NATIONAL QUALITY FORUM

Behavioral Health
Post-Comment Call
May 22, 2017
1:00 p.m. ET

Operator: This is Conference # 93586680

Welcome, everyone, the webcast is about to begin. Please note today's call is being recorded. Please stand by.

Tracy Lustig: Hi, everyone, it's Tracy Lustig with the National Quality Forum. I'm happy to be talking with you today. We feel like we just saw you all in person but a lot have happened since we were all together last.

The purpose of the call today is to go over comments that came in during the comment period. We had 52 comments in total. Most of which were in support of the decisions that the committee had come to in the in-person meeting. But we do have several key comments that we felt warranted discussion by the committee today. And we do have one formal request for reconsideration.

And so, the purpose of the call today is to discuss all of those issues and determine whether re-voting is needed on any of these issues or whether there are any other comments that we didn't highlight that the committee wants to discuss, issues that were raised. So with that I will turn it over to (Peter) and if (Harold) has joined us, for them to get us started.

(Peter): So good afternoon, everybody, welcome. I don't have a lot to say before we get started with the formal agenda. You'll see in our agenda we've built specific

discussions of four or five of the measures on which we got out, requests for reconsideration or several comments. And so, we'll work through those and then towards the end of the agenda we will aim to work through any other issues that people would like to delve into.

So would anybody like to have questions or comments before we get started with the formal agenda?

Hearing none I suppose we can start. So the first measure for reconsideration is Measure 108, follow-up care for children-prescribed ADHD medication. This is from NCQA.

Just a bit of a reminder of where we've been on this measure, we didn't reach quite a consensus on evidence and didn't pass the measure on the sub-criterion of validity. And concerns that were largely going around the table had to do with that, that 30-day timeframe, as well as the inability of the provider to engage with patients in ways other than a face-to-face visit.

And so, you know, if the staff would like to add anything to that preamble we ask NCQA to comment?

Tracy Lustig: I think we're good here and I just wanted to remind two of our committee members who have conflicts listed with Measure 108 (Connie Horgan) and (Harold Pinkus), so they should not be participating in the discussions. But otherwise we can turn it over to our developers if they want to give a brief opportunity to review the measure.

(Dan Roman): This is (Dan Roman) with NCQA. I'm joined here by my colleague (Chen Chin Lu). Thank you for this opportunity to have this conversation today.

In the materials for today's call there is a memo that kind of highlights what we would like the committee to consider. So I will just touch on it briefly and then turn it back over to the chair.

So after the in-person we felt that there was some follow-up that we needed to do given the feedback that we received. The first was to take another look at the evidence.

We cited (actually) two studies in the memo but we found numerous studies that support follow-up care that includes medication management and monitoring services, all showing improvement and outcomes in children who receive it versus those who do not.

The timeframes that typically are studied were within a few weeks from the first dispensing event to a year. So we do think that the measure is supported by the evidence that exists.

During the committee we also heard some comments that the (AAP) did not support the recommendations so we met with the (AAP) and their chair of the committee for ADHD treatment guidelines and discussed that comment, the evidence, the guidelines, the 2011 guideline, and our measure. And the feedback that we received is that they stand by their recommendations and they thought it was reasonable to have the follow-up within 30 days. And that the measure was reasonably supported by all of the evidence.

Another point that was brought up during the meeting was the validity. I think I believe we presented construct validity with our primary care access measure. And I believe that those comments that, you know, the measures were not the most related. So in our defense of using that we did our best to find a measure that seemed reasonable to do construct validity and construct validity analysis.

And we showed a moderate validity which in our assessment basically is saying that as a plan (model), a plan that is (doing well) with providing primary care to children they are also doing well with providing follow up services for children with ADHD. Again it is, you know, not the most direct construct validity analysis as far as the measures go but we are limited in what measures we have to do a construct validity analysis.

And so, you know, we will continue to look for further measures in the future. But again, the correlation we showed was moderate correlation and we think it makes sense that a plan that is doing well providing these primary care services is also doing well at providing follow-up care with children with ADHD.

The final point that I think we just want to make is that the measures, currently part of a number of programs including the Medicaid (child core) set and we just think that it is really important that it maintains its NCQA endorsement while it's in use in these programs to continue shedding light on the issue of following up and monitoring children who are prescribed ADHD medication.

(Chen Chin), did you want to add anything?

(Chen Chin Lu): I think you covered it.

(Dan Roman): OK, thank you.

(Peter): So with that, this is (Peter) again, so with that, you know, we'll open the discussion. Before we start the general discussion would anybody like to follow up with the developers? Are there clarifying questions or various issues that you'd like to ask NCQA?

(David Ainsley): This is (David Ainsley). I have a question.

(Peter): Please.

(David Ainsley): So I was asking the (AAP) about the, so it's reasonable to follow up within 30 days. I mean do they speak a little bit more behind with the 30-day mark came from, or was the follow-up question asked, you know, is 45 days reasonable, is it two months reasonable?

The question for me still remains why 30 days?

(Chen Chin Lu): This is (Chen Chin Lu). I spoke to the (AAP) staff and then their Chair, they mentioned that their recommendation is based on their panel discussion, it's

consensus-based. They think that when children are on ADHD medications early follow-up is important.

Their recommendation even mentioned the first follow-up visit within the month should be a face-to-face visit so that they can monitor side effects and check the vital signs. So that's really, to your question that it's consensus-based. They think that they would continue to support the timeframe. And we did look into the research studies showing that, you know, a few weeks to a month, to a year it's all important to follow up but if the time frame is (consensus-based) they continue to support the 30-day follow-up timeframe.

(Michael Tringle): This is (Michael Tringle) with a question also.

(Peter): Please.

(Michael Tringle): I know that you were talking about correlation and those systems of care that did better were following up within 30 days.

