NATIONAL QUALITY FORUM

Moderator: Behavioral Health
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Poonam Bal: Poonam Bal, (inaudible) rest of my team, (inaudible). And we just wanted to welcome you to the Post-Draft Comment call. We'll be going through the memo and going through – some of the comments that we received and going to propose responses.

So with that said, Peter and Harold, do you guys want to just greet the committee and …

Harold Pincus: Good afternoon or morning whatever the case may be and a happy new year.

Peter Briss: And welcome to everybody. I hope you had good holidays and we're delighted to have you back.

Harold Pincus: Great.

Female: Perfect. We're just going to do a quick roll call. Just to see who is on the line. Well, (Kaitlynn).

(Kaitlynn): Hi. This is (Kaitlynn), I'll just be reading off everyone's name. So first, there's Peter Briss.

Peter Briss: I'm here.

(Kaitlynn): OK. Harold Pincus.

Harold Pincus: I'm here.

(Kaitlynn): (Robert Atkins).

(Robert Atkins): I'm here.

(Kaitlynn): (Caroline Dublin)? OK. (Matthew Sulk)?

(Madie): (Madie).

(Kaitlynn): OK. (David Isaac)?

(David Isaac): Yes I'm here.

(Kaitlynn): (Julie Gomez)? (Thomson Morgan)?

(Thomson Morgan): Hello everyone.

(Kaitlynn): (Lisa Jensen)?

(Lisa Jensen): I'm here.

(Kaitlynn): Dodi Keller?

Dolores "Dodi" Kelleher: Dodi Keller are here.

(Kaitlynn): OK. (Craig Nunson)? (Michael Ladarey)?

(Michael Ladarey): Yes, I'm here.

(Kaitlynn): (Amy Mark)?

(Amy Mark): Hi, I'm here.

(Kaitlynn): (Raquel Jeffers)? OK. (Bernadette Womac)?

(Bernadette Womac): I'm here.

(Kaitlynn): Great. (Lawrence Miller)?

(Lawrence Miller): Hi. (Larry Miller). I'm here.

(Kaitlynn): OK. (David Padding)? (Vanessa Pandelia)? OK. (Ronda Bill)? OK. (Tina Sadiki)? OK. (Lisa Fey)?

(Lisa Fey): Yes, I'm here.

(Kaitlynn): (Jeffrey Susman)?

(Jeffrey Susman): I'm present. Cold.

(Kaitlynn): (Michael Chenggel)? Yes. OK. (Bonnie Zima)?

(Bonnie Zima): I'm here.

(Kaitlynn): Great. And (Leslie Zune)? OK.

Female: And are there any committee members that are on the line who did not hear their name?

(Julie Goldstein): This is (Julie Goldstein). I called in a couple of minutes after I had actually logged in, so I'm on.

Poonam Bal: Great. OK, great. So I guess before we start, do you want to do a formal introduction of the project teams since we have had a lot of changes? I did send the message out but I just want to make sure that everybody is aware. (Lorelei) and (Angela) are no longer with NQF and we've had some changes with (inaudible) leading as well.

So Sarah Sampsel and this is Poonam Bal speaking, we're still on the project as we were earlier and like role changes and then we've had (Kaitlynn) join us as a new project analyst.

With that, I'll go ahead and let Sarah begin with the purpose of this call.

Sarah Sampsel: Yes. So hi everybody. This is Sarah Sampsel and thank you again for joining us this afternoon. What we want to do this afternoon is discuss the public comments that we received. So as a refresher, after the in-person meeting that we had a couple of months ago, NQF staff put together a report of the

proceedings of the in-person meeting and that was put out for a 30-day public comment.

So we received comments and NQF staff then go through those comments and make some initial responses, you know, for you all to consider as well as the comments get sent out from the measure developers. And when their case is where we would like to measure developers to also provide some input, the comments do go to the measure developers to respond. And we received the measure developer responses late last week. So I appreciate you all taking the time this week to go over those responses.

So what we want to do is review and discuss the comments received during the post evaluation and public and member comment period. And sorry, I'm also working through a cough. And then, have you provide input on the proposed responses to the post evaluation comment.

We also need to determine what are reconsideration of any measures or other course of action as warranted and that is really the most specific measure which I'll talk more about when we get to that – the agenda and then discuss related and competing measures which Poonam will direct that part of the conversation.

So hopefully, getting us to today, you have an opportunity to review the briefing memo which, you know, you should have in front of you as well as the draft report. And have an opportunity to look through some of the comments and determine if you would like more information or if there's anything additional that you want to discuss that we could have those discussions on this call.

Overall, you know, we look for comments a number of times. One would be prior to the in-person meeting and those comments are brought to your attention during the meeting.

I believe for this project, we received very few comments prior to the meeting but we – and in fact, we received nine of them but we will discuss those during the in-person meeting and those were related to the diabetes measures, the diabetes and seriously mental ill measures.

And then finally, during this post evaluation comment period, while we receive a total of 58 comments from 12 organizations, the majority of those comments fell into specific themes which will – which we pulled out for you in the memo.

So with that, you know, the two major themes were stratifying the subpopulations and the current diabetes measures and those are in response to the NCQA measures for the SMI population, and then a comment regarding reconsideration of 0722 which is a pediatric symptom checklist.

So starting with the Theme 1, stratifying subpopulations and current diabetes measures, you know, basically, we heard from a couple of organizations, it seems similar to what has been discussed by this committee in-person during these phases of projects as well as previous phases and that was a concern about these measures being a subset of these listing measures and therefore causing undue or promoting undue burden for those collecting those measures.

And, you know, I did want to remind you that we have discussed this in the past and believe that NCQA has some mechanisms and rationale for highlighting these measures for the SMI but we'll give NCQA a chance to comment and then would want the committee to discuss anything further as they would want to on this topic.

So I don't know, (Sarah), are you on?

Female: Hi.

(Sarah): I am. Thank you. So you will just speak to this issue about the stratification of the subpopulation and why we have separate measures and it's really – we want to highlight the need to pay attention to quality of care for these strategic subpopulations.

There are – right now, there is a couple of different things going on. For some of the measures, that subpopulation is truly a segment of the original measure. And for some measures, that's not the case. There are changes in the

numerator of requirement that go along with the measure that make sense for it to be distinct.

And so – but at this time, we're not really sure how to represent that. It would not the – I believe that the commenter suggested well why you couldn't just use the measure as is and then just simply, you know, look at the results by different groups.

Our experience is that if one were to do that, pick a random sample of people with diabetes, that one would not have sufficient numbers to be able to do and stratify the analysis for people with serious mental illness.

And in addition, what one of our goals here was to define what that subpopulation – how one would define that population so that we would have, you know, a criteria that could be used nationally for that effort. And so that's why we propose that and we do see that's kind of an evolutionary process of presenting these looking to see – looking at how they work and looking for ways to work with NQF and with others to try to – to make these tools more useful and to limit the burden of using these kinds of measures. But we see that there's tremendous value and we have excellent stakeholder support particularly for this sets of measures saying, you know, this is a real crisis in here for this vulnerable population.

And I will just want to pause one moment and see whether my colleagues – I'm not in the office – my colleagues in the office, anything else to add?

