are probably better quote,
8 unquote outcome measures but we did include some
9 measures that have to do with perception of
10 benefits from treatment. And I was finally
11 convinced that those were reasonable because in
12 behavioral health, ones perception of whether one
13 was helped had some validity. So that is why it
14 is a little bit of a hybrid and why it has the
15 new name ECHO.

16 So, it is not really an outcomes measure
17 but it is what I would call a process measure.
18 It is part of the CAHPS family.

19 One, talking about stewardship, so the
20 CAHPS Consortium Stewards Survey, all CAHPS
21 surveys, we spent an enormous amount of time
22 revising, updating, testing and so on. And as

1 people have alluded, there hadn't been --

2 Oh, and the other thing that has been
3 done by AHRQ is there is a CAHPS database. So
4 people can voluntarily submit health plan CAHPS
5 or group clinician CAHPS and of course, CMS has
6 HCAHPS nationally. So, in those surveys, even
7 though the CAHPS Consortium is not a data
8 collector, we are an instrument development team
9 -- and by the way, all the instruments are --
10 everything about the instruments is in the public
11 domain. We don't get any financial remuneration
12 when they are used, of course.

13 So with those instruments, it is
14 relatively easy to pull data from the CAHPS
15 database or from the CMS data and to do the types
16 of analysis I think you would like to have seen
17 this morning, such as the variation across
18 providers or the average scores, or increases in
19 scores of these particular instruments. We don't
20 really have that just because it was never part
21 of the database. What we did for the application
22 is we do get routinely downloads of the

1 instrument and request for information about the
2 instrument. So that is really about the best I
3 could provide to you in terms of use. And I just
4 --

5 CO-CHAIR PINCUS: Paul, can you say who
6 the we is, a little bit more about the we?

7 DR. CLEARY: I'm trying to remember when
8 I said we. I am a principle investigator of one
9 of two teams which are cooperative agreements
10 with AHRQ Ron Hays directs. Ron Hays, Marc
11 Elliott, and I and Susan Edgman-Levitan direct
12 another. So I am at Yale. Ron and Marc are at
13 UCLA. We are the sort of CAHPS Development
14 Teams.

15 And when I say the consortium, that
16 includes AHRQ. Caren Ginsberg is our Project
17 Officer and we do a lot of work with CMS. So,
18 for example, a lot of the HCAHPS development was
19 developed with CMS. We are developing ACO CAHPS
20 and so on.

21 Is that what you were asking?

22 CO-CHAIR PINCUS: Yes, just to get a

1 sense of who owns the ECHO.

2 DR. CLEARY: Oh, I see. Well actually
3 AHRQ owns -- AHRQ has the trademark to all the
4 CAHPS instruments, to the word CAHPS. And at the
5 time when Chuck Darby was still alive, we
6 actually got the word ECHO trademarked.

7 Let me just fast forward because one of
8 your questions in the introduction was what are
9 we doing. There has actually been a resurgence
10 of interest. And we submitted for maintenance,
11 just because our maintenance cycle is up, to be
12 quite honest. But I would say over the last year
13 or so we have been getting increasing interest in
14 using the instrument. We have done some
15 cognitive testing, some focus groups. We are
16 about to field test a subset of items in the
17 State of Connecticut. And we actually, if we get
18 the funding, are proposing a major revamping or
19 updating of the ECHO and we will probably called
20 it Mental Health CAHPS.

21 And in the process of doing it, I cited
22 a number of studies. So when we developed it, we

1 did some fairly large studies with different
2 partners, both providers and professional
3 organizations, and then haven't done much of that
4 in the past. For example, Massachusetts General
5 Hospital is going to be using an updated version
6 that we developed on a PCORI project but I just
7 don't have much new information now. So that is
8 like sort of the 30,000-foot overview. But let
9 me stop and see what you would like more
10 information about or how I can be helpful.

11 CO-CHAIR BRISS: Paul, this is Peter.
12 Can you give us a little bit more about you just
13 said that there is increasing interest in using.
14 And so can you give us a little bit more detail
15 about what kinds of people or organizations are
16 showing the interest and how they would like to
17 make use of the data or results?

18 CO-CHAIR PINCUS: And also, when you
19 said you are beginning to do some additional
20 studies, is that with funding from CMS or from
21 AHRQ? What is their intent in terms of this will
22 impact on ultimately its application?

1 DR. CLEARY: Okay, so two questions.
2 So, as I mentioned, the PCORI Group at Mass
3 General Hospital is doing a large study. I
4 believe it is on the treatment of depression.
5 They were interested on the perception of care.

6 When we developed the instrument, many
7 of the users were Medicaid state programs. So
8 for example, the State of New York was using it
9 for a while and some other states have used it.
10 Some insurers are interested in using it. We
11 just had a call this week with three of the major
12 health insurers, Anthem, United, and ConnectiCare
13 in Connecticut of possibly doing a survey. The
14 State of Connecticut has approached me reviewing
15 a state innovation model evaluation for CMMI
16 there. One of the priorities of the advisory
17 groups is trying to get a pulse of how well we
18 are doing with mental health treatment.

19 So for example, we are fielding a
20 statewide CAHPS survey but we are including a
21 subset of ECHO items in that, starting to get a
22 sense of that. And I am going to propose with

1 either the insurers or the State Medicaid offices
2 a large survey.

3 We also are doing a big study with
4 community health centers, 12 community health
5 centers in Connecticut and they have expressed an
6 interest in assessing the behavioral health
7 services. They have a very integrated -- they
8 are an FHQC. They have a very integrated model.
9 They are very interested in assessing the quality
10 of their care.

11 Regarding the second question, the AHRQ.
12 So I have a cooperative agreement with AHRQ. We
13 do a whole range of things related to CAHPS. And
14 one of those things, as I said, we have started
15 doing are like focus groups and cognitive -- we
16 have done I think like four rounds of cognitive
17 testing. And that is paid for by the cooperative
18 agreement. And on this year's budget we have
19 proposed a major revision and field testing of
20 what we think will probably be called the Mental
21 Health CAHPS.

22 CO-CHAIR PINCUS: So a number of people

1 have sort of raised their cars around the table.

2 So, Vanita?

3 CO-CHAIR BRISS: So, again, for this
4 one, we are not trying to approve a measure the
5 way we were doing yesterday or the way we will do
6 for the last two today. We are trying to have a
7 conversation and talk about trying to get a
8 better sense of some of the questions that some
9 of us couldn't answer easily through the
10 application materials, like how is the measure
11 being used. And we are trying to --

12 DR. CLEARY: I'm sorry to interrupt. As
13 you go -- during the discussion, I am eager to
14 hear what kinds of information would be most
15 useful to you in the future for making a
16 decision. So, we have certain kinds of
17 information we routinely collect but you may have
18 a different set of priorities or different
19 interests. So, I will be eager to hear that.

20 CO-CHAIR BRISS: And so this is a little
21 bit different kind of a conversation.

22 Paul, maybe I will take a chair's

1 prerogative and ask you a question to start with.
2 As I hear you discuss this, this is a bit of a --
3 it sounds a bit less like a standard quality
4 measure and it sounds more like, in some ways, a
5 public health surveillance system or a survey
6 instrument or a more science kind of project.

7 So can you help me with is this really
8 a quality measure? And does NQF endorsement help
9 you use this instrument in the way you are trying
10 to use it? This is a bit of a different kind of
11 thing, at least as it has been teed up I think.
12 I would love to hear you comment on whether you
13 really see this as a quality measure and not a
14 more surveillance or science project and would
15 endorsement or re-endorsement help you; and if
16 so, why?

17 DR. CLEARY: Sure. So it is probably my
18 fault for talking like an instrument wonk. I do
19 that kind of stuff. But I would absolutely say
20 it is a key quality measure.

21 Let me just start. The CAHPS
22 instruments, we consider patient-centered care to

1 be a key component of quality and one of the best
2 of ways of assessing that is by listening to
3 patient experiences.

4 So for example, HCAHPS is now used
5 nationally to determine a percentage of
6 reimbursement for basically all hospitals in the
7 country. Health Plan CAHPS is used by NCQA as a
8 quality measure in every accredited health plan.
9 I think like 30 Medicaid programs use CAHPS
10 surveys to assess quality of care.

11 We are now using CAHPS surveys in
12 Connecticut to determine payment on shared
13 savings programs as part of the main insured. So
14 they look at patients' experience, how they vary
15 and we have a contract with CMS on both
16 hospitals, ACOs, now and the new MIPS surveys.
17 All those are quality measures that CMS is
18 actually using to determine reimbursement on
19 their quality metrics.

20 So I talked about the development
21 process just because that is what we do and the
22 way to it being used as a quality measure but

1 really the only reason for developing them is to
2 assess and facilitate improvement of care
3 quality.

4 CO-CHAIR PINCUS: I think that one of
5 the things that makes this somewhat unique is I
6 have, and a number of other people, you know and
7 the integral study that you are talking about at
8 Mass General that use the measure in the context
9 of research studies or use elements of the
10 measure or certain items in the measure. So it
11 gets a little bit murky in terms of its overall
12 use.

13 DR. CLEARY: Okay, that is a good point.
14 That particular study, I agree with your
15 characterization. And our interest in doing it
16 was A) to be helpful; and B) we thought that we
17 would get a lot of -- we used a variation. We
18 have made some modifications. It was an
19 opportunity to test psychometric properties and
20 so on. So, in terms of that particular study,
21 you are right. That would be, in their opinion,
22 maybe a surveillance study; in my opinion, part

1 of the development process.

2 But would NQF be necessary or helpful?
3 This comes up a lot with our instruments but, as
4 you know, many payers or CMS require NQF
5 endorsement to use a survey in a program. So we
6 want to use this eventually in our SIM program.
7 I can't answer you exactly but I am pretty sure
8 that endorsement would be very, very helpful when
9 we go to the State of Connecticut. I am now
10 leading the evaluation of their SIM project to
11 say we want to use this statewide to evaluate the
12 quality of care in Connecticut.

13 CO-CHAIR PINCUS: Okay, so why don't we
14 go around? So, Vanita and then we will come
15 back. Vanita, and then Tami, and then we will go
16 up the other side.

17 MEMBER PINDOLIA: Good morning. Thank
18 you for sharing a little insight about how the
19 outcome surveys were developed with feedback from
20 providers and others.

21 Could you expand on the patient focus
22 groups that are included for the survey

1 development?

2 DR. CLEARY: Sure. Originally, I don't
3 have an exact count, I'm guessing we did 10 or 20
4 focus groups. And the ones we do now, there is
5 several iterations of information that we get
6 directly from consumers. One is, especially
7 during the original development and we would redo
8 this if approving to upgrade the ECHO is
9 confirmed, we talked to patients who have had
10 behavioral health services and go through a semi-
11 structured protocol to understand how they
12 perceive the quality of care, what they
13 experienced, what they think about, what they
14 mean about quality. We also do extensive reviews
15 of the literature, what we consider appropriate
16 communication, et cetera, et cetera.

17 We did a Federal Register request for
18 all available instruments and so on. We often,
19 then, develop a preliminary instrument and we
20 will have focus groups where we combine what I
21 would call cognitive interviewing with focus
22 groups. So you will sit down with a group of

1 half a dozen people, have them go through the
2 survey. And there is two levels at which you try
3 and understand the instrument. One is, what was
4 their understanding of Question X? So, I will
5 give you one example. One big issue that
6 advocates were very concerned about was a feeling
7 of safety. Well, it turns out that is a very
8 hard concept to get at, what you really want to
9 know about in terms of safety. So you have a
10 focus what did safety mean to you. How did this
11 term interpret it? You know and you ask it two
12 or three different ways just to see if they
13 understood the questions, how they interpret the
14 questions, and what their responses meant.

15 And we go through iterations with
16 different subsets of patients. They tend to be
17 homogeneous. We might have a -- we will for a
18 CAHPS instrument always do focus groups with
19 people whose first language is Spanish, maybe a
20 group of people on Medicaid, people with private
21 pay and so on.

22 CO-CHAIR PINCUS: Tami.

1 MEMBER MARK: This is really
2 informative. Thank you very much, Paul.

3 Can you talk about the extent to which
4 the current ECHO is relevant to the substance use
5 disorder population? And you mentioned that you
6 might be renaming it the Mental Health CAHPS. So
7 does that mean the future CAHPS is not going to
8 apply particularly to patients with substance use
9 disorders?

10 DR. CLEARY: No, we originally used
11 behavioral health for the reason a lot of use the
12 term behavioral health. We would probably change
13 it because when we have done preliminary focus
14 groups and cognitive interviewing, virtually not
15 a single patient identified with the term
16 behavioral health. They just didn't know what we
17 were talking about.

18 So in the survey there we try and frame
19 it very, very broadly and substance abuse
20 absolutely would be an emphasis, especially at
21 the time it was a key component and with current
22 issues we absolutely will focus on that and try

1 and understand how we can get at those
2 experiences.

3 The renaming is purely a -- people just
4 didn't understand the term.

5 CO-CHAIR PINCUS: But I guess the
6 question is so it would be designed to be
7 applicable to groups with substance abuse?

8 DR. CLEARY: Yes.

9 MEMBER MARK: Thanks.

10 CO-CHAIR PINCUS: Let's go up the other
11 side.

12 MEMBER KNUDSEN: Hi.

13 DR. CLEARY: And by the way, just when
14 we originally developed with SAMHSA, of course,
15 there was tremendous interest through SAMHSA for
16 substance abuse or a range of treatments now.

17 MEMBER KNUDSEN: Okay. This actually
18 follows that. You had said that SAMHSA had asked
19 you or requested you to basically help develop
20 this but they didn't endorse it and they
21 continued to use the MHSIP. So, I was just
22 wondering --

1 DR. CLEARY: No, it wasn't that they
2 didn't endorse it. Actually, Ken was very -- it
3 wasn't -- I wouldn't say it was official. Ken
4 came to us and said -- you know MHSIP actually
5 refers to a broader program. Within that, there
6 is a MHSIP survey. And it was a long time ago.
7 I don't remember the specific discussions but
8 they were very interesting. We went through a
9 very, very elaborate process and they didn't
10 endorse one or the other. We did adopt ECHO.

11 My only comment was that a number of
12 states continued to use MHSIP. They had been
13 using MHSIP. They had historic data on MHSIP.

14 By the way, the CAHPS Consortium has --
15 we try and develop standardized surveys with
16 protocols, with analytic programs, with supports
17 and report formats, put it in the public domain.
18 Whether people adopt it or not is up to them.
19 AHRQ says nothing to any -- I mean CMS has done
20 this in many instances. We just try and make
21 available an instrument that people will find
22 useful for quality assessment and improvement.

1 CO-CHAIR PINCUS: Okay, Mike.

2 MEMBER TRANGLE: I want to share a
3 perspective that is really sort of a delivery
4 system-based perspective. From a system that is
5 regional, pretty large, very active, and kind of
6 quality and patient satisfaction work, really
7 sort of pursuing the triple aim, I would say it
8 seems, for like the last five or ten years, the
9 kind of questions we have are should we just have
10 our CD, you know substance use disorder patients
11 and mental health patients in with the general
12 survey. If that is true, is there any way we can
13 get a subset to benchmark ourselves against a
14 like cohort, whether it is just mental health or
15 combined mental health and CD?

16 Do we do the behavioral health? And
17 even then, when we have done it, could we get any
18 benchmarking to figure out where we are at and,
19 ideally, find out places that are doing better
20 that we could talk to them and learn from them?

21 We actually, our vendor was NRC Picker.
22 About two or three years ago, we forced them and

1 they did sort of like a teleconference to see who
2 is doing well and who is not and how to learn.
3 And it was such a polyglot group. Some of them
4 were inpatient CDs, some of them were outpatient
5 CD. Some were large urban, like ours, 100-bed
6 psych hospital, 100 psych beds in a bigger
7 hospital. Others were like an eight-bed unit out
8 in the rural hinterlands. You know, I am not
9 even -- we never hear of in the cities.

10 And it just felt like walking in
11 molasses or something to try and sort of just get
12 down to reality and do something useful with the
13 data that we know is important. And in some
14 sense my perspective is less esoteric; is it
15 viewed under quality or is it separate but equal,
16 equally important and how it fits into NQF?

17 Are you going to sort of start
18 answering some of the questions that my system
19 and I think other systems like that are trying to
20 get answered? And I could be pretty agnostic if
21 there is a large enough end within the general
22 HCAHPS for inpatient or ambulatory CAHPS and we

1 could compare ourselves to behavioral health
2 patients, I would be okay with that versus a
3 separate survey but it would be really nice to
4 have one of them sooner versus later.

5 DR. CLEARY: Boy, if I could answer
6 that. That's a great question. I will give you
7 a quick background and then what our current
8 thinking is.

9 The quick background, back in 2000 or
10 so, we -- the ECHO actually has two versions.
11 There is a health plan version and then there is
12 a Behavioral Healthcare Organization version
13 because carve outs were very distinct and
14 consumers identified with them and so on. And
15 the ECHO, unlike CAHPS surveys, CAHPS are very
16 anyone who has received care in the last six
17 months, ECHO is designed and used by people who
18 could identify behavioral healthcare users.

19 So, for example, with the State of New
20 York, we identified people who had a diagnosis,
21 had a psychotropic medication, had -- there was
22 three or four condition and we used their record

1 systems to identify a cohort of people who had
2 received behavior health services. So, that was
3 a distinct survey and their approach was how are
4 patients in Plan A, B, and C receiving their
5 behavioral health services.

6 The focus groups we have been doing over
7 the last year or so indicated -- I think you have
8 characterized the situation well. We think what
9 is likely to emerge is a subset of questions for
10 a general population about access to a behavioral
11 health services and a survey for people who are
12 known to have received behavioral health services
13 to assess quality of that care.

14 So for example, the State of Connecticut
15 is going to do a CG CAHPS survey statewide as
16 part of their state innovation model evaluation.
17 They wanted behavioral health items and we
18 included I believe six items. We did some
19 cognitive testing and some initial, many field
20 tests and so on. And they are basically you know
21 did you have the need for behavioral health
22 services; were you able to get some sort of

1 access to care items? And we are going to test
2 those statewide.

3 And what many people have been telling
4 us, again, this will be part of the development
5 process, is it would be good to have something
6 for a general cohort of patients, many of whom
7 everyone in this room knows have behavioral
8 health problems to get a sort of 20,000-foot
9 assessment of need and access and then a more
10 detailed instrument for a drill down.

11 One thing I will just mention, these are
12 all issues that are very difficult when you are
13 developing things, one of the ways in which the
14 ECHO is very different from some of the other
15 CAHPS surveys, so for example, CG CAHPS, the
16 Clinician Group CAHPS, it focuses on a specific
17 provider group. That is very important because
18 attribution is part of the quality. When NCQA
19 gives a score to a health plan, they want to know
20 that that care is attributable to that health
21 plan.

22 As people in this room, behavioral

1 health services are provided by a wide range of
2 providers. There is also often very complicated
3 comorbidities. And so it is a much broader
4 thinking about the range of services that one
5 got.

6 And so that is, in terms of your
7 question, a balancing act is knowing what is the
8 overall quality of care that the person received
9 as opposed to what is attributable to your system
10 and what do you want to be accountable for and/or
11 approve.

12 So the short version of that is I think
13 we are probably going to have -- we are thinking
14 right now our goal is to develop a set of items,
15 you know five or ten items that could be a
16 supplemental item set for health plan CAHPS or CG
17 CAHPS or even HCAHPS. There is a lot of interest
18 in inpatient treatment and that is a separate
19 ball of wax and a survey that would be more
20 detailed for people who have received behavioral
21 health services.

22 CO-CHAIR PINCUS: Okay, Connie. You're

1 microphone is not on.

2 DR. CLEARY: I can't hear her speaking.

3 MEMBER HORGAN: Oh, sorry. Hello, Paul.

4 DR. CLEARY: Hi.

5 MEMBER HORGAN: My questions have
6 already been asked by Tami and Mike. So, thank
7 you.

8 CO-CHAIR PINCUS: So, I guess I was next
9 in the queue. And I actually have three comments
10 and a question.

11 One is similar to Mike's in terms of
12 thinking about the particular target uses of
13 this. And I have been familiar with its use in
14 terms of evaluating health plans and behavioral
15 health plans but to think about if you are going
16 to the trouble of developing these items, and so
17 to think about their adaptation for other
18 settings, in particular, sort of outpatient
19 specialty behavioral health settings. I would be
20 interested to see whether it can be generalized
21 between substance abuse and mental health and
22 whether there might need to be some specific

1 items that relate specifically to substance
2 abuse, potentially.

3 And in particular, something that came
4 up and I know that this was something that came
5 up on the MAP side of things for the Inpatient
6 Psychiatric Facility Reporting Program, that
7 there was an early effort by CMS to put in place
8 a survey for inpatients that was going to be part
9 of that program. And that got rejected by the
10 MAP because it was an adaptation of a survey that
11 was developed for adolescent inpatient settings
12 that happened to have been an endorsed measure.

13 And so something, if there is going to
14 be this program on inpatient reporting, having a
15 CAHPS ECHO kind of thing that is aimed at
16 inpatient would also be useful for that program
17 and to think about that.

18 Number two, when I was at Pittsburgh,
19 our health plan actually was doing ECHO surveys
20 and they found that there was actually a
21 substantive difference between different ways in
22 which it was administered so that whether it was

1 administered by mail or by phone, that there was
2 sort of a different level and type of response.

3 And so it would be useful now,
4 especially also, the potential to administer it
5 electronically by email or through an open
6 website. So, I would hope that that would be
7 part of the analysis and work that you are doing.

8 Number three is the original ECHO was
9 out before really the recovery movement was in
10 full swing. And to look at whether there are
11 certain aspects of a recovery orientation that
12 could augment the work that you are doing in
13 terms of the kinds of items that you might be
14 selecting.

15 And then the question I had is why has
16 it taken so long for the CAHPS group to come back
17 to looking at behavioral health or mental health?

18 DR. CLEARY: Okay, quick answers. First
19 of all, I hadn't -- I will admit I didn't even
20 know about the inpatient measure until I saw it
21 referred to in some document. So, I wasn't part
22 of that. I wasn't aware of that. That gets

1 raised periodically with us. I will definitely
2 raise it. That is a big deal, so to speak. So
3 my guess is it is not going to be done this
4 iteration because it just takes a lot of effort
5 but I will put that on the agenda.

6 We always do testing with mail versus
7 phone and now spending a lot of time, one of the
8 reasons for going with MGH because it is a portal
9 type data collection, we do randomized studies of
10 mail versus phone to assess mode effects. In
11 some of the national surveys, we have mode
12 adjustment factors and so on. So that is
13 definitely part of any CAHPS development
14 protocol.

15 Thanks for your comment about the
16 recovery orientation. It is a good point and
17 that will be useful as we go forward.

18 Why is taking so long? It is just we
19 have a lot of activities that have been going on.
20 I mean the good news is that CAHPS is very widely
21 used. Now the bad news is it is very widely
22 used. So we have spent an incredibly intensive

1 effort focusing on like Hospital CAHPS, Clinician
2 Group CAHPS, working on MIPS and ACO and so on.
3 And it is just, maybe like in many cases, it gets
4 less attention than many of these other areas.

5 We have sort of know that it is -- and
6 we just started a general updating process I
7 would say a year or two ago trying to reconcile
8 all the various instruments because minor
9 modifications develop over time.

10 And by the way, back to the -- there was
11 an earlier discussion what roles should NQF play.
12 We are very worried about the proliferation of
13 CAHPS instruments and so we have spent a lot of
14 time trying to standardize cores, make them as
15 compatible as possible. When people come in with
16 a new survey we say now if you are going to do a
17 cancer survey, use the same communication
18 composites, et cetera, et cetera.

19 The big issue in the field that we see
20 is the overlapping and multiple mandates. So
21 what we are scratching our heads just nationally
22 how to do is to sort of coordination of these

1 various mandates.

2 So for example, in the State of
3 Connecticut you may get a survey as a Medicare
4 beneficiary because you are in an ACO, because
5 you are in an NCQA accredited health plan,
6 because you get HCAHPS. Most people don't but it
7 is these overlapping mandates. And I know that
8 is not NQF's problem but that is the bigger issue
9 in our mind.

10 And so I guess the short answer is we
11 just haven't gotten to it. No good answer.

12 CO-CHAIR PINCUS: Peter.

13 CO-CHAIR BRISS: Paul, this has been a
14 really helpful discussion. I have a comment and
15 a couple of pieces of advice.

16 And the comment is I think the world has
17 changed some since this was first developed and
18 we are kind of in a world of more primary care
19 integration. So were I you, I might think a
20 little about whether you want to limit this kind
21 of measure just to people that are seen in
22 specialized behavioral health settings. I think

1 it might deserve a broader patient population.
2 It is something for you to think about but it
3 looks like there at least a few head nods around
4 the table when I say that out loud.

5 And then a couple of pieces of advice.
6 You know the NQF process is kind of very
7 specialized in Byzantine. And there are all
8 kinds of things that came out in your teeing up
9 of the measure this morning that I didn't get
10 clearly, at least on my read of the materials.
11 So I think if you want this to be NQF-endorsed, I
12 think you could get it endorsed. I think you
13 would benefit from some help from somebody who
14 does this a lot. So, whether that is NQF staff
15 to try to help you tee it up to fit the kind of
16 pro-crusty bed of NQF jurisprudence or something
17 like that I think, or somebody else that has done
18 this a lot, I think that would really help.

19 And then a couple of things that as you
20 are doing that that I think might be beefed up.
21 This is a fairly complicated measure with a lot
22 of moving parts. And so in the initial framing,

1 I think you might do more about how these kind of
2 patient-reported outcome kind of things relate to
3 structures and process of care, I think you might
4 do better about the kind of logic modeling that
5 would make it easier to follow the measure.

6 And especially when you are bringing
7 measures back, there is an increasing focus here
8 on kind of usability and use. You know who is
9 using it and for what and why. And so the kind
10 of stuff you talked about this morning, so people
11 are using it for state SIM projects and so on and
12 so forth didn't come out to me clearly in the
13 materials. And that, in particular, might be
14 beefed up more than it is.

15 Thank you for talking to us this
16 morning.

17 CO-CHAIR PINCUS: I like the NQF
18 jurisprudence. That is sort of interesting. I
19 use the term quality measurement industrial
20 complex.

21 Rhonda?

22 MEMBER ROBINSON BEALE: Okay, thank you,

1 Paul. I have some questions for clarification
2 and also to get a better understanding.

3 So I didn't read through all the
4 materials but I did read through and was a little
5 bit confused by the numerator/denominator that
6 you offered. I was wondering if you could
7 explain how you were conceptualizing that using
8 this ECHO survey.

9 DR. CLEARY: Sure. Basically, as I
10 mentioned, the denominator was conceived as
11 people who have received behavioral health
12 services. And by the way, this was applicable to
13 primary care, as well as specialty care. And
14 that is defined based on either the -- usually
15 record information has been used in the past but
16 you could ask screening questions of a general
17 population.

18 So you have let's say a thousand people
19 who have used behavioral health services in the
20 last six months and then you say did someone tell
21 you about the options for treatment in a way that
22 you could understand. And you calculate the

1 number of people who say always, sometimes, you
2 know yes versus no. So 60 percent of the people
3 -- I was just looking up one number in the
4 application. Did you try and get a referral? In
5 one system it was 67 percent of the patients were
6 able to get a referral and in another part of the
7 system it was 85 percent.

8 So the idea is the denominator is people
9 who have used behavioral health services, what
10 proportion were able to get an appropriate
11 referral and then people who say yes is the
12 numerator.

13 MEMBER ROBINSON BEALE: Okay, so you
14 were talking about using individual elements
15 within the survey itself.

16 The second question --

17 DR. CLEARY: Yes and then maybe this is
18 too wonky but CAHPS surveys are really, the main
19 goal is for assessment of providers or systems
20 not -- they certainly can be used at the
21 individual level. So you can monitor a patient
22 and say they did or did not get a referral or

1 were black patients less likely to get a referral
2 than white patients. We do a lot of those types
3 of analyses but the main CAHPS Analysis Program,
4 it is called our macro create scores at, let's
5 say a primary care clinic, or a primary care
6 group, or a behavioral healthcare organization.
7 And then those numbers are rolled up to say you
8 know the Yale Medical Group of the people who
9 used behavioral health services, 70 percent said
10 they could get a referral whereas as in community
11 health centers, 90 percent said they could get a
12 referral.

13 CO-CHAIR PINCUS: One clarification on
14 your response to Rhonda. So, does that imply
15 that for users of the survey they don't -- they
16 can pick and choose which items they would
17 include in the survey, since it is an item level?

18 DR. CLEARY: Well, I mean people can do
19 whatever they want to do. I don't mean to be
20 facetious but CAHPS feels very strongly because
21 we know that there is order effects and context
22 effects in the survey that to be called a CAHPS

1 survey, they should use the entire survey.

2 MEMBER ROBINSON BEALE: Okay, thank you.

3 My last -- my next question had to do with
4 whether or not there are benchmarks established
5 for this. So that one, I think Michael that
6 brought it up, if you really wanted to understand
7 whether one system is functioning better than the
8 other and to understand what is best practice,
9 are there benchmarks established?

10 DR. CLEARY: So the short answer is no.
11 Basically and, again, what the consortium does is
12 makes available data. The CAHPS database accepts
13 voluntary submissions. So you can go into the
14 CAHPS database and look at in Medicaid programs
15 what is the 90th percentile of plans where people
16 said someone answered their question in a way
17 they could understand. So you can look at the
18 distribution of CAHPS scores. Or the State of
19 New York did it in their entire Medicaid
20 population and they could look at the
21 distribution and look at -- one of the things we
22 always calculate and is in some of the articles I

1 submitted is inter-unit reliability. One of the
2 criterion we use for selecting questions is not
3 sort of the individual psychometrics but because
4 we like one to make assessments of providers or
5 systems, inter-unit reliability.

6 So when we do it in Connecticut is are
7 the different groups that are assessed, do
8 certain items reliably differentiate from the
9 groups and then they use whatever data they have
10 to say what is our benchmark, if you will.

11 So an example is we do HCAHPS for CMS
12 every year. We calculate regionally a whole
13 variety of adjustments in waiting and so on but
14 then calculate distributions of the HCAHPS scores
15 and the Star Rating System, if you will, comes
16 out of the assessments of the distributions in an
17 individual hospital, vis-a-vis the regional
18 distributions.

19 So there is no absolute -- you know you
20 could argue an absolute -- you could say what is
21 the best performing system in your -- best
22 performing group in your system but we don't have

1 like an absolute everyone in the country should
2 have an 87.

3 MEMBER ROBINSON BEALE: Okay, thank you.

4 My last question has to do with the
5 section that is called perceived improvement and
6 whether or not that has been tested at all or
7 cross-referenced with actual measurement of
8 outcome, where you are looking at the perception
9 of patients in terms of perceived improvement
10 against actual measurement of outcome.

11 DR. CLEARY: The short answer is no. In
12 terms of general improvement, really the only --
13 for a lot of reasons it is obviously very hard to
14 assess rigorously but since HCAHPS has done
15 nationally for many years and Medicare CAHPS has
16 done nationally for many years, we have done
17 analyses of improvement in HCAHPS scores and
18 Medicare Advantage and Fee-for-Service scores and
19 have written a number of articles showing how
20 those scores have improved. We think they
21 improved more after public reporting of HCAHPS
22 scores, et cetera, et cetera. So, we could show

1 that.

2 Whether it is related to outcomes,
3 again, the answer, we have no idea in terms of
4 mental health. The couple studies I have been
5 able to do, it is a very hard question to answer
6 but I did a study of all heart attack patients in
7 New Hampshire and heart attack patients
8 nationally in the VA and showed that -- I know
9 this isn't behavioral health -- but showed that
10 patients that had better patient-centered care,
11 were their questions answered, et cetera, et
12 cetera, et cetera, and the New Hampshire study
13 actually had better outcomes a year later in
14 terms of dyspnea and angina. And in the VA
15 study, we actually showed a significant impact or
16 relationship with mortality using a national data
17 set from the VA. But we haven't even tried
18 anything comparable in behavioral health.

