

NATIONAL QUALITY FORUM

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BEHAVIORAL HEALTH PHASE 3  
STANDING COMMITTEE MEETING

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THURSDAY  
OCTOBER 2, 2014

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

PRESENT:

PETER BRISS, MD, MPH, Medical Director, CDC,  
National Center for Chronic Disease  
Prevention and Health Promotion

HAROLD PINCUS, MD, Director of Quality and  
Outcomes Research, New  
York-Presbyterian  
Hospital, The University Hospital of  
Columbia and Cornell Universities

ROBERT ATKINS, M.D., MPH, Senior Medical  
Director, Aetna Medicaid

MADY CHALK, PhD, MSW, Director, Policy  
Center, Treatment Research Institute

DAVID EINZIG, MD, Medical Director of Child  
Psychiatry, Children's Hospital and  
Clinics Of Minnesota

JULIE GOLDSTEIN GRUMET, PhD, Director of  
Prevention and Practice, Education  
Development Center/Suicide Prevention  
Resource Center/National Action  
Alliance for Suicide Prevention

CONSTANCE HORGAN, Sc.D., Professor and  
Director, Institute for Behavioral  
Health, The Heller School for Social  
Policy and Management, Brandeis  
University

LISA JENSEN, DNP, APRN, Associate Director  
Workforce & Leadership, Office of  
Nursing Services, Veteran's Health  
Administration

DOLORES (DODI) KELLEHER, MS, DMH, Principal,  
D Kelleher Consulting

KRAIG KNUDSEN, PhD, Chief, Bureau of  
Research and Evaluation, Ohio  
Department of Mental Health and  
Addiction Services

MICHAEL LARDIERI, LCSW, Assistant Vice  
President, Strategic Program  
Development, North Shore-LIJ  
Department of Psychiatry

TAMI MARK, PhD, MBA, Vice President, Truven  
Health Analytics

RAQUEL MAZON JEFFERS, MPH, MIA, Director of  
Health Integration, The Nicholson  
Foundation

BERNADETTE MELNYK, PhD, RN, CPNP/PMHNP,  
FAANP, FNAP, FAAN, Associate Vice  
President for Health Promotion,  
University Chief Wellness Officer,  
Dean and Professor, College of  
Nursing, Professor of Pediatrics &  
Psychiatry, College of Medicine, The  
Ohio State University

LAURENCE MILLER, MD, Senior Psychiatrist,  
Arkansas Medicaid, Arkansas Medicaid

DAVID PATING, MD, Chief, Addiction Medicine,  
Kaiser Permanente

VANITA PINDOLIA, Pharm.D., VP, Ambulatory  
Clinical Pharmacy Programs, Henry Ford  
Health System/Health Alliance Plan

RHONDA ROBINSON BEALE, Medical Physician,  
Former Chief Medical Office at Optum  
Now Health Care Consultant, Health  
Care Consultant

HENA SIDDIQI, M.D., Medical Director,  
Broadlawn Manor Nursing and  
Rehabilitation

LISA SHEA, M.D., D.F.A.P.A., Deputy Medical  
Director, Quality and Regulation,  
Butler Hospital (Providence, RI)

JEFFERY SUSMAN, M.D., Dean, Northeast Ohio  
Medical University, Northeast Ohio  
Medical University

MICHAEL TRANGLE, MD, Associate Medical  
Director for Behavioral Health,  
HealthPartners

BONNIE ZIMA, MD, MPH, Professor in  
Residence, Child and Adolescent  
Psychiatry, UCLA Semel Institute for  
Neuroscience and Human Behavior

LESLIE ZUN, MD, MBA, Chair, Department of  
Emergency Medicine, Mount Sinai  
Hospital

**NQF STAFF:**

POONAM BAL, Project Analyst

HELEN BURSTIN, Chief Scientific Officer

LAURALEI DORIAN, Project Manager

ANGELA FRANKLIN, Senior Director

**ALSO PRESENT:**

STEVE DAVIS, M3 Information

KENDRA HANLEY, AMA PCPI

SARAH HUDSON SCHOLLE, NCQA

JUNQING LIU, NCQA

COLETTE PITZEN, Minnesota Community  
Measurement\*

D.E.B. POTTER, AHRQ

SARAH SAMPSEL, MPH, Azul Quality Solutions,  
Consultant to NQF

COREY WALLER, Spectrum Health

\* present by teleconference

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

2 8:31 a.m.

3 Welcome, Recap of Day 1

4 CHAIR BRISS: So good morning and  
5 welcome.

6 MS. DORIAN: Good morning  
7 everyone, and welcome back to Day 2. It's a  
8 good sign that you're back, and we're excited  
9 to get started to review some exciting  
10 measures again today. Just before we get  
11 started on these measures, we wanted to remind  
12 you what happened yesterday. So Poonam will  
13 bring the slide up.

14 Okay. So the slide isn't working  
15 at the moment, but I can just remind everyone  
16 from my notes. So we reviewed -- the first  
17 measure we reviewed was the ADHD 1 from NCQA  
18 which passed.

19 The second one, which was the only  
20 one that didn't, was not recommended, was the  
21 pediatric symptom checklist and psychosocial  
22 functioning from Mass General, which went down

1 on reliability.

2 CHAIR BRISS: Although we made  
3 some recommendations about it being important,  
4 and some ways that it could be adjusted over  
5 time.

6 MS. DORIAN: Exactly, yes, and  
7 then here's the slide. And then so the Health  
8 Screening and Assessment, the NCQA measures  
9 were all recommended, but with the note the  
10 2601, we had consensus not reached on  
11 validity.

12 So when that -- when the report  
13 goes out for public comment, we'll really  
14 solicit comments on that measure in  
15 particular, and then when this committee  
16 reconvenes for the post-comment call at the  
17 end of October, the end of November I think,  
18 we can discuss those comments that have been  
19 received.

20 CHAIR BRISS: And on that set too,  
21 there were a number of important -- there was  
22 a lot of important discussion about this

1       essentially being a step in the right  
2       direction, and I think there was a fair amount  
3       of consensus on the committee that we'd like  
4       to see more steps in the right direction,  
5       towards composites or stratifications.

6               MS. DORIAN:   So were there any  
7       sort of overarching comments or questions  
8       about yesterday?

9       Tobacco, Alcohol and Substance Use

10              MS. DORIAN:   Okay.   I think we can  
11       jump right into our first measure then.

12              CHAIR BRISS:   And just for  
13       planning purposes, so two things.   We know  
14       already that we're going to start losing  
15       people this afternoon as they're running for  
16       planes, so it will be important to try to stay  
17       on time again today.

18              I appreciated everybody's hard  
19       work on being efficient yesterday, and we'll  
20       need to do a lot of that again, and we're  
21       going to propose for short term conflicts,  
22       we're going to do a slight modification of the

1 morning schedule.

2 So we'll start as proposed with  
3 2597. We'll then move to the alcohol and  
4 tobacco measures, 2599 and 2600, after which  
5 we'll circle back and pick up 2605.

6 CHAIR PINCUS: So we're starting  
7 with the Substance Use Screening and  
8 Intervention Composite from the American  
9 Society of Addiction Medicine, and the measure  
10 developer is here.

11 MR. WALLER: Yes, the measure  
12 developer is here.

13 CHAIR PINCUS: Okay. So do you  
14 want to sort of tee this up? And this is a  
15 little bit different, and you want to talk  
16 about that Angela?

17 MS. FRANKLIN: This is a measure  
18 that's coming into our alternate pathway.  
19 We're looking at this eMeasure as a trial  
20 measure, meaning that our recommendations  
21 today will relate to whether the measure is to  
22 be used for testing, further testing, to



1     gather the data needed to determine the  
2     measure's reliability and validity.

3                 So it won't be used for use in  
4     accountability applications. It will be for  
5     use for testing purposes, and you will have at  
6     your table a quick guide on how to evaluate  
7     this measure as a trial eMeasure. Just to  
8     give you a quick refresher, we'll be looking  
9     at this measure against the NQF criterion.

10                However, when it comes to  
11     scientific acceptability, we'll only be  
12     looking at the first criterion for  
13     reliability, looking to see whether the  
14     measure specifications are precise, and then  
15     we come to the validity criterion.

16                We'll only be looking at the first  
17     criterion again, which is the criterion as to  
18     whether the measure specifications are  
19     supported by the evidence presented for the  
20     measure.

21                Are there any questions about how  
22     we're looking at this measure today as a

1 committee?

2 DR. BURSTIN: Just one piece of  
3 context for this. This sort of comes out of  
4 the blue for you, so just a moment on this.  
5 So the idea is that we very much want to push  
6 on the idea of moving to really good new  
7 eMeasures.

8 Lots of new concepts. You know we  
9 can't keep getting out of claims, we can't  
10 keep cracking open medical records every time  
11 to do them.