(Jin Ching): Yes, I think you covered everything. This is (Jin Ching) from NCQA.

Harold Pincus: This is Harold. I just had a question. Do the comments distinguish between the ones that do not require a numerator change versus those that do?

(Sarah): I don't think that they did. I think it was a consistent comment for all the measures.

Harold Pincus: Because it's usually that I know the burden is not very much for those that do not have a numerator change.

(Sarah): The burden would be more because you'd have to drive separate samples. I mean, depending on how you're doing this, if these were in a health plan environment, the burden would be drawing another sample. And there are ways to limit that burden that we would look to. If these measures were used in HEDIS or in other federal state programs, we would advise there are ways to limit that burden that we would propose that those are really kind of implementation considerations of how you build the sample whether you build the sample from an existing diabetes sample or whether you build it from an interesting, you know, SMI sample.

Tami Mark: So this is Tami Mark. Just to be absolutely clear on this, the actual measure is not any different for the whole population and the subpopulation.

(Sarah): That's true for some measures but not for others. For the – I believe it's for the hypertension and diabetes measures, the numerators are the same, the denominators change, or some of the other measures that look at screening, the numerators are different from the original. But there are two reasons for that. One is the original measures we were building on were identified for survival level reporting and the measures were proposed in the population reporting where, for example, for health plan. And then also there are changes in the numerator requirements that are related to (the) population's needs. So there are differences in the numerator.

Tami Mark: And can you explain a little bit more about them. Yes, I'm trying to remember what the …

(Sarah): OK.

Tami Mark: You know …

(Sarah): Yes.

Tami Mark: … that one related to the willingness for, you know, like I guess would it be a different level of hypertension or the way you'd capture it and nothing will – I guess it's not related to the definition of sample. It was actually the measure is different.

(Sarah): So a difference would be for the – So actually in the diabetes and hypertension measures, the numerators are the same. And (Jin Ching), would you just say a few words about the change in the screening measures?

(Jin Ching): Sure. So the screening measures, the differences in the numerators, for example, BMI screening and follow-up are measures required two events of counseling for those people with positive screening or one counseling in pharmacotherapy. So that's different from the existing provider measures which requires, you know, any counseling basically one event of service with accounts. Our stakeholder groups strongly recommend us to, you know, strengthen our numerator to meet the needs of this vulnerable population.

And that's true for the other two screening measures as well. So that whole screening and follow-up, alcohol screening and a follow-up, they also require two events of counseling to meet to the higher needs of the population.

Tami Mark: Thank you. That's helpful.

Jeffrey Susman: You know, one of the things – this is Jeff Susman, that I think we commented on in our last face to face meeting, was the hope that NQF had a higher level, could start looking at issues of harmonization across different uses about the diligent merits of changing definitions or further emphasis like, in this case, the issues of serious mental illness in patients with diabetes or what have you, because I think there is added burden, there's slight confusion because of differences in the definitions and finally, to a certain extent, while I understand why we want to highlight and focus on an enriched, if you will, sample of individuals, we also tend to balkanize them to care for individuals with (SSMI) and maybe even contribute to stigmatization.

So I think there's some higher order issues and it's not just in the behavioral health field, it's across many areas where we're going to have potentially multiple measures looking at serious mental illness and diabetes, looking at kidney disease and diabetes, looking at, you know, X, Y and Z which I think complicate the measurement world considerably. Thank you.

Helen Burstin: And Jeff, this is Helen Burstin. Thanks for that comment. That is something we talked about at the meeting and it's very much still on our list of really

important things to think about how we could pull it together. You know, if nothing else in that is figure out a way visually to make it very clear to people and measures are linked in similar and used for different populations. So it hasn't fallen off our radar screen.

Jeffrey Susman: Thank you so much.

Helen Burstin: Sure.

Sarah Sampsel: OK. So are there any other comments, and basically at this time, we have for the report, what we would do is update it with both the developer's response as well as the proposed committee response which is in the memo that you received. And we just wanted to make sure that folks, unless you had anything additional to say, we would also add these comments as discussed on the call right now.

Jeffrey Susman: Seems like a reasonable response to me. Jeff.

Sarah Sampsel: OK. So then, we can move on and the next issue is regarding measures 0722 which is the pediatric symptom checklist. And this is a measure that was brought to you because (inaudible) is a time limited endorsement. And if you might recall from the meeting, there were a number of questions about the measure. It had passed the importance criterion, but then when we moved into scientific acceptability, they were requesting first about the measure specifications. This is a fairly complicated measure with four different parts. And then there were some questions related to validity because of the lack of clear guidelines and specifically around the type of assessment that's being suggested through this pediatric symptom checklist.

And before I turn it over to Harold and to Peter, I just on the staff side wanted to let you know that we've had a number of conversations with the developer since we met in-person. And they truly want to make this a measure and they – that would be – that can retain as NQF endorsement and are starting to take the steps to do that.

Unfortunately, timeline-wise, they weren't able to make all of those suggestions prior to this call in order for you all three vote on this call and reconsideration on what your recommendation would be.

And so what we'd like you to do is have a conversation on your comfort level on perhaps changing the status and revoting on this call so it's not – we do not recommend but moving to an area of deferment or more of an open status so that the developer could submit and this could be reconsidered either by this panel or another panel in the future.

So with that, you know, Harold and Peter, we talked about this a little bit – a couple of weeks ago and wondered if you had any additional comments.

Harold Pincus: This is Harold. I also had a separate call with the measure developer. And what I tried to do is explain to them the response that we had that it seems to many people that this is more of how this one transform a clinical measure into something that is actually a quality measure and, you know, giving them the example of how the (inaudible) committee (inaudible) different people (inaudible). And that the importance of providing some kind of data at the proximal link between the implementation of the measure and some outcome and encourage them to think about how that is to be screening plus some further action that brings that closer link to outcomes.

Now, the real question is that how they could do that in some kind of time-sensitive way to actually make the changes and sort of implement the research to actually document that.

Male: Do you want to open it up to further comments or Peter, did you have …

Peter Briss: Yes. And maybe, you know, I'm not sure that I have anything much to add. I just want to – from my perspective, if deferral makes it easier for the measure developer to, you know, consider issues and rework the measure and the rationale, it seems to me that that would be a reasonable way to go.

Harold Pincus: Yes. My question is what are the details about the difference in those categories in terms of what type of time expectations there are?

Helen Burstin: So I'm not sure that there are clear time expectations. Basically, if the committee would move forward with the do not recommend status, it kind of closes one door on them requesting an ad hoc review and which would be, you know, kind of an off cycle review outside of the phase of this project.

So the same degree, you know, based on the content of this specific measure which frankly is a lot broader than behavioral health and goes into some issues of socio-economic status et cetera, this measure may be considered when they bring it back depending on – dependent on timing to a different standing committee as well although we might, you know, want the behavioral health committee or members of the behavioral health committee to help inform that other committee.

That's something we're dealing with right now is, you know, how do you deal with some of these measures that are measures based on specific tools that may lend themselves to one condition or area over another and making sure that we have the right expertise.

So timing-wise, what we have committed to the developer is to be providing them and so staff-wise, with some technical assistance and what exactly we're looking for so that they could do their research in relation to that. And, you know, I think from talking to Michael Murphy, he is, you know, thinking that once they have some clear direction and clear plans that it would probably take them a couple of months or so to do that.