And follow-ups we're talking about are still basically face-to-face, and one of the points they made was monitoring for side effects, high blood pressure, et cetera. Is there, how do I want to say this, is there any evidence that all that, what proportion or when do you do face-to-face versus telephone or other kinds of follow-ups makes a difference, you know?

Because an alternative hypothesis would be there are many places out there that are sort of jumping through hoops and contorting themselves to get the first face-to-face and then, but the real significance of doing that versus telephone may just be tradition, you know. And if there's someone working hard to look good and meet the measures you could be having that correlation but you're doing a ton of extra work to make that happen.

Do you see just to my question?

(Chen Chin Lu): Yes. That's a good question, (Michael). So we do look into the research evidence on the Telehealth modalities, video-conferencing and telephone to see if they are as effective as in person visits (for a case) management for

children who are on ADHD medication. And that we reviewed the evidence with our behavioral health measurement (as an advisory) panel because as we mentioned to you last time we are going through a process of considering Telehealth more four our measures and this measure was one of them.

So based on our evidence review and our panelist feedback we made a recommendation, and also in consultation with the American Academy of Pediatrics. They also supported our recommendation which is that one of the continuation-based visit could be conducted via video-conferencing or telephone visit. So that is our recommendation and we could, you know, go through (and conduct an) annual update process to update that.

So the evidence is showing that video-conferencing and telephone can be effective in providing medication management services, however, there is still a need to have some in-person visits to check the vital signs, so that's why we struck the balance between the different services that are needed as well as the (shortage of), you know, child psychiatrist and the providers. So based on those we made it the recommendation of Telehealth inclusion specifically for the one of the continuation site visits.

(Michael Tringle): So it doesn't have to be – you're changing so it doesn't have to be within the first 30 days (face-to-face then)?

(Chen Chin Lu): The first visit has to be face-to-face. The specific way of (call-out) in the (AAP's) recommendation.

(Michael Tringle): OK, thank you.

(Chen Chin Lu): Yes, sure.

(Peter): And any other questions for NCQA? OK, with that we'll open for general discussions. So again, last time I think everybody was in general agreement about the importance of the clinical condition that we're talking about. Everybody was in agreement about, in a conceptual way about the importance of follow-up. The concerns about the measure had to do with the specifics of issues including follow-up time and follow-up modality.

We've heard additional information from NCQA. And our options at this point range from sort of the continuing with the conclusion that the committee reached in the in-person meeting or alternative. We could do a re-vote, and so, with that we'll open it up for the committee for general discussions.

(Jeff Sussman): So this is (Jeff Sussman). And actually during the comments that we have heard just reinforced my sense that we should not re-open this. For example, the idea that there is some evidence (at least) that would support Telehealth or phone call as opposed to face-to-face. Well, we should get a measure that states that rather than the measure we have now.

Moreover I don't think that there's good evidence beyond tradition of why the number frequency and (while) I would admit that there is some perhaps (face validity) to that, I just don't see that we should be endorsing measures that don't have a strong evidence base and they're not responsive to the new environment of care which we find ourselves in. Thank you.

(Peter): Thanks, (Jeff). And would anybody like to comment?

(Tammy Park): This is (Tammy Mark). The only (harm) that I am hearing is maybe inconvenience or cost. And it seems to me that if you're prescribing a medication that has potential side effects, I don’t -- I don’t kind of understand the resistance to having the child come in at least once to see how things are going and to check, you know, with blood pressure and weight for side effects.

And this is the only endorsed pediatric HIPAA health measure that we have. It's used in many, many programs to try to encourage follow-up of children with prescribed ADHD medications which are widely prescribed, so I am all for reconsidering maintenance of this measure which we've endorsed previously and has been widely adopted.

(Crosstalk)

(Peter): Are there…?

Male: We have both end of the spectrum.

(Dodi Kellerher): This is (Dodi Kellerher). I just want to say I agree with (Tammy's) remarks.

(Peter): Are there…?

(Crosstalk)

(Lisa Shay): This is (Lisa Shay). And I also find that the information that was just presented would warrant us reconsidering.

(Peter): And anybody else from the committee that would like to comment.

(Maddy): This is (Maddy). I would like to support what (Tammy) said about the measure.

(Raquel Jeffers): This is (Raquel Jeffers). I just have a question about the process. What is the process for reconsidering something with this particular measure?

(Peter): So they all start in staff and add or amend if they'd like, but essentially what happens in a – for all of the measures is we had the meeting, we came to a set of conclusions, we made a report available to field. We got some comments which you just heard reflected or what you've seen in the memo and of which you've reflected in NCQA's follow-up comments. And now we as a committee, are reconvening after the meeting to see if we find the comments persuasive enough that we'd like to re-vote. And would the staff like to – would the staff like to add to any of that?

Tracy Lustig: Yes, I think you -- I think you got it, so just the technicality that we will not revote right now. We will send a follow-up survey to the committee to revote and we will have to go back and revote on the evidence itself because we had consensus not reached on that. And then there'll be a revote on validity. And if it does pass this time, the survey will also allow you to proceed and vote on the other criteria that we did not get to at our in-person meeting. And so we can send the instructions on how to do all that after this call.

(Michael Tringle). This is (Michael Tringle). You know, I know these things are kind of set up so that we're presented with something and it's a binary situation of we either vote yay or no nay, you know. I would like to make a comment, I don't know how to, that's separate from that yes or no process, you know.

I fully agree with the comments that I heard that it's important to sort of stay in touch with our patients and monitor them, whether it's blood pressure or weight loss or things like that. The part that I'm a little bit more concerned about especially given the fact that these things, these measures come up infrequently is that I know in our system we're doing a lot of work where we're doing Televideo and we're having people having wearable devices and patients kind of calling in with weight gain or weight loss, (most advanced) with people that have congestive heart failure.