19 As you might imagine, the design issues
20 are very daunting.

21 MEMBER ROBINSON BEALE: Thank you.

22 CO-CHAIR PINCUS: Actually there may be,

1 just to put out it there, there may be some ways
2 of actually doing some of that testing now that
3 at least there are places that are doing sort of
4 consistent measurement of PHQ-9 scores as part of
5 actually an NQF-endorsed measure. And that might
6 be sort of a place where you could actually test
7 what Rhonda suggested.

8 DR. CLEARY: Yes, it's --

9 MEMBER ROBINSON BEALE: Well there is
10 also another organization called ACORN, which
11 does a lot of extensive data collection in terms
12 of sets of providers who are using standardized
13 tools during the treatment. And so you have
14 beginning of treatment, and during treatment, and
15 outcome and they actually are able to calculate
16 effect size. So that could be a very -- and they
17 have a large database. So it might be a really
18 good partner to have them administer this in
19 correlation --

20 DR. CLEARY: Is that A-C-O-R-N?

21 MEMBER ROBINSON BEALE: Yes, A-C-O-R-N,
22 Jeb Brown.

1 DR. CLEARY: Okay, thanks. Yes, some of
2 these things you know we have large EHRs and so
3 on. So I think it is much more feasible than it
4 used to be. That is a great idea. Thanks.

5 MEMBER ROBINSON BEALE: Okay, thank you.

6 CO-CHAIR PINCUS: Mady.

7 MEMBER CHALK: I'm going to try to be
8 brief about this. Just because MHSIP was raised,
9 when Ron Manderscheid and I, about 12 years ago,
10 decided we were fed up with MHSIP and a variety
11 of other things, Connie will remember this, under
12 the auspices of the Washington Circle, we created
13 and worked on a perception of care survey. We
14 weren't happy with the CAHPS at the time. Ron
15 wasn't. I wasn't. I was in the federal
16 government. He had money. I had money. And we
17 used it to fund this effort to develop what
18 became known as the Modular Survey. Adult,
19 adolescent, mental health, substance abuse
20 disorders. Each one was about 10 or 12 items,
21 pretty short.
22 We got it to be web-based, et cetera, et

1 cetera, and tested in a couple of places. And
2 then you know it needed further funding. I left.
3 Ron left. And there it sat. I have still got
4 the disks sitting with me. It's ready to be -- I
5 will give them to you.

6 The point being it was the kind of
7 perception of care survey that allowed whatever
8 population were working with, whether it was at
9 the treatment program level or in aggregate to be
10 administered in pieces without having to look
11 through an entire survey and then try to subset
12 it. All the items had had IRT testing. I mean
13 it was -- it is, continues to be the kind of
14 perception of care survey I think we need in
15 behavioral health.

16 I don't know if anything will ever
17 happen with it but we may offer it to Paul, if he
18 wants it and wants to see how the items subset
19 with the items that are in ECHO or somebody else
20 could pick it up.

21 DR. CLEARY: Thanks. It is coming back.
22 If someone could send me a reference so I could

1 just remind myself. I remember that process and
2 I don't remember -- I would be very grateful to
3 see that again, as we revisit this.

4 CO-CHAIR PINCUS: Raquel, and then
5 David, and Mike.

6 MEMBER MAZON JEFFERS: So I think my
7 questions are super concrete at the moment.
8 Exactly -- I just think I need some clarification
9 exactly for this proposed measure, how is it
10 administered and what is in the numerator and
11 denominator. So is it the entire CAHPS survey
12 that is administered to a random sample of
13 members in a health plan and then the measure is
14 calculated by pulling out the responses to these
15 items in the ECHO? So that is one question
16 because if I am -- because there are two other
17 clarifications that I am still struggling with.
18 One is at one point you said that you would only
19 be administering the ECHO to people who have
20 received behavioral health services and it is my
21 understanding that one of the things you are
22 trying to get at is how ready the access was to

1 the behavioral service so it would make sense
2 then to administer this survey to people who --
3 to everybody to see if they needed the behavioral
4 health service and then, therefore, didn't get
5 the behavioral health service.

6 And then the last thing is that I have
7 heard two different things, one that the measure
8 can be used in primary care settings but if you
9 actually read the PA that was prepared for today,
10 it says that the denominator exclusions include
11 people who receive behavioral health services
12 only in primary care settings.

13 I'm sorry, could you just nuts and bolts
14 help me understand those three things?

15 DR. CLEARY: Sure. The instrument was
16 designed, the existing ECHO was designed for
17 people who had received behavioral health
18 services identified in some way by a health plan
19 or Behavioral Healthcare Organization. So, only
20 people who had received. That was what the
21 design was.

22 What I talked about more recently

1 testing and developing was we perceive a much
2 broader need for questions about access and
3 availability in a general population. So we
4 actually are testing questions like that now in
5 Connecticut. Our belief now based on the focus
6 groups we have done and work with different
7 constituents is that it would be desirable to
8 have both a survey for people who have received
9 behavioral health services and a set of questions
10 that are applicable to a general patient
11 population addressing the questions you have
12 asked.

13 And when we originally developed it, it
14 was most people wanted to use it only for people
15 who had, in addition to primary care, received
16 specialty services. So that was the definition
17 of the denominator. But it does ask questions
18 that relate -- it could be used in people through
19 a primary care panel because as we all know, at
20 least many of know, a lot of behavioral health
21 services, there is a high proportion of primary
22 care patients with behavioral health issues. A

1 large number of those patients are not
2 recognized. And those who are recognized don't
3 get adequate treatment. So that is an important
4 subset of people.

5 CO-CHAIR PINCUS: Dave.

6 MEMBER EINZIG: Hi. So my question has
7 to do with concept of lumping. I am a child
8 psychiatrist and pediatrician doing a
9 collaborative care model in an urban setting and
10 see lots of patients. So I am having trouble
11 with lumping all people with mental health
12 together in the same group, not just with
13 substance use disorder and mental health but
14 within mental health itself. So, for example,
15 preparing a person with high stressed family, and
16 ten kids, and fetal alcohol, and poor executive
17 functioning, very poor, a lot of stress,
18 comparing that to a person with anxiety and an IQ
19 of 140 doesn't really makes sense to me.

20 And then even within the high needs
21 group, where they may need more intensive
22 supports and services and frequent visits, some

1 of those families may have supports embedded,
2 case management services, and home services, PTA
3 providers and whatnot, and comparing that with
4 folks who don't have those supports.

5 So, just help me understand how one
6 evaluation to folks with mental health services,
7 how that can be more useful.

8 DR. CLEARY: Sure. It's a great
9 question. I would just reiterate the role of the
10 CAHPS Consortium is to develop a way of assessing
11 care experiences. And we don't dictate that it
12 be used in a particular way. You know we tried
13 to define a numerator and a denominator for
14 precision but what typically happens is let's say
15 I, as an individual rather than a CAHPS
16 representative, starts talking to you about how
17 to evaluate your services. You make the
18 statements you just made. I would say it sounds
19 perfectly reasonable to me. What would be in
20 your opinion the appropriate groups to compare
21 let's say across providers? So let's say you say
22 well, I am really worried about severe and

1 persistent mental health problems. I say okay,
2 can that be defined. Can we compare those across
3 what subsets of providers and such?

4 What I am saying is that is basically an
5 evaluation design issue that I don't dictate. If
6 the State of Connecticut uses this, what they
7 have told me is they are interested in general,
8 broad access. Maybe on the next iteration they
9 would be particularly interested in population X
10 or Y. Because inevitably when you do the first
11 assessment, you say gee, I don't have enough
12 precision to answer the questions that you just
13 asked. Is there a better design for providing
14 information to your system or your providers
15 about how well you are doing with different
16 subsets of patients? That is really a design
17 issue that you know in part of my life I do a lot
18 of work but as a CAHPS developer, it is not what
19 we dictate.

20 CO-CHAIR PINCUS: Kraig, is your card
21 up?

22 Mike.

1 MEMBER TRANGLE: I have I think one
2 question and two or three comments that will be
3 kind of quick.

4 One is that in my part of the world,
5 which is very similar to David's, integrated care
6 is becoming more and more the mode, instead of
7 the exception to the rule. And to sort of say it
8 would be a rare patient that, in our system, it
9 would always start in primary care. Somebody
10 might try and treat them for depression. They
11 don't do well, they go to behavioral health. And
12 they may see the behavioral health provider in
13 primary care or they may see the same person in a
14 separate behavioral health clinic.

15 When you are excluding people seen in
16 primary care, it strikes me as that it is going to
17 become increasingly problematic. And then you
18 will get this thing about only seen in behavioral
19 care, or only seen in primary care, or both. As
20 the world is evolving, I just think you should
21 rethink that in a way so that it is both
22 practical and useful of how you are subdividing.

1 DR. CLEARY: That is a good comment and
2 I agree with you. And as Harold and some of you
3 know, I started my career looking at the
4 recognition and management of mental health
5 problems in primary care. So, I totally
6 understand what you are saying.

7 MEMBER TRANGLE: You know and the same
8 thing pertains for substance abuse.

9 DR. CLEARY: Yes.

10 MEMBER TRANGLE: As we are dealing with
11 the opioid epidemic, we are having both
12 behavioral health and primary care doing Suboxone
13 and having people do kind of supportive therapies
14 in primary care. It is just not distinct.

15 DR. CLEARY: I agree. And to be honest,
16 that was part of the original specification that
17 we maintained and I think that was dictated by
18 some groups we were working with but I agree with
19 your observations.

20 MEMBER TRANGLE: And then you said
21 something that maybe I misheard. But I think
22 when you were talking about CG CAHPS and HCAHPS

1 you sort of said it is not meant to somehow give
2 feedback on the individual. Did I hear that
3 correctly? Individual clinician, you know.

4 DR. CLEARY: Oh, no, I meant individual
5 patient.

6 MEMBER TRANGLE: Individual patient but
7 individual clinician --

8 DR. CLEARY: Now it is true, also, for
9 -- there is also a huge issue with individual
10 providers in that relatively little care is
11 provided by an individual provider but Clinician
12 Group CAHPS is designed if one wanted to assess
13 clinician care.

14 MEMBER TRANGLE: You know my comment is,
15 at least in my part of the world, I don't know
16 who one is. I mean sometimes it is a health
17 plan. Sometimes it is an employer doing
18 contracts where patient satisfaction is
19 important. But it is probably getting more legs
20 and more use for that than the group level.

21 And you know even most sort of say you
22 have to have an n of 100 or more to think that it

1 is at least somewhat statistically plausible but
2 it has been used that way a lot.

3 DR. CLEARY: I understand but, for
4 example, HCAHPS has been used like that and --

5 MEMBER TRANGLE: And our system is --

6 DR. CLEARY: -- and CMS is really trying
7 to push back. It is not appropriate to use an
8 HCAHPS score to make an attribution to let's say
9 the admitting physician because it asks about the
10 hospital experience. You have to very careful
11 about the design to make attributions to
12 individual physicians, although I agree with you
13 many people are eager to do that.

14 MEMBER TRANGLE: And the focus is on the
15 questions asking about did your doctor listen,
16 did they explain things intelligently,
17 understandably.

18 DR. CLEARY: Yes.

19 MEMBER TRANGLE: And then my last
20 question is kind of a half question, half comment
21 but we have been struggling to help ease people
22 sitting in our hospital psych beds that are

1 always full with people flooding the ERs. We
2 have developed transitional housing to get them
3 out, crisis beds, and now have our second or,
4 depending on how you define it, third group home
5 coming online. And when I try to get data about
6 can we look at patient satisfaction in that
7 realm, and the same thing plays out for quality
8 actually, too, it feels like I don't even know
9 where to start. I do literature searches and you
10 can see the Army has some things that they have
11 out there on their website and this and that but
12 it feels like it is the Wild West. And I don't
13 even know where to start of how to -- you know
14 what are good surveys to use for patient
15 satisfaction in those zones. Do you know
16 anything about that, group homes, long-term
17 residential treatment centers, that kind of
18 place?

19 DR. CLEARY: I mean I know about it. I
20 don't have experience with our instrument. We
21 are doing a lot of that work with CMS. I mean it
22 is not the same but analogous work of like

1 assisted living, different types of facilities.
2 So there is a whole family of instruments. We
3 haven't done that in behavioral health services
4 but it is a good point.

5 CO-CHAIR PINCUS: Okay, so Tracy said we
6 have somebody from the public.

7 DR. LUSTIG: Hi, so we did receive a
8 public comment that was sent to us yesterday that
9 couldn't stay. So I just wanted to read it and
10 Paul, also give you some feedback.

11 It is from D.E.B. Potter who says that
12 she is speaking as an individual, not as a
13 representative of HHS or ASPE and she notes that
14 since 2011 she has been an ex officio member of
15 the MAP Dual Eligible Beneficiary Workgroup.

16 And she writes the CAHPS behavioral
17 health experience with care measure ECHO is like
18 several other CAHPS measures included in the MAP
19 Dual Eligibles Beneficiary family of measures.

20 In 2015, the MAP Duals Workgroup
21 undertook a measure alignment exercise to
22 identify the users of measures in the Duals

1 family of measures. Based on the 6/25/15 version
2 of the MAP tool, which is no longer on the MAP
3 site, several of the States involved in the
4 Medicare-Medicaid Financial Alignment
5 demonstration use ECHO to assess performance.
6 NQF obtained data on ECHO's use by abstracting
7 information from the Memorandums of Understanding
8 signed between CMS and the states. In 2015, the
9 following states were using ECHO and these are
10 all capitated state demos in California,
11 Illinois, Massachusetts, Michigan, New York,
12 Ohio, South Carolina, Texas, and Virginia.

13 And she says as of 2017, all of these
14 demos are ongoing, although Virginia will end
15 this year. She also noted a Commonwealth Issue
16 Brief from march 2014 which further identified
17 ECHO and the CAHPS plan measure as CMS core
18 measures for the demonstration.

19 She says that in the worksheet that was
20 done for this measure it is noted that no recent
21 data on performance results were provided for the
22 17 PRO PMs included. And she says based on

1 ECHO's required use in CMS-funded programs that
2 involve multiple health plans, I suggest that
3 perhaps some recent data from multiple years do
4 exist for the ECHO items, just not easily seen or
5 obtainable by the public and/or the research
6 community.

7 She says given the importance of having
8 NQF-endorsed PRO measures for the behavioral
9 health population, I, as an individual not
10 representative of HHS or ASPE, urge the
11 Behavioral Health Standing Committee members, the
12 ECHO measure steward, and/or the NQF behavioral
13 health staff to reach out to CMS MMCO, these
14 states and their health plans to determine if
15 more recent PRO item data does exist and to
16 request that the data be submitted to the
17 committee for evaluation. And she also says that
18 we could begin the conversation with Alice Lind,
19 who is a member and former co-chair of the MAP
20 Dual Eligibles Workgroup.

21 DR. CLEARY: Wow. I didn't know any of
22 that --

1 DR. LUSTIG: And Paul, we can forward
2 you the information and help get those started.

3 DR. CLEARY: Yes, if you could forward
4 that to me. Obviously, or I don't think, that is
5 the role of NQF but we would delighted to try and
6 -- we work very closely with CMS to try and get
7 those data and do the kinds of analysis that
8 would be informative.

9 DR. LUSTIG: Yes, we are happy to help
10 you make those connections. And we literally
11 just got this last night ourselves and so we
12 would be happy to share that with you.

13 DR. CLEARY: That would be great.

14 CO-CHAIR PINCUS: And I would also
15 suggest, Paul, that you also contact Kate
16 Goodrich and Jeff Buck and her group who were
17 involved with the Inpatient Psychiatric Facility
18 Reporting Program and looking different
19 opportunities for PRO kind of and perceptions
20 opportunities.

21 Peter, and I think you are the last one.

22 CO-CHAIR BRISS: Do this has been a

1 great conversation, thanks to everybody.

2 Paul, I have one more piece of advice
3 for getting through the NQF system. So as I
4 listen to you talk, there is sort of a current
5 state of the measure and there is sort of you are
6 frequently leaning forward into potential
7 improvements, or tailored applications, or more
8 specialized things. And for the purpose of
9 getting through the NQF process simpler is better
10 and what we need is the off-the-shelf generic
11 version that we can identify today -- that we can
12 evaluate today.

13 And the forward leaning work is really
14 good but it makes hard on the committee to kind
15 of get a sense of where the current reality is.
16 So this is my other piece of advice that I didn't
17 give you before was I would focus just on the
18 generic version for this audience.

19 DR. CLEARY: No, I totally agree. I was
20 just giving you my thinking because I don't get
21 to talk with a group this knowledgeable very
22 often. So, I thought I would share sort of our

1 thinking and the input has been incredibly
2 helpful. But I understand that discussion and
3 the approval process are very different.

4 CO-CHAIR PINCUS: So Paul, thank you so
5 much for your time and for your expertise.
6 Please, we would like to continue this
7 conversation and get feedback on an ongoing basis
8 about progress with this measure. And please,
9 with your colleagues at AHRQ, and CMS, and the
10 CAHPS group, convey our enthusiasm for sort of
11 moving ahead with this.

12 DR. CLEARY: That's great and thank you
13 very much for everyone's time. And if you could
14 forward that comment, that would be great.

15 And I will just make an ask. As we move
16 forward, we are very interested in input from
17 technical advisory panels, experts, et cetera, et
18 cetera, and we have done that in the past. If
19 anyone is interested informally, with very low
20 burden, providing comments or input on the
21 development issues, not the application but the
22 development issues as we move forward, I would be

1 delighted to get your information and keep people
2 in the loop because we have gotten some
3 incredibly useful comments this morning that I
4 really appreciate.

5 CO-CHAIR PINCUS: Okay, terrific. So,
6 for the committee, we are going to take a break
7 and get back together at 10:15.

8 (Whereupon, the above-entitled matter
9 went off the record at 10:03 a.m. and resumed at
10 10:16 a.m.)

11 CO-CHAIR BRISS: So, everybody, could we
12 reconvene, please?

13 So the next measure is Continuity of
14 Pharmacotherapy for Opioid Use Disorder. I will
15 keep trying this until it works. The next
16 measure is Continuity of Pharmacotherapy for
17 Opioid Use Disorder. And it is customary to stop
18 other conversations and rejoin the conversation.
19 And the measure steward is RAND. Would you like
20 to introduce yourself and take three minutes or
21 so and key up the measure for us, please?

22 DR. MATTKE: Okay, thank you, Peter.

1 Hi, Soeren Mattke at RAND. I am a
2 senior scientist in the Boston office and I am
3 the project director for this development
4 exercise. I am here with Liz Sloss, who worked
5 with me closely. She is an epidemiologist.

6 And I always say I am a cardiologist by
7 training. So anything north of the carotid
8 artery is kind of a mystery to me. So we have
9 Kate Watkins on the phone here from Los Angeles.
10 She is actually a psychiatrist and knows what she
11 is talking about. She was working on this
12 project as well and will help me when the
13 questions get too clinically technical.

14 Okay, so great to be here. We are
15 discussing this opioid treatment continuity
16 measure first. As you all know, opioid abuse has
17 become a national public health crisis. It is
18 now killing on average 90 Americans each day,
19 about four times as many as 15 years ago, which
20 makes it on par with quite common diseases like
21 chronic liver disease or motor vehicle accidents.

22 In a 2014 survey, more than ten million

1 people reported prescription opioid misuse, which
2 puts them at risk for both overdoses and then
3 subsequent heroin addiction. This dramatic
4 increase has brought the treatment of OUD to the
5 top of the agenda for clinicians and
6 policymakers. The Surgeon General, for example,
7 recently mailed a call to action to over two
8 million clinicians and the governors of many
9 states, red and blue, have prioritized improving
10 access to prevention and treatment.

11 Pharmacotherapy for OUD is an effective
12 but underused treatment option but we expect that
13 to change for three reasons. First, we have now
14 several FDA-approved drugs for use in regular
15 clinics and offices, which facilitates treatment
16 greatly compared to methadone, which, as you
17 know, can only be dispensed in specially licensed
18 treatment programs.

19 Second, leading professional societies
20 and SAMHSA have issued support of statements to
21 promote OUD pharmacotherapy.

22 And third, national quality measurement

1 and reporting schemes such as HEDIS and the Joint
2 Commission set are capturing or will capture
3 initiation of mitigation-assisted treatment.

4 But as the evidence in our application
5 shows, there is actually a deadly risk with
6 prescribing opioid pharmacotherapy treatment
7 without ensuring continuity of care.

8 Pharmacotherapy for OUD is not like putting
9 patients on statins. Both the agonists, the
10 partial agonists and the antagonists alter a
11 patient's tolerance of opioids and thus, there is
12 a risk of overdose when treatment is
13 discontinued.

14 As we have shown, that risk was up after
15 about three days of treatment interruption and
16 persists for at least two weeks and that finding
17 is quite consistent for the different opioid
18 medications.

19 For that reason, we have proposed here
20 a treatment continuity measure that capture where
21 the patients on pharmacotherapy for opioid use
22 disorders remain on treatment for at least 180

1 days and have no gaps of greater than seven days.
2 We hope that this measure will encourage
3 providers and health plans to institute adherence
4 interventions when starting pharmacotherapy in
5 order to keep this effective treatment option
6 safe.

7 Our data show that improvements in
8 continuity of care are both needed and possible.
9 The average measure score at the health plan
10 level was around 25 percent and ranged from close
11 to zero to over 60 percent, suggesting both room
12 for improvement and best practices to emulate.
13 We provide expert panel support for validity and
14 usability of the measure. We provided data on
15 reliability testing and expect this claims-based
16 measure to be feasible to implement.

17 I am looking forward to our discussion.
18 Thank you.

19 CO-CHAIR BRISS: Thank you. So, we will
20 move to importance of measure and report. Would
21 one of primary reviewers like to tee this up for
22 us, please?

1 MEMBER GROSS: Is the importance of the
2 measure is that --

3 CO-CHAIR BRISS: Importance of measure
4 and report. So, we will -- we are back to the
5 drill that we were doing yesterday. So, we will
6 run criterion at a time. So, the first criterion
7 is importance of measure and report.

8 MEMBER GROSS: Just a quick question to
9 -- Charlie Gross with Anthem.

10 The database you based it on included
11 commercial Medicaid numbers as well?

12 DR. MATTKE: No, it is only
13 commercially-insured employees of large and self-
14 insured employers.

15 MEMBER GROSS: I still think it is a
16 very important measure but I think maybe -- and
17 this may be more of an NQF sort of discussion
18 that we can save for later. I think
19 increasingly, as government business is a bigger
20 part of the payer mix, particularly with
21 disorders such as this, that the need for those
22 populations to be part of the measurement data

1 set is critically important.

2 Having said that, I think this is an
3 incredibly important measure.

4 DR. MATTKE: And we do intend to test it
5 on Medicaid. Actually, we have the data. We
6 also intend to test it on Medicare patients for
7 which we couldn't get the data in time. It is
8 just this call came out with such short notice
9 that the best we could do was commercial claims,
10 which is the easiest to secure.

11 MEMBER GROSS: Sure. Thank you.

12 CO-CHAIR BRISS: So, Raquel?

13 MEMBER MAZON JEFFERS: I also am very
14 enthusiastic about the importance of this
15 measure. So thank you for bringing it forward to
16 the committee. I just had a couple of questions.

17 One is that the measure is focused on
18 the use of medication-assisted treatment to
19 support opioid use disorders alone and doesn't
20 include any counseling component as part of the
21 measure. There is a lot of evidence to support
22 the increased efficacy of medication-assisted

1 treatment coupled with counseling.

2 I know this is a matter of debate in the
3 field. I was wondering if you could talk a
4 little bit to why you chose to move forward with
5 medication alone as part of the measure and leave
6 out the counseling component.

7 I am going to hold off on --

8 DR. MATTKE: Okay, this is really a
9 practical issue. With medications, you can
10 basically track whether a patient adheres to the
11 treatment plan because the claims tell us how
12 many days were supplied and how many refills a
13 patient did or how many injections a patient got.
14 There is no normative source to tell us how many
15 counseling sessions you ought to have to
16 accompany your pharmacotherapy. Like some
17 patients may have to see a counselor or
18 psychiatrist once a week, even twice a week.
19 Some may go in once a month. Others might
20 receive the counseling component through sort of
21 non-medical settings like self-help group or
22 churches and we wouldn't see those in claims.

1 So, we had long debates in the team
2 whether we could also measure continuity of
3 counseling but we couldn't find a way of
4 operationalizing it for measurement purposes.

5 MEMBER MAZON JEFFERS: I would just --
6 I can understand the practical constraints that
7 you are struggling with but there are criteria
8 based on ASAM patient placement criteria based on
9 the level of severity of the patient for a
10 recommended level of counseling intervention that
11 are scientific and consistent. So based on
12 someone's level of severity, there are
13 recommendations for the level of intensity of
14 their counseling that are standardized.

15 DR. WATKINS: I think -- this is Kate
16 Watkins. I think the problem is that getting
17 that out of claims data is difficult because a
18 person may see -- first of all, it is really not
19 clear what counseling means and what is the --
20 how you define it. And getting that information
21 out of claims data, whether or not it is a
22 physician who is just counseling the patient in

1 the process of when they are prescribing the
2 medication, that could count but that wouldn't be
3 necessarily captured in the claims data.

4 CO-CHAIR BRISS: So, Mike.

5 MEMBER LARDIERI: Yes, I guess I just
6 need to understand why you wouldn't be able to --
7 I can understand if they are going to a church
8 group or something like that but every other
9 outpatient service, the outpatient providers
10 would be providing a claim to get paid. A
11 psychiatrist would provide a claim to get paid.

12 If they are not doing just medication,
13 the E and M codes, I believe show that you are
14 doing counseling or not. So I am having a hard
15 time understanding why you wouldn't be able to
16 get it under the claim. Because it is so
17 important to have the counseling component as
18 well as the medication.

19 I'm just looking through the ASAM. Do
20 you know what the ASAM criteria states around
21 that, whether you have to have counseling as
22 well? Because so many of behavioral health state

1 programs are requiring you to follow the ASAM
2 criteria. So have you looked at that, what that
3 says?

4 DR. WATKINS: We have. It doesn't
5 define what counseling -- it doesn't say is it --
6 and it is actually psychosocial treatment. So
7 but, again, it doesn't define whether or not it
8 is contingency management, whether it is relapse
9 prevention, whether it is just your physician
10 talking with you.

11 And yes you could use the E and M code
12 to code for delivering the medication and talking
13 to the patient but, again, you really don't know
14 what is happening in that interaction.

15 MEMBER LARDIERI: And maybe it is not
16 that important what is happening, the importance
17 is that it is happening I think is the way I
18 would look at it.

19 DR. MATTKE: Again, if you had more
20 content on the interaction, you could do that but
21 if somebody has regularly, say primary care
22 visits where increasingly addiction treatment

1 takes place, we really have no idea does the
2 patient talk about the addiction or is this about
3 diabetes.

4 I understand sort of conceptually what
5 you are trying to do, it is just from a
6 measurement perspective, it is extremely
7 difficult.

8 MEMBER LARDIERI: I'm still having a
9 hard time with that because we are so much
10 integrated now and we need to bill for both sides
11 of the house. And even many Medicaid programs,
12 now this is just on the commercial side, but on
13 the commercial side you pay for both a physical
14 health and a behavioral health payment on the
15 same day. So I am still having a hard time why
16 you wouldn't be able to capture that claim. I
17 don't get it.

18 CO-CHAIR BRISS: So I think I would like
19 to suggest that several of us had a variant of
20 this kind of comment about the medications work,
21 the counseling works, they are likely to work
22 better together. This isn't a part of the

1 measure we have in front of us today.

2 And so for the future, you guys might
3 want to think about whether at least there is
4 some minimum standard. You can never get a
5 perfect measure of the content of a counseling
6 session but you might be able to do some minimal
7 standard of whether some interaction happened
8 that might be better than nothing. And that is
9 likely to be a future-looking thing about the
10 measure that is in front of us.

11 So, Shane.

12 MEMBER COLEMAN: I am just curious if
13 you guys could comment a little bit on the six
14 month time period that it shows. I know you
15 mentioned preventing overdoses when people come
16 off the medication, though I think that occurs at
17 any time, like you mentioned. I think you guys
18 quoted three days.

19 And then also, trying to improve
20 people's outcomes or, I am guessing, maintain
21 sobriety. And I know that you mentioned
22 methadone maintenance having maybe higher rates,

1 I'm not sure of maintaining sobriety but, of
2 retention of certain time frames. But I am just
3 curious for other MAT medications, non-methadone
4 medications, I'm curious why the six months.

5 DR. MATTKE: We don't say just six
6 months. We say minimum six months. So, if a
7 patient stays on MAT longer, we would still say
8 give me the risk of a lethal overdose if you
9 interrupt. You still want to look for the gaps
10 in treatment. We do not advocate putting
11 somebody for just six months but I think that is
12 kind of a lower bar in terms of a sort of
13 reasonable duration of treatment that you can say
14 somebody is actually in OUD pharmacotherapy as
15 opposed to somebody just gets initiated and then
16 there is no follow through and the patient drops
17 off the radar.

18 DR. WATKINS: There is no question that
19 longer is better. I think the evidence is really
20 clear across the different medications that when
21 you stop, you do worse.

22 But given that, there is also empirical

1 data about how long is sufficient. And that is
2 why we ended up choosing six months because of
3 the FDA. The FDA approval trials were between
4 three and six months. Because there is no
5 empirical evidence about whether it should be six
6 months, nine months, twelve months, two years,
7 five years, forever. I think that is an area
8 that is in need of more research.

9 And we elected to go with the six months
10 because it should be at least six months.

11 MEMBER COLEMAN: Okay, thanks. Yes, I
12 guess I just bring it up because it is almost in
13 any venue you start thinking about offering MAT.
14 That is a question that comes up. So I am just
15 kind of curious at your guys' rationale. So, I
16 appreciate it. Thanks.

17 MEMBER ZUN: So I have a couple of
18 questions. So the first one is isn't the
19 ultimate goal to get them off of any medication?
20 So that is my first question. And how would we
21 then -- or maybe they transition to some other
22 therapy. And I am seeing no. Okay.

1 And then the other thing is if I
2 initiate treatment in the ED, who would that
3 apply to this? Would there then be that -- if
4 they did -- if they continued for six months,
5 then it would apply but would it be -- would it
6 come under my -- would my hospital be dinged if
7 they didn't follow through? Do you follow that
8 one?

9 DR. MATTKE: So the second one is easier
10 to answer. We are currently calculating on the
11 health plan level partly because the attribution
12 is actually tricky with these patients maybe
13 being initiated in like a detox center and then
14 going back into primary care. So we haven't
15 figured out attribution to providers. We just
16 say okay, a health plan who has the sort of
17 totality of the 30,000-foot view of the patient's
18 care should work with the contracted providers to
19 ensure treatment adherence and continuity.

20 The first one, whether the objective is
21 ultimately getting patients off any substance I
22 think, Kate, I defer to you on what the evidence

1 says.

2 DR. WATKINS: I do not think that is the
3 goal, necessarily of treatment. I mean
4 obviously, it is up to the patient and you have
5 to think about what the patient's goals are. But
6 in someone with diabetes -- I mean typically,
7 opioid addiction is thought of as a chronic
8 illness. And you would never say to a person
9 with diabetes the goal is to get you off
10 medication. People do better when they are --
11 the longer term treatment -- outcomes are better
12 with longer term treatment.

13 It may be that you have a patient that
14 wants to be off medication and that would be fine
15 and you would work with them on that but for many
16 patients, they stay on methadone for years and
17 years and years and that is what allows them to
18 have productive lives.