12 But we also recognize that we're  
13 at the point right now a lot of the EHRs just  
14 aren't ready to test some of these new  
15 systems, and we found a lot of the developers  
16 are having a really hard time finding EHRs,  
17 three EHRs with which to test some of these  
18 measures, because they are new and important  
19 concepts.

20 So this has been our thinking, of  
21 at least allowing some of these measures to  
22 flow out there, get used, get tested and then

1       they'll just come back to us to bring actually  
2       to you guys likely, just to bring their  
3       testing results for reliability and validity.

4               It is at least sort of a stepwise  
5       progression, and at least pushing forward and  
6       allowing some of the more innovative concepts  
7       to move forward.

8               CHAIR BRISS: Carol, do you have a  
9       question?

10              CHAIR PINCUS: Oh yes, Tami.

11              MEMBER MARK: Yeah. Can you  
12       explain some reasons why we wouldn't want to  
13       go forward with testing, and then sort of  
14       thinking like it seems -- I'm not quite  
15       understanding the bar for voting against  
16       additional testing? It just seems like it  
17       would --

18              DR. BURSTIN: We're not asking you  
19       to vote against additional testing. We are  
20       expecting these measures to be tested.  
21       They're just coming to you today not yet  
22       tested. So they will not be endorsed. That's

1 another important distinction here.

2 What comes out of this designation  
3 by you is they are approved for trial use,  
4 trial use measures. Not endorsed, not  
5 endorsed until the testing results come back.

6 MEMBER MARK: So I guess why would  
7 we not approve something for trial use?

8 DR. BURSTIN: Because they may not  
9 pass the other criteria. It may not be -- it  
10 may not have any evidence in place. Among  
11 scientific acceptability, though, they're not  
12 yet tested for reliability and validity. You  
13 may not think those specifications are precise  
14 enough. There are other elements within  
15 scientific acceptability.

16 You would still want to look at  
17 feasibility. Very important for an eMeasure,  
18 and they're all required to have eMeasure  
19 feasibility testing, and then usability. So  
20 those other criteria are still in play, even  
21 if they have not yet had an opportunity to  
22 find three EHRs that could actually test it.

1                   CHAIR BRISS: I would say there  
2                   are also -- yes, this is hypothetical. But  
3                   imagine a measure that was measuring something  
4                   that you didn't think was important to  
5                   measure, that was badly designed. You might  
6                   ask them -- you might ask a developer to go  
7                   back and redesign the measure before going to  
8                   the time and expense of testing reliability  
9                   and validity.

10                  DR. BURSTIN: Right.

11                  CHAIR PINCUS: Just one additional  
12                  clarification. With regard to doing any kind  
13                  of testing, are they expected to have done  
14                  that, for example, with regard to feasibility,  
15                  to have tested the feasibility? So it's  
16                  really just the validity and the reliability  
17                  testing.

18                  DR. BURSTIN: Exactly, and NQF did  
19                  some work with -- for ONC just about a year  
20                  ago. The Office of National Coordinator came  
21                  up with a specific testing approach for  
22                  feasibility. So to at least ensure that these

1 measures are feasible as a starting point,  
2 before they start getting put into use.  
3 Another question?

4 MEMBER MAZON JEFFERS: I'm sorry.  
5 Could you just then reiterate which criteria  
6 we are expected to evaluate today for this  
7 particular measure, just so I'm clear?

8 DR. BURSTIN: Well, you will  
9 evaluate all four criteria. So none of them  
10 get pulled off the table, except within the  
11 scientific acceptability criteria. You will  
12 not vote on reliability and validity. We will  
13 only ask you to look at the remaining  
14 elements, which is really about precision of  
15 the specifications. Is that okay? Does that  
16 work?

17 CHAIR PINCUS: We do apply  
18 actually 2a1 and 2b1 for reliability and  
19 validity. It's the other reliability --

20 DR. BURSTIN: Just not the  
21 testing.

22 CHAIR PINCUS: Yes. Just not the

1 testing part of it. Okay. Any other  
2 questions? Rhonda and then Leslie.

3 MEMBER ROBINSON BEALE: Just a  
4 quick question. Given that this is an area  
5 that's using electronic health records, and  
6 even though there is a good penetration of  
7 electronic health records in the behavioral  
8 health space, it's still not as substantial as  
9 it is on the medical side.

10 Will I know, maybe -- it just has  
11 to be said. So I raised a question as to  
12 whether or not one will look at, as part of  
13 the feasibility, the penetration of electronic  
14 medical records in that particular area.

15 DR. BURSTIN: You know, it's a  
16 fair question, and I think some of the idea  
17 here is that we're just pushing them out, so  
18 they can be used for those who have them, and  
19 begin testing them. So I think we'll learn  
20 more over time, but not everybody has them.

21 But for those who can in fact pick  
22 up a trial use measure, test it, continue to

1 support their ongoing use and implementation,  
2 it is not an expectation that everybody now  
3 could take this measure and run with it.

4 MEMBER ZUN: So are there any  
5 vendors of electronic medical records that  
6 could use this and give data? Because all I  
7 heard was that they're not ready yet. So are  
8 we doing the horse before the cart or the cart  
9 before the horse?

10 MR. WALLER: The horse is  
11 definitely in front of the cart at this point,  
12 and so just -- so Epic, one of the largest  
13 providers of electronic medical records, we've  
14 already implemented this in our hospital  
15 system and we're beta testing it now, and it  
16 works pretty clearly.

17 What we've done, I mean I can --  
18 you want me just to -- we can wait. So I can  
19 explain that, how that's done and it's  
20 actually working pretty well.

21 DR. BURSTIN: Just to provide a  
22 response to Leslie, because that's a really



1     good question. I think what we learned is  
2     it's also a bit of a chicken-and-egg  
3     phenomena. So the vendors need to  
4     increasingly know whether the most important  
5     data elements they should program into their  
6     EHR, since some of that comes from knowing  
7     what the most important concepts are.

8                     So some of this is also the push-  
9     pull here, quite intentionally making sure  
10    there are in fact vendors who will add these  
11    data elements to EHRs because that's what we  
12    want --

13                    CHAIR PINCUS: That's very  
14    helpful, because I think one of the questions  
15    I had also was well why does NQF need to do  
16    this, then, and as you explained, it really  
17    has to do with helping, really, vendors and  
18    measure developers to focus, and not really  
19    focus on things that were not really worthy of  
20    putting effort into. Les?

21                    MEMBER ZUN: As a follow-up to  
22    that first comment, so I presume the vendors

1     have a professional organization. Has it been  
2     vetted to them and is that --- I didn't --- is  
3     that somewhere in our documents?

4             DR. BURSTIN: We've extensively  
5     worked with the vendors on this approach going  
6     forward, and they're very interested in fact  
7     in this approach, because it allows it to be  
8     more iterative.

9             I mean we recognize, you know, you  
10    want to just throw everything in there, or do  
11    you really want to make sure you're putting in  
12    what's most important? Even when we did our  
13    eMeasure feasibility project, for example,  
14    last year we had Epic at the table. We had a  
15    couple of other vendors as well, specifically  
16    to make sure we're going down a path that  
17    logically makes sense for all sides.

18            CHAIR PINCUS: Jeff.

19            MEMBER SUSMAN: I'm only going to  
20    say if you think about our discussion of the  
21    suicidal risk yesterday, I think it's a really  
22    good argument for going down this pathway, of

1 really teasing out a specification related to  
2 e-measurement. So is it just the checkbacks?  
3 Is it checking down certain behaviors?

4 How is that reported as we get  
5 more sophisticated, can actual language  
6 processing, being able to extract data from  
7 the written note and so forth, all of which I  
8 think would be helpful to have before it comes  
9 to this group for more formal evaluation?

10 CHAIR PINCUS: And that's an  
11 important point, that it would come back here,  
12 and because of the timing that's expected, is  
13 it a routine expectation?

14 FEMALE PARTICIPANT: Three years.

15 DR. BURSTIN: We gave the  
16 developers up to three years to return. We  
17 hope they could do it sooner but, you know, in  
18 some spaces truly, for example, some  
19 functional status measures that people are  
20 trying to test right now, it's going to be a  
21 heavy life to find an EHR to do it.

22 CHAIR PINCUS: Okay, good. So why

1 don't we get started? Okay. Oh Mady.

2 MEMBER CHALK: I'm hoping that  
3 this approach will be taken with lots of other  
4 measures. I really -- I think it's very  
5 useful. I think it does push the fields,  
6 whatever fields we're in, to pay attention to  
7 what's coming down the line, and to work with  
8 us. So I really appreciate this.

9 CHAIR PINCUS: Let me ask one  
10 other further clarification, Helen. Measures  
11 that are not currently specified as eMeasures,  
12 but are already endorsed, do they have to come  
13 back? Do they have to come back to be re-  
14 endorsed once they're an eMeasure, to go  
15 through this process?