And we also have people sort of with devices that are measuring blood pressure and they're reporting that to us. And what concerns me is that we're sort of going to once again sort of (reapply) and build in stone that if we come up with reliable, creative ways to do these things, the measure is still going to force us to do a face-to-face visit and it's got to be within the first 30 days versus one of them being that way and recording the key elements we need to monitor and stay in touch with. It's sort of like keeping us – the measure is going to keep us from kind of advancing in ways that are happening very rapidly right now. I don't know if that makes sense to people.

Male: Yes, that does make sense.

Male: Yes, it makes sense.

(Peter): And this is (Peter). This is (Peter). I'm going to take off my chair hat for a second just so that I can comment and...

(Michael Tringle): Oh, an ally. Thank you, (Peter).

(Peter): I tend to agree with -- I would say that the (inaudible)

Male: Hello?

Male: We can't hear you.

Female: (Peter), did we lose you?

(Peter): (Inaudible)

Male: (Peter) has been lost down the rabbit hole.

Male: You can hear some mutterings in the background though.

Male: Yes, he's talking to himself.

Tracy Lustig: Hi, everyone. This is Tracy. I can hear (Peter) I think as well. I think he may have accidentally hit the speaker button or something on his phone off. I'm going to try to...

Male: We were face to face…

Male: He's (inaudible) know.

(Tracy): Just give one minute, I'm going to shoot him a quick e-mail.

Male: Does that (inaudible) commenting on the...

(Dodi Kellerher): While we're waiting, this is (Dodi). I think that it's a larger issue that you're discussing, you know, and maybe more around the protocol of when and how often measures get called back or if they can get called back given the state of the changes going on. That said, and I'm a great proponent of Telehealth as a way to fill serious shortages and gap.

However, it is changing but it certainly isn't available – wearable devices the ability to measure vital signs remotely and all that is growing but it certainly is not ubiquitous especially in, you know, poor areas or where there might be more Medicaid patients in the South, et cetera. So I think we ought to be careful about using that as a reason to sort of dispense with the in-person visits for -- with kids for checking things like vital signs. But I think it does call for

a discussion on the part of the National Quality Forum about how do we address this going forward because I do think it's potentially a problem.

Male: You know, I think things as simple as phone calls are easy substitutes for , not all the information that's being gathered but for the majority of it. We...

Male: You know, that ethnicity…

(Cross talk)

Male: Right. Exactly. And I would be...

Male: If there's a way to do it, you could accept it. And if there isn't, you get them in and do it yourself, you know.

Male: You know, my sense is there's lots of ways we can get blood pressures these days.

Male: (Inaudible)

Male: Yes, exactly.

Male: And these drugstores.

(Peter): So this is (Peter). Again, I'm sorry it sounds like -- it sounds like the technology failed me a little bit. I don't know if I was heard. It sounds to me like we've heard opinions on both sides of the aisle on this one. It sounds to me like we're going to need to revote on this measure and so, you know, about of half of us, as I've heard it, feel like the measure as currently (specified) is a little too rigid in terms of time courses and modalities.

It sounds like other people feel like this is an important measure that's closed enough. And so I think I'd like to ask the staff to set up an offline re-voting procedure and let's revisit this measure.

Male: That sounds good, (Peter).

Tracy Lustig: Thanks, (Peter). Yes, we'll follow up after this call.

(Chen Chin Lu): This is (Chen Chin). I could make a quick comment just on the wearables, blood pressure, whether remote devices could provide information. I just want to let you know that NCQA has the project and we are evaluating Telehealth for NCQA's HEDIS non-behavioral health measures. Some are about, as you can imagine, blood pressure control, et cetera. So we are looking into the reliability of those devices for providing such information and if we, you know, reach a recommendation about those devices whether they are good enough for measurement, we will make an update to this measure accordingly.

(Peter): Thank you.

(Mike Fabiary): This is (Mike Fabiary). I just have a whole issue with – CMS has already identified that Telehealth services, Tele-behavioral health service is different than the blood pressure monitoring though. But if you're doing a Telehealth service or a medical service, it is considered as a face-to-face issue. So to go back, I'm just a little confused, if you go back and look at the evidence in CMS it's a standard practice, been standard for years that accounts as a face-to-face issue is, I guess I'm just grappling with that. I don't understand the disconnect there. And maybe it's more general issue with Telehealth in general.

(Chen Chin Lu): I think you're mentioning that CMS is paying for the Telehealth services, those are already covered in the measure. Those are the key team modifier services, the (synchronous) services, telephone and video...

(Mike Fabiary): OK.

(Chen Chin Lu): Yes.

(Mike Fabiary): So that's already included.

Female: OK.

(Chen Chin Lu): Yes.

(Mike Fabiary): I got it. Thank you.

(Peter): So it sounds like we need to revote this one. And we're right about on time. So first I'll ask if anybody would like to make any additional closing comments that haven't already been made. And hearing none, let's refer this one for a revote and let's move on to the next measure-specific discussion.

So the next one the agenda is 576 follow up after hospitalization for mental illness. The comments around this sort of mostly fell into two buckets, the first is about whether – so this one's about follow-up, the first one – there were questions about whether same-day appointments should count as follow-up visits.

I think that we generally felt that it probably shouldn't in this context but that we thought that this measure sort passed the bar for endorsement. And so on this one the question is whether anybody feels like this one needs to be revisited in light of the comments. And I don't know staff or (Harold) has other -- has other issues that they'd like to tee up.

Tracy Lustig: Hi. This is Tracy again. I just want to clarify that we are considering the measure as it -- as it came to us. And so that's one to think about. And I just also wanted to remind again that (Connie Horgan) and (Harold Pinkus) both have conflicts on this particular measure and so will not be part of the discussion.

(Mike Fabiary): Could you just clarify that -- the measure as it came to us? So as the measure came to us, does that mean a same-day appointment does count or does not count?

Tracy Lustig: So the specifications as we had it, it does – if I have this right and please, other people, correct me. It does count. It's recently, it's been said that it would not be allowed but if I have it, I'll pull up the measure but I believe that it's specified right now, it does count.