19 MEMBER ZUN: I'm not going to dispute
20 that but I am going to dispute the diabetes issue
21 because the goal is if their diabetes is because
22 they are overweight or they have an inappropriate

1 diet, you try to control that. So why would this
2 not be -- you know we want the least difficult
3 therapy. And if going to Narcotics Anonymous is
4 therapeutic for them, why would we want them to
5 continue taking methadone the rest of their life?

6 I am just not following all the
7 reasoning.

8 DR. MATTKE: And we are not saying they
9 should. We are just saying as long as you are on
10 methadone or other substitution treatment, you
11 should not have treatment gaps because that puts
12 you at risk.

13 CO-CHAIR BRISS: And it looked to me
14 like, just watching the body language in the
15 room, there appeared to be a lot of body language
16 suggesting that people feel like longer term
17 treatment, at least for some people, is a
18 reasonable thing. So I don't know that we need
19 to dispute the aptness of a diabetes analogy.

20 Next.

21 MEMBER PARISH: I just sort of had a
22 comment that was maybe something similar to his,

1 along the line that when is this going into
2 effect because I think that there is a large
3 culture of doing detox and the moving them off
4 into rehab without any medications.

5 In my work as a medical director I
6 cannot tell you how much I get well they need two
7 more days of detox because they still are on two
8 milligrams of Suboxone. And I am like, that's
9 fine, move him to rehab. But I think there is
10 really a culture there.

11 And the other concern I have is
12 especially for the rural areas, in terms of the
13 Suboxone prescribing, we do not have the
14 prescribers. And as you know, the DEA requires
15 at least the first visit to be done in person and
16 is there anything that can be done in terms of
17 looking at having that changed so that more can
18 be done through telehealth, et cetera for the
19 rural communities, where it would get hit the
20 hardest, I think, with this quality measure?

21 DR. MATTHE: Yes, very important
22 questions, well beyond what we can do with our

1 measure. I think we can just point out these
2 gaps and discontinuities. What to do with it are
3 probably people, policymakers, and other
4 decision-makers.

5 MEMBER TRANGLE: I'm a Suboxone
6 prescriber. I don't do it a ton. And I do think
7 there was something to what was said in terms of
8 when I have somebody coming to see me, one of the
9 first discussion we have is where are you coming
10 from, as a patient. And some people will come to
11 me and say well I want to go through detox and go
12 to NA and do some of that kind of stuff. And the
13 focus ends up being sort of an induction to get
14 them off. And if they really want that a lot, I
15 am willing to give them a try always.

16 I know that in reality most people that
17 are truly dependent are going to do far better on
18 a methadone program or a Suboxone maintenance
19 kind of program. But I think it is totally
20 within the scope of good practice to try an
21 induction and see if they can get psychosocial
22 supports and do okay.

1 And it doesn't seem like your measure
2 allows for short-term use, intending it to be
3 short-term use and then stop it. So that if I do
4 an induction and they just want to get off it, I
5 will get dinged for not keeping them on it for
6 six months when that was never their plan, unless
7 I am misunderstanding the inclusion criteria. So
8 that is one question.

9 I have a couple other questions but do
10 you want to just answer that one first?

11 DR. MATTKE: So there are initiation
12 measures like NCQA is in the process of adding
13 MAT to its initiation and engagement measures,
14 which would capture your patients.

15 MEMBER TRANGLE: But would they
16 automatically in or are they excluded, someone
17 where it has never been the intent to do
18 maintenance?

19 DR. MATTKE: We would require two
20 prescriptions before we can find somebody. So,
21 depending on how long your prescriptions are, we
22 may or may not capture that patient.

1 MEMBER TRANGLE: Okay.

2 DR. MATTKE: The question is can you
3 tell after a very short period whether or not a
4 patient is sort of well controlled and stable
5 under a Suboxone regimen or does this indeed need
6 the 180 days.

7 MEMBER TRANGLE: Sometimes yes,
8 sometimes no.

9 A couple of other questions. Well one is
10 really a comment. When I went through this, I
11 was on the committee or the three or four, or now
12 it is five or six people that reviewed these.
13 And one thing that struck me was that the
14 extended release naltrexone, the Vivitrol, only
15 had one study, 250 people in Russia. And it
16 wasn't graded.

17 But as it turns out, my qualms about
18 that sort of subsided because there was a New
19 England Journal article that came out March of
20 '16, the third week, where it was -- I jotted
21 some notes. Vanita, this is why we get along so
22 well -- where basically the median time to

1 relapse was twice as long for people that were on
2 Vivitrol, 10.5 versus 5 weeks. And there were
3 about a little bit less than 50 percent more
4 relapse events during the six months of the
5 active treatment. It was followed for 78 -- six-
6 month intervals but followed for 78 weeks. But
7 six months was active treatment with the
8 Vivitrol.

9 So there was at least another article
10 sort of saying yes, Vivitrol probably does work.
11 Otherwise, I was going to hassle you about that
12 but I won't.

13 DR. MATTKE: It is a little bit a quirk
14 of the NQF process in the way that they ask you
15 to present evidence. The first step is like are
16 there any nationally accepted guidelines that
17 support what you are trying to do here. And we
18 had the VA/DoD guideline which basically has the
19 -- which is the approval study for Vivitrol.

20 So then the question is so show the
21 evidence that is behind those guidelines and
22 explain what it does, which means then we go to

1 the Russia study which was the approval study.
2 And yes there are, not just the New England
3 Journal article but there is other papers in real
4 world settings that looked at efficacy of
5 Vivitrol.

6 MEMBER TRANGLE: So my last question is
7 I think the measure goes to 65. And if I am 66,
8 I am out, right? And I am just you know is that
9 because you didn't have evidence but it could
10 have been a good idea to do it later or just tell
11 me what your thinking was behind that.

12 DR. MATTKE: No, that was just a time
13 constraint. In order to test it in patients over
14 65, we would have had access to Medicare data
15 plus Medicare prescription plan claims.

16 MEMBER TRANGLE: Oh, you didn't have the
17 Medicare data so you didn't include it.

18 DR. MATTKE: So we had like three months
19 to prepare the submission and especially Part D
20 data, actually, not easy to get. And so it was
21 just a practical perspective and we completely
22 intend to test both Medicaid and Medicare going

1 forward.

2 CO-CHAIR BRISS: So you have heard a
3 couple of times now that broadening the patient
4 base in a variety of ways might be constructive
5 going forward.

6 So, Rhonda, I would love to get through
7 the remaining comments on this criterion
8 relatively quickly and be starting to think
9 moving toward a vote.

10 MEMBER ROBINSON BEALE: I have a patient
11 safety question. Has there been any studies to
12 look at patients who have been on medication-
13 assisted treatment, dropped off and looked at
14 that impact on the death rate?

15 So in other words, is this increasing
16 the number of people who are dying of overdose or
17 is it the access to the opioids in the streets?

18 DR. MATTKE: No we actually show quite
19 a bit of evidence the mortality goes up if you
20 interrupt medication-assisted treatment. And
21 that is because if you go on agonists, partial
22 agonist or antagonist therapy, your learned

1 tolerance of synthetic opioids, particularly,
2 decreases. And then if you relapse and use kind
3 of what you used before, you have a higher risk
4 of overdosing.

5 So the safety issue is not the
6 treatment. The safety issue is interruption.

7 MEMBER ROBINSON BEALE: Understood that
8 the treatment is making patients more sensitive
9 to that. So the reason why I raise that -- and,
10 believe me, I am for medication-assisted
11 treatment, I always get concerned when we put a
12 measurement in place, and particularly if it is
13 going to be used in any way to judge the efficacy
14 of treatment if there is a huge safety factor
15 that is not written into this. There is nothing
16 that warns people on this and also that there is
17 built into, and I don't know, maybe you can't
18 talk, but in the guidelines something that helps
19 providers to understand and that they need to be
20 very vigilant about counseling people on that, as
21 well as their families. I just want to make sure
22 that people are aware of that.

1 So, I see that as a huge safety factor.

2 DR. MATTKE: Yes, and that is precisely
3 why we want that measure because the NCQA measure
4 will look at initiation, how many people get put
5 on MAT. The Joint Commission measure already
6 does that but no measure, thus far, looks at
7 continuity, which is exactly what you point out
8 that unless you are also looking into continuous
9 care, you are creating a safety issue.

10 MEMBER ROBINSON BEALE: Do we know that
11 if the treatment stops at 180 days that the
12 incidence of overdoses goes down? Is there a time
13 frame to this?

14 DR. MATTKE: They are not saying you
15 should stop at 180 days.

16 MEMBER ROBINSON BEALE: I understand.

17 DR. MATTKE: So if you say this is the
18 minimum duration for which we have evidence, we
19 fully acknowledge that the duration could be
20 years but we say for the duration of your
21 pharmacotherapy, you shouldn't have these gaps
22 because these gaps are dangerous.

1 MEMBER ROBINSON BEALE: Understood. I'm
2 just to respond to the lay provider public who
3 will try and do this, even if they become
4 Suboxone prescribers and others, need to make
5 sure that the safety factor is being addressed in
6 some way because the measure is going to promote
7 the use, it is going to promote the use of 180
8 days. And unless the measures only apply to very
9 specific types of prescribers and not more
10 generalized, that is where I get more concerned.

11 I don't know if I am making my point.

12 MEMBER PINDOLIA: Hi. So this question
13 is we had a huge discussion at our PNT like in
14 March last year because of all the national
15 considerations on re-reviewing all the different
16 possible drugs that could be used, what is the
17 pros and cons, what is going on. And even after
18 removing all stops and making this publicly
19 acknowledged that please, if you have a patient,
20 these are available, with the only exception as
21 being Evzio because it is \$4,500 a dose of having
22 a little bit more criteria for that.

1 My question for you is with all this, we
2 are just completing a one-year post analysis to
3 take back to PNT. And it is like to your point,
4 after the first dose, there is very few that come
5 back for their refills. So, in your evidence for
6 wanting to have the six-month continuation, did
7 you run across the data of what makes that
8 discontinuation?

9 And the reason I am asking is it goes
10 back to the earlier comments about the
11 counseling. I think there was an NCQA depression
12 measure a while ago. And within the first six
13 weeks you had to have a follow-up phone call and
14 it was sort of linked with also drug
15 continuation. And it would really help for a
16 health plan who is trying to remove all the
17 blocks and trying to have the access of the drugs
18 available, trying to promote this in the
19 community but if they are not having a physician
20 or a someone to follow-up, even if it is a PCP,
21 there is nothing that we can do as a health plan.
22 And maybe if it was part of a quality initiative

1 to say the measure requires both, that is a
2 different message, as a health plan, we can send.

3 So, two questions. One is when you are
4 reviewing for this, did you come across the
5 evidence of why people are discontinuing? And
6 then second, to reconsider of having it coupled.

7 DR. MATTKE: Yes, Kate --

8 CO-CHAIR BRISS: On the second one, I
9 think we have essentially talked about that
10 already. So, I would like to suggest you answer
11 the first one and then we go on, please.

12 DR. WATKINS: We don't know why people
13 are discontinuing. We think that at least some
14 of it has to do with transitions in care, where
15 they are transitioning from one care location to
16 another and they are fall between the cracks.
17 But we don't know why people drop out.

18 CO-CHAIR BRISS: Thank you. Raquel?

19 MEMBER MAZON JEFFERS: I wanted to go
20 back to Rhonda's questions about safety. So this
21 is not a scientific study but based on
22 experiments -- based on experience, in New Jersey

1 we are seeing the highest rate of overdose
2 immediately post-NARCAN reversal for people. So,
3 individuals who have overdosed, they have entered
4 the emergency room or they have had an encounter
5 with a police officer who administers the NARCAN
6 has been reversed but they have received no
7 engagement in treatment and they have not
8 received any medication-assisted treatment, which
9 if it is a medication like Suboxone, it includes
10 a protection against overdose.

11 So the death rates we are seeing are
12 more to do with the chronic relapsing nature of
13 the disease. After the NARCAN administration,
14 people feel very uncomfortable. They go back on
15 the street and they are very driven to use.

16 So I see the continuity of care using a
17 medication like Suboxone for people with an
18 opiate use disorder and maintaining them for six
19 months, hopefully linking them with counseling to
20 begin to really address their underlying
21 addictive disorder is really increasing safety
22 because you give them a chance to actually

1 experience what they need and to grow and develop
2 and be able to achieve some recovery that would
3 prevent them from using right away. You are also
4 administering a medication that has an overdose
5 protection quality.

6 So, we are actually seeing more
7 overdoses for people who are, as Brooke
8 described, going into residential treatment with
9 no medication, being released, and then using
10 upon release because they are still feeling
11 withdrawal and craving. Their brain
12 functionality hasn't been normalized and then
13 they relapse and use. And that is where we are
14 seeing the overdoses happening.

15 CO-CHAIR BRISS: Thank you.

16 Tami and then I will give Shane the last
17 word and then I would like to move to a vote,
18 please.

19 MEMBER MARK: Okay, I just wanted to add
20 a couple of data points to the discussion. I
21 think the main paper people cite to show that
22 adherence is important is this Weiss paper that

1 followed people in my study that showed that when
2 people discontinued prematurely, there was a huge
3 relapse rate.

4 They published a study recently where
5 they continued to follow people for 42 months.
6 And after 42 months and about a third of the
7 population was abstinent and not on an agonist
8 therapy, meaning that after a significant amount
9 of time, three years or more, you can get a third
10 of the population into recovery and they don't
11 need buprenorphine. So it is not like diabetes.

12 But that is not saying that if they are
13 not on it for the first nine months, there is not
14 a high risk of what Raquel is talking about. So,
15 I just wanted to bring that data point up.

16 The other data point is on the safety
17 point, I believe the guidelines don't say that
18 buprenorphine is contraindicated in pregnant
19 women. I didn't see that as an exclusion.

20 And then the third point is when I have
21 done these -- I know you excluded methadone
22 because you said it is not available on drug

1 claims but when I have used claims, I can
2 identify methadone through a HCPC code. So I
3 think you can include methadone in your
4 specifications and that would be important.

5 DR. MATTKE: Yes and we do include
6 methadone if it is given through the HCPC code
7 H0020. We do not include it if it is dispensed
8 through a pharmacy claim because, legally, that
9 is not permissible.

10 MEMBER MARK: Yes. And then just my
11 final picky point, and this goes to the evidence,
12 I mean your evidence shows that the adherence
13 rate is low. You used a claim period, though,
14 right? Because I didn't see that you used a
15 claim period. These are all people who were
16 newly initiated on the medication. You are not
17 picking them up at --

18 DR. MATTKE: It is cross-sectional. So,
19 we did not specifically look for new initiation.
20 We basically start looking when we see the
21 patient.

22 MEMBER MARK: Yes, see that is

1 problematic. That is not what this measure is.
2 This measures is newly initiated and followed for
3 180 days, right?

4 DR. MATTKE: No, it is not.

5 MEMBER MARK: Well, some of these people
6 could have been on it for five years and --

7 DR. MATTKE: Correct.

8 MEMBER MARK: So, that is not the right
9 measure.

10 DR. MATTKE: I think the really critical
11 component of the measure is the gap, not
12 necessarily the duration.

13 MEMBER MARK: Well your measure is not
14 a gap. Your measure is a duration. Your measure
15 is whether people are on it for --

16 DR. MATTKE: In order to pass the
17 measure, you have to have at least 180 days in
18 our observation period and no gap greater than
19 seven days.

20 MEMBER MARK: So you are including
21 people who could have been on this for three
22 years and then they just stopped and so they

1 wouldn't have 180 days because they just were in
2 the last month of the three-year period on the
3 medication.

4 DR. MATTKE: We could, yes.

5 MEMBER MARK: That is very problematic.

6 I mean that is not the way the measure
7 is described and I don't think that is an
8 appropriate measure. The measure is -- we want
9 to get people who are newly initiated because
10 that is the critical time period. That is what
11 the evidence shows, if you are newly initiated,
12 you should be on it for nine months, unless there
13 is a safety issue. But that is not what this
14 measure is.

15 CO-CHAIR BRISS: So let me suggest on
16 this point we have had a pretty far reaching
17 discussion on this point. This is really a
18 measure spec thing that I would call reliability.

19 So I would sort of like to vote on --

20 MEMBER MARK: Well I think it -- let me
21 just say, Peter, it does go to evidence because
22 the evidence that they are presenting of a low

1 adherence rate is based on this spec that is
2 inappropriate. So I would argue the adherence
3 rate is probably much higher if they had the
4 appropriate spec. So I might say that when we
5 vote on evidence, we might want to say it is
6 insufficient.

7 DR. MATTKE: So to be clear, we are
8 aware that many patients are on long-term
9 treatment and should be. And what we want to
10 measure is primarily the gap in care because we
11 know that that is predictive of mortality. There
12 are other measures of treatment initiation, which
13 we didn't want to duplicate.

14 DR. WATKINS: I would also say that it
15 is unusual for someone who has been on long-term
16 medication-assisted treatment, it would be
17 unusual for after a number of -- or it would be a
18 minority of people after multiple years to decide
19 to stop.

20 MEMBER MARK: That is just the opposite
21 of the evidence I just cited from the study. It
22 showed that a third of the people after three

1 years stopped and were no longer addicted. So
2 that is what the evidence from the Weiss study
3 shows.

4 CO-CHAIR BRISS: Aren't you saying the
5 same thing? So a third of people is a minority
6 of people, right?

7 DR. WATKINS: That's correct.

8 CO-CHAIR BRISS: So, Shane, I will give
9 you the last word and then we will vote on
10 evidence, please.

11 MEMBER COLEMAN: I think I just wanted
12 to I guess comment on the retention rate issue
13 again, like understanding a little bit about why
14 people might develop more than a seven-day gap.
15 I mean I guess I just want to say how important
16 it is, again, because it is mysterious. It is
17 something we are struggling with too in our
18 system how to keep -- you know if you look at the
19 studies of retention rates might get as high as
20 60 or 70 percent. Some of them are seeing people
21 like every other day during the first week. Like
22 in our induction, we have them come back within a

1 week. So, we are playing with factors like that
2 but our retention rates -- I won't go into too
3 many details. Like we are also, because of our
4 priority systems in the state, focusing on IV
5 users and things like that so we don't get the
6 lower end of the spectrum as much but our
7 retention rates are like 20 or 30 percent. So we
8 are really struggling to figure that out, too.

9 So in this measure, I would be -- I mean
10 it is still good. I think it will prompt people
11 to continue to think about this but I am little
12 uncomfortable that I feel like there is no
13 answers out there for how to improve your rate.
14 But, again, maybe it will drive us to think about
15 that. I don't know.

16 And real quick, the natural course for
17 folks, in my experience, is that around two or
18 three years, they do start asking should I stay
19 on the medication. It is not unlike other
20 chronic diseases. And I would argue that at
21 least the majority of folks actually ask that
22 question. Not all of them will feel comfortable

1 getting off but I still actually think I feel
2 very comfortable with in my experience the
3 majority of folks, after if they make it three-
4 ish or so years to really start thinking about
5 coming off the medication.

6 CO-CHAIR BRISS: All right, so I would
7 like to move us to a vote. This is on the -- it
8 is essentially on the evidence of the measure
9 concept, which is the continuity of treatment
10 without gaps would make people better off.

11 MS. QUINNONEZ: We are not voting on
12 Measure 3175, Continuity of Pharmacotherapy for
13 Opioid Use Disorder. We are voting on evidence.

14 Voting is open for evidence. Option 1
15 is high; option 2, moderate; option 3, low; and
16 option 4, insufficient. Option 1, high; option
17 2, moderate; option 3, low; and option 4,
18 insufficient.

19 Okay, voting is now closed. For Measure
20 3175, the results read as follows: 17 percent
21 voted high, which is three individual votes; 56
22 percent voted moderate, which is ten individual

1 votes; zero percent voted low; and 28 percent
2 voted insufficient, which is five individual
3 votes.

4 For the evidence of Measure 3175, this
5 passes the criteria for evidence.

6 CO-CHAIR BRISS: All right, I have let
7 the discussion of the criterion get fairly broad.
8 I hope that will shorten the rest of our
9 conversation. So please, if things have already
10 been discussed, there is no need to re-discuss
11 them.

12 So, anybody want to tee -- the evidence
13 for gaps in care is on the screen in front of
14 you. Anyone want to tee this up for us, please?

15 Yes, Vanita.

16 MEMBER PINDOLIA: I'm sorry, I'm not one
17 of the primary reviewers. I'm not really teeing
18 it up but when I am looking at the chart that is
19 available for the gap, I was under the
20 misperception that this was for new starts. So
21 now relooking at this, how do you interpret these
22 gaps when you don't know at what point they were

1 at in their treatment to then say there was a gap
2 of discontinuation of six months if they really
3 were at the end of the two or three year when you
4 captured this?

5 DR. MATTKE: Yes, it is always an issue
6 with long-term measurement and cross-sectional
7 data. It is possible that we captured a few
8 people that were on the sort of natural end of
9 their treatment. But since this is chronic
10 treatment, I think given that they have a two-
11 year frame, a rolling two-year time frame during
12 which we look at numbers I think we still have
13 kind of the vast majority of people who are in
14 ongoing treatment and will continue treatment.

15 CO-CHAIR BRISS: And so it looks to me
16 -- so the way that I would interpret the chart,
17 in light what Tami has said is that just on its
18 face, based on the data presented, there is a
19 fair amount of room for improvement if you look
20 at the means. On its face over time, there has
21 been some improvement over time.

22 And even if -- and maybe Tami gives us

1 some context. So even if say for the purposes of
2 argument that a third of people actually
3 eventually quit and are appropriately off, add a
4 third to those means and you still get up to --
5 if conservatively you add another 0.33 to all
6 those means, you are still at 50 percent or 60
7 percent and that is almost certainly an
8 overestimate of the people that are appropriately
9 quitting. So it looks to me like the measure is
10 not specified perfectly but if they can't easily
11 identify new starts, this still seems to suggest
12 under treatment.

13 Raquel.

14 MEMBER MAZON JEFFERS: Wouldn't it be
15 possible to simply add an exclusion for
16 individuals who were on the medication for a
17 continuous duration of I don't know a year to two
18 years and just exclude that population from the
19 denominator, I guess?

20 DR. MATTHE: Yes, it gets tricky. We
21 had many discussions in the team how to best
22 specify it with respect to make it cross-

1 sectional and capture a larger population or make
2 it sort of new initiations and just drag those
3 guys where you lose two-thirds of the population.

4 We wanted to make it encompassing. We
5 wanted to have kind of the population on OUD
6 pharmacotherapy and chose the cross-sectional
7 approach over the just look after initiation.

8 It is in commercial claims very hard to
9 build a long-term patient trajectories because
10 people change health insurers, insurance quite
11 often. So if you start putting in
12 inclusions/exclusions that say we have to look
13 like three years back, you decimate your sample
14 and then you are back to the problem of having a
15 very precise answer for a very small subset of
16 the population.

17 That is, unfortunately, always the trade
18 of the claims data like how specific are you
19 getting versus how sensitive is your definition
20 to what you are trying to measure.

21 MEMBER MARK: I mean I have done a lot
22 of these claims studies and typically what we use

1 is a 30-day claim period. And you do lose some
2 generalizability but you don't lose a lot.
3 Thirty-day claim period just means you are
4 excluding anyone who is on the medication for 30
5 days prior to the index. So you are only getting
6 new initiators, which I think is really what you
7 want. I mean that is the sample you want. You
8 want to know if someone is starting this
9 medication. They are going to stay on it for
10 nine months. It is a pretty easy exclusion. It
11 is done all the time. It is probably done in the
12 antidepressant measures. I don't know if anyone
13 knows that but it would be harmonized with that
14 antidepressant measure if you also used the same
15 claim period.

16 So, I think it could be done and it
17 would be consistent with our other adherence
18 measures.

19 DR. MATTKE: I don't dispute that you
20 could have done it that way but the problem is if
21 you only look at the initiators, you just lose
22 all the people in ongoing treatment who are also

1 at risk with these caps. I mean it is kind of it
2 is a philosophical difference whether you want to
3 have a cross-sectional measure or a new
4 initiation measure and we chose one of the two.

5 CO-CHAIR BRISS: So I don't see any
6 other cards up. So maybe let's try to move to a
7 vote on performance gap.

8 MS. QUINNONEZ: Voting is open for
9 performance gap of Measure 3175. Option 1, high;
10 option 2, moderate; option 3, low; and option 4,
11 insufficient. Looking for a couple more votes.

12 Voting is now closed. For performance
13 gap of Measure 3175, 28 percent voted high,
14 that's five individual votes; 11 -- oh, excuse me
15 -- 61 percent voted moderate, 11 individual
16 votes; 6 percent voted low, one individual vote;
17 and 6 percent voted insufficient, one individual
18 vote.

19 So for performance gap of Measure 3175,
20 this passes the gap criterion.

21 CO-CHAIR BRISS: Reliability. Would
22 anybody like to tee this up for us? Raquel?

1 MEMBER MAZON JEFFERS: So I just had a
2 question about the definition of the care setting
3 being quote, unquote outpatient setting. Can you
4 just clarify if this measure can be used in
5 primary care settings as well?

6 DR. MATTKE: Yes, I think we made a bit
7 unfortunate choice in checking boxes but we are
8 agnostic to care settings. So it could be
9 primary care. It could be specialty and mental
10 health, behavioral health. But any encounter is
11 used in care settings, et cetera.

12 CO-CHAIR BRISS: Mike.

13 MEMBER LARDIERI: Yes, thanks. Could
14 you just explain why you stop at age 64? We're
15 all getting a lot older and many older people are
16 abusing substances all over the place. So why
17 stop at 64?

18 CO-CHAIR BRISS: I think we did that
19 already. So, the answer was availability of data
20 for testing. They didn't have Medicare data.

21 So they have already gotten advice to
22 broaden the pair mix and broaden the age --

1 MEMBER LARDIERI: I missed that. Sorry.

2 CO-CHAIR BRISS: Anybody else, comments
3 for reliability? We have gotten a number of
4 comments about specifications already. Let's try
5 to move to a vote.

6 MS. QUINNONEZ: Voting is open for the
7 reliability of Measure 3175. Option 1, high;
8 option 2, moderate; option 3, low; and option 4,
9 insufficient. Option 1, high; option 2,
10 moderate; option 3, low; and option 4,
11 insufficient.

12 All votes are in, voting is now closed.
13 For the reliability of Measure 3175, zero percent
14 voted for high; 79 percent voted moderate, which
15 is 15 individual votes; 11 percent voted low,
16 which is 2 individual votes; 11 percent voted
17 insufficient, which is 2 individual votes.

18 So for the reliability of Measure 3175,
19 this passes the criteria.

20 CO-CHAIR BRISS: So and we move to
21 validity. I'm going to tee this up. There was
22 face validity testing where eight out ten

1 clinicians mostly just agreed that the results
2 were meaningful that -- I've lost my place.
3 Sorry. While I try to find where I am -- we have
4 talked about so face validity testing is as we
5 discussed. We have talked about exclusions. We
6 have talked about meaningful differences.

7 And I'm open to comments from the
8 committee. Yes, Shane.

9 MEMBER COLEMAN: I don't know if this is
10 a huge deal but I just guess I want to say it out
11 loud. Mostly like yesterday someone brought up
12 kind of gaming the measure of sorts.

13 I would want to make sure that somehow
14 this didn't incentivize systems to not offer MAT
15 to the sickest folks who, arguably, might be the
16 most likely to have a hard time not having a
17 seven-day gap in the system. And in the spirit
18 of, again, thinking through how can incidentally
19 or accidentally do harm to folks. And I don't
20 have an answer for how to fix that of sorts but I
21 would worry that people -- you know if I were a
22 system and I wanted to reach some sort of

1 benchmark with this measure, I might exclude the
2 people who need it the most because I know they
3 are the people to keep good retention rates of
4 sorts. So I don't know. I guess I would just
5 offer that as a caution of sorts.

6 DR. MATTKE: Yes, keep in mind, though
7 that there is going to be an NCQA measure very
8 visible measure that looks at initiation rates
9 starting in 2018. So if you actually played that
10 game, you would get dinged on that measure.

11 So we hope that together those actually
12 capture both the ability to start patients and
13 the ability to keep patients in treatment.

14 CO-CHAIR BRISS: Mike.

15 MEMBER TRANGLE: I really would like to
16 hear details, if you could share them, about why
17 most of the experts disagreed. You know?

18 CO-CHAIR BRISS: But eight out of ten
19 agreed.

20 MEMBER TRANGLE: What?

21 DR. MATTKE: Eight out of ten agreed.

22 MEMBER TRANGLE: Oh, maybe I heard it

1 wrong, then.

2 Never mind.

3 CO-CHAIR BRISS: All right, I think we
4 are wearing the committee out. Anybody else want
5 to make a comment before we vote on validity?

6 It looks like we are ready to vote.

7 MS. QUINNONEZ: Voting is now open for
8 validity of Measure 3175. Option 1, moderate;
9 option 2, low; option 3, insufficient. Option 1,
10 moderate; option 2, low; option 3, insufficient.

11 All votes are in. Voting is now closed.
12 For validity of Measure 3175, 74 percent voted
13 moderate, which is 14 individual votes; 11
14 percent voted low, which are 2 individual votes;
15 16 percent voted insufficient, which is 3
16 individual votes.

17 For the validity of Measure 3175, this
18 passes the validity criterion.

19 CO-CHAIR BRISS: So on feasibility, this
20 was calculated based on a publicly available
21 database and the developers didn't report
22 problems.

1 Anybody want to make additional
2 comments? Yes, Tami.

3 MEMBER MARK: So I just want to clarify.
4 So this will encourage providers to keep anybody
5 on the medication, regardless of how long. I
6 mean what is the implication of your
7 specification is what I am trying to think
8 through.

9 DR. MATTKE: Again, the implication is
10 that you should avoid treatment gaps. You are
11 going to see a few patients that will pretty much
12 go off medication as a conscientious decision and
13 carefully, not in terms of a gap but really
14 treatment end. But other than that, we would
15 like to see that people are in continuous
16 treatment and don't have these interruptions.

17 MEMBER MARK: So by treatment gaps, do
18 you mean treatment discontinuation ever?

19 DR. MATTKE: No, treatments of
20 interrupted treatment that you have a short
21 period during which you are not on the MAT
22 because we do know that those periods are kind of

1 the highest risk people.

2 CO-CHAIR BRISS: Except it is true -- it
3 would be true that the way the measure is
4 specified that if somebody appropriately stopped
5 these meds at four years, that would also count
6 as a treatment gap, right?

7 DR. MATTKE: Correct.

8 CO-CHAIR BRISS: So it is one of those
9 measures that specified in a way that you are not
10 going to be able to get a perfect score. And you
11 have to decide how you feel about that. That is
12 not always a problem with the measure, in my
13 view.

14 MEMBER MARK: It is not just you are
15 always going to have a perfect score, you are
16 going to encourage people to keep them on the
17 medication, regardless of how long they have been
18 on it. There is no disincentive to ever take
19 them off because -- after the six months. But
20 they are not -- no matter what, it is going to be
21 measured.

22 CO-CHAIR BRISS: Yes, it is true. That

1 is probably a usability and use issue. Depending
2 on, at least the way that I would frame that up,
3 it is true here, as elsewhere, that sometimes
4 high stakes measurement might be able to
5 precipitate clinically inappropriate behavior on
6 all kinds of measures. My residents periodically
7 wanted to do mammograms on structure-bound
8 people, people with six-month life expectancies.
9 So it is possible in all kinds of measurement
10 issues that if you are paying too much attention
11 to the measure and not enough attention to the
12 patient, that you can get yourself into trouble.