16 DR. BURSTIN: Yes. Essentially  
17 the answer is yes. As they come back up for  
18 maintenance, we will look at their eMeasure  
19 specifications. In the early days of this  
20 conversion, there was a lot of PCPI and NCQA,  
21 I know this well, this idea of just retooling,  
22 taking exactly what the measure was, in

1     whatever form it was, and just converting to  
2     whatever point, you know, to whatever data  
3     made sense in an EHR.

4             I think what we've learned over  
5     time is that's kind of really pounding a  
6     square peg in a round hole big time, because  
7     in fact to develop an eMeasure, you want to  
8     take advantage of the eMeasure, and what's the  
9     best, or even of what an EHR and other  
10    electronic data systems can bring to the  
11    table, and starting with the idea of this is  
12    what we did in claims and just kind of making  
13    it what you do in an EHR doesn't make sense.

14            So we're hoping we've gotten the,  
15    you know, the developers are no longer  
16    constrained by saying and it matches what the  
17    claims based one says. It's really what makes  
18    the most sense in the EHR context.

19            CHAIR PINCUS: So they would be  
20    actually endorsed as two separate measures in  
21    principle?

22            DR. BURSTIN: We're working

1 through those issues.

2 CHAIR PINCUS: Okay. So why don't  
3 we get started? Oh ---

4 MEMBER ROBINSON BEALE: Just one  
5 point of clarification. Then is there an  
6 entity that will take a look at the core data  
7 elements, so that there's some standardization  
8 around the data elements that go into the  
9 electronic health records? Is that the role  
10 of the electronic health record trade  
11 organization? Is that a role for NQF?

12 DR. BURSTIN: Good question. So  
13 there's actually a fair amount of work being  
14 done right now to think that through. There's  
15 actually something called, through the  
16 National Library of Medicine called the Value  
17 Set Authority Center, and the value sets are  
18 essentially the way to -- I know, with that  
19 look from Andy, it's a funky description.

20 But essentially value sets are the  
21 way to bring together all the codes for  
22 something to describe something. So this is

1     addiction. This is what a visit looks like,  
2     things like that. So the measures are --  
3     we're trying to increasingly make sure that  
4     those value sets get into the NLM, and there's  
5     actually a process for collectively thinking  
6     about that.

7                     What does it look like to  
8     harmonize those, to make sure they make sense  
9     across measures?

10                    MS. HANLEY: Yes, so there's a lot  
11     of work ongoing in the standards field  
12     nationally, to look at how to ensure that  
13     we're representing the data elements in a  
14     consistent manner. So we use a data model  
15     called the Quality Data Model to categorize  
16     our data elements that we're looking for to  
17     use in the measure.

18                    As Helen mentioned, we're building  
19     the value sets in this national repository,  
20     and there's great emphasis to not reinvent new  
21     value sets every time you need something for  
22     a new measure. So all the measure developers

1 are working together, you know, using this  
2 National Library of Medicine-hosted tool as  
3 the space to facilitate some of that work, to  
4 really see okay, you know, AMA, we've  
5 developed some value sets that NCQA might be  
6 able to use in their measure, vice-versa.

7 So we're looking at, you know,  
8 what was the purpose? Why was that value set  
9 developed? What's the purpose? Does it meet  
10 our needs, or do we actually need something a  
11 little bit different here, and in that case we  
12 then do develop a different value set.

13 So the measure development  
14 community is definitely looking at that.

15 MEMBER ROBINSON BEALE: So I  
16 assume that that would include the use of  
17 things like the tests that we were looking at  
18 yesterday, suicide assessments and standardize  
19 that type of use of tools, validated tools?

20 MS. HANLEY: Yes. I think to a  
21 certain extent, a lot of that is still going  
22 to rely on the evidence base to include those



1 types of tools and measures. But to the  
2 extent that we are using those tools in  
3 measures, we are representing them in a  
4 consistent way.

5 DR. BURSTIN: I think there's  
6 still more work to do specifically on the tool  
7 side though, to your point there Rhonda, that  
8 I think is not going to be captured by the  
9 Value Set Authority Center. I think that's  
10 where you're inputting --- around  
11 harmonization and best in class --

12 CHAIR BRISS: And that the value  
13 sets are more about -- or seem to me to be  
14 more about general concepts that get used in  
15 lots of measures.

16 So it's the kinds of problems that  
17 they're trying to solve with that are -- some  
18 of us just looked at sets of diabetes  
19 measures, and there were like to decide who  
20 had diabetes.

21 People were doing this in like 17  
22 different ways, and that's the problem, more

1 the problem that they're trying to solve, than  
2 how you define a specification intervention,  
3 as in the suicide case.

4 CHAIR PINCUS: Les.

5 MEMBER ZUN: So I agree this is  
6 the right thing to do, but I'm not sure this  
7 is the right way to go about it, and I'll  
8 explain that, because I've actually been  
9 trying to do this with our vendor. For  
10 instance, if a patient says they smoke or they  
11 do drugs, they get a referral to substance  
12 abuse treatment.

13 But the vendor keeps telling me  
14 they can't do an audit for me. So you know,  
15 I can't audit it electronically. I have to  
16 manually go through and audit it. So there  
17 must -- I know it's crazy, but that's, you  
18 know, like order sets. Are the order sets  
19 being used, well I have to manually go through  
20 every single patient to see if an order set  
21 was used for a certain condition.

22 So what concerns me is rather than

1 going, working with one vendor or another  
2 vendor, there must be an organization, another  
3 way to do this through some, whoever sets the  
4 standards for electronic medical records or,  
5 you know.

6 Is this the right forum to push  
7 the agenda, to get these folks in the same  
8 place, so they can help us do the quality  
9 measures we want to do. I'm not sure that  
10 setting up an eMeasure does that.

11 CHAIR PINCUS: Mike may have some  
12 comment on this.

13 MEMBER LARDIERI: Yes thanks, and  
14 you know, with that, it's really of a vendor  
15 problem. Any vendor can do this. If you're  
16 looking for them to do it, pick it from your  
17 note, no vendor's doing that right now. You  
18 need natural language processing to do that.

19 But if you have a structured data  
20 field that the patient says they smoke, that  
21 is easily computable to make a referral. So  
22 I don't know who your vendor is or how they're

1     trying to do this, but that's easy. Any  
2     vendor can do that. You have to pay them  
3     whatever you have to pay for that little  
4     piece, but you have to pay everybody anyway.

5                 So even going through this  
6     process, you're still going to have to pay the  
7     vendor to do it, unless -- until it becomes a  
8     national thing that they actually put in place  
9     that everybody is doing. You're paying your  
10    vendor to do it, right, and they want to do it  
11    for you.

12                So it's not a -- it's really just  
13    a vendor reluctance issue versus lack of  
14    capability.

15                DR. BURSTIN: I'll quickly respond  
16    to Leslie's issue. So we have been doing this  
17    collaboratively with the Office of National  
18    Coordinator and very supportive of these  
19    efforts. I actually just finished my tenure  
20    for the last two years as chair of the Quality  
21    Measures Workgroup for the Health Policy  
22    Committee.

1                   So this is something very much  
2           done with the vendor committee, with the  
3           leadership at ONC. I think it's an important  
4           -- those are all really important issues, and  
5           I guess the question is can quality  
6           measurement be kind of a way to help push some  
7           of that, and if you can play a role there, I  
8           think that's our hope.

9                   But really good thoughts about  
10          keeping it all connected.

11                  CHAIR PINCUS: And I think, you  
12          know, I mean really the lead for a lot of this  
13          stuff is with ONC. Like they are developing,  
14          for example, standards for behavioral health  
15          EHRs that are not mandatory, but that are sort  
16          of recommended and sort of to try to main that  
17          standard setting. Like one last comment on  
18          this general issue.

19                  MEMBER LARDIERI: Yeah, and then  
20          the best place to go to deal with the vendors  
21          is through the HINS EHR Vendor Group. It's a  
22          specific group that represents almost all of

1 the vendors in the country. So that's the  
2 best place to be.

3 CHAIR PINCUS: Okay. So let's now  
4 talk about the measure under review.

5 MR. WALLER: All right. So we've  
6 talked around it a lot, so let's get down to  
7 it. So I'm Corey Waller. I'm a physician.  
8 I still see quite a few patients, including a  
9 couple on my cell phone last night.

10 So let's run through what the  
11 basis of this is. So this is a composite  
12 measure. It has three focus areas. You could  
13 call it four, but it's three main focus areas  
14 and four fields that would need to be  
15 identified.