(Peter): I think that's, I think, this is (Peter). I think that's right. Sorry I may have said this confusingly. I think that the measure is currently specified and it sort of -- sort of allows the same-day visit and may be evolving toward not allowing that visit but as it's currently specified, that would count.

(Mike Fabiary): OK.

Tracy Lustig: And this is Tracy again. I also want to clarify that there has been no formal request for reconsideration on this measure. It's just that we receive several comments, I believe, both ways in talking about the same-day visit. And so we just thought it warranted a discussion by the committee and to see if you agreed with our response, in which we did discuss the same-day appointment issued during our in-person meeting but that the committee still felt that as it stands that the measure – that they recommended the measure for endorsement. And so here we're not necessarily talking about whether we want to revote on the measure unless people have changed their minds based on the comments we've received.

(Mike Fabiary): Yes, and this is (Mike Fabiary) again. I guess my problem is and then there's a disconnect out in the field. I mean we have a measure that says, "OK, you can use this measure," and it includes same-day but now, NCQA is going to not accept that when they go in and do a review and look at it. So, I mean you have a measure but the measure doesn't work anymore.

I mean it does – how do you even make that happen in the -- so on the provider side for us, you know, how do we do that with our plans? Are they going to be using the measure or are they going to be using what NCQA now requires and the measure doesn't work? I have a problem with them being so – you know, with coming in with a measure and then say, "Oh, we're changing the measure, we're going to do something else on reality, doesn't make sense.

(Peter): Well, it -- yes, this is (Peter). You know, as we, as perhaps as we heard in our last discussion that, you know, it is always a discussion on, you know, how and when and whether measures ought to -- ought to evolve to better reflect current realities of practice. This one -- this one is currently specified, as you've heard, this one is currently specified, includes a same-day measure.

We got comments as you saw in both direction on this, and we talked about that issue at some point in the in-person meeting and approved the measure

anyway, and so the fact that the field is having an ongoing discussion about this, it may not change the committee conclusion.

(Cross talk)

(Mike Fabiary): Well, see, I guess my problem, (Peter), is that I don't see the field having an ongoing discussion as opposed to NCA coming with a measure. Now, they just change the measure and doesn't have anything to do with what we talked about in the committee. So it's not the same measure because in the reality, nobody can use it.

(Chen Chin Lu): This is (Chen Chin Lu), if I could jump in quickly. So I think that the timing issue regarding this measure, the change, as well as the NQF process, we submit all our materials to NQF for re-endorsement late last year. And after that, we met with our committee behavior health measurement and advisory panel and we made a decision recommendation to remove the same-day visit from the HEDIS version of the measure. It's our intention, you know, when we come to the NQF annual update we want to make that update, make sure it's all aligned so we have one version of the measure for the field.

(Mike Fabiary): Yes. I guess my – I would like to propose that we revote on the measure and use the measure that's going to be out there. I don't necessarily agree with not accepting a same-day appointment as discharge as meeting the criteria. So since it's going to be different, I would propose we revote on the measure. That's just my proposal.

Tracy Lustig: And this is Tracy. Just to be clear. If the committee does want to revote, we'd be still re-voting on it as it stands, as it came to us with -- including the same-day visit.

(Mike Fabiary): So you're re-voting on what we already voted on?

Tracy Lustig: Yes, yes, this is a timing issue as I said with -- this is something that would be considered usually during the annual update but right now, we're still considering the measure as it was specified to us in the submission.

(Cross talk)

(Maddy):This is (Maddy). So what would have to happen is we'd have to vote it down and then wait for them to go for their -- to NCQA again and then they would have to resubmit for a completely new measure?

Tracy Lustig: No. As part of the annual update, if there is something that's a significant change, we call it a material change, something like that where you're changing the specification, that would trigger an ad hoc review of the measure at that same time.

Male: Except trying to – Tracy, it sounds like our – what we voted the first time was to approve the measure as submitted so if we re-voted and got a different conclusion at this point, wouldn't that mean that the measure loses endorsement and presumably a measure that had lost endorsement isn't just an annual update thing, is that...

Tracy Lustig: That sounds right. And (Karen), unless I'm getting it wrong, are you able to jump in on that?

(Karen): Yes. So, yes, it's a matter of timing that makes it difficult. So if you guys wanted to revote because of this issue and took the measure down, it would lose endorsement, and then the developers would have to bring it back through the whole process again which, you know, may not be kind of where we want to go with that. I think you'd be probably better off and that's why we have annual updates because we do realize the things (can still) change. And that gives developers an opportunity to bring things back because we know that our timing and theirs do not always do not always kind of mesh. So hopefully that's clear.

(Cross talk)

(Mike Fabiary): Another suggestion?

(Cross talk)

(Mike Fabiary): Can we suggest that NCQA not make a change until they align the measure and the measure gets approved? Because otherwise...

(Cross talk)

(Mike Fabiary): ...things out in the field that doesn't...

(Michael Tringle): This is (Michael Tringle). But that's exactly what I was thinking. It's like -- part of the chaos around this is, is the order in which things happen, you know, and I've been on this NQF committee for a while but I don't think from the inception but this is sort of the first time I'm aware of in my three years or four years however long it's been, is that somebody changes a measure first nationally and then comes to us instead of vice versa.

Male: Right.

(Michael Tringle): You know.

(Peter): So this is (Peter). I actually we – because of the timing issues, we have – so I think I'm taking off my chair hat and trying to think this through for a second so I think we -- so we're kind of -- we're kind of stuck with living with two sub optimal choices, and so, either we're stuck with, you know, having the measure evolving between when it might get endorsed and next year's annual update when they'd like to refine the specifics of the follow-up or pulling endorsement entirely while they refine the specifics of the follow-up.

My guess is that, actually, the polling endorsement while they're refining is actually – is actually more disruptive in the field. And so, this is not a chair opinion. This is (Peter's) opinion as a committee member. I think I would – I would prefer to maintain where we were on the in-person committee vote while we wait for the refinements. And if for some reason, we decide we -- you know, we'll have an opportunity in the year to clean up the refinements (if we were planning) to do so. And with that, I'll put my chair hat back on.