Jeffrey Susman: This is Jeff Susman. I guess we heard or rather (exhausted) discussion and presentation. And I guess, I don't hear that there's anything substantively new except in detail doing this to try to pursue this.

I guess I'm not clear why do we consider this at this time and why we shouldn't just stick and let done if they provide new data and back to NQF. And try to go through a process within that maybe I'm missing some of the nuance (different) groups versus voting against it.

Helen Burstin: Jeff, this is Helen. That's a good question as well. I think part of our thinking is that by differing the endorsement rather than rejecting it and having it come

in a new. It just allows more continuity, they'll just allow us to flow into the next project which we think will be fairly soon in the next couple of months.

It really is in anything substantive I think from the perspective of the committee. I think it's more such as an easier glide path for allowing them to bring it back in without having, had it been removed from endorsement they've brought back in for reconsideration.

Jeffrey Susman: May I just …

Female: I guess …

Jeffrey Susman: … if I might say, what I would say is to make it easier from the staff perspective if it needs to be (draft). I don't think we should stand in that, stand in the way on that (inaudible), I just didn't find it (inaudible) perspective and I'm not (inaudible) that.

Tami Mark: So this is Tami Mark. Just so clear but if differed, they keep the endorsement but if it is not differed, it actually indicated that it's no longer endorsed. So, there sort of a stamp of approval removed in one instance and not the other.

Helen Burstin: Correct. And it's a temporary thing that we suspect will be done in just a couple of months.

Tami Mark: Well, that I'm not sure. I mean done is, I think what worse – the concern was the link – the lack of the link between the screen – as I recall is a lack of a link between the screening and the outcome. And that to me doesn't seem to be a couple of month exercise because I thought that's what you're saying Harold.

Harold Pincus: Yes. That is my concern that's really talking about a different measure. You know, it's not just simply, you know, the use of the PDS or symptom checklist but is the use of the pediatric symptom checklist and then, taking some based on that.

Jeffrey Susman: And affecting some outcomes.

Harold Pincus: And that would affect some outcome. And it does seem like more than a couple of month kind of thing.

(Caroline): It's is (Caroline). And I couldn't agree more with the discussion. I would have concern about moving this measure forward having it look like it was approved when I think there's still quite a lot of works to be done.

(Lawrence Miller): And this is (Larry). There's no timeline, no specific timeline for this either. That's another concern. So they would to retain endorsements for how long?

Dolores "Dodi" Kelleher: And this is (Dodi). From what – do we know, does NQF know when – where I'll see that another phase or this would be brought back if we were to continue the lack of recommendation but put it on the next ground if you will. Do you have any time, you know, when this committee, the standing committee again would need to consider?

Helen Burstin: So for behavioral health specifically, there is not a timeline for next phase. There are two – there are couple potential options. One would be if they were able to pull this together, you know, basically on their timeline, they would ask for an ad hoc review, is it retained its endorsements.

In the event, you know, the other option would be, it could potentially go to another committee and we think that would be potentially the person and family centered care committee where we're awaiting a new timeline for that committee as well. We believe there'll be another phase in 2015 but we don't have firm confirmation so we don't have a clear timeline. So, I guess that your answer is we don't really have a real timeline.

Jeffrey Susman: You know, this sounds a little bit concerning to me at least. This is Jeff Susman. If, you know, you don't get the right answer from mom then you go to another committee and ask dad. It seems like there's a lot of potential for gaining not that I think there's any nefarious, you know, behind the scene. But I think from a consistency perspective, this is maybe more for Helen and we need to have a policy around who owns a measure if we're going to have standing committees and not shifting from one to another to another.

Helen Burstin: Yes.

Jeffrey Susman: Because, these are total measures across the board, they aren't simply resting with the committee.

Helen Burstin: Right. And I totally agree. I think part of it is just a concern that since we don't actually know when the next phase of behavioral health would be.

Jeffrey Susman: Yes.

Helen Burstin: You know, how long do we kind of leave this out there. We – then we could always do something where we actually, you know, bring it to that person have the center committee as an example since already looking at patient for the outcome measures and surveys as their primary expertise. And then get inputs from your committee as well.

So again, if this doesn't work for the committee, we don't want to pound a square peg into round hole or whatever that expression is. But, you know, we felt like we were asking them to do more than I think their expectations were coming in and they indicated a willingness to try that, have that happen if, you know, in the next six months or so. If that's not doable then, you know, this is for the committee to decide.

Jeffrey Susman: So, I guess – Helen, can we just in an ad hoc basis if we said, "OK. Show us your data, show us this link, this (causal) pathway." Why wouldn't it just come back to us? I mean, if – what's the formality that would have to have and considered by a different committee because I don't understand.

Helen Burstin: Yes. Some of it is truly the degrees of our funding, our ability to bring you guys together with our funding. But again, we could potentially do it virtually. I don't want to let that be the issue that is the …

Jeffrey Susman: Yes. I mean, I was thinking if, you know, another phone conference or something would be – was the expenses not daunting …

Helen Burstin: Just for that as well. Can I …

(Michael Triangle): You know, could I – this is (Michael Triangle). I think this is the – in some instance is similar to issue that wasn't raise but in the previous

discussion about folks with SMI, tobacco and alcohol. You know, and that when is the general medical measure going to be able to implant a sort of subdivided by populations including the SMI or mentally ill folks. And we contrast with what would happen versus we need to get involved and kind of track it ourselves because it doesn't (inaudible) what's happening generically, right?

Jeffrey Susman: That's a good point.

(Michael Triangle): I tried – I couldn't connect earlier using my computer. So I can make the comment when we're talking about our poll, wasn't able to – I'm on my phone now.

Helen Burstin: I mean, ideally with your role as a standing committee, we very much like to come back to you with those kinds of possessions and give you the progress on some of those other initiatives as well. And that was our vision of standing committee, I just don't want to overlay commit without knowing necessarily what our workload and other issues might be in the coming month.

(Raquel): Can I ask a question? This is (Raquel). How much of a (gap) in the field does closing off on this measure really leaves? Is there – I'm just not familiar enough with kids ADHD measures that are in the field, is there any other measure that – I'm just trying to understand, you know, in this question that seems to come up a lot around that whether the perfect should be the enemy of the good, whether in – if there's another measure that's already in the public domain that touches upon some of the underlying clinical processes that we're trying to improve by putting this measure in the public domain and endorsing it to series and to another measure that in some way trying to address the same issue of making sure that kids who are prescribed medication for ADHD have good follow-up care. And I'm just not familiar enough with the literature on this particular issue of kids.

Peter Briss: Yes. And that's not exactly the focus of the measure though.

Helen Burstin: Yes.

(Raquel): What is it?

Helen Burstin: Why?

Peter Briss: It's more of – It's a general screening measure.

(Bern): Right. This is (Bern). I was going to say the pediatric symptom checklist, the beauty, you know, of it. It's a short, valid and reliable instrument that has those (inaudible) at least red flags kids or internalizing and externalizing behaviors.