16 This looks at screening and brief  
17 intervention. It really is a measure  
18 dedicated to those two things happening in  
19 concert, and it's looking at tobacco use,  
20 alcohol use, illicit drug use and prescription  
21 drug abuse. In order for us to evaluate  
22 whether or not those are happening, we have to

1 ask those questions, and those questions are  
2 not being asked consistently within a primary  
3 care space.

4 So this measure very specifically  
5 was developed so that all of those would need  
6 to be asked, and then a brief intervention  
7 would need to be done, in order for it to be  
8 completed as a task.

9 Ultimately, there's a large amount  
10 of research that backs up the utilization of  
11 this for tobacco use and the prescribing of  
12 medication for tobacco use disorder, as well  
13 as a growing amount of literature for the  
14 alcohol space, that shows a significant  
15 reduction in at risk drinkers, decreasing the  
16 amount that they drink.

17 Following that, we have a little  
18 bit of a mixed bag of information concerning  
19 the illicit drug utilization, but that seems  
20 to depend a couple of main issues, and one of  
21 those is how severely ill are the people that  
22 you're asking the question to.

1                   We find that many that find no  
2                   benefit from the brief intervention aspect are  
3                   seeing patients who are sicker or homeless.  
4                   I was talking with one of my colleagues this  
5                   morning, and said instead of brief  
6                   intervention and referral to treatment, it  
7                   should be screening, brief intervention,  
8                   referral to housing.

9                   But at the same time, we do have  
10                  really good significant data at large scale  
11                  implementation pathways. The New Mexico study  
12                  showed a half a million people that they were  
13                  able to screen and do a brief intervention on,  
14                  and then also refer to treatment showed a  
15                  significant improvement.

16                 So they did that in an area which  
17                 is mostly rural, which is not fully  
18                 implemented on EMRs, and they were able to  
19                 show good efficacy and implementation and good  
20                 outcomes. So what this really focuses on is  
21                 using a known, standardized screening tool,  
22                 that would allow for people to choose



1       whichever tool that is.

2                       So we're not specifying which  
3       tobacco screening tool or which alcohol  
4       screening tool or which illicit drug screening  
5       tool, just one of the validated tools are  
6       completed, and then once that is completed,  
7       that a brief intervention is done if they are  
8       positive on any of those tools.

9                       Once that is done, then that would  
10      complete the measure. An example would be if  
11      a patient smokes tobacco and has more than,  
12      you know, 15 drinks in a week, then they would  
13      receive a yes for those two. It would be  
14      negative for the illicit drug screen and then  
15      they would do a brief intervention that covers  
16      both of those topics.

17                      The way that that's captured  
18      within an EMR is the screen sits within the  
19      EMR, and when that's finished, it shows up as  
20      completed, and then the brief intervention is  
21      a code. I mean ultimately it's charged out as  
22      a code. It was completed and that's how it's

1       tracked, because those two things are matched.

2                   The way that we've set it up on  
3       our EMR for trial, just to answer to Rhonda's  
4       question, is very specifically, you can't  
5       check the brief intervention unless you've  
6       done the screen. So you can't even charge for  
7       the brief intervention on that visit unless  
8       you've completed the screen to do that.

9                   And for this one, the composite  
10       measure, there would be whichever screen it  
11       is, screens for all of them. So you would  
12       have to finish the entire screen for tobacco,  
13       alcohol, illicit drugs and prescription drugs,  
14       prior to even being able to code for the brief  
15       intervention. Then what that does is it keeps  
16       it from being a push-button or a check-box  
17       measure.

18                   So that's the approach that was  
19       taken by the group that put this together.  
20       This was started and pushed by NIDA, as well  
21       as SAMHSA. It was brought up on HHS as one of  
22       the high, you know, areas of need, as far as

1       being able to evaluate this.

2                       But ultimately, implementation has  
3       been successful in a number of different areas  
4       for specifically, the large scale application  
5       of this pathway, and what we would be doing is  
6       just specifying that all of it needed to be  
7       completed so that it wouldn't be chosen, if  
8       you only feel comfortable talking about  
9       tobacco or only feel comfortable talking about  
10      alcohol, that we would miss one of the bigger  
11      issues.

12                    MS. HANLEY: I would just like to  
13      add that the alcohol and tobacco components of  
14      this composite are existing NQF-endorsed  
15      measures already in use.

16                    CHAIR PINCUS: So Peter, you're  
17      the lead reviewer.

18                    CHAIR BRISS: So as you've heard  
19      briefly, this is -- all four of the proposed  
20      components of this composite are unarguable  
21      big sort of public health burden issues. As  
22      you've heard, there's a performance gap in the

1     sense that all of the issues are under-  
2     ascertained. Even the ones that are currently  
3     better supported, tobacco and alcohol, are  
4     still under-ascertained.

5             The evidence to support the  
6     measure focus. This is actually a good  
7     measure that tests the approval of testing,  
8     for the evidence to support the measure focus  
9     does have some challenges, I would say.

10            So tobacco and alcohol have been  
11     well-studied. It's clear that screening and  
12     brief intervention improves outcomes. They're  
13     both recommended by the Preventive Services  
14     Task Force. The other drug measures, whether  
15     you consider them one or two, are mostly  
16     untested. They're mostly unrecommended by the  
17     task force and others.

18            The weight of the evidence, as  
19     nearly as I can tell, is that screening and  
20     brief intervention actually hasn't worked.  
21     It's not just on the study. It actually  
22     hasn't worked, including two recent good

1 studies in JAMA.

2 And so the -- so there are  
3 legitimate questions, I would say, about  
4 whether this would have a net positive or net  
5 negative public health impact. You could make  
6 an argument from where we are today that this  
7 would move forward.

8 All four issues, you could make an  
9 argument from where we are today that the  
10 additional burden and confusion introduced by  
11 adding other drugs could actually have a net  
12 negative effect on tobacco and alcohol  
13 screening.

14 The other thing that I would say,  
15 that testing the measure doesn't actually --  
16 it might help you assess what the net effect  
17 is on performance of screening, but it won't  
18 help you assess what the main question is,  
19 which is can you find a screening and brief  
20 intervention that actually works for other  
21 drugs, right?

22 So testing the measure won't

1 actually answer what seems to me to be the  
2 core question, and I guess I'll stop there.

3 CHAIR PINCUS: David.

4 MEMBER PATING: No. I just want  
5 to add that I do think this is the perfect  
6 kind of subject to do a trial measure on,  
7 because I think we really just need to answer  
8 the question, and the question is can we do  
9 screening and brief intervention for the drug  
10 component, and does it make sense to do it in  
11 the context?

12 Because we know that there's just  
13 a lot of overlap and comorbidity between  
14 alcohol and drugs, and so I think you're  
15 really testing that component.

16 Regarding the JAMA article that  
17 just came out, that was a 40 percent homeless  
18 population. So I really don't know if that  
19 should weigh negatively in terms of the  
20 ability to intervene in screening for drugs,  
21 as well as having interventions. It's very,  
22 very -- was it an insured population? I'm not

1 even sure they're a public sector population  
2 or a Medicaid population.

3 So that again, with regards to  
4 this, I think these are the open questions  
5 that make this, you know, ripe for making this  
6 a trial measure.

7 CHAIR PINCUS: So other comments  
8 on this issue with regard to evidence around  
9 the measure focus and importance?

10 MR. WALLER: I just wondered if it  
11 would be okay if I spoke to the specific  
12 articles. So I called Rich Sates, so that we  
13 could figure out. I needed to understand this  
14 as well, because I came at this measure late.  
15 I wasn't the developer. I'm helping shepherd  
16 this through from a clinical perspective, and  
17 so I needed to know this.

18 So a couple of things about the  
19 information that's come out, is the sites that  
20 were utilized in that have already done three  
21 other trials with SBIRT. So their control  
22 group is going to probably deliver SBIRT at a

1 higher rate than most people who are doing it  
2 as the experimental, meaning that their  
3 control group is already getting the  
4 intervention on a regular basis, and it just  
5 wasn't a track. So that was an interesting  
6 thing, is that -- so they were sicker, but at  
7 the same time, the control group was a little  
8 better.

9 So I just -- this has been an  
10 interesting thing to track, and there's good  
11 data on large-scale studies and on the  
12 smaller-scale studies. They seem to not have  
13 the efficacy. I think there's a good question  
14 to answer, whether brief intervention is a  
15 good use of time for this, and that's where I  
16 think that this measure gets to the crux of  
17 it.

18 CO-CHAIR PINCUS: So one thing  
19 actually, just before we get to people's  
20 comments, just to clarify, and it may be  
21 useful as, you know, in thinking about this  
22 process. What exactly will be tested? What



1 are the sort of key elements of the testing,  
2 and how will -- because in a sense, we're  
3 approving this for testing, and it seems to me  
4 that we ought to understand what it's being  
5 tested for, and in a sense, what hypotheses  
6 are being projected within the testing  
7 process, and under what circumstances would  
8 you then sort of come to a conclusion that you  
9 need to modify this?