(Jeff Sussman): This is (Jeff): I would support that as well.

(Mike Fabiary): Yes. Yes, I mean the pull -- this is (Mike). I mean it would, you know...

Male: (Inaudible)

(Mike Fabiary): To revote on it, I don't want to pull it if it's just going to make it, you know, not workable but it's not workable the way it is. And so, again, I think we need to have NCQA to, you know, not make the change until they bring this thing into alignment because otherwise, in the field, you're going to have some payers or states or other folks who want to use the measure, they're going to use the measure as it is but I'm a hospital and I'm dealing with my Medicaid program. My Medicaid program accepts the same day as discharge but NCQA doesn't. So now I have to do two different things for the same patient and that doesn't make a lot of sense.

(Chen Chin Lu): This is (Chen Chin). If I could just quickly mention that we -- this change has been communicated with the users of these measures. For instance, we mentioned this in the public comment period that was in February and March. So plan providers were communicated with about this change. CMS was on our committee. And also, I just want to quickly mention, Medicaid (the core sets), reporting of the measure is always behind, high half year behind the HEDIS reporting of the measure. So I think, you know, given this change that is implemented in HEDIS and, of course, that it will be lagging behind half year, the time may still work for the users of the measure.

(Peter): And this is (Peter) again. It sounds – it also sound to me like if you were a system that was reporting to both NCQA and using the measure for the other purposes, the things that you did to make the measure acceptable for NCQA would still work for the other measure that would -- for the other purpose. You would just – you would just have to avoid the same-day visits. So that might not be, you could – you could, if you were working for the NCQA measure (would) hurt you on the old version. So I think – I think two of us have been mostly having this conversation. Are there – are there other people that would like to weigh in on this one?

(Michael Tringle): You know, I'll just make a couple of comments. This is (Michael). In some of our places we've committed some workflows where we have connected people up the same day and when it works, it works splendidly. In some sense the essence of what needs to happen clinically is hook people up and it's ideally with the person they're going to keep working with, not a transitional

person who talks to them and doesn't really know them and isn't going to be sticking with them.

And that's the gold standard and the day is almost irrelevant. Although the idea and the evidence that if it's too long out isn't good clinically and you get more readmissions is really – is also good evidence. And so I guess I kind of have mixed feelings because I think the essence is not exactly the bean counting of what day it is but who you hook them up.

Male: Yes.

Male: Well, yes. That's exactly right.

(Peter): So I don't think I've heard a -- let me check this one. I'm not sure about this one. I don't think I've heard a strong view for a revote on this one. I've heard sort of advice to NCQA to do whatever you can to line up the versions of the measure as rapidly as you can which I hope NCQA has now heard. And does anybody - does anybody feel strongly that they want to try to provoke a revote on this one? All right. Hearing none. Thank you for that discussion. Anybody have closing words of wisdom on that one?

(Michael Tringle): I have one closing words of wisdom and it really has to do with both NCQA and NQF somehow being able to be a bit more nimble and not have such long delays and lags. That helps promote (more of) these situations.

(Peter): Yes, and NQF at least was talking about exactly that on last Thursday and Friday so this is a -- this is -- they're aware of the problem and at least on the NQF side, they're working on it.

Male: Good.

Male: That's excellent.

(Peter): All right. The next one we wanted to talk about was 3205. Medication continuation following in-patient psychiatric discharge. This one the -- so I think we endorsed this one. We got some comments back that essentially – that essentially we're wondering about attribution of filling prescriptions after a

hospital stay because there were some folks that felt that it might be unfair to hold hospitals accountable for this issue. And so, we wanted to give the committee an opportunity to hear this comment. So the staff and the chairs thought that we did consider that issue in the in-person meeting. We concluded that the hospitals do have a role in helping, encouraging and helping patients to get prescriptions still even though they're not entirely in control of that.

The NQF general guidance on attribution notes that it seems increasingly deliver care on facilities become more integrated attribution model sort of reflect what accountable entities are able to influence and not just the things that they can directly control. So that – say something different. So with that, we'll open it up for discussion.

Tracy Lustig: And this is Tracy. I'm just going to jump in and remind (Lisa Shay) has a conflict with this measure and won't be part of the discussion. And once again this is not a measure that we did recommend endorsement. There is no formal request for reconsideration, we just felt that the comments we received were significant enough to warrant a discussion by the committee even though these were all things that we did discuss.

(Peter): So with that, the discussion is open.

(Jeff Sussman): Yes, this is (Jeff). I think we considered the comments and I would not favor reopening this and continue our recommended endorsement.

(Peter): Other comments? Maybe hearing none will give -- will give (Jeff) the last word on that one. Thank you, (Jeff).

(Jeff Sussman): You're welcome.

(Peter): And with that, one more that we wanted to open up. So Measure 3207 was the medication reconciliation on admission. So essentially for this one, the committee had some issues with the measure chiefly around two interrelated issues.

The first was that the measure was complicated and the committee was worried that it would be burdensome to implement. And second that the – second that the evidence that the measure as specified within improved outcomes was something to be desired I guess.

I would say that the committee said. So this one – we aren't (being asked) to reconsider the conclusion on this one. We are – the developer has given us some stuff to think about as they're -- as they're considering sort of reworking the measure to make it more acceptable so the question to us at this point is do we have to the developer that they might consider as they -- as they consider reworking this measure with an eye towards the future. So I don't know if the staff would like to further embellish that or whether – or whether (HSAG) is on the phone and would like to make any additional comments or ask for specific advice.

Tracy Lustig: This is Tracy. Again, (Lisa Shay) does have a conflict with this measure. We'd ask you not to participate in the discussion. The developer did provide a memo that you should all have and I believe they're on the phone and we can give them a few minutes to ask what they're looking for from the committee at this point. (Kyle)?