Peter Briss: Yes. I think the issue is not so much a problem with the clinical measure of the pediatric symptom checklist but how it gets applied as a quality measure for accountability purposes. And again, the extent to which there's evidence of a proximal linkage to outcomes by just simply the use of it as a screening test as compared to look …

Jeffrey Susman: OK.

Peter Briss: … incorporating some kind of follow-up or other kinds of action.

Jeffrey Susman: OK. Now I get that.

Dolores "Dodi" Kelleher: And again, this is (Dodi). I'm sort of stuck in process here. So I do not recommend this not allow for a request for ad hoc meeting in some future time.

Helen Burstin: No because it would then be not endorsed. Our ad hoc review policy is only for changes to endorsed measures.

Dolores "Dodi" Kelleher: OK.

(Crosstalk)

Female: If we don't – If we endorse it then it – to me, it looks like a task (inaudible) sanction of the measure when we all have concerns about it.

Male: Yes.

(Crosstalk)

Helen Burstin: Again, it's totally up to the committee to decide. It's just a recommendation. It's not – it should be your decision.

Sarah Sampsel: So this is Sarah again. And so, I mean, at this point from this conversation, you know, what we could – there are two things one, we could put up for a vote after the call for you to weigh in yes or no if you want to reconsider this measure. And if yes, we would, you know, then have to go through the voting process.

But from what we're hearing is, you all seemed be comfortable with your original decision which was to not recommend this measure at this time.

Peter Briss: Yes. This is Peter. That's what – that's how I hear the discussion as well.

Helen Burstin: We should just move on, I think.

Sarah Sampsel: OK.

Helen Burstin: Yes.

Sarah Sampsel: So, sorry nothing else.

So now, we do have a couple of other comments and there are measure specific comments that are further down in your memo. The first one is regarding measure 0108 which is the follow-up care for children prescribed in ADHD medication.

And it was, again, a comment that was discussed during the in-person meeting regarding the 30-day follow-up timeframe. Here, NCQA did response and that response is in your memo regarding the clinical guideline recommending early and ongoing monitoring for potential side effects. And therefore, the measure is establishing a minimum necessary expectation for monitoring in follow-up care.

And the proposed committee responses during their deliberations, the committee acknowledged that the evidence supporting the 30-day timeframe

and it's linkage to improve outcomes within direct. However, agreed with the developer that the 30-day follow-up period work best in balancing when it was most possible to get children seen and allowing the claimed system to process the claim.

So here, we're looking for any additional input you would want documented regarding your response or if you have additional questions for the measure developer.

Harold Pincus: This is Harold. It seems like a reasonable response.

Sarah Sampsel: OK.

(Bonita): This is (Bonita). I had a question more for the group that asked or provided that comment. I think it was the – was that the AAFP that provide – I don't know who provided that comment.

Sarah Sampsel: The comment regarding the 30 days?

(Bonita): Yes.

Sarah Sampsel: I don't know if they're on the call.

(Bonita): No. But I'm trying to find it on the table, I'm sorry, on the spreadsheet to figure out who was the – what was the organization that submitted it.

Sarah Sampsel: OK. We're looking that up.

(Bonita): Because what I'd really like to know is that, that they think it's too prescriptive that they offer insight on what would be a timely – what's the timeframe they were looking into having the follow-up visit, because we did have a discussion there at the meeting about this.

Sarah Sampsel: Are there still folks from NCQA on the call? We – and I think we have a problem with the (person) computer and actually we just found it. Thank you.

Male: Yes. They …

(Bonita): Which one is it?

Sarah Sampsel: Actually, they did not offer – It was AAFP and it says that they agreed the follow-up care for children prescribe with ADHD medication as important. However, the measure is too prescriptive. The measure should leave room for the clinical judgment of the physician when determining the frequency of follow-up care.

And this is where NCQA did provide, you know, some feedback regarding why they put it almost just stake in the ground regarding the timelines for the measure but I can let NCQA comment if they're on the phone.

(Ching Lee): Again, that's, you know, we reviewed that – this has been (Ching Lee) from NCQA. The timeframe in these always challenging guidelines, you know, don't always recommend specific timeframe but the AAFP guidelines didn't mention that early and ongoing monitoring is important.

So, you know, based on that we consulted our expert panelists and they recommend that 30 days is a reasonable timeframe to start monitoring and that's also feasible to do comparison across entities.

(Bonita): I'm wondering if the AAFP is having this concern because we're seeing here. And I know it's not unique for Southeast Michigan, it's everywhere. As more and more of the patient portal is go live for our physician they really do assess but maybe not in face to face but there's a lot of e-mail communication, there's a lot of direct patient portal communication. And, you know, parents can also send the question on behalf of their child to the physician as well up to a certain age and then, the child has to sign off on it. Because I don't believe that gets captured for NCQA so far for any other measure, does it?

I'm wondering if that's where the concern is that, to bring them in. We have so many issues with high co-pays but this kind to make sure that they are being assess, the parent as if they're doing good or their side effects. And then, what is – I was curious if maybe that is where this is coming from because we're starting to get a lot of push back from a lot of physicians in the area because of all of those types of communications that are going on.

But then, on their report card they look like they're not needing quality metrics and as CEOs are held responsible then there's money on the table and that causes problem.

(Michael Triangle): This is (Michael Triangle). If I could piggyback on that.

In our system, we (inaudible) on this measure because we are documenting in patient portals and inform sort of with phone calls that we're routinely having contacts within the 30 days but they're not necessarily all face to face.

Sarah Sampsel: So maybe that is something that …

(Bonita): Do you allow that?

(Michael Triangle): Oh, it doesn't count for this because it's not build, you know, was it claimed, which is how this is captured I think. But I think we'll converting to more and more of those.

(David): This is (David).

Sarah Sampsel: I think many – go ahead.

(David): Thank you. I mean, it seems like one of the recurring themes in the conversation here is, is this a good quality measure for ADHD outcome. There's a lot of other quality measures that you can use for ADHD outcome with indication with family, getting feedback from questioners, from parents, from teachers.

And my problem is, still I just having trouble understanding how 30-day follow-up necessarily is correlated with improved patient outcome or how the evidence behind that that should be use as a strong quality measure.

Female: As with this was really like a safety measure that was supposed to drive (practice), right. If a child is having an adverse reaction to their medication there should be a physician who has been notified of this and there should be some communication to make sure. To me, this is …

Male: But why face to face, right?

(Caroline): This is – and there was another issue that I had with this measure that I brought up in the discussion – it's (Caroline) by the way, which was – that's the way that the measure is constructed any physician could count if looking at a hip (inaudible). Whether a visit occurred or not, it doesn't necessarily even need to be the prescriber so this kid can show up in a (PMC's) office and have an (inaudible) check. Have the ADHD medicine and condition never assess during that visit but because there's a hit in the claim system that would count as a positive hip toward meeting this measure.

And I have significant problems with that because it doesn't track back to what the intense of the measure is which is the follow-up the kid, make sure they're not having adverse drug reaction, to make sure they're responding positively, make sure doses don't need change. And that's not truly what this measure if measuring. And I agree with all the folks who said that health system were developing other ways to follow up by using para-professional, non-MDs these sorts of things.

So I continue to have the same issues I had with the measure early on.