10 MR. WALLER: So I'll speak first,  
11 and then they're going to have some extra  
12 comments on this. But the screening piece is  
13 not the piece being directly tested. We know  
14 that screening and referral, the treatment for  
15 illicit drugs has a significantly positive  
16 impact.

17 What's being tested with this is,  
18 one, can this be implemented in large scale  
19 and consistently evaluated through an  
20 eMeasure. So there's that component of it as  
21 truly can we see this happening and watch the  
22 outcomes from that, and the outcomes would be

1 are we finding a decrease in utilization on  
2 retesting for these patients.

3 CO-CHAIR PINCUS: So that's going  
4 to be part of the testing?

5 MR. WALLER: Well, that's going to  
6 be the determination. So there's the testing  
7 piece that tells us whether or not the measure  
8 is implementable and usable and consistently  
9 valid within the system, and then the second  
10 piece is to determine whether or not it has  
11 efficacy.

12 That efficacy is whether or not  
13 the brief intervention makes a difference for  
14 a decrease in the prescribing for nicotine, as  
15 I stated earlier, which I don't think will  
16 happen. I think we have some good evidence to  
17 show that that's not happening.

18 But the other thing will be does  
19 it decrease the utilization of the substance  
20 that was screened for and then intervened upon  
21 by a brief counseling session, and determining  
22 whether or not that had a significant impact

1 on the utilization.

2 Or do you just not brief intervene  
3 once you've screened? We have to answer that  
4 question. Do we add another thing to a  
5 primary care doctor's docket if it's not  
6 working, and if it's not working, we need to  
7 have that understanding that those patients  
8 should be referred for treatment after a brief  
9 discussion. So the brief discussion and  
10 intervention --

11 CO-CHAIR PINCUS: So wait a  
12 second. So you are in fact going to be  
13 testing the efficacy? That's the plan?

14 MR. WALLER: Yes. Yes, sir.

15 CO-CHAIR PINCUS: Okay. So why  
16 don't we get started? Why don't we sort of  
17 work our way up here and then go around there?  
18 Okay. So let me see. Who's at the end there?

19 MEMBER MAZON JEFFERS: So I'm  
20 really glad that you said that this measure is  
21 about testing the brief intervention  
22 component, because actually one of the things

1 I found interesting about it is that the  
2 specifications of what a brief intervention  
3 is, it's incredibly vague, right. So it's a  
4 doctor having a chat for five minutes, and  
5 there are evidence-based brief intervention  
6 strategies that we know to be effective.

7 I also think, I'm having trouble  
8 re-finding the measure specifications. But  
9 for tobacco, I think you can either have a  
10 counseling session or do pharmacotherapy, and  
11 we know that the intervention that is most  
12 effective, based on the evidence, is the  
13 combination of the pharmacotherapy with the  
14 counseling session.

15 So I'm just wondering if the point  
16 of testing the measure is to better understand  
17 the impact of the brief intervention. I'm  
18 wondering why the specifications around the  
19 brief intervention aren't more explicit and  
20 don't require more adherence to what we know  
21 to be the evidence for that piece to be  
22 effective?

1 CO-CHAIR PINCUS: I'm wondering  
2 whether given the number of comments, that we  
3 should go through the comments first and then  
4 have you respond. So next, Tami.

5 MEMBER MARK: Just a point of  
6 clarification. So it seems like the validity  
7 issue, it's most of concerning to the illicit  
8 drug abuse screening brief interventions. So  
9 are these -- it's a composite measure, but  
10 each of those separate types of screening and  
11 intervention are going to be tested  
12 separately?

13 CO-CHAIR PINCUS: Now let's keep  
14 track of these, okay.

15 MEMBER SUSMAN: So two questions,  
16 one very nitty-gritty and one much more  
17 conceptual. The nitty-gritty one is I was  
18 trying to understand the specification for  
19 misuse of prescription drugs, and is there an  
20 evidence base around that, and this  
21 particularly in an electronic record could be  
22 difficult to tease out consistently.

1                   And then the more conceptual one  
2           is maybe I'm not understanding how this  
3           measure will be reported, that as I'm reading  
4           it, it's going to include those who are  
5           screened and are negative, and those who are  
6           positive and have an appropriate follow-up.  
7           But if you have different rates of substance  
8           use in your underlying population, it's going  
9           to be very hard, I would think, to control for  
10          that different prevalence.

11                   The hard part of those who screen  
12          positive and get a brief intervention whereas  
13          if you're actually toting up everybody, and  
14          there's only a very small number of drug users  
15          in one population, a great number in another  
16          population, it's going to be carrying apples  
17          and oranges.

18                   That's more a matter that could be  
19          easily cleaned up with the actual  
20          specification of reporting. But at least as  
21          I read it now, it sounds like that would be  
22          sort of confabulated within it.

1 CO-CHAIR PINCUS: So just to add  
2 to that, I mean the example of that is in a  
3 study that we did, evaluating the quality of  
4 mental health services in the VA, in which we  
5 compared that to the databases. This is the  
6 administrative database, comparing that to a  
7 private sector database.

8 The VA actually did somewhat  
9 better, in some ways considerably better on  
10 all measures, except for those initiation  
11 engagement measures and substance abuse.

12 The reason was is that we think  
13 that the VA, in the population we looked at,  
14 had a 23 percent prevalence of substance  
15 abuse, and the private sector had one percent,  
16 and the VA was doing 100 percent screening,  
17 and they were identifying people with much  
18 less motivation, and likely they were less  
19 likely to follow up.

20 So there it is. So I don't want  
21 to extend it. It's just in responding to that  
22 sort of thing, just how you deal with that

1       problem.

2                   MEMBER SUSMAN:   Thank you.

3                   CO-CHAIR PINCUS:   Okay, Connie.

4                   MEMBER HORGAN:   Thank you, Harold,  
5       for asking your question about what exactly  
6       can be involved in testing, and this question  
7       relates to how creative can one be with  
8       testing.

9                   My understanding is that the  
10       efficacy on the drug measure really relates to  
11       it being a universal screen, and is there any  
12       opportunity for creativity for defining the --  
13       who is tested by perhaps high-risk populations  
14       or patients who have screened positive on  
15       alcohol and tobacco?

16                   Is that kosher in composite  
17       measures, to basically change what you're --  
18       the base across the three measures?   Because  
19       I think that one problem with the drug measure  
20       has been related to whether it's universal or  
21       not, and is that something that can be  
22       considered, or is it even kosher in a



1 composite measure to do something like that?

2 CO-CHAIR PINCUS: And then --  
3 Mike. And then we'll give you a chance to  
4 respond to the questions thus far. Right now,  
5 we'll go halfway and then let them respond,  
6 and go on. Because people won't be able to  
7 keep it in their head.

8 MEMBER TRANGLE: Okay. I'm coming  
9 from a practical perspective probably more  
10 than theoretical. We've been doing this for  
11 a number of years, you know, starting way back  
12 when with ERs and trauma units in hospitals,  
13 and expanding it to primary care clinics and  
14 then health plan case managers telephonically  
15 doing kind of SBIRT for folks with alcohol and  
16 opiates and soon to be benzos.

17 And as we've kind of worked with  
18 this, several thoughts occur to me. One is  
19 the fact that you're trying to get data from  
20 an EHR/EMR is really much better than trying  
21 to do it any other way. And to some extent,  
22 finesse, the issue that's plagued us forever

1       about who counts?

2                       Does it have to be a billable  
3       provider if it's claims-based, you know? When  
4       most of the evidence is you can take lower  
5       level people that don't need to really be  
6       billable providers to do this, as long as  
7       they're supervised and trained. So you  
8       finesse this huge issue that's beleaguered, I  
9       think, a lot of people trying to work on this.

10                   Two, in our state, as in a number  
11       of states, there are a lot of sort of  
12       coordinated initiatives going on, to sort of  
13       stem the tide of prescription drug abuse.

14                   We're finding that we're getting  
15       much better. I mean clearly a patient, if a  
16       prescription drug becomes hard to get or  
17       becomes too expensive, they'll just buy heroin  
18       cheaper on the street. So I know that there's  
19       a lot of flow back and forth.

20                   But we're beginning to get a  
21       handle on what's going on through our EMRs  
22       with prescription drug abuse that's really

1     pretty accurate, even though we don't totally  
2     get the sliding over to the guy on the street  
3     stuff. And we're having reports that we're  
4     starting to routinely see about, you know,  
5     whether they're sticking to our protocols and  
6     whether you can capture it automatically.

7                 I would encourage you to think  
8     about, is this a bite-sized, actually very  
9     feasible, doable piece that can show a big  
10    improvement, even though it's not all illicit  
11    drugs lumped with it, you know, because I  
12    think there's room to grow there, and maybe  
13    I'm also going against the room as a caution  
14    here, and well, I guess those are my two main  
15    thoughts.