(Kyle Campbell): Sure. Thank you, Tracy. Yes, this is (Kyle Campbell) from (HSAG) and I just wanted to say we appreciate the committee's consideration of this request. And I think (Peter) framed up very nicely the concerns that we heard about the committee largely rested around the complexity of the measure and its relation to the evidence and the original measure was specified as a composite measure. As we went back to look at the comments that we'd received both from the committee and from the public, we started to envision a way in which the measure could be greatly simplified and still potentially capture what we were seeing as really a large opportunity for improvement.

And so, what we proposed to do is to create a single process measure that would be scored as past scale rather than a composite measure, and that aligns with the existing endorsed measures related to medication reconciliation in both hospital and other settings. And we suggested to remove the data elements required for each individual medication. So initially, one of the

components of the measure required that the facility abstracted whether there was a name, those frequency route, and last time taken.

When we look at that individual component, we didn't see a lot of variation in performance for the medications that actually do show up on the list and that seemed to be very burdensome and complex. So we suggested we're moving that as well as the comparison of the PT and medication list to the H&P or the psychiatric evaluation which seems to be also a concern related to the burden. We then aligned the source requirements with those of the related NQF endorsed measures. So before the measure required at least one health system source and one patient level source and we modify that to be just at least one external source.

So any source of medication information would count regardless of whether it was health system or patient related but it would need to be an external source from the facility's own electronic health record or own record system. So the measure classifications that we arrived at, the number of admissions with the designated PTA and medication list generated by referencing on a more external sources and medications but which all PTA medications have a document reconciled action within 48 hours of admission and the denominator being admissions to an in-patient psychiatric facility from home or non-acute setting with a length of stay greater than 48 hours.

And as we look at, again, the measure in thinking about re-specifying it, the action step by the prescriber was one of the most important components and was out there one of the components that contributed to the variation. And so in your memo, there was a table where we use the existing testing data that we had abstracted from the nine IPFs in the field and you can see with the new measure definitions there's still quite a bit of range from one facility scoring, seven percent and another facility scoring 98 percent. So there's quite a bit of opportunity for improvement.

And one of the things that I did want to mention in relation to the evidence is that we did look back and of the 36 studies that we had on our view, 23 of the 28 that were relevant demonstrated a reduction in discrepancies, six of the 28

measured or demonstrated the reduction and potential adverse events, so those would be the types of medication errors that could potentially cause harm but harm wasn't actually measured. And then three of the 28 studies actually demonstrated the reduction in (ADEs) use itself related to patient injury or drug use.

And so, our questions for the committee, given that the evidence would generally remain the same, there are some additional articles that we could pull in to this systematic review and review that HSAD conducted, would the committee reconsider the evidence supporting the measure based on the clarifications provided and the proposed revision of the measure to make it more simple.

And I don't know if it would be easier to pause there and get your feedback on that particular item or go to the questions, whichever you prefer, (Peter).

(Peter): And, (Kyle), just to make sure that we're all clear when we started the discussion, you're talking about a reconsideration at some point in the future, you're not talking about a reconsideration today, is that correct?

(Kyle Campbell): That's correct because we're looking for input from the committee because we would need to go back and revise the entire submission based on this. So we're not asking for a reconsideration today, just input.

(Peter): Yes. I just wanted to make sure that we were all in the same page. So with that, let's open it up to the committee and see if we have some advice.

(Tammy Park): This is (Tammy Park). I mean I think I'm very supportive of this, I think it's a huge problem and occurs frequently that people get admitted and their information on their medications, they don't follow them.

So conceptually I'm very supportive of this and sounds like the evidence shows that it's good practice and I agree that our prior discussion revolved around the fact that this is overly burdensome and it would be hard to implement so one suggestion is that if you bring it back to the committee,

bring some evidence from providers that implemented it, you'd see the bowl overly burdensome.

(Kyle Campbell): OK. Thank you.

(Peter): Other comments?

(Michael Tringle): Well, this is (Michael) and I have a question, it's not really a comment. Part of the measure involves having at least one sort of separate or independent source of information about medication utilization.

(Kyle Campbell): That's correct.

(Michael Tringle): How would this – how would this play out? In my organization, it's not a majority of patients but some of the patients that we have and it might be like Kaiser or some other ones that are around where there's a potential for a patient to be get admitted to our hospital, follow-up with one of our clinics and be insured by our health plan.

And it's one EMR that's basically scanning different sites. So it's like one medical record and to call there in the same chart. And I guess you could say there is still some separate claims data from health plan but how would that play out? What's independent?

(Kyle Campbell): Yes. I think that's a really good question and I think something we'd have to explore a little longer but we were thinking that documentation and the record that there was a conversation with the patient or the patient's caregiver or even potentially for patient's prescribed controlled substances that there was documentation that patient access the PDMP – or the clinician access the PDMP database.

So those were the types of things that we were envisioning in terms of kind of that blending of health system and patient level sources that might count for something that would exist outside your EHR.

(Michael Tringle): OK, thanks.

(Peter): (Kyle), this is (Peter). This is a committee member comment, not a chair comment. So I think that your movement toward simplification and burden reduction on the measure side would likely help greatly with this.

I think it's a good direction. I also am sympathetic with the general thrust of the measure on that. Your submission of additional ideas didn't really touch much on the evidence side and that might behoove you to try to beef that up a little bit to the evidence. As I recall the evidence that was included in the first submission, you know, left something to be desired, so I think it was more than half of the studies were characterized, there's low quality and only two or three of them, something like that actually got to outcomes.

And so anything that could be done, I know that you're not in the evidence generation business but I think whatever could be done to better highlight good quality evidence on outcomes might help people sort to work out that there is enough good to be had with this particular strategy to make it work, the burden of doing the quality measure, so that's the other thing that you might – you might have some opportunity to be (talking) in a subsequent submission.