Harold Pincus: So this is Harold. I had a question for NCQA. These issues, I would assume if come up with other kinds of measures that NCQA developed that require some kind of digit based follow-up. And I wonder how they dealt with these issues about the increasing use of patient portals and other forms of communication with patients.

Bob Rehm: Thanks. This is Bob Rehm, assistant vice president for performance measurement, NCQA. So this, the terrain that you're exploring and we do appreciate your comment is the cross cutting one. It cut across issue just mentioned multiple measures. And I think that there are some measures that are more sensitive than others to this and there are others where it's a little bit more distance and maybe not as critical.

So our committee on performance measurement actually is exploring a range of cross cutting issues. This is one of ten that we've identified and just like this panel, these panels discover things that other panels had brought up as

well. And that's how we're going to be able to – in a efficient measurement environment capture both what I would call new technologies and also just new ways of practice that are patient centric and you've characterize, you know, having conversations with parents. Maybe that's an ultimately get into – get document in ways that make it efficient and low burden measures, you know, possible. So this is the tension.

And I think clearly, when we think about many of our measures, you know, three, five, ten years from now, we would certainly hope that we evolve our ability to do that but do that in a way that again because burden is such a sensitive issue that we were able to capture it. And the mechanisms for capturing this kind of what appears to be somewhat informal data compared to others actually becomes part of that patient medical history so that we can take full advantage of that.

So that's aspirational. It doesn't describe what we have today. I do think that in the areas of mental health and patient safety our panels have generally been more conservative than others in their willingness to say, "I don't know if we really need a face to face visit." That's a general statement. I'm not trying to characterize with this measure in particular. We're just trying to characterize how our behavioral health panels and our CPM feel about that domain just the ability to look at the patient and pick up the varying signals.

So anyway, I think it's a point well made and we would agree that there's a point where you would say so much is the, you know, the floor. We don't – we want a floor for patient, the clinicians (around) condition. And then the feeling could be characterized in different ways of accessing that patient and that information.

And I think we're all about exploring that terrain and we are actively engaged in multiple levels on that. And because we're still engage in e-measurement work here as well, we're finding out things that we maybe didn't think were possible or more possible than we thought. So I hope that's helpful.

Male: I'd like to make a comment. I'm not with NCQA but I've been involved with the depression measure. And over time, the same issue played out where it

used to be since six months utilization and it used to be 12 months utilization. And it also had a optimal contact which because of this issue is was arrive to decision to drop the optimal contact part where the 6 and 12 continued.

Jeffrey Susman: Well, the other issue here is raised for ADHD. I don't believe one month guideline is probably high (inaudible) based. I mean, there is some evidence around the emergence of treatment emergent side effects and effectiveness that did help guide the time. But to say, should that as a floor come in in two weeks, four weeks, six weeks, eight weeks.

I think there's a lot of arbitrariness in that. And it is my (read) that the AAFP's comment and similar concerns is that it reflects a certain amount of arbitrariness here where there is not a clear evidence basis to tell us what those tradeoffs are.

Female: I think it reflects the limitations of the claim system, right? So claims are usually filed within 30 days. They're trying to glean the data out of the claim system so that it is less administratively burdensome.

So I think it's not arbitrary, but driven by the availability of the data and the claim system.

(Crosstalk)

Male: … switch it to contact instead of face to face, you know, so that that first one is in prescriptive face to face. There will be more of a collection burden but clinically, you get less objection.

Female: Is that …

(Crosstalk)

Harold Pincus: I think one of the issues is that, you know, when we talk about evidence base, you know, I seriously doubt that anybody is going to really be able to fund a dose response study looking at, you know, at a randomized way to look at whether one month, two months, three months, you know, if visits result in

better outcomes. So ultimately, we're never going to get away from some arbitrary.

Male: Yes. I agree. And then I think at this point, I mean, we covered all of the possible issues here. Are we ever really going to resolve them? I think the response that propose this is, you know, yes, we recognize that there's some downside that we think this ultimately it's going to improve the quality (inaudible) and adequate, if not perfect (inaudible).

Bob Rehm: Hi. It's Bob Rehm with NCQA. Again, I just wanted to add to my comments if I could real quickly. For the continuation of maintenance phase, our value sets include one telephone visit. You need two but one of those can be a telephone visit and we have a value set for that and we're seeing increased utilization of that particular code. Just to clarify.

Sarah Sampsel: OK so if there is nothing else, we will stick with the current response as well as add some additional notes and follow up to this call when we review the transcript from the call to the overall committee report before it goes to the next phase of the NQF process.

So the next slide …

Male: So it's your sense that there's not a real consensus of what to do here, we've got so many disparate comments?

Helen Burstin: Well, I mean, our sense is that we actually, you know, this is a measure that what is recommended after the additional committee and I didn't hear anything on this conversation as part of this conversation that would change, you know, the proposed committee response at this time related to the specific comment.

Female: I'm sorry. What does that mean? That means that the measure is going to move forward?

Helen Burstin: Correct. That this is, you know, you originally voted in-person and I think for the most part, had a similar conversation. And, you know, what we'll just do is add to this additional documentation and this would go forward to the

CSAC which will happen in February, we can certainly highlight for them that there was considerable discussion about the measure for their consideration but we do make sure that that is documented in the report before it goes to them.

Female: I mean, I think there was a lot of discussion and then hearing from a large position organization that's going to be directly impacted when they have, you know, if there is money on the table for it, I don't know if I agree with it. All I'm saying that I agree to move this forward.

It differ when we were saying it and we did have this discussion but what another organization points it out as well, I don't know, that makes me rethink it, you know, even more.

Female: This measure is currently being used by health plans and by state Medicaid agencies as a performance measure. There is money, real money on the table for the measures today.

Female: I know. And I think that's why I'm telling you, I'm hearing from our physicians in the area that there's just so much change that have happened with all these patient portals that instead of just continuing to say, "Yes this is OK", I think it needs a strong reconsideration.

Female: I'm with you on that. That's why I was bringing up that I know it's being used and I support what you're saying.

Female: OK.

(Juliet): This is (Juliet).

(Crosstalk)

(Juliet): … even if we don't, you know, make any changes here that there needs to be – whether it be with NQF and the developers or some other body around capturing data that reflect the current state of practice with the use of portals and alternative contact that are legitimate and meet the need.

Unfortunately, I think we haven't quite caught up with, you know, the rapid changing and it isn't uniform and consistent either. So I think, you know, at a minimum, you know, there has to be some recommendation to aggressively address the issue of – other than face to face contact being considered when these measures go forward.

Peter Briss: So for those of you who are – this is Peter. So for those of you who are expressing concerns today, would (text) to that effect sort of be enough to deal with these concerns to the extent that we can today, or are there enough people that feel strongly about this that you want to revote this measure in light of the comments we have received?

Jeffrey Susman: Personally – this Jeff Susman, I'm OK with this continuing on as an endorsed measure. Though it's not perfect, I think that it is useful.

(Madie): This is (Madie). I'm OK with it continuing but I'm very concerned with us figuring out a way to address this issue of other than face to face because it's happening across the board. And …

(Michael Triangle): I endorse – this is (Michael Triangle). I would endorse that. You know, I wouldn't want to stop it instantly when it's already been done but could we somehow tee it up that we have a discussion and perhaps amend it for next year, you know?