13 Yes.

14 MEMBER MAZON JEFFERS: So, let's say I
15 was initiated and then I began on the medication
16 and I stayed on the medication for six months or
17 five months. And then I -- well, let's say six
18 months. And then I terminated the medication.
19 Is that called a gap or that is fine?

20 DR. MATTHE: That would be fine because
21 you had 180 days of uninterrupted treatment. I
22 think what your colleague referred to is the

1 situation where somebody kind of comes into our
2 database with a two-year history of preexisting
3 treatment.

4 MEMBER MAZON JEFFERS: Right.

5 DR. MATTKE: You don't see that history
6 we think you are only -- we only see you have
7 four months and we count you as insufficiently
8 treated whereas, this may have been a
9 conscientious decision to go off treatment.

10 I don't disagree that there is some
11 measurement error in this kind of without our
12 ability to not see the entire patient trajectory.
13 But we wanted to err on the side of sensitivity
14 over specificity and that is a choice. We can
15 debate it but we thought this is the better
16 choice, given that the performance gap is so
17 large.

18 CO-CHAIR BRISS: Okay, so I think we
19 have explored that issue in detail and it is not
20 -- I don't consider it really a feasibility
21 issue.

22 Anybody have other issues about

1 feasibility? Could we please vote on this
2 criterion, please?

3 MS. QUINNONEZ: Voting is open for
4 feasibility of Measure 3175. Option 1, high;
5 option 2, moderate; option 3, low; and option 4,
6 insufficient.

7 All votes are in. Voting is now
8 closed. For feasibility of Measure 3175, 42
9 percent voted high, which is 8 individual votes;
10 53 percent voted moderate, 10 individual votes; 5
11 percent voted low, one individual vote; and zero
12 percent voted for insufficient.

13 For the feasibility of Measure 3175,
14 this measure passes this criterion.

15 CO-CHAIR BRISS: And usability and use.
16 New measure so, not being currently used.

17 Vanita?

18 MEMBER PINDOLIA: Peter, I had a
19 question. Can we ask the developer that over the
20 next -- because it will come back for renewal in
21 three years if it passes, right, so can we ask
22 the developer that, over these three years, can

1 they track some of questions that we are having?
2 The one that we are all concerned on is the
3 reason for the gap. It is like a big unknown for
4 all of us that are really trying to improve this.

5 I don't know if you are capable of
6 getting that data in any sort of way but they
7 would have the largest amount of data from lots
8 of different plans and patient population.

9 And then second, to address the concern
10 that a patient that might be ready to stop might
11 inadvertently continue. So, if the data could be
12 collected to say this was a new start or 50
13 percent were new starts, 20 percent had a prior
14 fail before we started counting the six months,
15 that you can tell. I understand if you are new
16 the plan you can't but that might help during the
17 renewal period for those questions.

18 CO-CHAIR BRISS: And you have gotten
19 other suggestions as well.

20 MS. MUNTHALI: You can definitely ask
21 the developer for that. And as part of our
22 evaluation, even though it is not currently in

1 use, we do ask for a plan for use by your next
2 maintenance in three years. So, I am not sure if
3 this submission included that but that is
4 something we would want you to get into your
5 submission rather quickly.

6 CO-CHAIR BRISS: Charles.

7 CO-CHAIR PINCUS: What is the time frame
8 for that?

9 CO-CHAIR BRISS: Charles.

10 MEMBER GROSS: Harold, did you get your
11 question answered? Did you get your question
12 answered? Oh, she's looking.

13 MS. MUNTHALI: Oh, now it is working.
14 So did you have the plan ready? Tracy, does it
15 have an end of submission? And that should be
16 fine but with regards to the other suggestions,
17 you are nodding, so it looks like they will be
18 able to update the submission by the next
19 maintenance.

20 MEMBER GROSS: So just to follow-up on
21 Vanita and Tami's point I mean I think this is a
22 useful measure but it may be the law of

1 unintended consequences with it being useful.
2 And opioids being such an important topic, from a
3 payer perspective, many state plans will see a
4 measure like this, if endorsed by NQF and they
5 want to attach dollars to it. And that goes to
6 performance issues. In fact, there may be a good
7 clinical outcome to fail with certain patients on
8 this measure and yet from a health plan
9 perspective, states may want to include this.

10 I wonder from an NQF perspective are
11 there ways to address that sort of issue or talk
12 about it so that new measures that need further
13 development don't automatically slide into a
14 contract that Anthem has to deliver on or that
15 Rhonda has to deliver on because the state says
16 gee, opioid, you should keep people in treatment
17 for six months and a day, irregardless, and if
18 you don't, there is a big penalty.

19 CO-CHAIR BRISS: So I think we have
20 talked about this issue a lot already. So right
21 now we need to vote the measure as it is
22 currently specified and you have to decide how

1 important you think that issue is today.

2 It sounds like me it would behoove you
3 to see if you can -- the truth is my guess is
4 that the number of people that you pick up after
5 two and a half years that come off appropriately
6 before they get to 180 additional days is likely
7 to be a relatively small number. And it sounds
8 like, based on -- Harold I think you are recused.

9 CO-CHAIR PINCUS: I have a question.

10 CO-CHAIR BRISS: But anyway, my guess
11 would have been that this issue is likely to be
12 relatively small numbers of people but you are
13 going to have to vote today knowing what we know.

14 And then I think it would behoove you
15 guys to see if you can figure out how big that
16 population actually is.

17 DR. MATTKE: Yes, we are happy to look
18 into it. Now that MAT gets more common, we
19 actually kind of a better sample to track people
20 over time. And as you see in the national
21 database, we only had like 40,000 in the
22 denominator so it became really, really hard to

1 do long-term observations but going forward, that
2 should be possible.

3 MEMBER MARK: I will just say when I
4 looked at claims data, the adherence rate seems
5 much higher than what I am seeing in this data
6 set. That is another for my skepticism.

7 CO-CHAIR BRISS: Tami are you still --

8 MEMBER PINDOLIA: If I could just add
9 comment. I think what Charles is saying is a
10 comment I gave to Helen yesterday at the end of
11 the meeting. When it comes to usability because
12 now what gets endorsed with NQF has a very
13 powerful meaning for Pay-for-Performance and
14 incentive and provider incentives.

15 And I did suggest to Helen that we need
16 to look at it a little differently now in NQF
17 when we look at -- and I know you can't say this
18 is endorsed for Pay-for-Performance or not but I
19 really like the idea of being able to say that
20 NQF at least recommends that this measure is
21 endorsed as NQF of bringing quality. However,
22 because of these certain caveats, can it

1 recommend, at least, not that anyone has to
2 follow it, of course, but that it cannot be put
3 into a Pay-for-Performance during that first
4 initial phase.

5 CO-CHAIR BRISS: Don't we have an option
6 for --

7 MS. MUNTHALI: The committee can
8 strongly put out that statement. We can put it
9 in the report that accompanies your
10 recommendation that you would strongly advise
11 application for this level. So that is something
12 we can do.

13 CO-CHAIR BRISS: And don't you also have
14 an option to endorse for further testing or
15 something or -- what is the NQF language? There
16 is a -- I'm getting blank looks from all the
17 staff.

18 CO-CHAIR PINCUS: Let me just ask a
19 question. In terms of overall NQF policy, so it
20 is not just endorse or not endorse, it is endorse
21 and you can specify things?

22 MS. MUNTHALI: You are giving

1 recommendations. They can be strong
2 recommendations. NQF is not the committee. And
3 part of your discussion, we would have captured
4 this anyway in the report, but we can pull out
5 specific recommendations for the field and for
6 the developer.

7 CO-CHAIR PINCUS: So in terms of both
8 its application, also requesting we need in X
9 amount of time additional information?

10 MS. MUNTHALI: Right. So while we say
11 that our process is use agnostic, we do know that
12 the policy around application has changed and we
13 are evolving. And the stakes are higher. But
14 you did not factor this into your evaluation.
15 This is not must pass for a reason but we want to
16 reflect that there is some tension there. There
17 is a strong recommendation for the failed with
18 regards to how you see this measure being used.

19 MEMBER TRANGLE: Along those lines, I
20 think we should make a strong recommendation,
21 one, that the data be subdivided into new starts
22 and ongoing use. And once again, I think in some

1 sense in my own system we are trying to track
2 opioid use. We have defined new starts as six
3 months and our health plan uses that and our
4 delivery system uses that. And once you start
5 defining just some of these fundamental blocks
6 around which everything else is built, other
7 things flow. But if everybody is going to have a
8 different definition of what is a new start, how
9 much of a clean period do you need?

10 And I think the systems need some
11 definition of that around which we can kind of
12 build other sorts of measures. Does that make
13 sense?

14 So minimally, the recommendation is I
15 don't know that I care a lot whether it is only
16 new starts or it is everyone, as long as you can
17 subdivide the data and we could look at both
18 discretely.

19 And then two, the tobacco people have
20 come up with a way to measure counseling in some
21 of the measures we have already approved and
22 endorsed. And I would encourage you to build

1 that in and look at some of the other
2 methodologies.

3 From my perspective, these aren't enough
4 things to sort of say I won't vote for it but it
5 really needs to be improved and more useful.

6 MEMBER LARDIERI: And how is that
7 exemption displayed? Is there like an asterisk
8 behind the numbers so it is like visible or do
9 people have to go into the report and read the
10 report to get to it?

11 MS. MUNTHALI: They would have to go
12 into the report. So it would not be displayed on
13 our Quality Positioning System where you find our
14 measures. It is our external database but they
15 will have to go into the report. I mean we
16 could, perhaps, bold it or something.

17 MEMBER GROSS: I was going to say let's
18 vote but could the committee reconsider how they
19 have displayed it? Nobody is going to find it in
20 the body of the report or many people won't. You
21 guys don't need to respond but just consider
22 that.

1 MS. QUINNONEZ: Voting is now open for
2 usability and use of Measure 3175. Option 1,
3 high; option 2, moderate; option 3, low; and
4 option 4, insufficient information.

5 All votes are in. Voting is now closed.
6 For the usability and use of Measure 3175, 5
7 percent voted high, one individual vote; 58
8 percent voted moderate, 11 individual votes; 26
9 percent voted low, 5 individual votes; and 11
10 percent voted insufficient information, just 2
11 individual votes.

12 CO-CHAIR BRISS: We will have closing
13 arguments before we vote on the overall
14 suitability for endorsement that haven't already
15 been raised.

16 MEMBER GROSS: So we are voting on it
17 with the asterisk?

18 CO-CHAIR BRISS: Right now it sounds
19 like the current thing for the asterisk means
20 that the body of the report will include relevant
21 concerns. And you have got to -- we are always
22 voting on the state of the universe as it

1 currently exists.

2 MS. QUINNONEZ: Voting is now open for
3 overall suitability for endorsement of Measure
4 3175. Option 1, yes; option 2, no.

5 All votes are in. Voting is now closed.
6 For the overall suitability for endorsement of
7 Measure 3175, 63 percent voted yes, which is 12
8 individual votes; 37 percent voted no, which is 7
9 individual votes.

10 For the overall suitability for
11 endorsement of Measure 3175, this passes the
12 recommendation criterion.

13 CO-CHAIR BRISS: All right, so we move
14 quickly to the next one. So, these are sort of
15 related to each other and so some of the issues
16 may be the same or at least some of the issues
17 may be similar.

18 So, measure developers, if you would
19 like to tee this up for us and please try to
20 limit yourself to not repeating issues that we
21 already addressed in the first measure.

22 DR. MATTKE: Okay, so we are now turning

1 to alcohol use, which is a related but slightly
2 differently specified measure just because the
3 clinical dynamics and treatment considerations
4 are different.

5 I don't want belabor the point how
6 common and damaging alcohol use is and that
7 medication-assisted treatment is both a supported
8 and underused option.

9 Also, there are going to be two NQF-
10 endorsed measures that are capturing the
11 initiation so that is the same issue like with
12 the opioid measure.

13 And we are looking at treatment
14 continuity. And we do that because we know that
15 even in the small subset that does get put on
16 medication-assisted treatment, adherence tends to
17 be very poor in alcohol use disorder patients.
18 After six months, for example, in one study only
19 about 10 percent of patients on oral drugs and
20 about 20 percent of patients on injectables were
21 adherent. And this is problematic because
22 patients with longer duration and better

1 adherence show fewer relapses to heavy and/or
2 frequent drinking.

3 So therefore, we specified that measure
4 to focus on the continuity of pharmacotherapy, in
5 this case defined as treatment duration of at
6 least 180 days and sufficient adherence for the
7 duration of treatment.

8 In contrast to the OUD measure, AUD
9 pharmacotherapy is a little bit like putting
10 patients on statins. With a linear relationship
11 between the episodes of heavy drinking and poor
12 health outcomes, the objective of AUD
13 pharmacotherapy is less reduction, not
14 necessarily complete abstinence but reduction of
15 heavy drinking episodes.

16 So the definition of adherence,
17 therefore, follows the established NQF convention
18 of having access to the medication for at least
19 80 percent of treatment days, as it is done for
20 all the other NQF-endorsed adherence measures.

21 Our testing results show that the
22 measure captures substantial performance gaps

1 with an average pass rate of health plans around
2 20 percent. So some plans the rate was as close
3 to zero percent, versus others were has high as
4 40 percent.

5 We believe that this measure will
6 encourage health plans and providers to develop
7 communication and education tools, as well as
8 processes to improve treatment continuity in AUD
9 patients and, again, we provide expert panel
10 support for validity and usability data on
11 reliability testing and expect that this claims-
12 based measure will again be feasible to
13 implement.

14 CO-CHAIR BRISS: Thank you. Anybody
15 like to -- so, we will run through the criteria
16 again, the evidence criterion.

17 Yes, ma'am, Rhonda.

18 MEMBER ROBINSON BEALE: Okay, there we
19 go. In review of the evidence, as already
20 stated, there is quite a bit of evidence
21 regarding the use of pharmacotherapy for alcohol
22 disorders.

1 In review of the evidence, there was a
2 systematic review. There was also evidence
3 reviewed in terms of quantity and consistency of
4 the evidence and the evidence was graded.
5 However, there was -- some of the medications
6 that were recommended there was very little
7 evidence to really support the length of time or
8 having the evidence returns of the effect or the
9 efficacy of it.

10 Overall, the rating by the NQF staff was
11 one of a moderate level and primarily due to the
12 issue with the medication itself.

13 MEMBER PINDOLIA: So my question, Soeren
14 is the recommendations are all for moderate to
15 severe alcohol for the drugs that are available
16 that are FDA approved. And I just want to make
17 sure I understand the denominator for this
18 because it says just alcohol use disorder, which
19 is a very wide range. Was the intention for this
20 to be limited to the moderate to severe and is
21 that the stipulation that is for the CPT codes
22 for the entrance into the denominator?

1 DR. MATTKE: There is, unfortunately, no
2 severity code in the ICD system. So we can't say
3 moderate to severe based on diagnoses.

4 MEMBER PINDOLIA: I'm not good at coding
5 but I thought I have heard people say that there
6 is a way to differentiate that. I don't know if
7 someone can speak up. I'm not good at coding.

8 Because it is really hard for me to
9 understand and I understand that this could be
10 similar like last time we won't ever achieve 100
11 percent. I get that no problem. But unlike the
12 last one, we really might have a lot of people
13 because there is a lot that are more on the mild.
14 And so it would be very difficult to say as a
15 quality metric are we really -- what really is
16 our problem in the U.S. with this, how bad is it,
17 and what are we trying to improve it to if we
18 really don't know how much of a noise we have
19 down there?

20 DR. MATTKE: I mean the advantage in
21 this case is, Vanita, that we don't have the
22 initiation measure. So we are not judging

1 whether or not the decision to put somebody in
2 treatment was appropriate. We basically say
3 okay, we respect the clinical decision, which we
4 cannot second guess, based on the data that we
5 have at hand. But if you put somebody on these
6 drugs, you had better make sure that they take
7 them for at least 180 days and sufficiently
8 adhere.

9 MEMBER PINDOLIA: That helped clarify.
10 Thank you, Soeren. I didn't think of it from
11 that perspective.

12 MEMBER MARK: Yes, the evidence cited is
13 from a Jonas paper and also from the Department
14 of VA and DoD. And if you look at the Jonas
15 paper, it actually doesn't say that adherence,
16 lack of adherence leads to relapse. In fact, it
17 points out that many people discontinued before
18 they even relapse. So they can't actually --
19 what it actually found was people began to drink
20 before they even discontinued. So, they didn't
21 find that once people discontinued it increased
22 relapse. They found that people started drinking

1 even before they stopped the medication. So they
2 didn't find -- I didn't read the paper as
3 supporting that.

4 And then when you read the VA and DoD
5 guideline, they don't actually talk about the
6 need for adherence. The guideline just says that
7 medication must be offered to anybody who has an
8 AUD.

9 So actually, I am very supportive of the
10 continuity of care issue for OUD. I think the
11 evidence is pretty strong for nine months. I
12 think it is very different when you get to AUD.
13 The evidence is really not there to support nine
14 months.

15 And then just finally on the evidence,
16 if you look at the largest clinical trial, the
17 combine, they find that cognitive-behavioral
18 therapy does just as well as medication in
19 reducing AUD. So, people are going to do very
20 well in cognitive-behavioral therapy in contrast
21 to I think OUD, where the evidence is much more
22 stronger that yes, that you need medication. I

1 mean relapse can be fatal.

2 DR. MATTKE: So I think that there were
3 several questions embedded. Unfortunately, no
4 guideline ever says if you recommend treatment we
5 also recommend that the patient is adherent to
6 treatment because our inherent bias is that yes,
7 if it is a recommendation the patient trajectory
8 also follow it if it is prescribed. So I have
9 yet to see a guideline that says adherence
10 matters.

11 Yes, I agree that there is a greater
12 number of patients that do not need drugs. But
13 as I said in my response to Vanita, we respect
14 the prescriber's decision to put a patient on MAT
15 and just then follow whether or not adherence is
16 there.

17 I think I lost the third question. Yes,
18 none of these drugs actually are getting people
19 to be completely abstinent. It tends to be a
20 risk reduction strategy in which as long as they
21 take these drugs reasonably regularly, they tend
22 to have fewer drinking episodes.

1 And since there is very good evidence
2 that the harms from alcohol are a linear function
3 of sort of your exposure to heavy drinking, that
4 is the treatment objective. And that is slightly
5 different from the treatment objective in
6 opioids, which is why we specified that component
7 a bit differently.

8 MEMBER MARK: So I just forgot one other
9 thing. Yes, I think the counterargument is that
10 if there would be no negative, that would be
11 fine. Just give everybody the drugs. But these
12 are associated with some serious side effects and
13 so that is the -- you have to balance the harm
14 against the positive.

15 DR. MATTKE: But again, that is the
16 prescriber's and patient's decision, which we are
17 not measuring. We are saying if you make that
18 decision jointly, you should stick to the
19 treatment plan for a specified duration of time.

20 MEMBER MARK: Regardless of whether they
21 have side effects or not after they start the
22 medication.

1 DR. MATTKE: Yes, you could stop the
2 treatment.

3 MEMBER ZUN: I'll be brief on my soapbox
4 today but I figured you know I needed to do it
5 once a day.

6 So, if we know there are other treatment
7 modalities that are non-pharmacologic that work
8 as well as the pharmacologic, why don't we have a
9 measure that looks at those options, rather than
10 the one, the easiest one out, which is the one
11 that we know about that is measurable?

12 I do believe there are billing codes for
13 counseling, and CBT, and all those other things.
14 So, why are we just focused on one treatment
15 modality when that is not in the patient's best -
16 - may not be in the patient's best interest?

17 I'm done. Thank you.

18 CO-CHAIR BRISS: As I used to tell my
19 kids, I think we need to talk about the
20 definition of need. Lisa.

21 DR. WATKINS: This is Kate Watkins. I
22 think that is a really good point that that is

1 not what this measure does but I do believe that
2 patients should be given choice. And this
3 measure deals with one aspect of treatment, which
4 is pharmacotherapy.

5 MEMBER SHEA: So, I know these are
6 complicated issues but unlike the opioid use
7 disorder, I was just wondering what the evidence
8 was for continuing medication for alcohol use
9 disorder for that amount of time is one question.

10 Two, in my clinical experience, you are
11 often switched. People switch the medications
12 because they have an issue or whatnot. So, they
13 would look like they have dropped off the
14 medication but be on another one. So that was my
15 other question. How do you account for that and
16 how do you account for sometimes people are on
17 more than one of these at a time?

18 And then my last question was there is
19 a couple of them that are used for other reasons,
20 as well. They are not even necessarily FDA-
21 approved for alcohol use disorder. So how would
22 you know if a person stopped the gabapentin or

1 the topiramate if it was the alcohol use disorder
2 that they were on it for that in the first place?

3 DR. MATTKE: Good questions and those we
4 love.

5 So the treatment duration we justified
6 by the fact that the approval trials for the
7 drugs that have an FDA label typically ran for
8 about 180 days. So, we can basically say we
9 don't really have good evidence that shorter
10 treatment durations work and so we take that as a
11 minimum limit.

12 The switches we would capture. We are
13 not forcing you to be on one drug. So if you
14 switch somebody from naltrexone to gabapentin, we
15 just count the number of days in treatment and
16 you would still be in adherence. The same for
17 more than one, if they overlap we don't double
18 count the days.

19 Other indications, Kate, you can
20 probably speak to that better. That was the
21 trickiest thing to deal with, especially with
22 gabapentin because it has such a broad range of

1 indications and is not usually labeled for
2 alcohol but recommended for it. But Kate, you
3 want to explain on that gabapentin?

4 DR. WATKINS: We gave you a pass,
5 essentially. If you had a diagnosis of an
6 alcohol use disorder and were being prescribed
7 gabapentin, that you got a pass for being on it.

8 DR. MATTKE: Yes.

9 MEMBER TRANGLE: I mean the reverse of
10 that would be if you are on it for diabetic
11 peripheral neuropathy and you stop it for that,
12 you would get dinged.

13 DR. MATTKE: Yes, I mean that was one of
14 the choices we had to make. We give you your
15 credits or are we taking it out because it is not
16 specific to AUD. I mean you be the judge whether
17 we make the better choice.

18 CO-CHAIR BRISS: And Soeren, I am going
19 to take off my chair hat for a second and make a
20 couple of comments.

21 I sort of share many of Tami's concerns
22 on this one. I think the evidence for

1 persistence is of the same quality for this as it
2 is for opioid use disorder. And when you
3 actually look at the effect sizes in the studies,
4 they are modest I would generally say. And so
5 whether this, as it is currently specified really
6 -- and then there is all of that makes the issue
7 of leaving out talk therapies, which might be
8 preferable sort of relatively more important and
9 so I wonder whether all that stuff changes the
10 thinking on importance to measure and report.

11 Raquel.

12 MEMBER MAZON JEFFERS: So people have
13 sort of alluded to this in their comments but I
14 just want to highlight it. Two of the
15 medications that you have listed are not approved
16 by the FDA for the use of alcohol use disorders.
17 That is a really -- I mean I am normally not on
18 the conservative side of these kind of
19 conversations but that is a really important
20 consideration for a committee like this to
21 approve as a measure a medication that hasn't
22 been approved by the FDA for this purpose.

1 DR. MATTKE: Yes, it was a tricky choice
2 because the guidelines explicitly say we
3 recommend using it, even though there is no
4 label. And given that some of these drugs have
5 been around forever, there is no manufacturer who
6 will do a trial to get a label because there is
7 no commercial interest involved. And that,
8 unfortunately, is occasionally the case with
9 these old generic drugs that nobody cares anymore
10 and then the guidelines go based on off-label
11 use, even though the FDA has never endorsed it.

12 MEMBER SPERLING: So as the patient
13 advocate in the room I feel compelled to speak up
14 here. This is, I mean it strikes me as dangerous
15 territory for NQF to be implicitly endorsing off-
16 label use. And if it is going to be done, I
17 strongly recommend that it at least be tethered
18 to peer-reviewed treatment guidelines from
19 respected medical society like the American
20 Society of Addiction Medicine or be part of peer
21 reviewed literature that has something to back it
22 up.

1 Because the FDA label isn't the only
2 thing. Because in psychiatry I can tell you have
3 lots of off-label treatments but they are backed
4 up by strong evidence, endorsed by APA treatment
5 guidelines. And I know the American Society for
6 Addiction Medicine does a lot of this.

7 But let's just make sure we are tethered
8 to the science, that's all, from the patient
9 safety perspective.

10 CO-CHAIR BRISS: You may or may not
11 agree with the guideline but they list the
12 guideline on which their recommendations were
13 based. So, you may or may not consider the
14 VA/DoD to be the most appropriate guideline
15 developer but there is a guideline that they have
16 tried to tether to.

17 So, David, you were next I think.

18 MEMBER EINZIG: So just qualifying this
19 with this is not my patient population but for
20 those who work with this population, a question
21 for the room, is this an accepted standard of
22 care that people are using?

1 And then my second question is if the
2 medications aren't helping and you stop and after
3 a couple of months, why continue something that
4 is not working?

5 DR. MATTKE: Well, the last is easy. If
6 you stop after 180 days, you are fine because you
7 have tried it for at least that period. So you
8 wouldn't get dinged.

9 The first, of course, it is a
10 recommended, a guideline-recommended treatment
11 option and it is only of the options, as Kate
12 says but we are not looking at whether it was
13 appropriate to put the patient on that option.
14 That is the decision of the patient and the
15 prescriber. We are looking at if the patient is
16 on that option, are they getting treatment for
17 evidence-based period.

18 CO-CHAIR BRISS: Yes, sorry. Any of the
19 relevant clinicians in the room want to talk
20 about standard of care issues?

21 MEMBER COLEMAN: I mean I would just say
22 that to me it is tethered around that six month,

1 180-day period. I don't know that that is the
2 standard of care, per se, identify it as yes, it
3 is going to be way more effective if you can
4 reach that point. I think people have kind of
5 already mentioned the difficulties with what that
6 evidence base may be.

7 Certainly, the medications are pretty
8 standard of care. Those are the exact
9 medications I would have listed off as potential
10 options. But again, this measure kind of comes
11 in after that has already been said. Like they
12 mentioned, it is about continuity I guess of the
13 medication or the time without gaps, things like
14 that.

15 So I think we are questioning the
16 evidence base for this for exactly what they are
17 measuring is part of the problem.

18 MEMBER TRANGLE: Yes, and it is maybe
19 not binary. You know the evidence for gabapentin
20 and Topamax would not be the same as acamprosate
21 or naltrexone or Antabuse.

22 So, I wouldn't answer totally thumbs up

1 or thumbs down for the evidence. It varies.

2 You know and sometimes we use stuff when
3 somebody is relapsing so much. We have tried
4 everything else, so what the hell? You know you
5 can grade evidence but it is part of the standard
6 of care then.

7 MEMBER KELLEHER: Yes, I am not a
8 prescriber but Mike's variance in being in
9 agencies where there is prescription mostly for a
10 dual diagnosis, that they may not be the first
11 line of defense but if other things are not
12 working for whatever reason, it is common, I
13 think, to keep going to try to find something
14 that works.

15 My question is if the data shows that I
16 am one for two months and then all of a sudden
17 that is discontinued and now I am on another on
18 the list, that would count as a continuation or
19 no?

20 DR. MATTKE: Correct, yes.

21 MEMBER KELLEHER: It would still be a
22 continuation?

1 DR. MATTKE: Yes.

2 MEMBER KELLEHER: So if I keep changing
3 because of one reason or another but it is on the
4 list, that would be considered still continuity.

5 DR. MATTKE: Correct.

6 MEMBER KELLEHER: Correct?

7 DR. MATTKE: Yes.

8 MEMBER KELLEHER: All right.

9 CO-CHAIR BRISS: Are we ready to vote on
10 the evidence to support the -- Tami, first.

11 MEMBER MARK: So there was this
12 randomized trial that show people who discontinue
13 buprenorphine, they relapse. Is there a similar
14 randomized trial that shows people who
15 discontinue acamprosate or naltrexone they
16 relapse?

17 DR. MATTKE: I'm not sure that I
18 understand the question.

19 MEMBER MARK: So I am saying the
20 evidence that it is important to take the
21 Suboxone for 180 days comes from a randomized
22 trial that shows that when people discontinued,

1 they had a very high rate of relapse. And I am
2 wondering if there is comparable evidence on the
3 AUD side to show that if people discontinue --
4 from a randomized trial, that if people
5 discontinue before 180 days on naltrexone, there
6 is a huge -- what is the rate of relapse?

7 DR. MATTKE: Yes, so the approval trials
8 for these drugs typically ran for about six
9 months. The endpoint is typically not relapse
10 because in AUD the treatment objective is sort of
11 risk reduction, as opposed to abstinence. So you
12 want to avoid as many heavy drinking days as
13 possible.

14 So most drugs were approved based on an
15 endpoint of fewer heavy drinking days, not based
16 on the endpoint of complete abstinence of
17 alcohol. But yes, there is randomized --

18 MEMBER MARK: Even if you weren't
19 calling heavy drinking relapse, is there a
20 similar study that shows that when people
21 discontinue there is a huge risk of returning to
22 heavy drinking? That is the evidence that

1 supported -- if you want to explain it.

2 DR. MATTKE: The evidence is there that
3 as long as you are on the drug, you have fewer
4 drinking days. So that is basically showing if
5 you are off the drug you have more drinking days.

6 CO-CHAIR BRISS: Michael.

7 MEMBER TRANGLE: I can comment a little
8 bit. I mean I think the evidence is kind of low
9 to moderate level evidence and it really is the
10 way you talk about it.

11 The relapses that are going to occur
12 will likely be not as intense drinking during the
13 relapse and maybe a little bit shorter but not
14 versus no relapses.

15 Does that answer your question kind of?

16 MEMBER MARK: Yes, just some
17 perspective. What is your perspective on the
18 risk of these medications? Like I have heard
19 some clinicians say you know naltrexone, you have
20 to override if you have surgery because it is a
21 -- or you know the side effect profile seems
22 pretty safe.

1 MEMBER TRANGLE: I don't see them as
2 super dangerous. I mean you know in some sense
3 Antabuse has been around forever and that can
4 injure your liver but use it if it works. I
5 don't know. You guys should comment on that,
6 too.

7 MEMBER COLEMAN: I'm happy to bring --
8 should we bring it up later though in usability
9 or something like that or later? I don't know if
10 the evidence-based is the right time to --

11 CO-CHAIR BRISS: I'm okay with calling
12 this evidence.

13 MEMBER COLEMAN: I mean so I am mostly
14 in favor of using these medications so I don't
15 want this to come across the wrong way but
16 naltrexone certainly has challenges. It is
17 actually more on the Suboxone side than it is on
18 the alcohol side because usually naltrexone you
19 can just stop prior to surgery. It's no big
20 deal. With an opioid use disorder because folks
21 go into withdrawal and that is the biggest thing
22 you are trying to avoid. It becomes a much

1 bigger deal because folks can't just go off of
2 it. And I do have campus-wide hospital
3 procedures that we had to develop that are not
4 perfect that none of the medical docs like
5 dealing with. So it is Suboxone actually more
6 than this maybe is an issue.

7 CO-CHAIR BRISS: So I think -- I wonder
8 if we might be ready to take a vote.

9 So again, this is on evidence that this
10 measure, as specified, is going to result in
11 people being better off.

12 MS. QUINNONEZ: We are now voting on
13 Measure 3172, Continuity of Pharmacotherapy for
14 Alcohol Use Disorder. Voting is now open for
15 evidence. Option 1, high; option 2, moderate;
16 option 3, low; and option 4, insufficient
17 information.

18 All votes are in. Voting is now closed.
19 For the evidence of Measure 3172, zero percent
20 voted high, zero votes; 37 percent voted
21 moderate, 7 votes; 47 percent voted low, 9
22 individual votes; and 16 percent voted for

1 insufficient, which is 3 individual votes.