(Kyle Campbell): Sure. Sure. That's really helpful. And one thing I did want to note which was a conclusion of the systematic review that was included in the evidence, the author's conclusions or comments suggested that errors in obtaining an accurate preadmission medication history have great potential for harm as they can propagate throughout a patient's hospitalization and then on after discharge. And they are also the most common reason for potential adverse drug events caused by medication discrepancy.

So we feel like that we are focusing on by looking at admission which is something that the other measures don't focus on in the hospital setting are really critical steps in making certain that, you know, the patient's medications they are capture accurately and that doesn't propagate, you know, post discharge.

(Peter): Are there other comments from the committee? It's important work. Indeed. So (Kyle), have you got what you needed? Is there anything else you'd like to ask us?

(Kyle Campbell): I think we've covered it. It sounds to me like I've heard from the committee that folks feel that changes to simplify the measure have really addressed or could address the burden concerns. And the refinements of the measure seem in line with what the committee would like to see. So I think we would just need to go back and re-specify and also include some additional narrative around the evidence that's been collected.

Is that accurate (Peter)?

(Peter): Yes, I think that's a good summary. And if anybody else have comments?

(Kyle Campbell): Great. We really appreciate your consideration and your time on this, thank you.

Tracy Lustig: And (Kyle), this is Tracy, you know, here at NQF. We staff can also continue to work with you for any technical assistance you need.

(Kyle Campbell): We appreciate that (Tracy). Thank you.

(Peter): So with that – with that, maybe there's one more – one more measure specific thing on my list. So on 3175, this is discussed on (fixed) of your memo was one we recommended for endorsement based on data out of commercial health plans.

We told the developer that we'd love to see it tested in additional (beta sets), and they said work was ongoing. They've since – they've since provided sort of similar data out of in the Medicaid population which would seem to be responsive to our comment. And would anybody else would like to opine about that issue?

(Kyle Campbell): Just appreciate them doing that. I think it reinforces a direction we're headed.

(Peter): Yes, me too. Any other comments? And then Tracy or other staff, are there other things we need to do in response to any of the other comments that we've received?

Tracy Lustig: So there's a table that has a link in your memo, that we listed all of the comments we did receive. Most of them we thought were comments they didn't raise to the level of meeting a full discussion and so we had drafted responses to each and every comment.

If the committee member saw anything that they wanted to raise based on these individual comments, we can discuss it at this time. But actually how we view it as we drafted these responses, and unless the committee doesn't agree with our responses, they're all ready to go and those will be the official response to each of those comments. But like I mentioned in the beginning of the call, I think the vast majority of them were actually comments agreeing with our decisions to either recommend or not recommend specific measures.

(Peter): So would any of the committee members like to have an additional conversation related to any of the other comments or any of the other measures?

(Tammy Park): I'm trying to find, there was some comment about the opioid medication, major concerns and I don't remember whether it was from the APA or something? Having trouble getting my finger on it. That might be one just worth (inaudible) by folks on the phone. And, Tracy, I don't know if have it handy without having people finding it.

Tracy Lustig: I'm pulling it. I'm looking very quickly with you. I have the table in front of me, hold on.

(Connie Horgan): Yes, it is there (Tammy). This is (Connie Horgan). I think that I'm (reclused) from being able to speak on these measure as well.

Tracy Lustig: Yes (Connie), that's right. Sorry, I didn't get to say that.

(Connie Horgan): OK.

(Peter): Yes. So hang on (Connie), let's not break any rule.

(Connie Horgan): OK. Well, no. But it is there and anyway, so I can't say anything so.

Tracy Lustig: So this is Tracy. I pulled up – it looks like we have a couple of comments here. One is from (Carmela Batino) who is – she said that – sorry, I kind of look at what organization she's with. But it says, "We do not support endorsement of this measure at the health plan level. Plans don't always have access to drug claims because of carve outs. The measure does not appear to be way for implementation given concerns raised by the NQF committee."

(Tammy Park): That was the one I was talking about. I think they should have access to (carved-out) data.

Tracy Lustig: And then there's a second comment from (Samantha Sugarman). It says, "The APA has concerns with 3175 which focuses on medication assisted therapy for opioid use disorder, this measure fails to distinguish between dangerous non-therapeutic MAT discontinuation and appropriate planned opioid substitution treatment tapers."

"For example, discontinuation of Vivitrol, naltrexone for extended release injectible suspension. The risk for relapse is very high for Non-OST patients except perhaps for a specific subset of those with a short duration or low intensity opioid misuse."

And (Jessie) has just put it up on the screen share for you to be able to see and then specifically we did get some responses from the developer related to each of those comments.

(Tammy Park): And so the reply to that is the benefit outweighs the risk and that just on the…

Tracy Lustig: Let me see, the response to the first comment was, "Thank you for the comment, we are aware that health plans may outsource the pharmacy benefits that specialized companies which can complicate the process of combining medical and pharmacy claims for quality measurement.

But we assume that health plans have developed a capability to construct and report such measures because measures that use combined medical and

pharmacy claims are commonly reported at the health plan level. By our count, NQF has endorsed nine measures for use to health plan level that require with both medical and pharmacy claims, the NCQA HEDIS set has a total of 19 measures that require both medical and pharmacy claims.

We would argue that the urgent need to address the opioid crisis justifies adding one more measure at the health plan level that requires the combination of medical and pharmacy claims. Data on continuity of pharmacotherapy could inform intervention to improve adherence in care transition which could reduce the elevated risk through relapse and mortality during discontinuation."

It was too long, it's cut off when on the printed part.

(Tammy Park): Yes, it's (worse) than the second one, however, other committees are responding to the second concern.

Tracy Lustig: For the second comment, it had to do with – you're correct that we cannot exclude patients with planned termination for – we did struggle with this problem when developing the measure, the exclusion would have required us to restrict the denominator to newly start at MAT.