(Madie): Yes. Absolutely.

(Crosstalk)

(Michael Triangle): … NQF, is NQF actually trying to kind of develop just independent of any particular content area a way of dealing with this that will help inform and moving ahead more quickly in this area?

Female: I think there are larger systems issues that are at play, right. So I think there are two ways that you could begin to have not face to face counted as part – the data used as part of the claim's processing system. That's when the payers move to actually pay for services that are not face to face so that a claim might

be submitted and you might find the non face to face interaction in a claim data system.

Male: I know …

Female: The other systems issue that could eventually evolve to change this would be for the electronic health systems to have more interoperability which is an issue. I mean, there's just a practical concern of gathering the information. And …

(Crosstalk)

(Madie): But I don't understand why that derails the further discussion because if NQF had a present discussion about others and face to face, that might drive some of the insurers to behave differently.

Female: Yes, no, I don't disagree. I just think that there are – the discussion should take into account the systems issue …

(Madie): Absolutely. Sure.

Sarah Sampsel: OK.

(David): This is (David). If there's no harm with revoting, or is there any harm with revoting?

Sarah Sampsel: So actually – so this is Sarah with NQF and the reality is, you know, you already voted and the consideration for this call was really on the proposed committee response. We've heard the conversation, we will definitely – and NCQA has also heard the conversation.

So what we can do is just be very specific in the report and then the report that, you know, those – to the CSAC and to the NQF board for vote and ratification through this process, you know, that you did vote but you also had these discussions and have these recommendations for the measure going forward.

(Madie): Helping isn't good enough. So let's not help.

Male: Yes. I think – but I think, you know, this recommendation is not just for this measure, but for …

(Madie): That's right.

Male: … measures like these as well.

Male: Yes.

Male: Yes.

Female: So I'm going back, this is (Caroline), to this fundamental question of do we endorse something that we believe we know is wrong, may not be measuring the right thing and is perhaps being used in a way? But it shouldn't be used, or do we say yes we know it's out there and it's being used, but our stand from a scientific point of view, and from a practical – how is this measure being used point of view in such that we can't endorse it?

We have the discussions that we have concerns about it but yet, going forward with the endorsements, to me feels like it undoes the discussion.

Male: I guess I don't see it …

Male: I don't see that. I think this is very similar to the discussion we had before.

Male: I mean, every measure that we (include), usually, there are some significant drawbacks or compromise to make it effective or effectual. These are drawbacks (inaudible). I certainly agree that there needs to be more robust ways to collect data to reflect adherence to guidelines that we're in a new age where there are a lot of other tools that would make sense.

I think given where we are, the benefits outweigh the harm fairly significant and that these measures, I would argue that (inaudible) NQF (inaudible) are concerned and that this is a (inaudible) some real thoughts (inaudible) as we're moving forward.

Male: You know, it would be interesting if you could sort of say with a suggested timeline and when will we consider it so it doesn't just stay there hanging out forever.

Helen Burstin: That sounds like a good compromise.

Male: Yes. Continue to endorse it now but with a hope and an expectation that it starts to change. And let's review it so that the deadline for people to make sure it get back to us.

(Madie): OK.

Male: Is there a built-in timeline for endorsements?

Sarah Sampsel: There is. This will come back for the next maintenance review.

Male: How many years is that?

Female: How many years?

Female: Three years.

Sarah Sampsel: Three years.

Male: Could we speed that up in this case and do it sooner?

(Off-Mike)

Sarah Sampsel: You know, we would need to have a discussion with NCQA. And, you know, as far as already indicated, and this is one of the measures of NCQA is already talking about internally and looking for processes and systems in order to collect the data as you all has suggested, you know, for some systems enhancement for collecting for this measure.

Helen Burstin: And this is Helen, we can certainly work with NCQA to at least give an update perhaps in a year of their progress to date or something like that.

(Bonita): So, this is (Bonita). I understand, and that makes sense that put in place. The reason I'm pushing or pressing a little bit more for this one is, it's not like a

blood pressure or the other measure where the timeliness is pretty well-known of you don't want, you know, more safety issues or things, (inaudible) just 30-day and having face to face.

This is also coupled with concern of what value does this measure truly bring other than just that the guidelines by the Pediatric Association has some listed. So that's were my concern if kind of coupled with how strong is the evidence that is really driving some kind of – well, improvement and quality of care coupled with providers having concerns of – that they're really doing a good job but they're not getting acknowledged. But I'll end there, whatever the group decides, I just want to make note of that.

Sarah Sampsel: OK. So …

Jeffrey Susman: What are our options here, I'm getting lost about, you know, what's the A, B and C that we need to choose from and can we vote on those?

Sarah Sampsel: So in this case, either that you're really not being ask to vote, what we were looking for was continue discussion as well as a, you know, kind of review of the public comments which was about the 30-day follow-up timeframe, they developer response and the proposed committee response.

And going back to your original votes and it has already been mentioned and as part of this discussion, you know. This discussion that you just had is very similar to the in-person meeting and we've captured you're original votes in there, in the report. And so, what we will just do is to add more (inaudible), add more specificity to the report, you know, and indicate that the committee would like to have a response from NCQA in about a year regarding any follow-up or revisions to the measure in response to this. But at this point, the measure is not up for re-vote.

So with that, Harold and Peter, any last words on that measure?

Peter Briss: No, not on that measure.

Harold Pincus: No, not on the measure although I think – next time we have one of these follow-up and will be good to layout what the options are when, you know, in

the part we have the comments, you know, I mean, agenda that actually lay out what the (inaudible) is.

Female: OK.

Female: Yes.

Male: Exactly.

Sarah Sampsel: OK.

(Peter Briss): And in addition to that, I want to make one more suggestion on a different measure for a potential enhancement of the report.

Sarah Sampsel: OK.

(Peter Briss): So I would struck by, you know, we know that that we had a long suspension in the committee meeting about the composite substance of these measure. That this has been a continuing, you know, sort of point of fairly contingent discussion and it's reflected in several sort of big organizations and the important individual people in the comment we got back but it's not really reflected in the summary report.

And so, I think I would suggest that – and we have this discussion, I don't want to reopen it today but I – and I don't really think that the comment added much new that the committee hasn't already discussed but I do think that it's a complicated measure. It got some issues which is why we recommended it for trial use. And I think I'd suggest …

Sarah Sampsel: What?

(Peter Briss): … a paragraph that suggest that, you know, that maybe adds another theme to the comment that talks about the potential pros of that measure as well as the – as well as several potential concerns, and as a result of that, we recommend it for trial, you can – I think it might help to restate what trial you mean and we'd like the trial to address some of the concerns I think because that might strengthen the report further.

(Madie): I would agree with that.

Sarah Sampsel: We can certainly go back and look at the transcript and go back and try again on that section.

Before we kind of move on or in order to move on, we did have one more – we have one more measure and we need to have a related and competing conversation. So measure 1365 is child and adolescent major depressive disorder and suicide risk assessment. And we had a comment regarding concerns regarding the validity of the measures specifying one screening tool versus another and suggesting that the developer allow more flexibility by allowing multiple approved screens.