2 So for evidence of measure 3172, this
3 does not pass the criteria for evidence.

4 CO-CHAIR BRISS: So generally speaking,
5 we have given -- I thought the feedback was
6 pretty clear, actually but generally speaking, we
7 have given the developers an opportunity to ask
8 any clarifying questions about anything further
9 you would like to hear from the committee that
10 led to this conclusion.

11 DR. MATTKE: No. I mean we do know that
12 the evidence for AUD is weaker than for OUD, it
13 is just a much less researched issue than OUD.
14 We will just try to keep at it and see what we
15 can do moving forward.

16 CO-CHAIR BRISS: Thank you. And
17 presumably, some of the issues, as you are
18 reworking both of these, or if you decide to
19 rework both of these, many of the same issues
20 that applied to the OUD would likely apply here.
21 So, the breadth of the population and things and
22 counseling.

1 Yes?

2 MS. JOHNSON: Just a quick question from
3 the staff side. Since we have to write this up,
4 we want to make sure we understand exactly why
5 you landed where you did.

6 So three things that I think I heard was
7 the list of meds, the 180 days, and maybe a
8 little bit of VA/DoD guidelines versus others
9 that might exist. Did I have that right? Are
10 those the main issues that you guys had? Would
11 somebody just help us understand?

12 CO-CHAIR BRISS: I might have
13 prioritized slightly differently. So what I
14 heard was that the biggest issue was probably the
15 evidence for 180 days. And then secondarily
16 there may have been issues with -- there was hung
17 jury, as I heard it on the meds. There were
18 several people that thought that those were the
19 appropriate ones and some people that were
20 worried about the FDA approvals, about which I
21 didn't hear a single conclusion.

22 MEMBER MAZON JEFFERS: So I also think

1 there was one other recommendation on around the
2 use of the efficacy of CBT being on par with
3 pharmacotherapy for alcohol use disorder.

4 So unlike for opiate use disorder, where
5 there is overwhelming evidence that medication-
6 assisted treatment is more effective than
7 counseling alone, I think this is not the case
8 for the alcohol use disorder medication. There
9 is evidence to suggest that the use of
10 medications to support recovery from alcohol use
11 disorder is not that much more effective than CBT
12 alone or counseling alone.

13 MS. JOHNSON: Okay. And to that last
14 point, I just do want to make sure that you guys
15 didn't vote low or insufficient on this measure
16 as put before you because it wasn't constructed
17 in the way that you would like to have seen it.

18 So in other words, your vote would have
19 been based on the evidence that was presented for
20 the medications. And again, you guys know I am
21 not an addictions person. So I am struggling
22 here.

1 CO-CHAIR BRISS: Mike or Shane.

2 MEMBER TRANGLE: For me it really had to
3 do with the strength of the evidence of these
4 medications working, how well they work, and what
5 impact they have and the quality of the evidence
6 to support that.

7 CO-CHAIR BRISS: And Shane.

8 MEMBER COLEMAN: I guess I am just
9 asking is what you are saying is that if we are
10 interested or if someone were interested in not
11 supporting this on the basis of the CBT or other
12 that it would have been maybe a different
13 category of sorts that we would have voted down
14 on, other than evidence. Is that what you are
15 suggesting, like usability or something like
16 that?

17 Because I do think -- and the reason why
18 I bring this up for clarity is because I do think
19 you are going to come up against a tension both
20 with opioid and alcohol but certainly of a non-
21 pharmacologic versus pharmacologic. And I am
22 guessing that there are some folks that I guess

1 without the inclusion of the non-pharmacologic
2 don't feel comfortable supporting because it may
3 drive care and it may emphasize pharmacologic
4 without the non-pharmacologic.

5 So I guess another way to say that is
6 where would you have voted it down for that
7 reason of sorts or something if it wasn't in
8 evidence.

9 CO-CHAIR BRISS: And my friendly
10 amendment to that might have been that I feel
11 like there was plenty of concern about the
12 evidence about the 180 day stuff to result in a
13 no vote.

14 I also think that in addition to that,
15 it does appear that this could have the effect of
16 supporting medication use that is not necessarily
17 fully supportable on the evidence over other
18 options that might be better options. And so if
19 you don't have a place to currently put that,
20 that kind of thing as we are thinking more about
21 portfolios of measures, we ought to have a place
22 to put that.

1 Anybody else? Mike.

2 MEMBER TRANGLE: My comment really isn't
3 for you guys but in some sense this seems like we
4 get a lot of measures that are about little
5 slices of kind of treatment things that we might
6 be doing about something and we have got no
7 measure for some of the basics.

8 You know it is like if I think about my
9 system, the things we are struggling with is we
10 are trying to come up with an opioid measure to
11 figure out how many new prescriptions we are
12 having. When do they turn to chronic
13 prescriptions, which we have defined as three
14 scripts in six months of opioids? You know and
15 why are we -- what are the categories that they
16 are on for? And what is the number of pills in a
17 morphine equivalence?

18 We are just trying to get our handles on
19 the basics of sort for how many opioids we are
20 using in a system and that is like a fundamental
21 building block. And we are talking about a
22 little slice here and a little slice there that

1 is easy to measure but not fundamental to how are
2 we doing.

3 CO-CHAIR BRISS: So we are going to have
4 a lot of time this afternoon to talk about the
5 whole portfolio and I want to be respectful of
6 our RAND colleagues' time. So if you have
7 additional comments that you want to particularly
8 make while our RAND colleagues are here about
9 this measure, let's do that. I need to then move
10 us quickly to public comment.

11 And if we want to talk about the whole
12 portfolio and how things fit together, I would
13 rather move that conversation to this afternoon,
14 if we can.

15 CO-CHAIR PINCUS: I just have one
16 comment that actually is not related to this
17 measure per se but because Kate -- are you still
18 on?

19 DR. WATKINS: Yes, I am still on.

20 CO-CHAIR PINCUS: Yes, I think it would
21 be useful to talk about sort of our experience in
22 looking at some of the VA data in thinking about

1 substance abuse measures more generally and the
2 problem of in the absence of having a screening
3 program, how one looks at continuity because of
4 selective choices that people make in terms of
5 having an initial visit. I think that is
6 counted.

7 So, do you want to comment on that a
8 little bit? Do you know what I am talking about?

9 DR. WATKINS: No, I'm not sure I do.

10 CO-CHAIR PINCUS: Okay, so I guess I
11 have to make my own point and Kate you can chime
12 in.

13 So, Kate and I were involved in a study
14 looking at the VA in terms of the quality of care
15 for mental health and substance use conditions
16 within the VA. And among the findings we had in
17 comparing the VA performance on administratively
18 based claims measures to a private sector data
19 base, we found that the VA, by and large, did
20 somewhere around 5 to 15 points better on most
21 measures, with the exception of substance use
22 measures of engagement and initiation engagement.

1 And in part, it was based upon a huge
2 difference in prevalence between the two
3 populations. In the private sector there was
4 about a one and a half percent of an initial
5 encounter; whereas, in the VA, because they were
6 doing screening and maybe also in terms of the
7 prevalence there, it was a much higher
8 prevalence, actually an order of magnitude higher
9 prevalence.

10 And so our hypothesis was that part of
11 the reason why you were seeing this difference
12 was because by screening, you were getting a less
13 motivated -- it goes to your point, Mike -- a
14 less motivated group as compared to people that
15 actually in the private sector were coming in
16 because they wanted treatment and that is how
17 they got captured.

18 And so and Kate you may want to comment
19 more on this but I thought that just for our
20 discussion later, we should think about how to
21 think about sort of having more of creating a
22 common baseline around these sorts of measures.

1 CO-CHAIR BRISS: So, I actually think we
2 have been competing a little on how fast we can
3 get through measures as the two chairs and I
4 consider this to be an unseemly use of the four
5 corners to run up my time.

6 So I want to -- anybody else got
7 specific stuff for our RAND colleagues before we
8 let them go?

9 Shane, do you have something specific
10 that you want RAND to hear? No.

11 So, thank you.

12 And now I think we need to do public
13 comment before we break for lunch.

14 OPERATOR: Okay, at this time if you
15 would like to make a comment, please press star,
16 then the number 1.

17 CO-CHAIR BRISS: And I'm sorry. Public
18 comment can also come from people that are here
19 in the room.

20 OPERATOR: There are no public comments
21 from the phone line.

22 CO-CHAIR BRISS: So we actually have a

1 long lunch break scheduled. We are off until
2 12:45.

3 CO-CHAIR PINCUS: Do you want to make it
4 shorter so --

5 CO-CHAIR BRISS: Let's reconvene at
6 12:30. Is that okay? Good.

7 (Whereupon, the above-entitled matter
8 went off the record at 12:10 p.m. and resumed at
9 12:38 p.m.)

10 CO-CHAIR PINCUS: So Erin, do you want
11 to --

12 MS. O'ROURKE: Absolutely, thanks,
13 Harold.

14 So I should probably start by
15 apologizing to Harold. He's heard this
16 presentation before. So I'd welcome any
17 reflections you have, as we also shared this work
18 with the MAP Coordinating Committee, to really
19 think about how attribution impacts things when
20 the rubber hits the road and measures are put
21 into use.

22 CO-CHAIR PINCUS: And I just may -- I

1 want to point out that I think this issue about
2 attribution and accountability is especially
3 relevant -- and Erin and I were just talking
4 about this -- for this committee.

5 Because inevitably, there is an
6 interface between behavioral health and general
7 healthcare that sort of mushes up the whole issue
8 of accountability and enables finger pointing
9 about who screwed up and who's responsible, and
10 whether it's at the provider level or at the
11 healthcare organization level or at the plan and
12 carve out level, these kind of things come up.

13 Also it's an area where, because of many
14 of the sort of long-term aspects of these
15 conditions involve sociodemographic mediators of
16 health. And it's unclear who's responsible for
17 dealing with some of those issues.

18 So this is something that I think is
19 especially important.

20 MS. O'ROURKE: Thank you.

21 CO-CHAIR BRISS: I'm sorry, one more
22 point that needs to be made about this is that

1 attribution gets harder as we're all trying to
2 move toward outcomes measures. And the farther
3 you get toward outcomes, the harder the
4 attribution gets.

5 And we lived through some of that on the
6 population tobacco measure yesterday. So Erin's
7 going to solve all those problems for us in the
8 next 30 minutes.

9 MS. O'ROURKE: Well, with that
10 introduction, so, I'm Erin O'Rourke. I'm one of
11 the senior directors here at NQF supporting the
12 work of our attribution expert panel.

13 So we've continued to see through recent
14 legislation such as IMPACT and MACRA this focus
15 on value-based purchasing as a way to drive
16 improvements in quality and costs.

17 However, implementing these new payment
18 models means we need to know who can be held
19 responsible for the results of the quality and
20 efficiency measures that are used to judge
21 performance through these programs.

22 And as Peter was saying, there's also

1 simultaneously this increasing push to measure
2 quality through outcomes, and that makes it even
3 more challenging to know we can hold accountable.

4 So attribution is the process that tries
5 to determine who can be held responsible. It's
6 the methodology used to assign patients and their
7 outcomes to clinicians or providers.

8 And attribution models attempt to
9 identify a patient/provider relationship that can
10 be used to establish accountability for quality
11 and costs.

12 So as we continue to move away from fee-
13 for-service payment to alternative payment
14 models, we need to better understand how patient
15 outcomes and costs can be accurately attributed
16 in a system that's increasingly built on shared
17 accountability, particularly, as Harold was
18 saying, in fields like behavioral health where it
19 really is a team effort.

20 So taking all of this account, NQF
21 launched a project to provide guidance on
22 attribution issues.

1 Specifically through this project, we
2 aim to identify key challenges to attribution,
3 develop a set of guiding principles, identify the
4 elements of an attribution model, and explore the
5 strengths and weaknesses of various approaches.

6 And then finally, identify
7 recommendations for developing, selecting and
8 implementing an attribution model.

9 So we brought together a multi-
10 stakeholder group to really try to advance the
11 science behind this area of measurement.

12 You can see it was co-chaired by Ateev
13 Mehrotra of Harvard and Carol Raphael of Manatt
14 Health Services.

15 We included stakeholders across the care
16 continuum. We had developers, clinicians,
17 hospital representatives, methodologists,
18 consumers, purchasers, payers, and suppliers.

19 So to inform the committee's work, we
20 started by commissioning a white paper from a
21 group of authors out of the University of
22 Michigan and the University of Pennsylvania.

1 They performed an environmental scan of
2 the attribution models currently in use. They
3 found huge variation in how models are
4 characterized and what the different elements
5 included in each model are.

6 So I'm guessing this won't come as a
7 surprise for many of you that deal with this
8 every day, but I was at least pretty taken aback
9 by the scan turning up over 160 models that are
10 currently in use or proposed for use.

11 And the vast majority of these use
12 retrospective attribution and attribute it a
13 single provider, usually a physician.

14 So the commission paper included some
15 pretty interesting findings. The authors noted
16 that, currently, best practices for attribution
17 have not been determined.

18 Rather, new models are just built off of
19 existing approaches, so we just keep using what's
20 been previously used without really taking the
21 time to study the trade-offs of the different
22 approaches to an attribution model.

1 And really, the authors called that
2 there needs to be more transparency here, and we
3 need to explore the strength and weaknesses of
4 different approaches.

5 There's also currently no standard
6 definition for an attribution model, and this
7 makes it really challenging to compare them.

8 We have a limited ability right now to
9 compare cross models to evaluate what works best.
10 And it's really critical to developing the
11 evidence base that we get to a greater point of
12 standardization so that we can start to make
13 determinations of best practices.

14 So the committee wanted to tackle some
15 key challenges through this work.

16 First, they noted that greater
17 standardization is needed among attribution
18 models so that we can start to make those
19 comparisons between models and allow best
20 practices to emerge.

21 The committee found there's little
22 consistency across models, but there's quite a

1 bit of evidence noting that changing the
2 attribution rules can dramatically alter results.

3 So in turn, this can really change how
4 a clinician or a provider might score on a
5 performance measure or in an accountability
6 program.

7 There is also a lack of transparency on
8 how a patient and their outcomes are attributed.
9 This means there's often no way for a clinician
10 or a provider to appeal the results of an
11 attribution that may wrongly assign
12 accountability.

13 So to start to address these challenges,
14 the committee came up with a number of products
15 through this work. The aim of these products is
16 to allow for this greater standardization of
17 attribution models, to increase transparency
18 around attribution, and to hopefully get greater
19 stakeholder buy-in so that we can allow for
20 better evaluation of attribution models in the
21 future and start to lay the groundwork to develop
22 a more robust evidence base.

1 As a first to addressing these
2 attribution challenges, the committee agreed on a
3 set of core principles to ground its
4 recommendations.

5 These principles acknowledge the complex
6 multidimensional challenges to implementing
7 attribution models, as the models can change
8 depending on their purpose and the data that's
9 available.

10 The committee grounded its work in the
11 goals of the National Quality Strategy. So
12 better care; healthier people, healthier
13 communities; and smarter spending.

14 And the committee recognized that
15 attribution plays a critical role to advance
16 these goals and to continue to drive improvement
17 across the healthcare system.

18 So attribution can refer to both the
19 attribution of patients to a clinician, group of
20 clinicians, or facility for accountability
21 purposes, as well as the attribution of results
22 of a performance measure such as an outcome or

1 resource utilization to a clinician or facility.

2 The committee really highlighted that,
3 currently, there's no gold standard for designing
4 or selecting an attribution model. It's
5 therefore important to understand the goals of
6 attribution for each specific case when you're
7 assessing potential models to apply.

8 Some key criteria to consider when
9 selecting a model are actionability, accuracy,
10 fairness and transparency.

11 This is particularly important as the
12 application of an attribution approach can really
13 significantly influence the reliability, validity
14 and results of a measure.

15 Moreover, attribution can significantly
16 affect the size of a population for whom a
17 provider is assigned responsibility as well as
18 determine their performance under value-based
19 purchasing programs.

20 So on this slide, you can see the
21 committee's guiding principles. The committee
22 recognized the importance of a trusted

1 patient/provider relationship and the need to
2 continue to enhance patient centeredness and
3 coordination of care when developing attribution
4 models.

5 Again, attribution models are a set of
6 rules used to logically assign accountability for
7 a patient's care and to help drive improvement.

8 The term provider is defined broadly
9 here to include individual clinicians, clinician
10 groups, hospitals, other facilities like skilled
11 nursing facilities, system levels, ACOs, et
12 cetera. So again, provider is kind of default
13 term.

14 However, for the purposes of measurement
15 and payment, it can be challenging to determine a
16 patient/provider relationship, particularly for
17 outcomes where multiple providers may share
18 responsibility.

19 So the committee recognized the current
20 tension between a desire for clarity about a
21 model's fit for purpose and the state of the
22 science related to attribution.

1 There's a desire in the field for rules
2 to clarify which model to use in a given
3 circumstance, but the committee really felt that,
4 right now, there is not evidence to support the
5 development of such rules.

6 As noted above, a significant finding of
7 the paper was the current lack of standard
8 definition included in attribution model and how
9 this lack of standardization across models really
10 limits the ability evaluate the effectiveness of
11 different approaches.

12 So as an important first step to
13 evaluating attribution models, it's necessary to
14 determine what elements need to be specified.

15 And the Attribution Model Selection
16 Guide that we'll cover in a few slides is
17 intended to aid developers, evaluation
18 committees, and program implementers on the
19 necessary elements.

20 Apologies, I have a bit of a cold, so my
21 voice is a little froggy.

22 So the guide is really meant to enable

1 stakeholders to have a structured dialogue about
2 the various models and the decisions that should
3 be made when implementing a model.

4 The Attribution Model Selection Guide
5 represents the minimum elements that should be
6 shared with accountable entities.

7 The detail of an attribution model and
8 the choices made in developing a model should be
9 transparent to patients, accountable entities,
10 and other stakeholders.

11 An attribution model must be well
12 tested, defined, and precisely specified with
13 adequate testing so that it can be implemented
14 consistently. The Attribution Model Selection
15 Guide includes a series of key questions to
16 answer in development and selection of the model.

17 Again, it's designed to improve
18 standardization across models and to increase the
19 ability to evaluate models in the future.

20 So on this slide, it's a bit hard to
21 read, but we did want to share with you the
22 Attribution Model Selection Guide. Again, I

1 won't belabor this, but it takes the user through
2 a series of key questions and asks them to at
3 least think about these elements when they're
4 developing their model.

5 Again, there wasn't really enough
6 evidence to come up with set answers to each. If
7 you look at the report, the committee provides
8 some guidance on some of the pros and cons of
9 different approaches and some key considerations
10 that you might to take into account as you're
11 developing your model.

12 But at least we wanted to get people
13 thinking about these issues and perhaps
14 thoughtfully considering the trade-offs when they
15 are developing an attribution model.

16 So the committee's recommendations build
17 on the principles and the Attribution Model
18 Selection Guide. The recommendations are
19 intended to apply broadly to developing,
20 selecting, and implementing an attribution model
21 in the context of both public and private sector
22 accountability programs.

1 Through these recommendations, the
2 committee attempted to recognize the current
3 state of the science and to consider what's
4 achievable now and what is the ideal state for
5 the future.

6 The committee stressed the importance of
7 aspirational and actionable recommendations to
8 develop or to continue to drive the science of
9 attribution.

10 So the committee's first recommendation
11 is to use the Attribution Model Selection Guide
12 to evaluate the different factors that should be
13 considered in a choice of an attribution model.

14 The committee emphasized there is
15 currently no gold standard for attribution, and a
16 different approach might be more or less
17 appropriate in a given situation. The choice of
18 a model should depend on the context of its use
19 and should be supported by evidence.

20 It's also crucial to be transparent
21 about the potential trade-offs between the
22 accountability mechanism, the potential for

1 improvement, the degree of control a provider may
2 have over an outcome, and the scientific
3 properties of the measure.

4 The next recommendation is that
5 attribution models should be tested. Attribution
6 models of quality initiative programs should be
7 subject to some degree of testing for goodness of
8 fit, scientific rigor, and unintended
9 consequences.

10 While the degree of testing may vary
11 based on the stakes of the program, attribution
12 models would be improved by rigorous, scientific
13 testing and then making the results of that
14 testing public.

15 Again, the committee stressed that
16 sometimes pilot testing may be available under
17 certain circumstances such as private reporting.
18 This could help to generate the data to
19 understand what the model is achieving and if
20 it's doing what it's intended to do. And then if
21 so, that model could be used for high stakes
22 applications such as payment or public reporting.

1 When used in a mandatory accountability
2 program, models should be subject to testing that
3 demonstrates adequate sample size, appropriate
4 outlier exclusion and/or risk adjustment to allow
5 fair comparisons among attributed entities and
6 sufficiently accurate data source to support the
7 model.

8 The committee recognized that data for
9 an attribution model can really vary. It could
10 include claims, electronic health records,
11 clinician attestation, or patient attestation.

12 So the next recommendation is
13 attribution models should be subject to multi-
14 stakeholder review. Given the current lack of
15 evidence on a gold standard for attribution
16 models, a stakeholder's perspective can really
17 influence what is best and what model they feel
18 may be most appropriate.

19 Again, the committee emphasized that
20 this is an opportunity to bring together
21 stakeholders across the continuum to review the
22 models and determine if it's really the best fit

1 for its intended purpose.

2 The committee emphasized that models
3 should attribute care to entities who can
4 actually influence the care and the outcomes,
5 recognizing that, currently, models can unfairly
6 assign results to a provider that has little
7 control over the patient outcomes.

8 So for a model to be fair and
9 meaningful, an accountable entity must be able to
10 at least influence the outcomes for which it's
11 being held accountable, either directly or
12 through collaboration with others. Again, trying
13 to recognize that we do continue to move to
14 shared accountability, but a lot of these models
15 tie everything back to one provider.

16 So as care is increasingly delivered
17 through teams and as facilities become more
18 integrated, a model should reflect what
19 accountable entities are able to do to influence
20 rather than directly control.

21 And then, this was one that the
22 committee really wished to highlight, so this is

1 their final recommendation.

2 A set of minimum criteria for models
3 used in mandatory public reporting or payment
4 programs. Again, the goal here was really to try
5 to improve the current state and get to a greater
6 sense of buy-in and fairness from what patients
7 are being attributed to a set provider and how
8 their results of that patient's care are being
9 used to determine what's reported to the public
10 and how providers are being paid.

11 So I think with that, I can take
12 questions or open for any discussion.

13 CO-CHAIR PINCUS: So questions, comments
14 that people have?

15 Raquel?

16 MEMBER MAZON JEFFERS: I was just
17 wondering if you could elaborate a little bit
18 about how you see this issue of attribution
19 filtering into the kinds of measure review
20 processes that we're currently engaged in?

21 MS. O'ROURKE: Absolutely. So that was
22 something the committee recognized that we need

1 to start considering a little bit more in NQF's
2 review processes, both for endorsement and
3 selection.

4 It's kind of an underlying tide, if you
5 will, but it's not something that's explicitly on
6 the table right now.

7 So the committee didn't really have set
8 recommendations about where we could put this in
9 the NQF criteria. They explored, perhaps, once
10 there is a better evidence base, it's something
11 we could look at under the validity subcriterion
12 to, you know, start to at least make developers
13 explain how the results of a model might be
14 attributed and allow the evaluation committees to
15 determine if they think that's appropriate or
16 not.

17 So again, no set answer at this time,
18 but really, the call was to we need to build this
19 evidence base so that we can get there in the
20 future.

21 CO-CHAIR PINCUS: Rhonda? And then
22 Peter, Brooke and Vanita.

1 MEMBER ROBINSON BEALE: Just a couple of
2 quick questions. You had quite a few experts on
3 the panel. I'm just curious whether or not,
4 because I don't know the names, whether or not
5 CMS was represented there? Organizations like
6 Mehلمان, Truven, these are organizations that are
7 deeply in doing attribution modeling.

8 MS. O'ROURKE: Absolutely. So, we did
9 have a liaison with CMMI, actually. So, not out
10 of the group we usually work with at CMS, but out
11 of the Innovation Center.

12 We also had some group representatives,
13 not from Mehلمان or Truven, but we did have
14 developers from NCQA, Yale CORE, RTI. Let me
15 see, we had some experts out of groups like
16 Advisory Board.

17 So we tried to get the -- a
18 representative from some of the different groups
19 who are involved. But again, obviously, could
20 not be complete given we had only 25 spots on our
21 committee.

22 MEMBER ROBINSON BEALE: And the other

1 question, are your slides going to be made
2 available to this committee?

3 MS. O'ROURKE: Absolutely.

4 CO-CHAIR PINCUS: Yes, I believe the
5 report is available.

6 MS. O'ROURKE: Yes, the slides and the
7 full report are publicly available. Yes, it's
8 posted on our website. It was funded by CMS, so
9 this is all in the public domain, and we welcome
10 you to share it with anyone who might be
11 interested.

12 I can get the link to -- Desi and
13 Kirsten to share with you all after the meeting.

14 CO-CHAIR PINCUS: Peter?

15 CO-CHAIR BRISS: So Erin, thank you for
16 that. So I'm a notorious heretic; I'm going to
17 be a notorious heretic again.

18 I actually think we're asking the wrong
19 question for the most part. So it's -- the truth
20 is, medicine is almost always a team sport these
21 days. And these things are, generally speaking,
22 trying to attribute the structure, process, or

1 outcomes to individual physicians.

2 And so we're preparing for an in case
3 William Osler comes around again. You know? But
4 I don't think he's going to be back.

5 And so I know there's a big push from at
6 least -- advocate consumers would really like to
7 have kind of physician-level scores. But I don't
8 think it's reasonable.

9 And actually, if you -- I'm afraid it
10 interferes with setting up systems that encourage
11 team-based care in the way that we should be
12 encouraging team-based care.

13 So I actually think we're -- I actually
14 think this is, in some ways, a move backwards.
15 And if we want to be talking about attribution,
16 it may be, outside of a few procedural
17 specialties, we ought never to be talking about
18 individual physicians ever.

19 MS. O'ROURKE: Absolutely. And I think
20 that was some of the issues the committee really
21 grappled with, that you want to encourage the
22 move to team-based care. But like you were

1 saying, recognize that consumers are trying to
2 shop around for an individual physician and want
3 that level of information available.

4 I think, in particular, they also
5 struggled with, as we are moving out of fee-for-
6 service and towards population-based payment, how
7 do you do this?

8 So I think, again, it was trying to
9 recognize where we are currently, and
10 particularly in this one, if you are going to
11 attribute to an individual physician, set some
12 guidelines around that to try to increase
13 fairness and accuracy.

14 But absolutely, I think the committee
15 was with you on the need to recognize that
16 medicine is a team-based sport, and we need to
17 find ways to hold the team accountable.

18 I think, in particular, someone used a
19 baseball metaphor of the teams win or loses, but
20 it's perhaps to the team to determine which
21 player was MVP.

22 MEMBER PARISH: Yes, so very concrete

1 question. Is the report -- I know there's no
2 gold standard, but did it come up with a top five
3 or anything like that? And does it have the top
4 five with sort of recognition of the weaknesses
5 of it?

6 MS. O'ROURKE: So they do go into the
7 pros and cons of different approaches,
8 recognizing there is a number of ways to do this,
9 in particular, a push to move to patient
10 attestation, and that other groups such as the
11 Health Care Learning and Action Network said that
12 perhaps that is the gold standard.

13 Our committee noted there are some
14 limitations to that approach. They explore the
15 different pros and cons in the paper more, so
16 explaining.

17 MEMBER PARISH: But, that's all in the
18 public domain and on the --

19 MS. O'ROURKE: All in the public domain.

20 MEMBER PARISH: Okay.

21 MS. O'ROURKE: We can share that with
22 you if there's a particular approach you wanted

1 to see more what they said.

2 MEMBER PINDOLIA: So more of a comment,
3 I think, and then, maybe a question at the end.
4 I understand where Peter's coming from. But to
5 be honest, it's really difficult on the provider
6 end when we have one pair saying this -- we're
7 going to attribute these patients to you, and
8 you're in our PPO plan, so there's no assigned
9 PCP. And then, there's another with HMO, which
10 is very clean: you're the assigned PCP.

11 So I am really happy that there's been
12 maybe some kind of standardization to kind of
13 help guide that a little bit more for our
14 providers. And also from the payers perspective
15 when we do have our PPO.

16 But for behavior health in particular,
17 this has become a great challenge for especially
18 our opioid shoppers, and they just use ER, and I
19 don't know who to attribute. And so I can't get
20 a provider contract for those patients to kind of
21 lock them in to be able to limit their opioid use
22 in any sort of way.

1 So I think it's actually even more
2 needed -- needed more for us to help manage our
3 behavioral health, if we can try to figure out
4 who can be tied to wanting to take ownership.

5 Because that's the other part. Even if
6 there is a physician that's the most common
7 prescriber, they don't want to take ownership of
8 this. So that would be really nice to kind of
9 see.

10 So do you have a time line of when the
11 next step of trying to develop the model of
12 attribution?

13 MS. O'ROURKE: So that's something where
14 our group are currently really trying to explore
15 funding, and hopefully it'll launch in the near
16 future, so it's good to hear that this is needed
17 and hopefully useful to the field.

18 CO-CHAIR PINCUS: Connie?

19 MEMBER HORGAN: This is just a follow-
20 up. This is sort of my question. Is this an
21 ongoing committee, or is it one time?

22 MS. O'ROURKE: It was one time through

1 the last scope of work. We're hoping we can get
2 additional funding to reconvene the committee and
3 to continue to explore some of the questions they
4 raised.

5 MEMBER HORGAN: Okay, all right, thank
6 you.

7 CO-CHAIR PINCUS: I'm going to call on
8 myself now.

9 Just two points. One is, this is a
10 great opportunity to also disagree with Peter.

11 (Laughter.)

12 CO-CHAIR PINCUS: So yes, I'm a
13 heretical heretic.

14 So anyway, while I agree that we should
15 focus primarily on teams, but I think the key
16 challenge is, who's on the team? Making the
17 determination of who is on the team.

18 And part of it is also, once you've
19 determined who's on the team, the question is,
20 are they behaving or performing as if they're on
21 the team?

22 So I think that it's not totally --

1 there is an individual responsibility to be part
2 of a team and that they're playing with a team.
3 And so that's part of the, I think, the
4 accountability conundrum, is actually thinking --
5 figuring out who are the members of the team.

6 And. then it's whether is that an
7 individual provider level or at an organizational
8 level. So I think that's -- and so some part of
9 your modeling should include that kind of
10 consideration of how do you make that
11 determination.

12 Secondly, I really do think that this
13 should be part of the criteria that we go
14 through. And that there should be some sort of,
15 whether it's explicit attention to this as part
16 of the validity component or is a separate
17 component of the accountability model, should
18 probably be integrated into what we've been
19 discussing.

20 Because if you think about our
21 discussions over the past day and a half, it's a
22 lot of this comes down to, it's like, it's been

1 an accountability issue.

2 It's been framed under other categories,
3 but that's really what it's been.

4 So then, Mike?

5 MEMBER TRANGLE: I think what I'm going
6 to say is in the nature of comments.

7 I'm involved in at least three different
8 types of activities where attribution is
9 occurring. And so for one thing, we just, in our
10 state, we had discussions about as more and more
11 people get integrated, who gets the attribution
12 for depression results, for example? You know?

13 And I would say it's becoming the norm
14 in my area that at least the large systems of
15 care are designing their outpatients' behavioral
16 health systems, because of shortages and
17 difficulty getting in, to limit it to you have to
18 be an active patient of our primary care group to
19 get in. So everybody we get is also being seen
20 initially and probably treated a little bit by
21 primary care.

22 And then we get them in our behavioral

1 health clinics, or we see them in the primary
2 care clinics for co-locating and doing some kind
3 of shared care, collaborative stuff.

4 And we've argued it back and forth. We
5 want to sort of say it's okay to be -- to double
6 count. And that in some sense, theoretically, if
7 we're all part of the same team, baseball team or
8 whatever sport you want to say, do we all rise or
9 fall together?