16                CO-CHAIR PINCUS: So if you could  
17    respond to those comments thus far.

18                MR. WALLER: All right. So  
19    evidence on the type of brief intervention.  
20    So specifying the type of intervention. When  
21    I went through the list of who sits at this  
22    table, I saw a lot of psychiatric colleagues.

1     So the reality is the brief intervention,  
2     while there are standardized approaches, they  
3     sit under an umbrella of, you know, cognitive  
4     behavioral therapy, motivational interviewing  
5     and even mindfulness aspects of approach.

6                 So that becomes a delicate balance  
7     between how well you know the patient and  
8     anything, because you may know the patient  
9     where the brief intervention is. You know  
10    your wife wouldn't be very happy with this,  
11    and that may be more effective than following  
12    a full-on CBT.

13                I've had this conversation with  
14    now 85 primary care doctors. We have -- I  
15    work for a group that may have 400 primary  
16    care doctors in this medical group, and in  
17    having this conversation with them, they're  
18    going to brief intervene based on how they  
19    feel is best for the patient.

20                We all know that that's still, you  
21    know, throwing a handful of rocks at a target.  
22    So the reality is, is that I don't think that

1 we can truly move that needle without at least  
2 starting with the -- do the brief  
3 intervention, and then those that feel very  
4 uncomfortable will go to the education of how  
5 to do that, because we supply that education  
6 for what are the standard models.

7 But that's the one piece that's  
8 going to be difficult, is what brief  
9 intervention made the difference. So if you  
10 have one provider that falls out with more  
11 positives than another one, we're going to be  
12 able to figure out, because it is an eMeasure,  
13 because we can actually now look at population  
14 health statistics over a period of time to  
15 determine which providers do it better as  
16 compared to those that do not.

17 So I think early on, trying to  
18 specify, to over-specify the brief  
19 intervention may be actually a mistake, given  
20 the significant heterogeneity that exists  
21 within practice styles and approaches, and the  
22 fact that the brief intervention data is also

1     plagued by cultural inaccuracies, which  
2     populations it works best in and which  
3     populations it doesn't.

4                 So I think it also is one of those  
5     things that while tested, is only tested for  
6     the very specific populations that don't exist  
7     and from the peer world that we're trying to  
8     do that.

9                 Will they be tested separately?  
10    So it depends on how the EMRs bill them, to be  
11    honest. I mean if the EMR billed it as a  
12    package, and so if they billed it as a  
13    package, then it's going to be difficult to  
14    test it separately, because what you're going  
15    to get is a yes these were done as the measure  
16    comes out. If it's built --

17                CO-CHAIR PINCUS: Well, can't you  
18    specify about how -- I mean I guess, and Helen  
19    may want to explain to us. When we're  
20    approving a measure for testing, is it being  
21    tested along a particular protocol or it's  
22    totally up in the air what that protocol is?

1                   Because it seems to me that -- I  
2                   can't speak for the whole committee -- but  
3                   what people move toward is if you want to test  
4                   it, you want to test it both as a, you know,  
5                   either as a composite or as separate ones, so  
6                   that you modify it, given the fact that the  
7                   weakest link is the drug abuse piece.

8                   DR. BURSTIN: It's a good  
9                   question, Harold, and I think some of this is  
10                  I think when we were thinking through trial  
11                  measure use, we didn't really think some of  
12                  the first measures out the box would be  
13                  composites.

14                 It surprised us, and in fact this  
15                 is -- we've done this is in musculoskeletal  
16                 and they are all pretty simple measures. So  
17                 this is a little bit of a challenge. Our  
18                 current composite measure evaluation framework  
19                 really requires the analysis much more sort of  
20                 be at the level of a composite.

21                 Now in this case, being a trial  
22                 measure, we probably need to know a little bit

1 more about the validity in an individual -- at  
2 least the ones that aren't already endorsed.  
3 We could talk with PCPI on that.

4 MR. WALLER: In Epic, we're  
5 building this as each one individually and a  
6 composite, so it can be broken out. So I know  
7 it can be done, and they're connecting that  
8 still to the charge code of a brief  
9 intervention so that they can track it.  
10 That's any brief intervention within a defined  
11 office set.

12 So if it gets referred to a social  
13 worker for the brief intervention as compared  
14 to the provider, that will still count and it  
15 will connect, because they've connected that  
16 to the EMR.

17 DR. BURSTIN: But you know, one of  
18 the requirements is that composites can be  
19 unpacked, for the sake of quality improvement.  
20 I think they're going to have to be built  
21 individually.

22 MS. HANLEY: And also because the



1 individual data elements for each aspect of  
2 each of the measures will be collected  
3 separately, we will have that capability --

4 CO-CHAIR PINCUS: So we can -- so  
5 in principle, then, we can endorse this with  
6 an assumption that they will be able to be  
7 unpacked?

8 DR. BURSTIN: Yes.

9 CO-CHAIR PINCUS: Okay.

10 MR. WALLER: The next one was the  
11 evidence base for testing for misuse of  
12 prescription drugs. So we're at the point now  
13 where we can almost tell this without talking  
14 to the patient, I mean like you were stating.  
15 I mean so when you look into, you connect the  
16 electronic medical record with a health  
17 information exchange with a prescription drug  
18 monitoring program.

19 With the PDMPs, I mean you can  
20 pull a prescription drug monitoring program  
21 report, in all except for Missouri. And so in  
22 every state, you can pull that out and look at

1     this, to determine whether or not they're  
2     receiving prescriptions from other places.

3             You know internally whether or not  
4     they're calling early for prescription refills  
5     and things of that nature. So it's actually  
6     one of the easier things to tease out in a  
7     single practice nowadays. The question  
8     pathway is not as well developed as that for  
9     the misuse of illicit drugs, I mean, because  
10    that's what's been focused on for so long.

11            Because up until really the mid-  
12    to late 90's, we didn't write so many  
13    prescription drugs. That became the -- right.  
14    So in the end, it's the single-question effect  
15    has been shown to be really the easiest. In  
16    the last three months, have you taken your  
17    prescribed medication for something not  
18    indicated on the prescription, or for a reason  
19    other than it's prescribed?

20            That single question has been  
21    shown to be just as valid as any long-term  
22    input. So that's validated against known

1 mechanisms, but that single question seems to  
2 be just as valid. So that's why I think that  
3 this one has the ability to tease that even  
4 better.

5 We're testing this measure and,  
6 you know, as I say right now, in a couple of  
7 the pilot locations, we've already seen  
8 exactly what was seen earlier, was talked  
9 about earlier, in those pilot locations, a per  
10 person decrease in the opioids prescribed for  
11 chronic pain.

12 That is directly correlated with  
13 the percentage of the patients you screen  
14 positive for either illicit drug use or misuse  
15 of prescriptions, or alcohol or tobacco. So  
16 even the screening for those two have  
17 significantly impacted that with the  
18 education, that having a use disorder with any  
19 one of those increases your risk of having  
20 that.

21 So the screening piece has had  
22 really nice secondary effects already, and I

1 think a number of other people have shown that  
2 the screening by itself changes behavior for  
3 other things that negatively impact health,  
4 like prescribing an opioid to an opioid  
5 addict.

6 CO-CHAIR PINCUS: And Jeff's  
7 question?

8 MR. WALLER: That was the how  
9 reported prevalence?

10 CO-CHAIR PINCUS: Yes, the  
11 reported prevalence.

12 MR. WALLER: Yes. So if somebody  
13 says that they only have one percent of their  
14 patients that have a problem, they're not  
15 screening well. I mean I think that what  
16 we're -- what we're going to be able to do  
17 with this is also benchmark.

18 So what we haven't been able to do  
19 is actually benchmark the data set across  
20 hospital systems and providers, so that if you  
21 see in a population health statistic that  
22 you're two standard deviations from the mean,

1       you can guess that you're not doing it well.

2                   And it's not a matter of you have  
3       the best patients in the world. It's very  
4       much a matter of you're not asking the right  
5       questions in the right way at the right time.  
6       So I think that this is --

7                   CO-CHAIR PINCUS: Will you be able  
8       to report the percentage of people who are  
9       screened?

10                  MR. WALLER: Yes, absolutely.  
11       That's really important with this, because we  
12       need to determine --

13                  CO-CHAIR PINCUS: The percentage  
14       of people who screen positive?

15                  MR. WALLER: Yes, of those asked,  
16       of those screened for tobacco.

17                  CO-CHAIR PINCUS: And that's part  
18       of the report that comes out of this?

19                  MR. WALLER: Yes, and it's really  
20       one of the most important pieces, quite  
21       honestly, because we haven't even been able to  
22       benchmark this, this effect throughout, which

1 is why we sit at this abysmal ten percent  
2 seeking treatment number.