This is a measure, as a reminder, that you did not reach consensus. So it means there was the gray zone. And basically, you know, you don't revoke specifically in this measure but you look at the comment that – and the responses to the comment from the developer, and this was PCPI. So I'm not sure if they're on the phone but they also had a written response that's in your memo. And this is a case where staff did not come up with a proposed committee response, so we wanted you to discuss the responses that PCPI brought forward.

So with that, I don't know if anybody from PCPI is on the call and wanted to talk a little more about this?

(Tony Kaye): Hi, this is (Tony Kaye). Can you hear me?

Sarah Sampsel: We can …

Female: Yes.

Sarah Sampsel: … hear you. Go ahead, (Tony).

(Tony Kaye): So I actually did want to clarify a little bit. We actually interpreted the comment that we'd received a little bit differently than it's summarized here. The comment was from the (APA) and I interpreted it similar to discussions that we had during the in person steering committee call that the concern

wasn't that our measure was overly prescriptive because the measure as it stands doesn't limit the suicide risk assessment to a single tool, but rather that the measure wasn't prescriptive enough.

They were a little concerned that, you know, we don't specify any specific tool but rather assessing individual facilities and implementers to determine what tools, assessments they want to use and then it all relies on that being mapped to the SNOMED code, the suicide risk assessment reform. And so there was some concern that that's actually maybe a little bit too flexible making it hard to compare, you know, everyone may have a different type of suicide risk assessment.

And so to try to address that concern, we agreed that that is certainly a valid concern with this measure. So we went back to the ACAP guidelines to provide a little guidance on the minimum criteria that a suicide risk assessment should have. And you can see in there in our response listed there. And then we do list the Columbia suicidal severity ratings, you know, as an example. It certainly not the only one but it is the only one specified within the guideline which is why we didn't include other potential use of tool. We try to limit it to the clinical guidelines and what they recommend.

And so that's kind of where we were coming from with our response with the idea that the concern was maybe our measure wasn't quite prescriptive enough so that we needed to give a little guidance behind the intent of the measure to help make sure everyone is collecting and capturing the same thing.

Male: OK.

Sarah Sampsel: So Harold and Peter, do you want to lead the committee discussion?

Harold Pincus: So the question – So I'm trying to address what the question is. Now, is there a request that we make some change to our recommendation? What are the options that we have? What are the options that we have in terms of the results of whatever discussion we have?

Male: I'm not even seeing now what we're – what the …

Male: You know, what are we supposed to do?

Harold Pincus: Yes. So Sarah, could you maybe clarify? I mean, are we A, you know, is it a discussion (in that) changing the recommendation, B, changing the commentary that accompanies the recommendation, or C, giving sort of further feedback to the developer?

Sarah Sampsel: So what we – right. So what we're looking for is if the comments and the response that (Tony) just provided influences your overall vote and therefore we would be looking for a revote? So …

Harold Pincus: OK, so clarify …

Sarah Sampsel: … you know, are there any additional questions for AMA-PCPI that would help?

Harold Pincus: What was your – what was the original vote?

Sarah Sampsel: We're pulling that up.

So the original, so this was on both reliability and validity. So on reliability, you had high three, medium 12, low three, insufficient evidence six. And on validity, you had high one, medium 13, low four, insufficient six.

Female: And that led to – what was the final decision?

(Off-Mike)

Sarah Sampsel: Consensus was not reached. So that put …

Female: OK.

Sarah Sampsel: … committee in kind of a gray zone.

Peter Briss: I wonder about – so this is Peter. I wonder about whether – As I recall this measure, this wasn't the – the specific instrument wasn't the only challenge about the validity of this measure. There was also this issue about to what extent screening actually improved outcomes. And so I actually wonder

whether this is – whether the new information we've gotten in the comments and the – from the PCPI is actually exactly – actually fully addresses what the committee concerns were the first time. And so I actually – I've actually put the question to the group about whether we feel like we need a revote.

Harold Pincus: I would agree with Peter. If anything, I would say that the additional information is almost, you know, between the comments of, you know, both the comments that came in from member and public organizations and the response sort of further muddies the potential consensus.

Sarah Sampsel: OK.

(Sam Kearny): So this is (Sam Kearny) with the PCPI. I wonder if I could just ask NQF staff in terms of process and next step. So although consensus was not reached and the scientific acceptability criterion, the overall vote for endorsement, there was actually consensus on that and I know that the measure was put out for public comment as recommended. So it's unclear to me what you're asking the committee to potentially revote on. Are they revoting on scientific acceptability and if they – if it doesn't pass on that, then the measure wouldn't – the other votes on the other criteria wouldn't apply anymore? I guess I just am a little confused about the process steps here.

Poonam Bal: So yes. This is Poonam Bal. So if we were to revote based on this new information and the vote did come to a point where the committee did not – just basically voted low or insufficient on scientific acceptability, we would change – it would change the setting for the measure from recommended to do not recommend it. However, it's not necessary that we vote, as it was said by Peter and Harold.

If the new information you've been provided does not really change your stance on the measure, we can just move forward and say that the committee's taken your comment and the response into consideration and still maintains that they have not been able to come – that there's still issues that are not being followed and we can move forward with that statement.

Harold Pincus: So a measure – This is confusing to me a little bit. So a measure can move forward for recommendation if there's lack of consensus on the scientific evidence?

Helen Burstin: Yes, this is Helen, Harold. That's a good point. So essentially what will happen at the committee meeting is you didn't need consensus on scientific acceptability but then the committee voted overall to recommend the measure to move forward. So the reason …

Harold Pincus: I thought they can't proceed unless it reach a consensus.

Helen Burstin: I'm sorry. It cannot move forward if it fails. It's not that it failed, and correct me if I'm wrong, the team, I'm not sitting with them but it's just that it didn't reach consensus, it was in the 40 to 60 range. Those can move forward for further input as part of comment.

Sarah Sampsel: That's correct.

Male: Yes.

Jeffrey Susman: It's just sort of having the neutral zone or the – yes.

Sarah Sampsel: Yes.

Jeffrey Susman: Indeterminate zone.

Sarah Sampsel: Exactly except at the end, you weigh the criteria against each other and decided to recommend it.

Jeffrey Susman: Yes.

Helen Burstin: The comment period is another opportunity for you to consider whether anything comes in that gives you, you know, further thinking on that.

Peter Briss: So now, I understand what we might be revoting. And so the real question is do we – are we now officially concerned about the potential fuss and the reliability and validity of the measure that if you felt like Harold for example that you're a little more – perhaps more concern than you were at the meeting

and then we could vote to not pass on. Essentially, we'd be voting to see whether we felt strongly enough to not pass it on reliability, validity which would mean the measure failed, is that right?

Sarah Sampsel: Yes, that's correct.

Peter Briss: So is there a tenth of the room where – now that our choices are clear, we can go forward as we were or we can revote to see if we are concerned enough about this measure to fail it on reliability and validity.

Dolores "Dodi" Kelleher: You know, this is Dodi Kelleher. I just have a certain level of discomfort with sort of second-guessing our votes which were clearly not, you know, were either in the gray zone or were there were legitimate concerns but we decided after much, right, discussion to go ahead and endorse then – and I'm done – I'm, you know, my tendency would be be very conservative about this and say move on and just make sure that it's noted. Again, what the concerns are and what our expectations as a committee are going forward.