10 But I know within my medical group, when
11 you're looking at total cost of care, how much of
12 that's coming from primary care, how much of it
13 is coming from they got hospitalized with a heart
14 attack, and so would that be attributed to the
15 hospitalists? Or the cardiologists? Or both?

16 I'm involved in a number of discussions
17 where it feels like -- in one of our regions,
18 we've got a joint alliance with another large
19 system of care, and we're looking at total cost
20 of care. And we're doing a number of sort of
21 joint things to sort of add therapists and some
22 prescribers in our -- both our systems of care,

1 primary care clinics.

2 We've contracted with some outside
3 groups who clearly are not playing on the same
4 team, where their vision is not the triple aim,
5 but their vision is more business.

6 But it's a large group and --

7 CO-CHAIR PINCUS: Or less business.

8 MEMBER TRANGLE: Well, but so like, they
9 don't care about reducing readmissions or think
10 twice about sending people to the ER. And we
11 build in things to try and do that into our
12 clinics.

13 And it just becomes sort of dizzying.
14 And your point about, what are you talking about?
15 What's the issue? You may have a different
16 methodology or mix in the way of thinking about
17 it.

18 Because it's just so -- there are so
19 many different multifactors, what are the key
20 ones? I get dizzy thinking about it.

21 But I also sort of get annoyed that it
22 feels like you read in the literature about the

1 downstream effects and the indirect impacts of
2 mental health treatment on saving money, but the
3 way we measure our total cost of care, I don't --
4 we haven't been able to succeed at attributing it
5 in a way where we're giving ourselves adequate
6 credit for it.

7 It's all coming -- it's all sort of
8 laying on the primary care docs who really don't
9 know what we do or really care as long as we're
10 there to treat their patient when they want it.

11 So it's much more complex and difficult
12 when you're trying to do it separate from just
13 theoretically talking about a measure.

14 CO-CHAIR PINCUS: Thanks.

15 So Charles, then Rhonda, and then Mike.

16 MEMBER GROSS: A couple of related
17 questions. What's next with this?

18 The second is, the attribution model is
19 not specific to behavioral health. And if it's
20 not, then are there subsections related
21 specifically to behavioral health?

22 And that goes to Michael's question a

1 little about, what about when there's shared risk
2 or shared accountability for integrated care
3 practices?

4 And then the third area is, is the model
5 built with some thought to any potential
6 differences based on the product mix that the
7 practice may be addressing? Commercial,
8 Medicare, Medicaid?

9 MS. O'ROURKE: Sure, so, as far as
10 what's next, I think we're really hoping to
11 explore ways to get the Selection Guide in
12 greater use, to partner with some of our member
13 organizations and others to hopefully get that
14 out there to developers, implementers, even to
15 clinicians and providers as you're negotiating
16 contracts. What's a fair attribution model?

17 So I think anything -- if there's anyone
18 interested in the report and getting that out
19 there, we'd welcome some buy-in there.

20 We're also hoping that we could explore
21 ways to better integrate an attribution review
22 into our endorsement and selection work,

1 understanding that it's become a really key
2 question that has come up both through our CDP
3 and MAP processes.

4 I think we also recognize there's a need
5 to better understand the pros and cons and the
6 unintended consequences of what we can do to
7 continue to see what evidence is out there about
8 when a given model might be more or less
9 appropriate.

10 We didn't get into exploring individual
11 areas of care. I think the committee tried to
12 keep it at a more general level, so there weren't
13 necessarily specific considerations for
14 behavioral health, other than recognizing in the
15 report that it's an extremely challenging area
16 for attribution, but no set answers there.

17 And then I think, finally, for the third
18 question, the committee really grounded their
19 recommendations in the need to understand the
20 context of use and that a certain model might be
21 more or less appropriate, depending on how it's
22 going to be used, and what's okay for reporting

1 or internal improvement might not be fair for
2 payment purposes.

3 So the report gets into some of the
4 nuances there.

5 MEMBER GROSS: And just one of other
6 comment. First, this is great work, and I
7 support Harold with making this some factor in
8 the NQF evaluation.

9 And then, just to close, I'm surprised
10 you only found 160, because that must mean you
11 only spoke to 160 people.

12 (Laughter.)

13 MEMBER GROSS: I'm just off the top of
14 my head, even within Anthem, I can come up with
15 half a dozen different variants of attribution
16 based on specialty and provider type. And that's
17 within government business, to say nothing of the
18 commercial side.

19 So I think one of the complexities is
20 going to be the inevitable friction when you look
21 towards implementation, since all these are on
22 paper, imbedded in contracts with providers, and

1 to change them is a significant lift.

2 And I know many companies and provider
3 groups are already doing different versions of
4 attribution models. So it's a great project but
5 one that's going to be long-term, I think, but
6 much needed.

7 MS. O'ROURKE: Absolutely. I think you
8 hit on some of our key challenges for going
9 forward. Our 163, I believe is what the authors
10 could find that were publically available, and
11 recognizing that there's even more that are in
12 private contracts and not in the public domain.

13 So really reining in all of that is
14 quite the challenge.

15 CO-CHAIR PINCUS: Rhonda?

16 MEMBER ROBINSON BEALE: I also want to
17 applaud you taking on this work because I think
18 it's very well needed.

19 Just as Charlie said, I think, need to
20 look at it -- you talked about it from a product
21 perspective, I'm going to talk about it from a
22 different perspective, whether it's a PPO, okay,

1 versus other types of what I would say,
2 structures.

3 Because the PPO, which is where a lot of
4 our employer groups are still residing in that
5 area and still want their members to have the
6 choice to go where ever they want.

7 But yet, they want us to be able to
8 measure the effectiveness of the system and of
9 the providers so that the members can select the
10 providers who produce the best outcome.

11 So in trying to do that, it becomes a
12 very difficult situation because we're not to ask
13 the member to choose a primary care. They may
14 chose a whole system, or they may not. They may
15 -- you may just look at their pattern of where
16 they go and then attribute it silently to that
17 provider.

18 And I have a lot of problems with that
19 because I think it becomes real problematic in
20 terms of people who like to go from one place to
21 the next, and someone may have seen a primary
22 care physician three times in the beginning of

1 the year and then went to see a specialist --
2 because there is no rules whether it's just a
3 primary care or a specialist -- five times at the
4 end of the year, and now they're being attributed
5 for that year's outcome.

6 So there's a lot of problems with this
7 that really need to be addressed. And I would
8 really suggest that PPO is one of the areas where
9 it's going to be more problematic.

10 Talked about behavioral health, so I may
11 be sacrilegious, but I've already started this
12 with behavioral health in my plan, where we have
13 been introducing for the past year-and-a-half the
14 whole issue of attribution but accountability.

15 Accountability is far more important.
16 Attribution methodology is pretty simple. So for
17 example, substance use disorders, we're saying
18 that recognizing it's a chronic illness,
19 recognizing that the longer one's in treatment,
20 the better off they are.

21 We contract with I would call them maybe
22 semi-comprehensive providers who can provide IOP

1 as well as outpatient. Then they become
2 accountable for that population that they touch.
3 If they see that person more than three times in
4 their IOP, they're now accountable.

5 So any subsequent hospitalizations or
6 anything like that is attributed to them.

7 We've also challenged our
8 psychotherapists in the community with another
9 NCQA accreditation measure, which has to do with
10 people who have behavioral health illnesses
11 having a wellness exam at least once a year.

12 So that didn't go over well when I first
13 introduced that, but when we started explaining
14 to the behavioral health providers, particularly
15 the psychotherapists, that you see these people
16 more than the primary care physician; you have
17 more opportunity to convince them to get an
18 annual physical. We, as the plan, have to get
19 back information to them to let them know if that
20 was completed.

21 So that may sacrilegious, but I've
22 already started this experiment at this point.

1 CO-CHAIR PINCUS: Okay, Mike?

2 MEMBER LARDIERI: Yes, I guess I'm
3 backing to just support what Mike was saying
4 before, and I think, also on the teams, I think
5 we need to talk about ritual teams.

6 And I think it gets real difficult and
7 also crossing across systems. And so I think
8 that's what makes it difficult because, in our
9 situation in New York, we have these PPSs. It's
10 mostly on the medical side. They pay downstream
11 to behavioral health providers, but there's not a
12 lot of that money coming downstream.

13 But everybody's working with that same
14 patient, and it's across 10 or 15 different tax
15 IDs that all these services that are happening.
16 So it gets really difficult to manage.

17 And I guess it's all the other financial
18 relationships that people have and how they
19 structure it so they get a piece of that savings,
20 that bonus payment, whatever. And that's like a
21 real difficult thing to do so far.

22 CO-CHAIR PINCUS: Thank you.

1 So Erin, it seems like you've got a lot
2 of support for the healthiness of the --

3 Oh, there's one more? Oh, yes, I didn't
4 see yours. You're sideways.

5 MEMBER ZUN: No problem.

6 I think it's a wonderful concept. I'm
7 just thinking from some of the experiences that I
8 have as an emergency physician and patients
9 coming to the emergency department as their
10 primary care provider, how you would attribute
11 their care.

12 Besides that, the sharing of or the
13 collaboration between primary care and emergency
14 care providers. How do we decide who's
15 responsible for what?

16 It's a very complicated model. I guess
17 you guys are trying to make it really simple.
18 I'm just not sure how to apply it across the care
19 continuum.

20 MS. O'ROURKE: No, that's a -- it's a
21 great point. I think that is probably one of the
22 committee's chief findings is this is not simple

1 and will probably never be simple.

2 And really, they kept coming back to the
3 idea that each situation needs to be individually
4 assessed and what model might be most appropriate
5 could change.

6 But there was a recognition that dealing
7 with say 163 different models is causing a lot of
8 problems. So if there's a way to standardize and
9 allow for best practices to emerge, it could
10 hopefully reduce some of the noise out there.

11 CO-CHAIR PINCUS: And I think this
12 accountability for the emergency room providers
13 is among the most difficult conceptually when you
14 think about it.

15 So well, thank you. This has been very
16 helpful and we look forward to further
17 discussions. Because I think this is an area
18 where there may be -- it may be worthwhile to
19 actually do a deeper dive on sort of the
20 accountability models within the behavioral
21 sphere.

22 MS. O'ROURKE: Absolutely. Thank you

1 for the opportunity and your great feedback.
2 This was really helpful, and we'll -- I'd be
3 happy to keep the committee in the loop if we
4 move forward with additional phases of this work.

5 CO-CHAIR PINCUS: So Tracy, do you want
6 to lead us through a kind of look across the span
7 of, I guess our committee's responsibilities with
8 regard to behavior health measurement, and
9 thinking about both gaps as well as how we sort
10 of harmonize across the different measures and
11 categories of measures?

12 DR. LUSTIG: So I think we talked about
13 this very briefly on our orientation call. But
14 one of the things I had tried to do for you here
15 was try to take a step back at a few thousand
16 foot level and look at our portfolio overall.

17 I hope I don't confuse you more than
18 enlighten you. But what I tried to do was look
19 at our entire portfolio of measures and put them
20 into different categories and try to give us a
21 perspective overall of what our portfolio looks
22 like, either by the diagnoses that we're focusing

1 on or the part of the care continuum that we're
2 focusing on, or those sorts of things, just to
3 hopefully stimulate you think about where you
4 think the gaps are and where maybe measure
5 developers should be focusing.

6 So this is kind of our standard opening
7 slide about our portfolio, but obviously we're
8 charged with looking at behavioral health
9 conditions, measures that can be used for
10 accountability in public reporting for all
11 populations and in all settings of care.

12 Some of the common topic areas that our
13 measures to look at are alcohol and substance
14 use, tobacco use, ADHD, depression,
15 schizophrenia. And we currently have more than
16 50 endorsed measures within the area of
17 behavioral health. I think this number still
18 stands about right after our meeting today.

19 When I did look at the portfolio
20 overall, I was considering all of the measures
21 that we have looked at over the last two days.

22 I'll also say, as you can imagine, you

1 could fit in any of our measures into more than
2 one category, even when just looking at
3 diagnosis.

4 So this is sort of just like a rough
5 overview for you.

6 So the first thing I tried to do was
7 look at the main diagnosis that was being paid
8 attention to in each measure.

9 So how it kind of broke out when I did
10 this roughly was physical health, which, what I
11 mean by that is, we have a whole host of measures
12 that are really around things like: if you have
13 schizophrenia and you have diabetes, have you had
14 your neuropathy exam?

15 So I kind of categorized all of those
16 with really the focus was more about ensuring
17 that you're getting the physical health needs
18 assessed if you're a high risk.

19 Depression focus came out at 19 percent;
20 tobacco use 15 percent; alcohol and other drug
21 use 15 percent.

22 CO-CHAIR PINCUS: Is each measure

1 counted once in those?

2 DR. LUSTIG: Each measure is counted
3 once. So I made a decision of which one it fell
4 into more than others. So yes, there's no
5 duplication.

6 But like I said, there's a little bit of
7 wiggle room, because there were cases where I sat
8 there and thought, given this --

9 That's why you'll see these other two
10 categories also. 10 percent of specific
11 diagnosis, this would be things like the measure
12 we looked at yesterday about ADHD, where it was a
13 very specific diagnosis, but there were really no
14 other measures in our portfolio that were that
15 exact same specific diagnosis.

16 And then when I put general behavioral
17 health, this is where often it was things like
18 serious mental illness or other things where
19 there were more than one, or it was things like
20 experience of care where it would apply to kind
21 of all the diagnoses in our portfolio.

22 So this was one way that I looked at it

1 to try to help you think about it. The next way
2 I tried to look at it was, well, within some of
3 these larger diagnoses, what can I pull out to
4 try to further break down?

5 So you'll still see things like physical
6 health, depression, tobacco, AOD there. But then
7 the ones that I really tried to pull out here
8 were medication use, 20 percent of our portfolio.

9 And these were things like we've been
10 talking about today, certainly: adherence to
11 care, appropriateness of the choice of
12 medication, continuity of care, but specifically
13 focused on medication use for whatever the
14 diagnosis was.

15 The other thing I pulled out was care
16 coordination, about 9 percent of ours. These had
17 to do with things like follow up after a
18 hospitalization.

19 So I was trying to think about two
20 different settings that would have to coordinate
21 for the measure. And then our few experience of
22 care measures that I pulled out there.

1 And I'll just kind of go through these
2 quickly. And again, I was just hoping that it
3 would stimulate you to think about what's missing
4 here, or what are we concentrating on too much or
5 not enough?

6 And so then the last way I looked at it,
7 you may or may not remember this from our
8 orientation call, but I had also tried to think
9 about our portfolio in terms of where in the care
10 spectrum, as I would call it, are we -- are our
11 measures really focused?

12 You can think about the population at
13 risk, so that would be a lot of screening issues.
14 Evaluation and initial management, I tried to
15 think of that as, you know, what are you doing at
16 the initial diagnosis? And then the follow-up
17 care has to do with continuation of care and
18 continuing to follow up.

19 So when I --

20 (Off microphone comment.)

21 DR. LUSTIG: This borrows from another
22 group that had used this, but it was meant to

1 show that along these, depending on the care,
2 people can go in different trajectories. But
3 sorry, I should probably know that.

4 Yes, Raquel?

5 MEMBER MAZON JEFFERS: Did you also
6 distinguish between process and outcome measures?

7 DR. LUSTIG: That I did not do for this.
8 I'm sorry. But, I can definitely follow up with
9 that. I can certainly tell you that a majority
10 are process measures that we have like with every
11 portfolio, I think.

12 So this is --

13 CO-CHAIR PINCUS: So it would be useful
14 to actually have a discussion about -- at some
15 point, about what is the state of the art for
16 outcome measurement, in terms of -- and to what
17 extent do the existing outcome measures
18 demonstrate that state of the art?

19 DR. LUSTIG: And, so, when I was looking
20 over this, this is my very crude -- my art skills
21 are not as good as they should be -- but, this
22 was my attempt to show where, again, in that

1 breakdown.

2 And what this really means is that about
3 22 percent of our measures are focused on that
4 screening or that, you know, looking at the
5 population at risk.

6 I have the overlap there because we have
7 a certain number of measures that are about
8 screening and if you find something, you initiate
9 treatment. So, that's where those roughly 16
10 percent of measures fall.

11 And, again, nothing is counted twice
12 here. So, the ones -- yes.

13 Can you use the microphone? Sorry.

14 MEMBER TRANGLE: Right now, you want it
15 on? But I did see it.

16 I think we're getting sort of the
17 beginnings of what's going to be a growing
18 category of prevention, you know, versus just
19 screening.

20 If you think about some other point of
21 first episode of psychosis, you know, or some of
22 the health measures around people that have SMI,

1 how do we prevent the metabolic syndrome and
2 what's going to happen down the line from that?

3 Whether it's they don't become so obese
4 so you can prevent them from getting diabetic,
5 you know, things like that.

6 DR. LUSTIG: And just to finish it off,
7 it really was -- I categorized about 20 percent
8 of the measures falling in that. You've received
9 the diagnosis already, so how do you initiate the
10 treatment?

11 And then, that last group, the 40
12 percent, 41 percent, the measures are really
13 focusing mostly on follow up. So, you've already
14 had a diagnosis, treatment has begun and what are
15 you doing to follow up with it?

16 And then, I tried to put across the
17 bottom here just that experience of care that's
18 crossing all of those.

19 Yes, Mady?

20 MEMBER CHALK: We've got to get more
21 clarity and subdivide that follow up category.
22 Follow up can mean many things.

1 DR. LUSTIG: Absolutely.

2 MEMBER CHALK: It can mean follow up
3 with the primary care physician. It can mean
4 follow up in treatment. It can mean on and on
5 and on. So --

6 CO-CHAIR PINCUS: Yes, I think that
7 that's --

8 DR. LUSTIG: And we can do that --

9 CO-CHAIR PINCUS: Yes, because it's --
10 that's the most surprising thing because I don't
11 think about of having a lot of follow up care
12 measures.

13 DR. LUSTIG: Sure.

14 MEMBER CHALK: But I think sometimes we
15 don't know what we're talking about.

16 DR. LUSTIG: Yes.

17 CO-CHAIR PINCUS: Yes, like, you know,
18 seven-day follow up after a hospitalization, it's
19 not --

20 DR. LUSTIG: Right. And, again, this is
21 not a perfect science at looking at this either.
22 This really was meant to give you more of just a

1 general overview of where our measures are
2 falling.

3 I fully agree, I sat there arguing with
4 myself sometimes about which place a measure
5 would go. But, at least I thought this would
6 give us a rough idea of where our part fully
7 sits.

8 CO-CHAIR PINCUS: So, Les and Connie and
9 Peter?

10 MEMBER ZUN: Yes, before I have to
11 excuse myself.

12 So, I'm kind of wondering whether the
13 tail's wagging the dog or the dog's wagging the
14 tail.

15 Because, you know, it seems like NQF is
16 dependent on all these other organizations to
17 bring measures to us rather than saying, here's
18 the measure we think is needed.

19 And maybe I'm mistaken, but I think we
20 discussed some issues concerning integrated
21 healthcare and those kind of things.

22 And from my perspective as an emergency

1 doc is, to me, all the patients that come to the
2 ED because their care network has failed them.

3 And we always look at the measure of,
4 you know, their insurance status and that's the
5 way to capture all the data. And we've got to
6 make it easy to capture data.

7 But every day I take care of patients in
8 the ED because they can't get their meds. They
9 can't get follow up. They're in a care plan that
10 just let them fall through the cracks.

11 So, I'm not sure we're getting at the,
12 to me, some of the measures that really impact on
13 patients' lives that have chronic mental illness.

14 And I really think that we kind of need
15 to turn this on its head and say, what do we
16 think are needed, what are we, as a group, think
17 are needed and why don't we go to all those
18 organizations and say, we think you need a
19 measure to determine whether the -- why the
20 patients are coming to the emergency department?
21 Or, why they can't get their meds? Or, why they
22 can't get therapy? Or, why they can't integrate

1 their medical and psychiatric care?

2 Thank you so much.

3 DR. LUSTIG: I can say we agree and NQF
4 is definitely making steps -- taking steps to get
5 more into the driving toward the measures that
6 matter, as we call them.

7 I think some of you have heard about,
8 and probably something we should have maybe had a
9 presentation on is the Measure Incubator which
10 some of you may have heard about, but is really
11 our effort.

12 We can't develop measures, but we can
13 act as a convener to bring people together who
14 have ideas of where the measures should be and
15 start to help them think through those processes.

16 And do you want to mention about that
17 our strategic plan --

18 MEMBER ZUN: And I'm happy to volunteer
19 and so are the organizations that I represent.

20 MS. MUNTHALI: Great, so we'll follow up
21 with you because we are facilitating the
22 development of measures. It is part of our

1 strategic plan, not just by having the folks that
2 have the ideas, the concepts, but those that have
3 the technical knowhow, so the measure developers
4 and the data. And those that know how to test
5 data.

6 So, again, we're not developing
7 measures, but we are convening the folks that do
8 this sort of work.

9 The great thing about it is, we are
10 getting to those measures that matter through the
11 incubator.

12 A lot of the first measures to come
13 through are patient reported outcome performance
14 measures around, we know that there are gap
15 areas.

16 What we're trying to do is to spur
17 measure development in innovative areas where
18 there's significant gaps, behavioral health is
19 one.

20 If you go and look up our incubator
21 work, you'll see that behavior health is listed
22 there. That's deliberate because we know that we

1 have significant gaps in that area.

2 And so, I think we can share post-this
3 meeting, information about that. But, you are
4 very right. In the past, NQF has just kind of
5 waited for measures to come to us.

6 Peter can tell you a little bit more
7 about our strategic plan, being on our Board as
8 well, where we are beginning to focus on those
9 measures that matter and the gaps that matter.

10 And part of that is to have our
11 committees, like your committee, to, you guys
12 know where the gaps are. You know where we need
13 to focus, to help us to think about, you know,
14 what are those leading indicators of health
15 within the context of behavioral health, what are
16 those drivers that can get us to those
17 indicators.

18 So, this is just an early exercise for
19 us to start making decisions about how we are
20 saying that these are the priorities in
21 behavioral health.

22 What are the measures, quite frankly,

1 that don't move us towards improvement and are
2 increasing the burden with regards to reporting
3 and data collection?

4 So, we're beginning to empower
5 ourselves, beginning to empower the committees,
6 so more to come.

7 Peter, I'm not sure if you wanted to
8 mention anything.

9 CO-CHAIR BRISS: I'll --

10 CO-CHAIR PINCUS: Yes, Peter was next
11 and then we were going to go down this line and
12 come back up.

13 CO-CHAIR BRISS: All right, so, I was
14 going to ask for another slide that I'd like to
15 see eventually is the -- it sort of reflects an
16 issue that we've been talking about a lot this
17 meeting with behavioral health integration.

18 So, I'd actually like to see what kinds
19 of providers and settings are affected by our
20 measure portfolio. My guess is that it's heavily
21 -- it's still heavily skewed toward kind of
22 specialized behavioral health settings.

1 And if that's true, I think there's a
2 case to be made for more coverage of primary
3 care. I'd be happy to be wrong about that, but I
4 suspect that there's a whole lot of behavioral
5 health stuff that happens in primary care
6 settings that if we don't have a lot of
7 measurement, we ought to have more.

8 CO-CHAIR PINCUS: Although, actually, I
9 think we'd find that it's actually fairly
10 balanced, but it's not -- but, if you then
11 stratified it by the quality of the measure, it
12 might not be.

13 So, Mady and let's work our way down
14 here and then come back up the other side.

15 MEMBER CHALK: Now, I don't think you
16 and I agree about that, Harold. Yes, there are a
17 lot of physical health integration, serious
18 mental illness measures, but no discussion and no
19 measures here that have to do with substance use,
20 disorders and primary care.

21 Despite the fact that there are all
22 kinds of -- on these measures that are in our

1 thing here, this is all serious mental illness
2 and physical health.

3 CO-CHAIR PINCUS: I'm not sure what
4 you're looking at.

5 MEMBER CHALK: Within our folder, it is
6 behavioral health portfolio.

7 DR. LUSTIG: This is in your, you know,
8 an extremely shortened title, but meant to give
9 you a very --

10 MEMBER CHALK: No, I'm just looking at
11 this physical health --

12 DR. LUSTIG: Yes.

13 MEMBER CHALK: -- all this list of
14 things, matches, that's all. I'm assuming
15 everybody had the same materials.

16 And all I'm suggesting is that screening
17 for physical health, if we're going to -- I want
18 some discussion of if these are measures for
19 schizophrenia or serious mental illness, why are
20 they not for alcohol or drugs and what are we --
21 we're going to have 400 --

22 Now, I should have a developer show up

1 and say, okay, for all of these that are listed
2 here for schizophrenia, it should say alcohol and
3 then drugs and then we'll throw them on a
4 provider or a health plan and say, now you've got
5 42 different measures to respond to instead of 24
6 when you could have one.

7 CO-CHAIR PINCUS: What do you mean by
8 that?

9 MEMBER CHALK: What I mean by one is
10 screen for physical health for any major mental
11 illness or list them, schizophrenia, bipolar --

12 CO-CHAIR PINCUS: You're talking about
13 a composite measure.

14 MEMBER CHALK: Okay. However you want.
15 This says behavioral health up here, it isn't
16 behavioral health, it's mental illness. It isn't
17 behavioral health.

18 And I'm saying why doesn't it say
19 alcohol, drugs, however you want, a diagnosis?

20 CO-CHAIR PINCUS: So, let me just
21 interject something that -- so, we've had a
22 number of discussions about thinking of people

1 with fill in the blank, in most cases, serious
2 mental illness --

3 MEMBER CHALK: Right, okay.

4 CO-CHAIR PINCUS: -- as a disparities
5 category.

6 MEMBER CHALK: Okay.

7 CO-CHAIR PINCUS: And that being a
8 potential strategy for sort of potentially low
9 hanging fruit for measurement of sort of at this
10 sort of integration interface with physical
11 health and behavioral health.

12 MEMBER CHALK: Right.

13 CO-CHAIR PINCUS: And it -- because, you
14 know, because the measure's already being
15 collected on a general health basis and it's
16 simply a matter of stratification based upon
17 diagnosis which is readily available.

18 And there are two issues, though, that
19 come up once you think about that.

20 Number one is, does that constitute like
21 a doubling -- if you add subsidies, does it
22 become a doubling or a quadrupling of every

1 measure or is it simply that you report measures
2 in a stratified way? So that's --

3 But, I think this --

4 MEMBER CHALK: Okay, that's fair.

5 CO-CHAIR PINCUS: Okay, but I'm not
6 arguing with you.

7 MEMBER CHALK: That's a fair question.

8 CO-CHAIR PINCUS: I'm just --

9 MEMBER CHALK: Yes.

10 CO-CHAIR PINCUS: -- trying to
11 summarize.

12 And so, that's something that NQF should
13 think about is, if that's the case, does there
14 need to be a whole process and a separate
15 measurement category or can it be something
16 that's kind of routinely reported, you know, on
17 certain designated measures?

18 MEMBER CHALK: Good point.

19 CO-CHAIR PINCUS: As you might do, you
20 know, look at, you know, sociodemographic status
21 or something, not as a risk adjustment tool, but
22 as a way of actually stratifying to see

1 performance.

2 MEMBER CHALK: Good point.

3 CO-CHAIR PINCUS: So, that's -- and
4 then, if so, then that raises two further
5 questions. One is, how do you define that
6 segment?

7 MEMBER CHALK: Okay.

8 CO-CHAIR PINCUS: And number two is,
9 which of the preventative health measures are
10 most appropriate to put in there, you know, based
11 up the likelihood that this is going to be an
12 important issue relative to that population?

13 MEMBER CHALK: Right.

14 CO-CHAIR PINCUS: Or, for that matter,
15 if there's -- if you're doing it on the basis of
16 chronic disease comorbidity, which chronic
17 diseases, should that be like sort diabetes
18 ventures?

19 MEMBER CHALK: Right, diabetes and
20 hypertension.

21 CO-CHAIR PINCUS: Yes, so that's, you
22 know, I think that's a fair comment. But, to

1 actually have a systematic process for doing
2 that.

3 MEMBER CHALK: But we need that.

4 CO-CHAIR PINCUS: Yes.

5 MEMBER CHALK: We need that.

6 CO-CHAIR PINCUS: And it may not be
7 something that requires a whole measure
8 development process because the data exist there,
9 the measure's already being collected and it's
10 something that could be done, you know,
11 relatively easily, you know, with an additional
12 analysis of the data.

13 So, that's something to think about.
14 You know, almost having a different track for
15 that, that would help to round that.

16 And then doing some testing, though,
17 particularly if you want to make a composite
18 which might make an easier thing to digest and
19 use.

20 So, I think, you know, so, just sort of
21 summarizing what you were thinking about, that
22 might be sort of a recommendation as we move

1 forward to think about how we might do that.

2 They might, you know, in some ways nest
3 more of these measures under a single heading of
4 a measure without creating new measures.

5 MEMBER CHALK: That's right.

6 CO-CHAIR PINCUS: Yes.

7 MEMBER CHALK: That's right. That's
8 where I'm heading, I think.

9 CO-CHAIR PINCUS: So, Raquel?

10 MEMBER MAZON JEFFERS: So, Tracy, I
11 don't know if you had more slides, but it would
12 be helpful for me to think about gaps if I could
13 also see other cuts of the analysis like process
14 outcome which I said before, care settings which
15 was mentioned.

16 Also, is the measure patient report, is
17 it provider report? Is the measure at the level
18 of the health system or at the level of the
19 provider? You know, at what level -- at what --

20 Because I think we have a lot.

21 CO-CHAIR PINCUS: Shall we dare say
22 accountability?

1 MEMBER MAZON JEFFERS: Right, right,
2 that's right.

3 I think we have a lot of measures that
4 are at the health system level, but I'm not sure
5 how each of them fall out. So, that would be
6 helpful.

7 And then, I wanted to make a comment
8 picking up on something that Mike had raised
9 earlier and we agreed to defer to this part of
10 the day to talk about, and that was, particularly
11 in acknowledgment that much of the opiate
12 overdose epidemic has been driven by primary care
13 physician over prescribing of opiate medications
14 for the treatment of pain.

15 To what extent is it this committee's
16 responsibility to also look at prescribing --
17 opiate prescribing --

18 CO-CHAIR PINCUS: There is a measure
19 that was endorsed last time around.

20 MEMBER MAZON JEFFERS: I don't remember
21 that.

22 CO-CHAIR PINCUS: I thought there was

1 one.

2 MEMBER TRANGLE: Get a handle on
3 indications and then overusing, how do you start
4 triggering and capturing overusing their patterns
5 like that? You know? So, it's like monitoring
6 and then catching and hopefully preventing things
7 from getting too out of whack or catching them
8 earlier versus you've already got the new one is
9 find an easily discernable way we can measure use
10 of a med, you know, after the fact?

11 MEMBER MAZON JEFFERS: There are now
12 from the CDC nine evidence-based practices for
13 the -- for better pain care. And they would not
14 be hard and I know there are some groups already
15 working on trying to construct measures that
16 align with those best practices around pain care.

17 And I realize we're really talking about
18 primary care providers prescribing practices for
19 pain which is I guess not a behavioral health
20 issue, but it's so -- but it is very connected to
21 the opiate overdose issue.

22 CO-CHAIR PINCUS: You know, just a

1 comment. When we've looked at it, it's more than
2 primary care, dentists give out stuff.

3 MEMBER MAZON JEFFERS: Oh, dentists?

4 CO-CHAIR PINCUS: It's a post-surgery.

5 MEMBER MAZON JEFFERS: Dentists?

6 CO-CHAIR PINCUS: I mean, so there's
7 like -- there are, in fact, several measures
8 looking at opioid use, opioid prescribing, yes.