3 CO-CHAIR PINCUS: And so that,  
4 you're saying, in a sense is a balancing  
5 measure, as well as a performance measure?

6 MR. WALLER: Right, and so putting  
7 this out for testing in this way, I think, is  
8 really important, because it allows us to at  
9 least level set, you know, hospital systems  
10 and payors even to level set if the dollar  
11 they're spending is giving them the value for  
12 what they hope it will be, you know, in  
13 evaluating these patients for these very high  
14 risk.

15 The two biggest preventable causes  
16 for emergency department visitation is alcohol  
17 and illicit drug use. So this is a really  
18 important piece that we're going to be able to  
19 find with this measure.

20 MEMBER SUSMAN: But certainly it's  
21 possible, in fact probable, that certain  
22 populations have an increased risk of

1     underlying, for argument's sake, prescription  
2     drug abuse, or drug use overall.  So if I'm  
3     down at the homeless clinic seeing my  
4     patients, I think it's probably reasonable to  
5     expect the rates of screened positives, the  
6     overall true prevalence is a lot higher than  
7     some other population.  Not that I might not  
8     be missing some in either area but --

9                 MR. WALLER:  And I think we'll be  
10    able to find that and we'll be able to define  
11    that based on payor now, that the EMRs track  
12    that as, you know, it's beyond the specific  
13    data point.

14                So everything that's entered into  
15    a specific field can hold.  So we're going to  
16    be able to really define commercial versus  
17    public, you know, and private pay versus male  
18    versus female versus age range versus white  
19    non-Hispanic, Hispanic, Asian, African-  
20    American.

21                We'll be able to pull this data.  
22    All that stuff we can now start to cohort.

1 But at the same time, while those things are  
2 expected, I found that -- because one of the  
3 places that we piloted, that we're piloting is  
4 one of our good, nice places, and we're  
5 finding 16 percent positive rates in a working  
6 group with all commercial, with all of this  
7 and the primary care doctor calls me freaking  
8 out like twice a week now.

9 What do I do? My 72 year-old  
10 patient is smoking hooch on the side. I mean  
11 so I mean -- I mean but that's -- but these  
12 are things --

13 CO-CHAIR PINCUS: Tell her to  
14 smoke more.

15 (Laughter.)

16 MR. WALLER: But the reality is is  
17 that those are things -- yes, the highly  
18 technical term as a neuromolecular biologist.

19 CO-CHAIR PINCUS: Okay. So let's  
20 go -- let's now hear from Mike, Rhonda, Peter.  
21 I have a comment and then Raquel has further  
22 comment.



1                   MEMBER LARDIERI: Great, thanks.  
2           I guess my question is, is the brief -- does  
3           the brief intervention have to happen on the  
4           same day as the screen? Because if you're  
5           dropping it to a code to bill for SBIRT, you  
6           have to do 15 minutes, and that could be  
7           cumulative with all the staff, including the  
8           M.D.

9                   But if that's what you're using,  
10          most patients, the first time you talk to  
11          them, they don't want to deal with it. So you  
12          deal with it next time, and that's where the  
13          whole motivational interviewing stuff comes  
14          in, and maybe three times down the road before  
15          you're actually able to get your 15 minutes of  
16          intervention. So I'm wondering how that plays  
17          out.

18                  MR. WALLER: I can answer that  
19          quickly. It does not have to be on the same  
20          day, just within the specified 24-month  
21          period.

22                  CO-CHAIR PINCUS: Okay, Rhonda.

1                   MEMBER ROBINSON BEALE: This is a  
2                   very complex issue, to say the least. I just  
3                   have a couple of comments.

4                   On the drug use issue, National  
5                   Quality Forum several years ago sponsored, I  
6                   believe it was with NIDA, a national standards  
7                   work group, and out of that there was -- I was  
8                   co-chairing -- and there was a lot of argument  
9                   around the whole issue of screening the  
10                  general public around drug use.

11                  I think from that, there was a  
12                  recommendation for -- and it was heated, let  
13                  me tell you. It was not a fun time. At that  
14                  time, the recommendation was for high risk  
15                  populations, and even there was argument in  
16                  terms of defining what the high risk  
17                  populations were.

18                  Certainly those women who are  
19                  pregnant was high on the list. Adolescents  
20                  were high on the list. But then the issue of  
21                  other types of populations really got into  
22                  kind of issues of profiling populations and it

1 got kind of ugly. So that is when it became  
2 unclear.

3 I'm wondering whether or not with  
4 this measure, since there is that controversy.  
5 There's a lot of issues around this, whether  
6 or not what Connie was kind of suggesting, in  
7 terms of if this, then that, or if you have an  
8 identified high risk population, pregnant  
9 women, women who are pregnant and adolescents,  
10 there's enough data to suggest that there is  
11 high issues in terms of mortality and  
12 morbidity, particularly with women who are  
13 pregnant and with adolescents, the high  
14 prevalence.

15 If that might make an alignment at  
16 least with the guidelines, and therefore may  
17 be in a way more acceptable. Around the brief  
18 intervention, I just want to reiterate what  
19 you said around brief intervention, because it  
20 is -- falls in an area of psychosocial  
21 interventions.

22 You're absolutely right. There is

1     so much in the components of that, that makes  
2     it kind of -- it may appear to the general  
3     public as being kind of squishy when it really  
4     isn't. There are core elements within that  
5     that are still yet to be defined, and there is  
6     a committee that's kind of trying to work on  
7     defining that.

8                     One of the issues is that the  
9     components of that are not necessarily teased  
10    out. Like therapeutic alliance is a very core  
11    part of this, because if you have a good  
12    alliance with the patient, you can hopefully  
13    influence.

14                    But with that being said, I just  
15    want to support the issue that it has to  
16    remain somewhat vague like that, because it's  
17    not very well defined in the field.

18                    CO-CHAIR PINCUS: David.

19                    MEMBER PATING: As I'm actually  
20    listening to the discussion, I'm getting more  
21    excited about this measure and the possibility  
22    of answering some really important questions.

1       So my system has done alcohol screening now  
2       for three million people as a routine across  
3       all primary care services.

4               We continually do alcohol  
5       screening. We didn't go with drug screening,  
6       because we just didn't know the impact of it.  
7       So alcohol screening, we rationalize it,  
8       saying alcohol screening picks up 75 to 80  
9       percent of all comorbid drug use.

10              The question that I would be  
11       really interested in studying would be does  
12       alcohol alone, is that adequate? Is alcohol  
13       screening alone? Does alcohol plus drug  
14       screening add anything, or just drug screening  
15       alone pick up something that's more  
16       significant?

17              So I really like this combined as  
18       a measure, because I think you can't tease  
19       them out because of that. But that's the  
20       research question, is whether this adds extra  
21       value or not, and I'm just really excited to  
22       be able to dig into this data set, including

1 pulling out the pregnant populations, the  
2 young adults and seeing if it's high risk, if  
3 it should get a triple whammy as well, some  
4 other thing, you know.

5 So I just -- you don't need to  
6 comment there, but if you can later, just you  
7 know, the ability to segment these things just  
8 makes me very excited.

9 CO-CHAIR PINCUS: Okay, David.

10 MEMBER EINZIG: So I also think  
11 it's a very important measure. But my  
12 question has to do with I'm trying to think  
13 about this from a patient perspective.

14 So I'm a patient and I've been to  
15 my clinic twice in the past year, and I see,  
16 you know, my primary docs. I'm healthy, and  
17 I just see whichever doc, whichever provider  
18 is in the clinic.

19 So I'm going there for a sinus  
20 infection, sinusitis. So this screen is going  
21 to have to be applied to me. So I'm just  
22 trying to wrap my head around that. It seems

1     like a pop quiz, where if I'm going in for a  
2     preventive visit, I expect it.

3                 MS. HANLEY:   So for the  
4     eligibility --

5                 CO-CHAIR PINCUS:   Can we go to  
6     other questions.   Let's just kind of get  
7     through and then respond, just to keep it  
8     efficient.   Larry.

9                 MEMBER MILLER:   Yes, I think this  
10    is going to be a very important measure.   The  
11    question I have, and it's probably a very  
12    simple one, I understand that the intervention  
13    is met by a code, a CPT code or whatever  
14    that's done.

15                How would the screenings document  
16    that check that's been done is actually the  
17    results of the screening, so that you can look  
18    and see how those are done, and for different  
19    populations.   How is that sort of handled?

20                CO-CHAIR PINCUS:   So why don't we  
21    have you respond now after that, and then I  
22    have just one small thing and maybe Peter, you

1       could sort of summarize.

2                   MS. HANLEY:  So the -- regarding  
3       the intervention, a brief counseling, a brief  
4       intervention here is allowed.  So it does not  
5       need to meet the threshold for billing for  
6       that service.  So it can be a minimum of 5 to  
7       15 minutes.  The other -- can you repeat the  
8       second part of your question?