Harold Pincus: I mean, I would say – I'm (inaudible) to do it here, you know, even though I'd, you know, I'd recall that I'd voted sort of on low on scientific evidence on this, I, you know, the information we've done so far hasn't changed my view. So I wouldn't, you know, recommend making a change in what we have originally voted.

Jeffrey Susman: Yes. I guess I would be agree. I don't see anything outstandingly new in the comment to respond. It's just shift our opinion which I think was probably more detailed and more important with the time of our in-person meeting (inaudible) over the phone.

Helen Burstin: That's a very fair comment, yes. And the expectation of the comment period is very much that is the question is, is anything that has come in really shifted, we're thinking significantly. That in between what was, you know, as we all know quite a robust discussion of the in-person meeting.

Peter Briss: It sounds like all the comments that I've heard are in favor of staying with the status, anybody feel strongly the other way?

Female: So, I'm just wondering what the outcome is. So it was in the gray zone and no new evidence came in that shifted the position. What is the outcome that it is not endorse?

Peter Briss: Still in the gray zone and its still endorse.

Helen Burstin: No. I mean, at this point it's still pretty early in the process. So at this point, the measure was recommended by you but you did have concerns about scientific acceptability. That same information will flow forward to the next stages of process. Again, we're still not done. There's a couple of more steps for the measure is actually endorse.

Harold Pincus: Is there additional information that we would add to our report based upon these additional comments? Its, you know, it sounds like the measure developer is, you know, potentially considering getting some degree of greater specificity with regard to the numerator. Is that true?

(Tony Kaye): This is (Tony). I guess from the PCPI we do, we're often to, you know, more internal discussions about this measure and we tend to agree. But this is, you know, adding a definition is intended to provide guidance. I don't believe that this will respect any change to the actual specifications but more to help people when implementing how those specification are intended to be use.

Sarah Sampsel: OK. So hearing nothing further on this, we were – we are going to go ahead and move into – well, before I do that, out of, you know, if you look at the public comment report, were there any other measures, you know, people just brought up to one that he wanted some more language added to the report. Were there any other comments on the overall report or public comment that the committee felt they wanted to discuss?

OK. So let's move into – this is the harmonization discussion and since related in competing measures and Poonam will lead us through that.

Poonam Bal: Perfect. So the first one I'll be discussing is – right, depression readmission measures. They are part of the (inaudible) and have many the same numerators and exclusions. The main difference is that one is at six months and one is at 12 months. The developer has provided a response. They are

(inaudible) at this point and that is more following – checking at a different point. And making sure that those points, are there is something set to check at those points.

So at this point, I'll open up if the committee would like to have some discussion on this or if they feel the developer's response testify whatever harmonization has been done.

Jeffrey Susman: I think the response is adequate.

Poonam Bal: OK. Not hearing other voices, I'll go ahead and move on to our next related screening. So the next one is screening for alcohol, tobacco and substance use. There are two NCQA measures and one American Society of Addiction Medicine measure.

So, you know, all of these screening measures and (inaudible) all these categories. NCQA did provide a response in which basically says that – actually let me see if NCQA would like to kind of paraphrase. Would anyone on the line, (Sarah) or Bob?

(Jin Ching): Hey, this is (Jin Ching) from NCQA. I will start and my colleagues can add on to it. So we appreciate the opportunity to discuss harmonization of measures and when we developed this alcohol screening and the tobacco screening measures, we intentionally tried to harmonize what existing measures. That's why we have this screening and a follow up. And there are similar elements in the measures. However, there are also key differences between our measures and the (ACM) measure in terms of the denominator and numerator et cetera.

So we see these measures are related but also have a key differences and probably will keep evaluate the opportunities for future alignment and harmonization whenever possible was this related to measures.

Poonam Bal: OK. Thank you for that. So at this point, if the committee would really like to discuss these measures or do you feel that the developer's response has justified the level of harmonization so far?

Female: Can you scroll down?

Poonam Bal: Yes.

(Connie): This is (Connie). I would like some clarification because I was surprise to see this harmonization issue raise and it seems that the burden is on NCQA to harmonize. And my understanding was that we approve the (ACM) composite screening measure as a trial measure. And there was a lot of concern about certain aspects of it which are reflected in the comments.

So because someone from NQF explains what – because this is a trial measure is that not put it in a different category with respect to harmonization or how is that relate because this seems it's a different measure because it's a trial measure.

(Madie): That's a very good question.

(Connie): I have, you know, I'm new to the committee and I really, really don't completely get what the biggest trial measure mean. So I'm asking a question in ignorance.

Sarah Sampsel: OK.

(Madie): I would have thought this is maybe – I would have thought to put it in a different category because it's a trial measure and the measure for testing process rather than an endorsed measure. So I'm not understanding why it's being placed in the same category, doesn't make sense.

Peter Briss: This is Peter guys. It is true that a trial measure shouldn't pose an immediate issue for being related or competing if it is just being used in limited ways for testing.

(Madie): Right.

Peter Briss: Assuming that it survives testing, you know, it's not …

(Madie): That's another discussion.

Peter Briss: Yes. It was exactly …

(Madie): If it survives testing then we discuss it.

Peter Briss: Yes. Exactly not a bad thing. I would say that it's good to encourage the developers to think about that and think about that early and often, you know, NQF and developed – or others have been trying to encourage people to think about reconciling measures earlier in the process which I think most everybody thinks is a good idea.

So probably because the composite is just for trial use, we should just encourage the various developers to be thinking about that early but it's probably not in immediate concern.

(Madie): I think that's right.

Peter Briss: Again, the NQF staff want to add to or amend to any of that?

Poonam Bal: OK.

Female: Do you want …

(Off-Mike)

Poonam Bal: No. I think that's exactly what we needed. Thank you.

OK. So at this point, we'll go ahead and quickly go over the – what our next steps are. We will go out for voting. Hold on one second. We will go out to voting at the end of this month and then, we'll go to CSAC in February. And we'll be going to – sorry, to the board in March.

And at that point, once the board's approval, we will also be going to (appeals) in March. So this phase will be ending in April. So we'll continue to reach out to you and let you know what steps are occurring.

And – oh, yes. So we'll continue to reach to you and let you know what's going on. We'll take what you've said today based off the comments. And

(inaudible) and I'll take the memo for voting and for the CSAC. At this point, are there any other questions?

(Off-Mike)

Poonam Bal: OK. I don't a thing. So, (Brandy), could you open it up for member and public comment, please?

Operator: At this time, if you would like to make a comment, please press star then the number one on your telephone keypad. Again, that's star one to make a comment.

And there are no public comments at this time.

Poonam Bal: OK. Perfect. Peter and Harold, is there anything that you would like to say before we end the call today?

Harold Pincus: No, just thanks everybody again for your engaged participation.

Female: Thanks, Peter and team.

Poonam Bal: OK. Perfect. Well, then I hope everyone has a good day and I'll give you about 20 minutes back. Thank you.

Female: Thank you.

Male: Thank you.

Female: Happy new year.

Male: Bye-bye, happy new year.

Female: Happy new year.

Female: Bye.

Male: Happy new year.

Male: Happy new year.

END