9 Okay, so, they're not in our portfolio
10 apparently.

11 MEMBER MAZON JEFFERS: Right, a mistake.

12 CO-CHAIR PINCUS: Yes, so, I think -- so
13 this also, you know, raises the issues about how
14 we're defining the net -- for casting the net of
15 what's a behavioral health measure.

16 CO-CHAIR BRISS: Yes, and it -- remember
17 that there's never going to be a clean -- people
18 don't fit, real people don't fit into neat,
19 single boxes. And so, there's never going to be
20 a clean, unarguable sort of definition of what's
21 my turf.

22 NQF is already doing some -- trying to

1 do better than it has done about having
2 committees talk to each other on relevant things,
3 you know.

4 And so, one of our -- one of the tobacco
5 measures that we were talking about this couple
6 of days actually came out of the whatever we call
7 pediatric or child health or it's whatever.

8 And so, if it's childhood smoking, no
9 reasonable person could call it behavioral
10 health. A reasonable person could call it child
11 health. It's -- there's not going to be one
12 answer about where it goes. The committees just
13 need to kind of coordinate what they're doing.

14 MEMBER CHALK: Yes, and it would be good
15 if we could, particularly on the pain issue, on
16 the opioid prescribing issue. If we could at
17 least be informed that they're talking about it.

18 CO-CHAIR PINCUS: Yes, I remember
19 because I came through the MAP Committee. And,
20 so, I'd assumed it was there.

21 But, anyway, Tami?

22 MEMBER MARK: Yes, I just want to

1 emphasize, you know, I think it's kind of like
2 you said, low hanging fruit to extend some of
3 these measures to substance use disorder, post
4 discharge follow up, some of the screening
5 measures.

6 But if they're not extended, people are
7 reluctant to use them. And I found that when I
8 talked to CMS and states. I said, well, this is
9 basically, you could just use this measure to
10 substance abuse disorder. Oh, it's not endorsed.

11 You know, so I think there is something
12 you said for putting it in your portfolio and
13 finding some easy way to do that.

14 CO-CHAIR PINCUS: Mike?

15 MEMBER LARDIERI: Yes, and I'm going
16 down the same road as Mady. I think that if we
17 can get the developers to work together and then,
18 you know, stratify the responses. Like, it's one
19 measure, why should you have 20 different cuts,
20 you know?

21 Maybe that gets into, you know, what I
22 was talking about earlier, the economics of

1 bringing those developers into the incubator
2 program. And, you know, next time you're not
3 going to have ten or five, you're going to have
4 one.

5 You'll have to work together and figure
6 it out, which is a difficult thing to do but if
7 you don't do that, now we're sitting with 50, 60
8 when out of the 50, we could probably have 30
9 because a lot of those could be collapsed into
10 one if you just stratified some of these
11 responses.

12 In the opiate discussion we had this
13 morning, they kept saying, well, the initiation,
14 that's another measure. Well, it's not really
15 another measure if you use the initiation and
16 then the use of the opiates. And then ask the
17 next question down the road, you know, who's
18 opiate free at a certain period of time?

19 Now, we have an outcome measure and you
20 have all the steps you need to do to take it,
21 maybe we need to think about these are all the
22 steps you need to take in order to get to the

1 outcome. Make it one package as opposed to
2 pieces all over the place and that's sort of how
3 it is right now.

4 So, I would go for being stratified and
5 bring those folks together. I know it's an issue
6 with how it works, but I think we need to get
7 past that otherwise, it's hard.

8 CO-CHAIR PINCUS: Dodi?

9 MEMBER KELLEHER: So, I think my comment
10 is to even broaden out more than the individual
11 issues that are coming down the table that I
12 think is in sync with it.

13 One of the things that became a theme
14 for me over the last two days, not only with, but
15 especially with the maintenance measures is the
16 amount of time that goes by and they come back
17 with a measure that not only is sort of on
18 autopilot for the face validity, but has not kept
19 up with the practice, whether it's the clinical
20 practice or the business practice in the last
21 three to how many years.

22 And that we're looking at if there's

1 still a gap, so a reason to continue it. But,
2 that in and of itself seems to be insufficient
3 anymore.

4 What we need to be also -- and the fix
5 may be to advise ahead of time which is more work
6 for NQF, you know, what they need to look at
7 beyond whether there's still a gap.

8 So, and again, this is not the only
9 issue. For instance, there was a measure where,
10 you know, they're excluding behavioral health
11 done in a PCP's office when we know that 80 some
12 percent, maybe even 90 now, medication for an
13 antidepressant is done in the PCP's office in the
14 commercial practice.

15 So, it makes -- it doesn't really
16 reflect the actual practice as it exists today.

17 You know, I could pick out a few more,
18 but, you know, I think people will probably know
19 what -- I hope you know what I'm talking about.

20 And so, somehow I think that we need to
21 address that.

22 CO-CHAIR PINCUS: So, you're saying

1 essentially to place a higher bar for maintenance
2 measures?

3 MEMBER KELLEHER: Yes, that they can't
4 just come back without having, you know, also,
5 you know, reviewed, you know, their exclusions
6 and, you know, how they're going about it in a
7 way that is more in sync with what the current
8 clinical and business practices of the people are
9 going to have to deal with all these measures
10 once they're introduced.

11 CO-CHAIR PINCUS: You know, I would
12 agree with that and just to -- that's come up in
13 the MAP meetings where -- Measures Application
14 Partnership.

15 So, just be aware, NQF is basically two
16 lines of business. One is the standing
17 committees for consensus development, but the
18 standing committees for, you know, because that's
19 development like this one.

20 But then, there's a component of the
21 Affordable Care Act that requires that there be a
22 nongovernmental, multi-stakeholder group that

1 reviews all the quality measures used by CMS.

2 And where there's a recommendation about
3 whether or not those should be used in the
4 programs of the ACA and other related programs.
5 And so, that's -- so CMS every year proposes it.

6 So, anyway, that -- my point is that in
7 the MAP process, there's been a greater request
8 to get feedback from CMS about how the measures
9 have been used, what's been the performance?
10 What have been the problems encountered? You
11 know, in a more formalized way.

12 And I think that would apply here as
13 well that, rather than just update the same form
14 that actually have a somewhat different form for
15 a maintenance measure that would actually
16 include, you know, who's been using it? What
17 have they found? What have been the problems?

18 So, I think that that's, you know, I
19 think, Dodi, that's a very useful suggestion.

20 CO-CHAIR BRISS: And fair warning, as
21 Harold and I can tell you, you're eventually, if
22 you're around these tables enough, everybody --

1 you get sucked into all of the available lines of
2 business sooner or later.

3 CO-CHAIR PINCUS: Yes, yes.

4 MEMBER KELLEHER: So, my only other
5 comment is really not about the portfolio per se,
6 but I want to make sure I get it in, so I don't
7 like to have to talk too much.

8 I would find it useful, and I think the
9 committee would as well, it might make some of
10 the questioning and the decisionmaking a little
11 less torturous on some of these cliff hanger
12 ones.

13 If we had a little bit more pre-
14 orientation or maybe for those who are going to
15 be on the next phase, maybe not right before,
16 maybe it's, again, it's more work for you, it's
17 over the year or two before everybody gets that
18 together, around some of the stuff that you may
19 assume we all have a sense of but don't.

20 So, we were talking about how you can
21 endorse a measure and yet have specific, you
22 know, essentially saying don't come back unless

1 you deal with this on a maintenance measure, but,
2 you know, strong statements of required.

3 And then we got into the discussion
4 about whether you put an asterisk there or not.

5 That's the sort of thing that may have
6 made it easier, would have made it easier for me
7 if I'd known that before, right? So, I see a
8 measure, I think there's still evidence for its
9 need. I think it's not perfect, but it's good
10 enough, but it really -- I don't want to see it
11 again unless it addresses X, Y and Z.

12 And so, that's -- there's the sort of
13 orientation that, rather than you get it if you
14 sit through one of the phases, but maybe it'd be
15 easier to sort of anticipate and the orientation
16 be a little broader than that.

17 That's all, I'm done.

18 CO-CHAIR PINCUS: Andrew.

19 MEMBER SPERLING: Thank you.

20 So, this is my first meeting and it's
21 been very enlightening. I'm the rookie here.

22 I've learned a lot and I'm hoping to be

1 able to contribute a small amount. And I now
2 know that I have a lot more to learn about the
3 measure development processes in NQF.

4 The fact that, it is a -- and protractor
5 is probably an unfair word to use, but it belies
6 on, you know, validating at every point the
7 scientific evidence backing up a measure, its
8 use, its utilization, the gaps.

9 And I recognize there's a lot of
10 research that has to be go into developing that.

11 My sort of ambition in getting --
12 becoming a part of this panel was to try and push
13 NQF, particularly relative to measures on
14 psychotic disorders, schizophrenia, schizo-
15 effective disorder, bipolar disorder,
16 particularly around quality measures.

17 And not that the process measures that
18 have been developed already aren't important. We
19 know about the, you know, the 20 years of early
20 mortality experienced by these patients because
21 of poorly managed diabetes, asthma, heart
22 disease, on and on and on.

1 We know that's a public health crisis
2 and we know it needs to be addressed.

3 But we really, from NAMI's perspective,
4 we really want to see this body move toward the
5 development of real quality and outcome measures,
6 particularly around schizophrenia where we
7 believe there's an enormous void out there.

8 So, I look forward to continuing to
9 participate in this and figure out a way to work
10 with you, Howard and Peter to figure out, to work
11 with the staff and begin that, you know, plant
12 that seed, get that initiation of that process
13 going around development of quality and outcome
14 measures, particularly around psychotic
15 disorders.

16 And I look forward to continuing to
17 participate. And, so, thank you for allowing me
18 to be here and I look forward to the appropriate
19 people on the NQF staff, if you can recommend and
20 Tracy, and I'll follow up with that for this
21 meeting to sort of begin the process of planting
22 that seed.

1 Thank you.

2 CO-CHAIR PINCUS: Shane?

3 MEMBER COLEMAN: I'll try not to
4 pontificate too much or let myself get too out of
5 control, but, I'm going to come from a little bit
6 of an idealistic perspective. And I'm not sure
7 this totally falls within the scope of NQF, but I
8 guess I just -- I'm going to say it out loud
9 anyway.

10 So, I think that -- oh, let me also say
11 that I come squarely from behavioral health. So,
12 if any of my comments sound like I'm down putting
13 behavioral health, I'm including myself in that
14 group. So, don't take it that way.

15 So, I think that something that I'd be
16 really interested in is backing up even a little
17 bit more and really creating a roadmap of sorts
18 for behavioral health.

19 I mean, with behavioral health merging
20 into medicine, the difference in cultures and the
21 difference in the starting place of where folks
22 are with regard to measurement of health and

1 outcomes, things like that, behavioral health is
2 at a very different starting point right now than
3 medicine is.

4 I mean, it's complete -- it's a chasm,
5 okay, between the two places. If you, on the
6 ground level, go into a behavioral health clinic
7 in rural wherever, they don't -- and again, I'm
8 totally putting myself on the spot there, okay,
9 and I'm speaking generically and several types,
10 blah, blah, blah -- but, the starting point is
11 just very, very different.

12 And so, what would be very useful is an
13 actual roadmap, literally, to what does it mean
14 to measure behavioral health? What should the
15 focus areas be?

16 I mean, and I think about, you know,
17 just to be kind of concrete, things like
18 functioning, you know, assure of symptom
19 measurement.

20 And a lot of what we're talking about
21 fits into what I'm describing. But, I guess, to
22 just even endorse a bigger picture of like, hey,

1 these are the areas you should be thinking about
2 if you're going to start thinking about measuring
3 behavioral health in your healthcare system.

4 Here are some, you know, key
5 measurements that fit in each of these areas.
6 But, really a roadmap to begin with to say, oh,
7 you know what, we should be thinking about
8 measurements in these five core areas.

9 Oh look, they have, you know, ten
10 measurements in each of those core areas. They
11 have these ones starred because that's the plus
12 endorsement, they think these are the best ones
13 in those areas.

14 Like, that kind of roadmap would really
15 help folks really think about quality of care
16 that they're providing and be able to, I think,
17 deliver it in a more meaningful way.

18 And lastly, I won't go into why I have
19 this perspective. I mean, I feel like I have a
20 fair amount of experience with behavioral health
21 folks starting to grapple with this even I've
22 found this is CCO stuff in Oregon, but we deal

1 with it a lot back home, et cetera. So, I'm
2 trying to incorporate some experience that I have
3 in this area.

4 But, I think finally, I'll just say
5 that, even coming up with a roadmap like this, if
6 you, you know, like the fact that you've looked
7 at this in three different ways, I think three
8 different slides, right, you started with
9 diagnoses and then you went to kind of the
10 continuum of care and then you --

11 Even being able to say like thinking
12 through these slides and saying, no, no, these
13 are the key pieces and then in these key areas of
14 sorts and at the key levels.

15 Like, literally, in my organization, we
16 have division level data, program level data,
17 provider level data. Right? I mean, but it's
18 same exact process that everyone's thinking about
19 in this room.

20 So, if we could put kind of all of that
21 into a roadmap of sorts that endorsed, that's
22 meaningful, it would just, I don't know, it would

1 be an amazing resource nationally for behavioral
2 health. I think it would be a big deal.

3 CO-CHAIR PINCUS: Mike?

4 MEMBER TRANGLE: I tend to agree with
5 you, but that's not why I raised my name tag.

6 I have three year -- I have divided up
7 four things I want to say.

8 I think there's a category of things
9 that we should be thinking of doing and maybe the
10 incubator is a place to do it.

11 Just in this last day and a half, we
12 have two examples. You know, we talked about a
13 measure where we're screening for depression.
14 You know?

15 We also have a measure about we're
16 treating and what percentage of patients are
17 responding or reaching remission?

18 I think the absence in the middle there
19 is somehow we should have a measure, once you've
20 screened somebody, what percent and how do you
21 increase the percent to get into treatment? You
22 know? And sort of complete that gap in the flow.

1 You know?

2 The same thing exists for tobacco that
3 we've talked about. You know? We've screened
4 for tobacco. We're going to see if we give them
5 a med, but somewhere, we want to measure whether
6 or not they stopped smoking and what's the
7 duration? You know?

8 So, when we've got these dispirit
9 measures that could be important measures like
10 both of these, we should fill in the gap. And I
11 think the incubator should take that on to help
12 us think about, it's a key thing to do so they
13 really flow and become more meaningful. You
14 know?

15 And for some of them I might be willing
16 to volunteer. So, that's a category.

17 And I'll just give you the two examples
18 that came up just now, but I am sure there are
19 others.

20 Another -- I want to talk a little bit
21 about two other areas that I think are not gaps,
22 but like the Grand Canyon. You know?

1 One is, there are more mentally ill
2 people in jails than there are in all the psych
3 beds, psychiatric beds. You know? I our area,
4 we're a fledgling, the counties that I would with
5 and stuff doing stuff.

6 And some of the things we're looking at
7 is are people being screened for mental
8 illnesses? Do they get any modicum of treatment?
9 And do they get connected with resources when
10 they leave? You know?

11 I think we should somehow take on that
12 as a huge zone that's playing out nationally
13 everywhere. You know? And not ignore it.

14 Whether that's incubator material or
15 something else, I don't know.

16 The other area, the other thing that's
17 not the Grand Canyon, but maybe it's something a
18 little smaller, but most places, and it's
19 certainly true in our area.

20 So like, when we look at our state, I
21 can't remember the exact number, David, maybe you
22 would, but if you look at people that are

1 homeless, and every year we measure that. If you
2 look at the ones that have mental illnesses and
3 chemical dependency, it's risen every year.

4 It's up to either 62 or 64 percent, you
5 know, of people that are homeless or people that
6 have our two categories of stuff. The other
7 large category is chronic medical illnesses, too.

8 But I don't see that being addressed.
9 I see sort of, kind of the housing or access to
10 housing or doing something with that as being --
11 it's not even in the purview of most of our
12 Department of Human Services in our states.

13 It's in a housing bureau where our
14 people that are sort of couch hopping and living
15 beneath bridges and stuff don't even meet the
16 criteria. They become homeless and get funded
17 for stuff unless it's temporary bridge funding.
18 But, it's a huge issue for our patients, I think,
19 housing.

20 And then, the last thing is something
21 that we've been grappling with a lot and are
22 actually are measuring it and doing some

1 statewide studies.

2 But it has to do with, traditionally,
3 the only places that measure access to, I think,
4 access to mental health services are health plans
5 where they're mandated to do it.

6 And if you're commercial in some places,
7 you know, if there's a real shortage, the health
8 plan will pay places to get people in in a timely
9 manner, at least psychiatrists and prescribers.

10 But I think the lack of access which
11 leads to sort of the lack of flow of psych
12 patients is a national problem everywhere, you
13 know?

14 And I think we should be taking that on
15 and looking at that. You know? In our area,
16 it's sort of, we've been, actually, for a number
17 of years, we're measuring sort of how long people
18 sit in ERs. You know?

19 What percent get admitted? What percent
20 don't? But, you know, and we're also measuring
21 the people that get admitted which, in our area,
22 it's a little less than half.

1 But then, statewide, 15 percent of our
2 psych beds are filled with people waiting -- who
3 are safe, don't need a hospital level of care,
4 but need an intermediate level of care, group
5 home, a foster home or a crisis bed, something
6 like that. So, that's 15 percent of our beds
7 statewide.

8 And then, we're beginning to try to look
9 at we need to increase our group homes and things
10 they flow to.

11 But the flow of those psych patients,
12 essentially, is ending up with them sitting in
13 ERs and ending up in jails. And I think it's a
14 huge national issue. And if we wanted to be
15 aspirational, I think we should be thinking about
16 that in our incubator.

17 CO-CHAIR PINCUS: Connie?

18 MEMBER HORGAN: Maybe this less
19 aspirational, but I would like to extend two
20 points that were made earlier.

21 I'd first like to extend what Peter
22 spoke about of the emphasis on behavioral health

1 integration and let us not look at integration
2 between mental health and substance abuse. I
3 think we're overlooking that and I think it's
4 really a key issue given the amount of
5 comorbidity that's around.

6 The second extension that I would like
7 to make is a follow on to both Mady's and
8 Harold's comments related to, actually to Tracy's
9 presentation on follow up and we're looking at
10 follow up as the flow through the system.

11 And the examples that were given were
12 more front end that when they follow or in the
13 process.

14 But I'd like to link that back to what
15 we spoke about this morning and the importance of
16 including recovery as part of that follow up and
17 making sure that that's a priority for us as we
18 move forward.

19 So, that's it.

20 CO-CHAIR PINCUS: Mady and then -- oh,
21 Peter?

22 MEMBER CHALK: Okay, I just want to

1 extend some of the things that Michael said.

2 So, we do have a screening and
3 engagement measure for substance use disorders
4 which amounts to screening and then did you get
5 in to treatment somehow or other.

6 What we don't have is trends. We don't
7 trend that measure. I mean, we say, you know,
8 the comments, it's sort of a snide comment that
9 people now, well, the measure hasn't moved.

10 Well, there are a whole lot of reasons
11 why the measures don't move and we could have
12 that discussion another time. I don't want to
13 get into it.

14 But screening and engagement in
15 treatment could be another one of those across
16 the board kind of measures and trended.

17 With some, I don't know where that
18 responsibility would lie inside the NQF, but
19 certainly, I would like to see if measures are
20 coming up for maintenance, what's the trend? And
21 what have you done with it?

22 If you screen for depression and then

1 somebody got into treat, okay. But is that one
2 percent of people? Five percent? Ten percent?
3 And did it get better? Did it increase?

4 With regard to housing, CMS -- I'm
5 working on a lot of projects with CMS right now
6 and housing has become an issue as part of
7 behavioral health and as part of the portfolio
8 that has to do with patients with complex need
9 and is more and more being included.

10 As a matter of fact, there are portions
11 of the Medicaid benefit now that can be used for
12 housing. It's a little crazy to try to get into
13 the details of that but it's there.

14 And in the Duals Committee, which I've
15 been on for a number of years, that pushed
16 heavily the other services that are needed beyond
17 health. And I do think this committee should get
18 into it.

19 The other thing that's a big deal that
20 you mentioned is this access issue. And I don't
21 know how we would deal with that, but for CMS and
22 for the work that I'm doing with them, provider

1 capacity has become a very, very big issue.

2 And whether -- how you measure provider
3 capacity, what do you really mean by that? And
4 quality of providers. But a provider is not a
5 provider is not a provider.

6 And I'll leave it at that.

7 CO-CHAIR PINCUS: So, Peter, Raquel,
8 Tami, Mike and then I'll sum up. And then, we've
9 got to move on to an overview of the tobacco
10 stuff.

11 CO-CHAIR BRISS: On the housing front,
12 just for information, there are some places that
13 are really -- yes, sorry.

14 On the housing front, there are actually
15 some places that are now doing really innovative
16 things, Durham, North Carolina, actually looked
17 at their frequent fliers in emergency departments
18 and across hospital systems and found that they
19 had a definable population of people that kept
20 showing up at the ER and they could save money by
21 kicking in for some housing intervention as
22 opposed to spending a lot of money on

1 uncompensated care in emergency rooms.

2 So, there are some models that are
3 actually trying to deal with that that could be
4 generalized.

5 CO-CHAIR PINCUS: Well, it's actually --
6 today's New York Times has an article about
7 Canadian efforts around housing first in Alberta.

8 CO-CHAIR BRISS: So, but the point that
9 I really wanted to make here were I'm delighted
10 that we're looking at more of the portfolio as a
11 whole.

12 And I think that NQF, this committee and
13 other committees need to do more of that. I
14 think that we need more attention to kind of
15 families of measures and perhaps less attention
16 to one measure because this is probably an
17 extension of what Michael was talking about, and
18 it's an extension of the last RAND measure.

19 Today, part of the problem with that
20 measure was it's probably a relatively low-value
21 area of an important health problem where we have
22 better options where measures aren't available.

1 And so, part of the discomfort, I think,
2 was that we were kind of addressing the wrong
3 problem. And we don't have a good way to deal
4 with that. We ought to do better, I think.

5 There's been a lot of conversation
6 around this table that I've been really pleased
7 with about the general burden thing. And, so,
8 when we get to this stage of a meeting, we always
9 come up with our top three or five additional
10 things that we'd like to do.

11 And I'd like us, every time we do that,
12 to come up with a matched set of three or five
13 relatively low value things, at this point, that
14 we could get rid of.

15 And because, part of the problem with
16 NQF today is we've got too many measures and
17 probably too many measures that aren't likely to
18 really move the needle on population health.

19 And one of the things, I actually think
20 that we're not formal enough about thinking about
21 the -- this is a step forward from where we've
22 been. We're still not formal enough in the

1 families of measures thing.

2 So, we'll talk in a second about the
3 suite of tobacco measures taken together.

4 But I'd sort of like to do that
5 periodically on everything. I'd sort of like to
6 -- this is the suite of things that we current
7 have for schizophrenia, what's not essential,
8 what's missing? You know?

9 And you could do that with -- you can't
10 do it with everything all the time, but I'd like
11 to see us do that periodically in some kind of a
12 formal way. And maybe you can map it to the
13 continuum of care or something.

14 But you know, this is what we have in
15 prevention. This is what we have in initiation.
16 This is what we have in follow up. You know? I
17 suspect that'd be really instructive.

18 CO-CHAIR PINCUS: So, Raquel and then
19 Tami?

20 MEMBER MAZON JEFFERS: I actually think
21 Peter just said exactly what I was going to say,
22 that you could take Shane's idea of a roadmap

1 along the continuum of care and the various care
2 settings, put the measures through that -- those
3 different lenses and then do some serious
4 housekeeping and get rid of the measures that are
5 no longer relevant or not as strong as some new
6 measures that have come in and really identify
7 the gaps.

8 And I would go from like prevention to
9 access to early identification, initiation,
10 engagement, retention, maintenance, outcomes and
11 then these recovery support measures which are
12 housing that you're talking about.

13 So, I think it's really important,
14 though, that the rubric that Shane was talking
15 about be developed in a way first to help us
16 place the measures in the context of the whole.

17 CO-CHAIR PINCUS: Tami?

18 MEMBER MAKE: I'm concerned that we
19 don't have enough focus on the potential harms
20 for these measures. We're -- almost all our
21 measures are telling the system to do more stuff
22 and we always assume that that's going to be

1 innocuous and then when the measures come back
2 for maintenance, we have no data on the harms.

3 The harms could even be just more out of
4 pocket spending. But, I think about how we got
5 into the opioid epidemic, it was because we
6 started getting an outcome measure about pain
7 which we felt was a great idea and we ended up
8 with this huge opioid epidemic.

9 So, I'd like to see more data coming
10 back on potential harms. So, because I'm kind
11 of, you know --

12 CO-CHAIR PINCUS: Okay.

13 MEMBER MARK: When I -- yes.

14 CO-CHAIR PINCUS: First do no harm.

15 Mady, did you --

16 So, let me try to summarize.

17 MS. MUNTALI: I'm now going -- trying
18 to go back to a number of comments. This has
19 been very helpful.

20 And piggybacking on your comments about
21 harm and going back to some original comments
22 about how we could re-look at maintenance

1 measures.

2 When we looked at reassessing
3 maintenance measures, one of the things we were
4 trying to do is to reduce the burden on
5 committees.

6 So, not to revisit some of the things
7 that have passed before in terms of the evidence,
8 if the evidence hasn't changed or the testing.
9 And so, there is a great emphasis on things like
10 feasibility and use and usability deliberately so
11 we can get this feedback back from those that are
12 using the measures, those that are being measured
13 by it.

14 So, there is a global initiative for us
15 to -- in order for us to reduce the burden, get
16 rid of the measures that don't really matter, we
17 need to know how they're doing that in the field.
18 And that's something we haven't been focused on
19 until very recently.

20 With regards to -- I'm kind of putting
21 together a roadmap or -- Karen and I were talking
22 and it sounded very much like what we used to do

1 in the past, haven't done very recently, but
2 preferred practices for behavioral health. And
3 we endorse those. And we can do that. That is
4 definitely within the scope of this work.

5 One of the other things that we have
6 done, you know, we are predominantly funded by
7 CMS. It is unpredictable what projects we will
8 get. So, we are not able to give advance notice
9 to you or to developers about the projects that
10 may be available.

11 But, one of the things that we did build
12 into our contracting is what we call off-cycle
13 review where, if a project isn't funding during
14 the maintenance process, you can talk about
15 things like a framework for your gaps, where
16 you'd like behavioral health to go.

17 A really good example of how this has
18 been operationalized is through our care
19 coordination project. They were able to do this
20 and they've built a framework around care
21 coordination.

22 And I would encourage us, including

1 myself on the Behavioral Health Committee, but
2 encourage the Behavioral Health Committee to
3 think about that.

4 It will give developers, if this is
5 taken to the incubator, more specificity. This
6 is where developers come back to us with
7 feedback. They get general comments about the
8 need for maybe measures around schizophrenia.
9 But what should they be focused on?

10 And, so, I think the more that you can
11 get granular, the more that you can scope out a
12 continuum of care, treatment, whatever, that
13 gives them specificity and direction, the more we
14 will be better able to get the measures that we
15 really want.

16 CO-CHAIR PINCUS: So, let me add a
17 couple of things and also try to summarize.

18 So, one thing that I thought was very
19 notable in terms of when we looked at the
20 different areas, that the most prevalent mental
21 disorders are anxiety disorders, and that's not
22 represented anywhere. And, so, that's one area

1 that clearly comes up.

2 A second area is, you didn't look at it
3 in terms of children and adolescents. But,
4 that's another sort of cut to think about. And
5 here's sort of the overlap with the pediatric
6 group and how to deal with that.

7 Number three, which goes, I think a
8 little bit to really the last comment, that, you
9 know, Lisa, you were making, which is, you know,
10 take, you know, developing some kind of
11 framework.

12 And it's related to, I think the thing
13 that Shane brought up about, you know, a
14 framework or some kind of recommended best
15 practice.

16 But I think there were two different
17 things there. One was really, I think, you were
18 aiming it at, because you're a behavioral health
19 provider, you know, what are the key recommended
20 measures that you would use that would sort of
21 give a, you know, a first level cut at like how
22 well you're doing which is a little bit different

1 than sort of an overall framework for measure
2 development which is something.

3 And I think -- so, I agree with -- but
4 I think it's both and. I think that it would be
5 useful to do that. But I also think it might be
6 useful to convene us as a group to actually think
7 about developing a framework for how we ought to
8 think about best practices for measurement across
9 this.

10 And in addition -- so, that's I think
11 three or four items that I mentioned. There's
12 another additional thought that I had which is
13 that I think also it would be a good idea for you
14 to convene measure developers, but in a more
15 formal way.

16 Specifically around the topics we've
17 been discussing today. Because, it's quite clear
18 that, among the measure developers that
19 presented, they don't talk to each other and they
20 don't talk to other people about what are best
21 practices. You know?

22 And I was surprised at how sort of

1 isolated, you know, those, you know, they are.
2 And, so, I think that that's, you know, a
3 responsibility for NQF to, you know, to think
4 about how to solve that.

5 And, but I do think convening this
6 group, you know, not necessarily to measure -- to
7 review measures that have been submitted, but to
8 actually come up with, you know, several
9 different frameworks and revising some of the
10 process and looking over in a formal way that was
11 suites.

12 Just in the -- and then, to summarize
13 the other things that have come up, one is also
14 to look at something like this, but also looking
15 at, you know, by use cases or by sort of
16 accountable entities how the measures are getting
17 stacked up to see that we have enough across the
18 board.

19 I think the idea of a new maintenance
20 process and form that has more emphasis, maybe
21 it's okay if less emphasis is on the evidence
22 stuff evidence of importance to measure unless

1 there's new evidence, but to actually look at
2 what's happened as a result of the measures, how
3 it's being used, what have been potential
4 negative outcomes. So, that's really the focus
5 and the expectation.

6 The idea of adding sort of allowing sort
7 of stratification to be done without calling it a
8 separate measure, but actually building it in to
9 the standardized use of different measures that
10 can be adapted. So, it's not like adding
11 necessarily more burden.

12 The idea of nesting certain composite
13 measures together in terms of screening, follow
14 up, you know, consistent -- continued
15 measurements to outcomes. You know, as, you
16 know, like the, you know, the Minnesota Community
17 Measurement measures that have been developed.

18 Next one is, you know, I think the
19 approach to looking at non-health settings,
20 quote, non-health settings like jails, housing,
21 things like that that would incorporate that. I
22 think that's a really significant gap.

1 The issue of access is huge. I mean,
2 and there are, to my knowledge, really no
3 measures of access to behavioral health services.
4 And that is a major national crisis.

5 Sixty percent of psychiatrists don't
6 take any insurance.

7 MEMBER MARK: Maybe NQF could clarify
8 that because my understanding is NQF doesn't
9 approve access measures.

10 So, for example, the identification
11 measure which basically says, what percentage of
12 people are getting STD treatment is a HEDIS
13 measure, but it is NCQA people told me it can't
14 be NQF endorsed because it's an access measure.

15 MS. MUNTHALI: That's not correct. We
16 actually -- we do see a lot of access to care
17 measures through our Health and Well-Being
18 Portfolio.

19 And there was a struggle for measures to
20 come through, quite frankly, because developers
21 had a difficult time putting them together.

22 And, so, what that committee did is

1 develop a framework for developers to assist them
2 so that they would know what kinds of things we
3 should be looking for but also for the committee
4 and everyone else who is looking at those
5 measures. How should we be looking at access to
6 care measures?

7 CO-CHAIR PINCUS: Could we see that?

8 MS. MUNTHALI: This framework -- we'll
9 send you the framework. We just developed it
10 last year.

11 CO-CHAIR PINCUS: Yes, but it's --

12 MEMBER MARK: But, that's really
13 important.

14 CO-CHAIR PINCUS: You know, if you think
15 of one area of healthcare where there's
16 definitely an access problem, if you look at any
17 primary care provider in the country, it's
18 behavioral health. And there's no access
19 measure.