That is patients who would only be eligible for the denominator if they've had no MAT for six months. While this specification would alleviate the concerns and making the measure specific, it would also substantially reduce the sensitivity as we could exclude many patients who are meant to be an ongoing treatment but dropped out in an unplanned fashion. As the treatment paradigm for substance use disorder shifts to that of a chronic disease with long-term treatment and evidence for better outcomes under this paradigm, we believe that narrowly focusing on newly started patients would not be aligned with current evidence.

Further the majority of MAT discontinuations are unplanned, see for example the recent systematic review but eventually (around) 2015 in light of the elevated mortality risks during unplanned MAT discontinuation and the major

increase of opioid use and opioid overdose in recent years we have decided to favor sensitivity over specificity.

(Peter): And this is (Peter). It seems that we – unless I totally misremember, we had a very long conversation in the committee of the whole end person on exactly this issue and came to a place that was much like what the developer has stated.

Tracy Lustig: And this is Tracy. Just to clarify our comment was also that, yes, the committee understands it has discussed all these issues and so – but you are all free to continue to discuss it and see if these comments make a difference in your vote.

(Peter): So with that, the floor is open again for any additional thought.

(Raquel Jeffers): This is (Raquel), I would hold to course.

(Crosstalk)

(Peter): Yes, this is (Peter) taking off his hat chair for a second. I think we discussed all of these issues in great detail and the committee member – the meeting and it doesn't change in my view either.

Tracy Lustig: And this is Tracy. Operator, we have our developer on the line who'd like to response also. Could open (Soren McGee's) line? Hi operator, are you there?

Operator: Yes. (Soren's) line is open.

Tracy Lustig: Thank you. Sorry about that, (Soren).

(Soren McGee): OK, thank you. No worries, (Tracy). I was just going to say what (Peter) actually restated that especially the sensitivity versus specificity issue, we discussed that length through the in-person meeting and, yes, I think it is not ideal to not be able to distinguish the planned from the unplanned discontinuations, but it has very good evidence that the vast majority of discontinuation is indeed unplanned like in that paper that you submitted.

And if you really want to make it a highly specific measure, you can only really look at the incident cases of those who were just put on MAT i.e., you lose the vast majority of patients who already ongoing MAT and as (Peter) said that seems to be a worse tradeoff than on the one that's being made.

(Peter): So with that, this is (Peter) again, anybody want to – so I've heard several opinions in favor of staying in the course, anybody want – anybody want to propose something different?

OK. Hearing none, I think we can tie up this one and then another opportunity, does anybody want to raise any issues from any of the other comments or on any of the other measures?

(Raquel Jeffers): This is (Raquel).

(Peter): All right. Go ahead (Raquel).

(Raquel Jeffers): Yes. It's not specific to our measure but I recall in our meeting maybe because we will address in the next part of the agenda but there were a lot of discussions about off cycle meetings around harmonizing measures and work that could happen to kind of clean up the measure set, looking at it as a whole that I thought sounded really valuable and I don't know with anybody's given any more thought to whether that's conceivable.

Tracy Lustig: (Raquel), it's Tracy. Yes. As soon as we get through this endorsement cycle here, we'll be moving into our off cycle work and then we'll be able to plan for some off meeting, off cycle calls where we can start to address some other issues.

(Raquel Jeffers): Great.

(Peter): All right. So we can give that as advice to the staff of additional work that we'd love to help with and anybody else have any further sort of issues that they want to raise this around the comments or around any of the other measures?

So hearing none, we're a little ahead of schedule but, Tracy, is there anything else we should do better member and public comment?

Tracy Lustig: No. I think we're ready to move on.

(Peter): So can we ask the operator to open up the lines and see if anybody has any comments?

Operator: Yes sir. This time, if you would like to make a comment, please press start then the number one. OK. At this time there are no public comments.

Tracy Lustig: And we also checked in, we don't have any comments in our chat box. So I think we're ready to just tell you about what our next steps are and remind you of our timeline.

(Kirsten): Great. Hi everyone this is (Kirsten). So (Debbie) and I will be working on creating that survey where each of you can revote on measure 108.

So the instructions and the actual survey itself will be send out to you sometime before the end of the week. I do realize that it's a holiday weekend, so hopefully a lot of you are going to enjoy some time off and maybe hit the beach but it will be a bit of a tight turnaround. They're going to ask you to get those surveys back to us so please just try to find some time in those coming days to vote on that.

(Peter): So does that mean you'll get it out this week and ask for it to be done like Monday or end of the week.

(Kirsten): No, it won't be that extreme, it won't be that – I'll definitely give you at least two business days. Yes, it won't be – yes, we'll give you plenty of time but it's not going to be like two weeks time.

And we'll also re-share with you the full measure sheets that you can remind yourself about, everything about the measure. And I also just want to remind everyone that for this vote, we will have to go back and measure – revote on evidence because that was a consensus not reached and for that and other criterion that you vote on, if consensus is not reached, meaning that we don't get a 60 percent vote on one of the key criterion, the measure will not pass for recommendation for endorsement because we don't keep coming back again

and again. So this is sort of the last vote, so please do consider each of the criteria carefully when you vote.

Other than that, our member of vote will be open from June 5th through June 19th followed by our CSAT call on June 21st which you guys don't need to attend. And then we'll go into our appeals and then wrap up the report which will be due at the end of September. So we thank you guys for your time today, I think this is definitely the last big push that we're asking you, the last big thing that you guys need to participate in. So, yes, we'll be in touch for the next couple of days with voting.

And then like I mentioned, after that we'll be able to see how much effort, level of effort we have for an off cycle work and we can see how many calls we can have, and that's where we can start to do some of that other work about looking at our portfolio as a whole and starting to think about our gaps.

So with that, (Peter), do you have any closing remarks? Thanks to you for leading as always.

(Peter): You're welcome. And on behalf of me and (Harold), thank you, thanks, everybody, as always for your engaged participation, and we'll finish a little early and give everybody a few minutes back.

Male: Thanks.

Female: Thanks.

Tracy Lustig: Thanks everyone.

END