20 Next item that would be a focus on
21 outcomes. And looking at what are the
22 expectations for best practices on measuring

1 outcomes? Which relates, obviously, to that
2 nesting kind of issue.

3 But, you know, that needs to be sort of
4 laid out and then communicated to measure
5 developers in that regard.

6 You know, I think Mady mentioned before
7 the issue of integrating mental health and
8 substance abuse. So, it was Connie, both of you
9 did.

10 I think that that's, you know, that
11 clearly is also a gap. There's nothing that I
12 could see that currently exists in that area in
13 terms of coordination and linkage.

14 MEMBER CHALK: That main outcome
15 measures may need a different path.

16 CO-CHAIR PINCUS: Right. And then
17 different ways to capture them.

18 MEMBER CHALK: Yes.

19 CO-CHAIR PINCUS: I mean, like, you
20 know, in a sense, you know, segmentation of, you
21 know, preventive care measures for people with
22 schizophrenia is kind of a coordination measure

1 as much as it is a process and potentially, you
2 know, control of hypertension is an outcome
3 measure, but it's also a coordination measure --

4 MEMBER CHALK: Right.

5 CO-CHAIR PINCUS: -- you know, in terms
6 of those things.

7 Because, if you have shared
8 accountability, then you're, you know, people
9 have to talk to each other. You know, so those
10 kind of things.

11 And then coming back to what was
12 discussed at the end, putting together for us
13 sort of what's the suite of measures as we're
14 about to do now with regard to tobacco, I think,
15 is a very useful exercise for us to do and to see
16 where the gaps are.

17 So, let me turn it over to you.

18 MEMBER PINDOLIA: When you were talking,
19 I thought of what Tami had mentioned and then,
20 you know, when we do new initiatives or when we
21 do a P&T review or launch a program, the first
22 year is the most critical time to figure out what

1 are all the things you didn't think of when you
2 develop.

3 But, when we do an approval, it's a
4 three-year approval. Right? Shouldn't the first
5 time, could we change it that the first time is a
6 one-year approval so we can catch any patient
7 harm issues or, you know, any inadvertent
8 concerns that come up from that data so that we
9 can address it early.

10 And I'll tell you like just from the CMS
11 and a couple of the measures that we have to do
12 and without people realizing, because you want
13 them to get a five star and you're getting a one-
14 time bisphosphonate for a senior and they really
15 shouldn't be taking it when they're 79. But, you
16 know, things like that.

17 MS. JOHNSON: You know, it's a great
18 idea. I think a couple of things we do ask
19 about, you know, any evidence of harms. As a
20 matter of fact, that's one of the things
21 specifically that we ask about under usability
22 and use.

1 Usually, developers only tell us about
2 what maybe they found in testing. They don't
3 always tell us about what happens in the world.
4 And, sometimes, they don't know, which is a
5 problem.

6 So, what we've been trying to figure out
7 is how we get people who do know to tell us. We
8 haven't quite figured that out yet. So, if we
9 can -- if you guys have any great ideas about how
10 we can get that feedback, you know, have said for
11 years, please tell us. But it's a passive please
12 tell us.

13 (Off-microphone comment)

14 (Laughter.)

15 MEMBER MUNTHALI: Yes, right.

16 MEMBER COLEMAN: Yes, even a two-part
17 application process where they come here first,
18 we can at least generate which worries or
19 questions we have and then they have a time and
20 period to go investigate those of sorts before
21 they come back or something like that.

22 I mean, something like that might at

1 least start to get at the spirit of some process
2 like that.

3 MS. MUNTHALI: Yes, what we really -- we
4 thought it was very valuable the ECHO discussion.
5 We would like to do more of that before measures
6 are endorsed so that you can see these measures
7 before the developer goes further down the track
8 of measure development.

9 And it looked like it was beneficial for
10 you as well. I think for the developer as well
11 so that they can change gears if they need to and
12 we can get an early look at what might be coming
13 down the pike.

14 MEMBER TRANGLE: Yes, you know, how do
15 I say this? I think even what's in this group,
16 but I'm think that Mike is probably one of these
17 people. Some of the stuff that you're talking
18 about that we should get together and maybe think
19 about talking about, some of us have been playing
20 with and developing and using this for quite a
21 while. You know, it's imperfect.

22 We have an access measure, you know? It

1 measures outpatient access. It measures access
2 to clinics. It measures -- you can count virtual
3 consults and other kinds of access.

4 You know, we've got a composite bundle
5 for schizophrenia, a suite of schizophrenia
6 measures.

7 We're not a developer. It wouldn't
8 occur to me to take time, effort and energy to
9 bring it to you guys.

10 I think there's a fair amount of wisdom
11 if we'd just sort of try to capture it. But, it
12 hasn't been in the framework for you think about
13 including that way. You know?

14 MEMBER LARDIERI: I just have a
15 question. Does NQF have any idea where the
16 measures get implemented, like which state, which
17 health plans say, you know, we're going to
18 implement this, you have to do this now? Is
19 there any requirement on the developer to track
20 where their measure gets implemented?

21 Because if there was some of that, then
22 you might be able to get some of the data

1 quicker, faster and maybe that needs to be some
2 place.

3 MS. MUNTHALI: It's difficult for
4 developers, too, to know who and where our
5 measures are implemented. There's a lot of
6 misapplication of measures.

7 You may approve a measure for a certain
8 level of analysis and it may be applied at a
9 different level of analysis. We've seen that
10 happen a lot.

11 We just did a project on variation of
12 measurements specs. And not because people are,
13 you know, meaning to do bad, but they're just
14 trying to get around some of the challenges we
15 mentioned before, some of the data challenges,
16 some of the implementation challenges around
17 collection and reporting.

18 So, the answer to your question is, no,
19 although measure developers do have a contract
20 with us, it's a measure steward agreement. We
21 tell them to tell us when there are any updates,
22 tell us when there are changes.

1 And, you know, it's part of their
2 requirement. But, it is hard to enforce.

3 CO-CHAIR BRISS: And the addendum to
4 that is that, every time I've been in a
5 conversation along that line, it's like the
6 conversation this morning where, you know, three
7 people pop up and say, I know where your
8 measure's been being used in these places and he
9 said I have no idea. Right?

10 And, so, there's a whole lot of that and
11 it's trying to get a better sense of where things
12 are being used and if something good or bad
13 happened is sort of an undiscovered country, in
14 my view, that's gotten not nearly enough
15 attention.

16 MEMBER ZIMA: I just wanted one comment,
17 and that is that, I think with behavioral health
18 more than probably other fields, we are more
19 interested in how these quality measures are used
20 in other sectors.

21 And we talked about jails and
22 homelessness, but particularly for children, we

1 also think about health circuit med treatment and
2 foster care and things like that, and in schools.

3 And, you know, and I just sort of wonder
4 with NQF, are you taking the lead in advocating
5 for these siloed data infrastructures to link?

6 MS. MUNTHALI: We are. We just endorsed
7 our first home and community based services
8 measure which was -- which came after a project
9 on how we look at home and community based
10 services and measures. So, we built a
11 measurement framework around that.

12 And we would like to see measures that
13 are specific to populations, have broad
14 application. But it's really difficult, the data
15 issues that we find, especially as you're trying
16 to get into settings and areas in which are not -
17 - you're going further away from the clinical
18 settings and into populations that are
19 marginalized vulnerable populations in which, for
20 you to get a comprehensive look at, I mean,
21 health, health care, quality of health and health
22 care, you'd have to have a very integrated

1 approach.

2 What we find, and this is happening even
3 as we're thinking about SDS, the biggest
4 challenges are around data, linking the data.
5 And, so, that is one of the things. It's not the
6 thing that draws people, but it is -- it's a huge
7 obstacle for us and for developers as well.

8 MEMBER LARDIERI: I have a real quick
9 idea, why don't NQF set up an NQF registry for,
10 you know, a voluntary registry so all those
11 health plans state that use an NQF thing, go into
12 your website, identify what they're using and if
13 they're using the measure as is or if they've
14 modified it.

15 And it wouldn't be that much of a heavy
16 lift that way.

17 MS. MUNTALI: So, that was almost a
18 recommendation that came from our variation in
19 measurement specs project.

20 One of the things that they were saying
21 is, okay, we know that variation is happening.
22 It's happening for a number of reasons, how can

1 we mitigate it?

2 At a minimum, we should be transparent.

3 And the recommendation from the committee is that
4 a body like NQF house repository or a database in
5 which you can, you know, kind of catalogue all of
6 this information.

7 So, that's something that we're looking
8 into. We're hoping to, as with the attribution
9 project, get additional funding to look into that
10 and see if not us, who? And how would we do it?

11 MEMBER TRANGLE: I just want to make one
12 last comment. My organization is part of NIMH
13 got together and formed a mental health research
14 network of systems that had reasonably large
15 integrated multispecialty groups, inpatient,
16 outpatient and health plans where we could look
17 at the data.

18 And when that started, that network was
19 maybe ten, and it's up to maybe 16 places now.
20 It started out that all of our projects were the
21 pet projects of researchers who had already
22 gotten NIMH grants.

1 And over the last, I don't know how many
2 years we've been around, maybe six, seven years,
3 it's really evolved such that the questions that
4 are being researched are coming from a delivery
5 systems and the health plans that are part of it
6 saying, these are burning issues for us to
7 improve the quality of care or whatever it is
8 that we deliver.

9 And we've also come up with certain kind
10 of operating principles that, you know, if it's
11 going to burden staff at a clinic or clinicians
12 or secretaries or whatever it might be, it's not
13 going to happen.

14 It's got to be back office, you know.
15 It's got to potentially be sustainable. So, if
16 it's an improvement, we might continue it.

17 But, and maybe we're at this same sort
18 of evolution where, you know, developers who are
19 in it for the glory or the money or both come to
20 you with little slices of, I'm interested in
21 this, I'm interested in that, with really no
22 guidance as to whether it's a puny little thing

1 or it's a big ticket clinical issue.

2 And I hope we're evolving in the same
3 way that this research network is evolving where
4 it's got to be really by the -- and we may have -
5 - may not be the right -- we may not be
6 constituted as a committee to do this -- the
7 right committee to give you that feedback.

8 But that's where the direction should be
9 coming from and then the developers should be
10 told this is what we need. You know, and if it's
11 a n RFP process or whatever it might be instead
12 of vice versa.

13 CO-CHAIR BRISS: Let me take a minute
14 and share with you that the portfolio or most of
15 the portfolio of tobacco related measures.

16 So, as you've heard me say this before
17 that I'd love to be able to do this kind of an
18 exercise periodically.

19 DR. LUSTIG: And I just wanted to point
20 out, I tried to not try to shove everything onto
21 the slide because too many columns and rows. So,
22 you also have a handout that gives just a little

1 bit more detail.

2 CO-CHAIR BRISS: Yes, as this stands,
3 you really have to be an aficionado to be able to
4 make sense of it. But this shows most of the
5 portfolio of tobacco related stuff. I'd love us
6 to be able to periodically look at the suite of
7 measures related to certain topics every now and
8 then actually regardless of which committee, you
9 know.

10 And, so, one of these actually came out
11 of the Child Health or Pediatric Committee,
12 whatever you call them. And --

13 DR. LUSTIG: Yes, and so, actually, the
14 last column, we can now disregard because that's
15 the measure from yesterday that did not pass.

16 CO-CHAIR PINCUS: I don't know, but I
17 think that's where the --

18 CO-CHAIR BRISS: But they'll come back.

19 DR. LUSTIG: Yes.

20 CO-CHAIR BRISS: They'll come back.

21 DR. LUSTIG: Yes, it's good there.

22 CO-CHAIR PINCUS: I am disappointed, I

1 think it's actually important to think of it in
2 this.

3 CO-CHAIR BRISS: Yes.

4 DR. LUSTIG: So, but the other -- the
5 2803 and 2020 are from -- are in other committees
6 endorsed these.

7 CO-CHAIR BRISS: Yes, and so, if you
8 think about the portfolio, taken together, there
9 are sort of several measures that are about
10 screening and/or counseling at the clinic or
11 provider level.

12 So, 3225 and 3185 are the ones we
13 reviewed yesterday that are sort of the -- and
14 I've been doing these too long because I want to
15 characterize these as the ones that used to be
16 NQF 28, right?

17 The 2803 is a similar measure that's a
18 pediatric measure. It's a little bit different
19 on the treatment side because of the med
20 treatment isn't recommended for kids.

21 The -- you saw NQF 27 yesterday as well.
22 That's sort of a similar measure about screening

1 and treatment at the health plan level.

2 The 1651 to 1656 are three -- a suite of
3 three related joint commission measures that are
4 sort of did hospital screen and appropriately
5 treat among hospitalized people.

6 2600 is one of those did you do the
7 right thing in the behavioral health population
8 to, right, that Mady was talking about.

9 The 2020 and 3229 are more population
10 prevalence measures. They're not -- I wouldn't
11 really characterize either of them as screening
12 measures.

13 But 2029 is prevalence at the level of
14 a patient panel that you saw yesterday. And 2020
15 is at the state level from BRFSS.

16 And, so, in this subject matter, it
17 looks like a lot of measures. I can make them,
18 at least in my head, to look like a coherent set.

19 So, you've got did you appropriately
20 screen and treat in adults? Did you
21 appropriately screen and treat in kids? Did you
22 appropriately screen and treat in hospital

1 settings? And did you move the needle on
2 prevalence in patient panels or states? Right?

3 And, so, but we should -- and treat, as
4 I don't think that there are huge gaps in this
5 portfolio, but we ought to be looking at
6 portfolios as a whole like this.

7 And, you know, we talked about some ways
8 yesterday that 3229, for example, might be
9 consolidated with some of the processing
10 measures.

11 You know, there are ways that some of
12 these might be further composited or at least
13 looked at together as a suite in a way that would
14 communicate better.

15 So, this is an example of a set of
16 measures. And this has already been said that
17 they didn't all come out of our committee. And,
18 so, it's good to look at the whole bunch of them
19 together periodically I think.

20 MEMBER MAZON JEFFERS: So, I don't know
21 if you're asking for this feedback, but there
22 seems to be a tremendous amount of overlap and it

1 would -- a great opportunity for simplification
2 with a little careful study.

3 CO-CHAIR PINCUS: So, Peter, I need some
4 of your thoughts about what the opportunities are
5 there for consolidation. You know, obviously, we
6 have, you know, an alignment.

7 I mean, you know, one is getting, you
8 know, some of the age issues, you know, sort of
9 clear. Some of it might be, you know, you know,
10 having sort of similar, if we're applying the
11 concept of what is counseling to do it in a
12 consistent way across, you know, is screening
13 defined in the same way across all of these?

14 That includes 28 -- so, those are the
15 kind of things that -- so, part of alignment, I
16 mean, if you want to operationalize the concept
17 of alignment, part of it is, you know, sort of
18 nesting or consolidating very similar overlapping
19 measures.

20 MEMBER MAZON JEFFERS: Or could a single
21 measure --

22 CO-CHAIR PINCUS: Let me just finish.

1 MEMBER MAZON JEFFERS: Sorry.

2 CO-CHAIR PINCUS: And the second part is
3 for similar concepts to use the same
4 operationalized definition for those concepts.

5 And then if there's competing measures,
6 to select the ones that are, you know, are the --
7 have the greatest feasibility, that don't, you
8 know, in terms of how much effort is required to
9 get it.

10 CO-CHAIR BRISS: So, Raquel, did you get
11 --

12 MEMBER MAZON JEFFERS: The only other
13 thing I would add is -- or if there's a single
14 measure that we really like how it's constructed,
15 could it simply be applied in different settings?

16 CO-CHAIR BRISS: So, I'm personally less
17 -- so, for example, I don't think that -- I think
18 that counseling and treatment and primary care
19 and counseling and treatment in hospital
20 settings, for example, are both important and I
21 personally wouldn't favor dropping on in favor of
22 the other, at least for something that's as

1 important as tobacco.

2 For example, there are people -- there
3 have been people at CMS that feel like one of the
4 -- like everybody could measure one of the
5 outcome measures. And we could drop all the
6 process measures.

7 I personally am skeptical about that,
8 truth is. You know, but that's the conversation
9 that kind of -- at this point, I'm not trying to
10 give a formal vote to how I would solve this
11 mess.

12 I think reasonable people could -- at a
13 minimum, I think we could do better about
14 presenting and talking about our suite of things
15 and what they -- what we think they uniquely
16 contribute.

17 So, in this one, I can make a case for
18 unique contributions maybe with the exception of
19 I don't much favor -- I think I'm echoing Mady a
20 little, I don't much favor did you do appropriate
21 chronic disease prevention in a special -- in a
22 population with some other comorbidity because

1 I'm afraid that what that always gets you is 50
2 measures.

3 You know, did you do smoking prevention
4 in people with mental health makes perfect sense
5 until you also have to do it for people with
6 diabetes and cardiovascular disease and every
7 other condition under the sun.

8 And, so, I don't actually favor -- I
9 don't much favor measures like 2600 on that
10 basis. The rest of these, I can make a case for
11 that you could -- the joint -- there's three
12 joint commission measures could be composited in
13 principle instead of having three measures that
14 are essentially about did you screen? Did you
15 treat it in the hospital and did you assure
16 treatment going out the door?

17 It could be a smaller number of
18 measures. You know? And, so, there are
19 opportunities to talk about that stuff. But, I
20 do think lining these up and having that
21 conversation is a good thing.

22 And the point of this at this moment

1 isn't to micro manage that conversation but to
2 talk about -- I think we ought to do more of this
3 and have more of that conversation.

4 CO-CHAIR PINCUS: But, I guess, just to
5 follow it up in terms of the -- but, what is the
6 next step? I mean, we can opine that, you know,
7 that's there possibilities of X, Y and Z. But,
8 who -- how does that get operationalized into
9 actually a change?

10 What's the role of NQF in, you know,
11 communicating to measure developers or the groups
12 commissioning measure developers like CMS?

13 I mean, is it, you know, is it our -- is
14 it, you know, a responsibility of this committee,
15 obviously, at another meeting, to you know, to
16 say, well, here, why don't you consolidate, you
17 know, these three.

18 Add a, you know, a secondary screen X
19 amount of time after, see how many people stopped
20 smoking. You know, I mean, you know, is it our
21 job to do that or is it, here's issues, the field
22 figure it out.

1 CO-CHAIR BRISS: I have a couple of
2 suggestions. So, a couple of suggestions is that
3 I generally think that when a committee gets to
4 this point in a meeting and everybody's
5 exhausted, we all shoot from the hip and opine
6 about what are my three favorite things that I'd
7 like to see additionally done? And I think that
8 that's wrong.

9 So, I'd love to see us, even if we could
10 just tee up a couple of subject matters every
11 once in a while, I'd love to see us tee up
12 something like this on a periodic basis, point
13 one.

14 And then we could at least give some
15 more informed feedback about what we think we can
16 do more of and what we'd like to do less of is
17 point one.

18 Point two is that you guys are always
19 looking for constructive stuff to do off-cycle.
20 Right? And I think we could do this kind of
21 exercise in off years.

22 So, imagine a state of the world where

1 we did a -- say, for the purposes of argument,
2 next year or the year after is an off-cycle year
3 for the behavioral health committee.

4 I could image we did a quarterly webinar
5 and teed up one of these things every quarter.
6 And we could get a lot of constructive stuff done
7 even in an off year, I think. Right?

8 And, yes, and it would have the
9 additional advantage of having committees stay at
10 least a little in contact and not have to feel
11 like they're completely starting over in the
12 years where they do get funded. You know?

13 And, so, at least some of that kind of
14 stuff could get done and the results could be --
15 the results of that could be used both to pair
16 the portfolio, which I'd really like to see done,
17 truth is, and to feed the measure developers and
18 the incubator and other things that might have
19 opportunities to fill gaps or -- and/or improve
20 existing measures.

21 MEMBER KELLEHER: I second that.

22 CO-CHAIR BRISS: Wow, I've thirded. I

1 need to quit while I'm ahead.

2 Anybody else have comments about this
3 kind of stuff?

4 MEMBER CHALK: The only comment I wanted
5 to make is that, the population prevalence
6 measure, the 2020 I guess it is, there could be
7 some conversation about how population prevalence
8 measures are used to nest everything else that
9 we're talking about.

10 In the area of substance use disorders,
11 we're talking about those measures being
12 contextual measures and being essential to
13 everything else that's built on top of them.

14 You want to know what the prevalence is
15 and then you build on top of that a bunch of
16 measures.

17 They set the context for everything
18 else.

19 CO-CHAIR BRISS: Yes, and maybe could I
20 add to that? I mean, one of the problems with
21 those kind of measures is we didn't have as much
22 conversation about this as I thought we might

1 yesterday.

2 But, there's -- particularly, these kind
3 of measures have -- the outcome measures have a
4 big attribution problem. Right?

5 And there's inevitably a lot of worry
6 about penalizing providers that take care of high
7 risk populations. Right?

8 And if you -- and these measures would
9 be easier to sell, I think, if they were always
10 packaged with other things and weren't treated as
11 if they were standalone and going to be, in my
12 view, and if they weren't packaged as if they
13 might be standalone high stakes measures that
14 we're going to penalize people that we're taking
15 care of sick people. Right?

16 Yes, Michael?

17 MEMBER TRANGLE: Your suggestion of
18 eliminating, which I get when you start
19 generalizing it, but eliminating looking at how
20 we're doing this measure with patients with
21 serious mental illnesses, I get that you don't
22 want to do it in every population.

1 But, on the other hand, if you truly
2 eliminate that without having this a dispirit
3 group or at least a sub-specification --

4 CO-CHAIR PINCUS: And I think the
5 assumption is that one would have a generic
6 measure and one could stratify that.

7 MEMBER TRANGLE: And, so, mandating
8 stratifying so that we can see within that
9 population then it sounds fine. Otherwise, we're
10 back to where we are now where it's lost.

11 CO-CHAIR BRISS: Although, like NCQA,
12 for example, today does things like some years
13 they mandate that you report your performance on
14 27 in a specified subpopulation. Right?

15 You know, so, they have years when HEDIS
16 reporting says we want to focus on -- we want to
17 have a focus on mental health or cardiovascular
18 disease or whatever it is.

19 And, so, there's capacity in some of
20 these today to do something that's kind of
21 similar to what 2600 is trying to do. I think we
22 could do that in other subjects.

1 MEMBER TRANGLE: But make it a ten-year
2 period, not this year.

3 CO-CHAIR BRISS: Yes.

4 CO-CHAIR PINCUS: No, but I think that
5 if you -- the issue is stratification is that you
6 can do it and then that gives, you know, as a
7 single measure and it gives options for
8 stratification but do it in a standardized way so
9 everybody's using the same methodology for
10 defining a stratum.

11 CO-CHAIR BRISS: And the other thing
12 that we need to keep in mind is that it's not
13 going to be generally true that all these have --
14 all of these collect -- currently collect the
15 data that would allow you to stratify it. So,
16 we'll have to be careful about -- that raises its
17 own set of burden issues, too.

18 So, we're going to have to be -- that's
19 -- there's never a perfect measurement solution.
20 Right? That's got no cost and no harms, but at
21 least that's something that can be talked about.

22 MEMBER TRANGLE: It might be an

1 incubator kind of issue to work on. Which ones
2 could be stratified to get mental health? I can
3 see the excitement reigning supreme over there.

4 (Laughter.)

5 CO-CHAIR BRISS: All right, Tami?

6 MEMBER MARK: You're on a winning streak
7 so I had to disagree with something.

8 CO-CHAIR BRISS: Okay, good.

9 MEMBER MARK: Yes, I guess I get the
10 point that it gets too onerous when you start
11 slicing and dicing. But, most people who are
12 going to pick up these measures aren't going to
13 know that there's a huge problem with smoking
14 among SMI or aren't going to know that there's a
15 huge problem with cardiac conditions among SMI
16 unless there's a separate measure.

17 So, that's been my experience.

18 CO-CHAIR BRISS: I agree.

19 MEMBER MARK: So, that's the counter-
20 argument.

21 CO-CHAIR BRISS: Mike?

22 MEMBER LARDIERI: I'm trying to say,

1 Peter, I think, you know, if we move to eMeasures
2 and I don't think then the burden gets that -- to
3 stratification gets that difficult. Because you
4 already have the data in there and you're going
5 to be able to stratify whichever, you know,
6 whichever component or silo that you're looking
7 at as it gets less difficult.

8 CO-CHAIR BRISS: It does, assuming that
9 you can find the data in an appropriate field.
10 You know, there's never a perfect solution as I
11 think I -- my answer to everything at this point
12 is there's never a perfect solution. Right?

13 MEMBER MAZON JEFFERS: Would be okay to
14 take five minutes right now and have someone
15 explain to those less initiated, what is the
16 measure development process and where do the
17 costs sit?

18 The question that Mike asked earlier, I
19 feel like it would help us understand
20 contextually the cleanup process as well.

21 (Laughter.)

22 CO-CHAIR PINCUS: We have seven minutes

1 because we have to stop at three.

2 (Off-microphone comments.)

3 (Laughter.)

4 MS. MUNTHALI: So, we actually could do
5 that. Actually, we have -- we do engage with
6 measure development -- measure developers outside
7 of the review. We do have a standing measure
8 developer committee, but it's a community.

9 We meet with them monthly. We do
10 webinars, but we also have an advisory group of
11 measure developers.

12 And, as through the incubator, we have
13 a learning collaborative.

14 So, those issues I think, Harold, you
15 talked about, you know, noticing that developers
16 are not talking to each other. It's -- that is
17 very true. Because they do have different
18 business agendas.

19 These are organizations that are
20 developing measures, you know, for the greater
21 good, but also they have business reasons for why
22 they're developing measures.

1 So, it is very difficult. It's
2 something we don't talk about often, but it is a
3 reality. And it's very expensive. We don't know
4 -- we have rough figures around how much, you
5 know, it may cost, but we don't know because some
6 of that is proprietary.

7 We see those measures once they are
8 close to be fully spec'd or spec'd here. But, it
9 is a very, very long process that involves
10 testing.

11 A lot of the obstacles that they
12 encounter is around the testing. They go into
13 something and sometimes things don't work out the
14 way they anticipated. Their access to data,
15 their -- we can have a developer walk you through
16 that.

17 We went through this when we did a lean
18 improvement activity around our consensus
19 development process, a kaizen, in which we had a
20 stream that looked at measure development from
21 concept on to testing. And we were like, wow.
22 We were quite impressed.

1 There are a lot of steps, a lot of
2 challenges, things that go into the, you know,
3 into the pipeline don't always come out.

4 And, so, it will be very difficult.
5 That's why we have been stressing since that
6 kaizen to really do a lot more upstream
7 engagement with developers before they even start
8 thinking about ideas for developing measures,
9 really being able to influence that there as
10 opposed to when they come to you here.

11 Because a lot has gone into in terms of
12 resources, human, all sorts of resources.

13 CO-CHAIR BRISS: And the only other
14 thing I would add is that I don't get the sense
15 that this is much of a money center for anybody,
16 it's the generally feeling in the field seems to
17 be that it's a long-term expensive project to get
18 any measure to the table.

19 It's probably on the order of a quarter
20 of a million dollars and years to get any measure
21 here which is why they get so -- one of the
22 reasons they get so gray. These people have --

1 when they get to here and we turn them down,
2 they've just sunk a quarter of a million dollars
3 and two and half years.

4 And there's not much of a financial
5 reward if they get through.

6 So, I think it's -- I personally think
7 it's too much of a bottom up process and I
8 personally think that it's got all kinds of
9 problems. I don't think that there's -- that the
10 primary problem is that it's a lucrative thing to
11 be a measure developer.

12 I do agree that having too many measures
13 and especially too many low value measures
14 generates a lot of costs to the system that are
15 really important that nobody thinks about enough
16 at any level of the measure development process
17 which is one of the reasons that you've heard me
18 on my soapbox constantly about I'd like to see
19 less measures. I'd like to see less measures.
20 That's what I'm thinking about.

21 But, I don't think a primary problem is
22 likely to be very --

1 DR. LUSTIG: We technically have three
2 minutes left and we actually need to ask about
3 public comment and Kirsten has some follow up.

4 MEMBER LARDIERI: Okay, so maybe it's in
5 a different discussion, but maybe we would be a
6 little more transparent because nobody's putting
7 a quarter of a million dollars in there for
8 nothing. For all the measures that we have,
9 that's not happening. So, maybe we need to be a
10 little more transparent about that.

11 I know there's -- do they pay NQF a fee
12 to get this? So they don't do that. But, you
13 know, there's more than, you know, nothing to it.

14 CO-CHAIR PINCUS: Well, you need to
15 distinguish between measure commissioners and
16 measure developers. There are groups, most
17 commonly CMS, that commissions other groups to
18 develop measures, you know, that as their
19 clients.

20 CO-CHAIR BRISS: So, we've got -- the
21 staff are trying to get us to public comment.

22 Not, right now, we can further this

1 conversation in a follow up phone call if you
2 guys want to. So, can -- would anybody on --
3 either on the phone or in the room like to make a
4 public comment?

5 OPERATOR: And, at this time, if you
6 would like to make a public comment on the phone
7 line, please press star one.

8 And there are no public comments from
9 the phone line.

10 CO-CHAIR BRISS: Okay, follow ups?
11 Follow ups?

12 DR. LUSTIG: So, one of the questions is
13 we do have reserved time next Thursday for a post
14 meeting call. We do that in case there are any
15 issues related to the measure endorsement that
16 weren't resolved. We don't have anything related
17 to that to discuss, so we can cancel the call or
18 we can hold it and continue to talk.

19 But, otherwise, we can go ahead and
20 cancel that and then we can prepare some things
21 related to our discussions today and have that
22 for a future time.

1 CO-CHAIR BRISS: And before everybody
2 sort of goes off to the four winds, I want to
3 thank the staff for all their ages and ages of
4 prep work.

5 (Applause.)

6 CO-CHAIR BRISS: And especially this
7 stuff which was mostly new people who hadn't done
8 this before. So, congratulations on surviving
9 your first one.

10 (Off-microphone comment.)

11 DR. LUSTIG: Next Thursday, yes, it
12 sounds like we're going to cancel that.

13 CO-CHAIR PINCUS: And I also want to
14 thank all of you because, I mean, we really had
15 some superb, vigorous discussion. People really
16 had great input and that's the kind of, you know,
17 work that we like to get done at these meetings.

18 DR. LUSTIG: And, so, before you run
19 off, Kirsten, you just want to talk about, just
20 so you know the process after this.

21 MS. REED: Sure. Okay, so, this March
22 9th webinar, we will go ahead and cancel. So,

1 enjoy your free two hours next Thursday.

2 In the meantime, Tracy, Desi and I are
3 going to be drafting the report to prepare for
4 the public commenting period which will run
5 through April 5th through May 4th.

6 And then, once we do get all of those
7 comments, we will compile them and prepare for a
8 post draft report comment webinar with all of you
9 where we will present all of the comments we
10 received and start preparing our responses to
11 those.

12 That does need to be scheduled, so I
13 will reach out and see which dates and times work
14 best for you. But, it will be a couple weeks
15 after that May 4th deadline or ending of the
16 commenting period.

17 Other than that, thank you all for
18 coming. I think our meetings department will be
19 following up with you with the reimbursement form
20 for all of your expenses in traveling here. If
21 you don't get that or have any questions about
22 it, please let me know and I will talk to you

1 soon.

2 DR. LUSTIG: And everyone got thanked
3 except our co-chairs. So, I'd like to thank our
4 co-chairs for doing a great job.

5 (Applause.)

6 (Whereupon, the above-entitled matter
7 went off the record at 3:01 p.m.)
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Before: NQF

Date: 03-01-17

Place: Washington, DC

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