9                   MEMBER MILLER:  I'll try.  With  
10      that follow-up, so how has that even been  
11      documented if it's not a billing?  But that  
12      wasn't the question.  The question was about  
13      the screening, how is it done.

14                  MS. HANLEY:  The screening, thank  
15      you.  So those -- that information is captured  
16      in the electronic health record, with the  
17      result of the screening.  So if you're a  
18      tobacco non-user, if you don't use drugs at  
19      all, those answers are captured as part of the  
20      screening, and that's required as part of --  
21      to be able to report it from the EHR.

22                  MR. WALLER:  And that's the way



1     that we're building it right now in Epic, and  
2     Cerner is actually paralleling this at the  
3     same time, because we have both of those  
4     systems in our hospital, which is awesome.

5             But the reality is we're able to  
6     say on the soap, you know, if we're going to  
7     do an evaluation, then what we can do is say  
8     Question No. 2 is answered positive by more of  
9     these patients. So we can start to even  
10    validate some of those subsets of questions.

11            It's really going to be helpful  
12    for us, because we're making it -- so those  
13    that screen positive are actually trying to  
14    validate the 11 subsets of the DSM-5 for SUD  
15    on those independent factors, and those are  
16    being mirrored as well.

17            So yes. I mean we're going to be  
18    able to cohort this data to death. I mean  
19    that's the point of it. I mean we want to  
20    flog it at the end of the day. I mean it's  
21    going to evaluate everybody from 18 and up,  
22    and if you come in for your sinusitis, why do

1       you have that? Are you smoker?

2                       So these are -- it becomes very --  
3       I mean those are the questions that become  
4       realistic if you're, you know, the high risk.  
5       If you smoke and you have sinusitis, the  
6       chances of antibiotics helping decrease by 60  
7       percent. So it becomes highly relevant, even  
8       on a very basic issue.

9                       Chronic back pain absolutely does  
10      not get better in patients who smoke, you  
11      know. Chronic shoulder pain or bursitis,  
12      because you get drunk on Saturday nights and  
13      you sleep like this the whole time. Those are  
14      very specific questions that can -- you can  
15      elucidate cause and effect by asking these  
16      questions.

17                      But you're responsible for the  
18      vast majority of non, you know, emergent  
19      visits that come in if you have a respiratory  
20      illness --

21                      CO-CHAIR PINCUS: Could we move  
22      to, you know, sort of respond to Rhonda and

1 the two Davids?

2 MR. WALLER: Yes. So with  
3 Rhonda's question, so there's two pieces.  
4 One, I see all the pregnant patients in our  
5 county who are on controlled substances. So  
6 I agree that without question, that's a high  
7 risk population.

8 But what percentage of patients  
9 are currently screened in an OB/GYN office?  
10 Less than five percent nationally, because  
11 there is no requirement to push that out.

12 So less than five percent of moms  
13 are screened for alcohol or drugs. They're  
14 screened for smoking, because that's just a  
15 part of what's already on the EMR. But in  
16 general, less than five percent even do the  
17 screen, even on the highest risk population.

18 So that is definitely concerning  
19 to me, and I echo that. I've also been in  
20 some of those rooms with these conversations  
21 that were heated about -- most of that has to  
22 do with a fear of the perception of the

1 disease, and a worry about creating a those-  
2 patients approach when you cohort those, and  
3 whether or not this would be utilized as a  
4 negative for the patient rather than a  
5 positive for treatment or intervention.

6 This is -- since I've been  
7 involved in addiction medicine been Topic No.  
8 1, part of the problem is that this disease is  
9 treated in a closet, and getting it outside of  
10 that and allowing it to be aired as no  
11 different than diabetes or hypertension nor  
12 urinary retention.

13 It doesn't matter. It's the same  
14 thing. We have treatments, we have  
15 approaches, we have evaluations. But it  
16 starts with screening and asking the  
17 appropriate questions that are validated to  
18 give us an answer that we know it needs  
19 intervention.

20 So I think that this is an easy  
21 Step 1 in making the disease and the risk of  
22 the disease within a population visible, and

1 I think that if we're unable to take Step 1,  
2 Steps 2, 3 and 4 will never happen. So my  
3 concern is that the risk to our population by  
4 not asking these questions is made evident by  
5 the fact that we have more people die of  
6 overdose than car accidents in three-quarters  
7 of the states.

8 So the reality is not asking that  
9 question and then writing a prescription for  
10 an opioid or benzodiazepine or a combination  
11 of those two that causes all of this problem  
12 is, you know, quite honestly it escapes me why  
13 this hasn't already been asked for a decade.

14 I know the answers to that, but I  
15 think that this puts us in a position, and in  
16 really a wonderful timing situation, to be  
17 able to drop this into an electronic stream,  
18 so that we can pull population health data,  
19 which is going to allow us to understand on a  
20 large scale the impact, rather than, well,  
21 when I talked to my ten patients, I had a  
22 really good effect, or it didn't seem to work

1     for me, because that -- quite honestly, that  
2     anecdotal stuff doesn't really matters. It  
3     matters to the physician who gets the data,  
4     that says you need to figure out how to do  
5     this better or good job, continue to do that  
6     and maybe you can help your colleague.

7             But I think the reality is, is  
8     looking at the population health data also  
9     takes out the individual bias that seems to be  
10    worried about so much, because as this gets  
11    dumped into an EMR stream, you're going to be  
12    able to look at data sets and not people, and  
13    that becomes helpful for disseminating.

14            CO-CHAIR PINCUS: You need to  
15    shorten a response a little bit, and get to  
16    the two Davids' questions.

17            MR. WALLER: Sorry.

18            MEMBER PATING: Actually, I'm  
19    fine.

20            CO-CHAIR PINCUS: You're fine?  
21    Okay.

22            FEMALE PARTICIPANT: Well, if we

1 could just explain the denominator population.

2 Oh sorry.

3 MS. HANLEY: So for preventing --  
4 if a patient's coming in for their annual  
5 wellness visit, that visit alone will count  
6 for inclusion in the measure. Otherwise, we  
7 require two other types of visits. So again,  
8 if you don't address it at that one visit, you  
9 do have the opportunity of another one.

10 (Off mic discussion.)

11 MEMBER EINZIG: Just the  
12 complexity of if a patient sees a different  
13 provider at the same clinic, not a primary  
14 care provider per se but a different provider,  
15 it's --

16 MS. HANLEY: Is your concern that  
17 they would be included or not be included?

18 MEMBER EINZIG: Well, I'm just  
19 trying to think. So the process of patients  
20 coming in for their sinus infection or what-  
21 not. They're seeing the doc de jour. You  
22 know, they're not necessarily going to be

1 looking to see if the screen was done in the  
2 past 24 months. They're just there for a  
3 sinus infection, and they have no other  
4 history with this patient. So just real world  
5 scenarios.

6 MS. HANLEY: Yes. So it would --  
7 I mean because this is specified at the  
8 individual clinician level, it would require  
9 two visits with the same provider.

10 CO-CHAIR PINCUS: And Raquel had  
11 sort of a question, just coming back in terms  
12 of your response.

13 MEMBER MAZON JEFFERS: Okay. So I  
14 just want to also say that I do think that  
15 this is an incredibly important measure, and  
16 learning about the prevalence in primary care  
17 settings of substance use and bringing it, as  
18 you said, out of the closet is really  
19 significant.

20 I understand that the brief  
21 intervention today is more of an art than a  
22 science. But I'm wondering if you can't use



1     this measure in a way to help bring more of  
2     the science into the brief intervention, and  
3     try and understand a little bit more about  
4     what is working in terms of a brief  
5     intervention, because the way the measure is  
6     constructed now, we're not -- you're not even  
7     going to be gathering data on what in fact the  
8     brief intervention entailed.

9                 So it might be helpful to at least  
10    gather information on what in fact was done  
11    during that brief intervention, so that we  
12    could begin to accumulate information about  
13    what would be effective, what would be more  
14    effective, understanding that this today,  
15    we're working in more of an artistic world  
16    than a scientific world around the brief  
17    intervention.

18                CO-CHAIR PINCUS:  Thank you.  
19    Peter, you want to summarize?  I had a couple  
20    of comments, but I could do that at the end,  
21    because this actually doesn't require a  
22    response.

1 CO-CHAIR BRISS: No. Everybody's  
2 excited about the importance of the issue. I  
3 do want to make some comments. So one of them  
4 is that I think that the verbal description of  
5 the evidence is for the drug interventions  
6 doesn't match what's in the printed materials,  
7 and frankly what's in the various intervention  
8 studies.

9 So I think I'd encourage the  
10 developer to if you have data that isn't  
11 written down, that makes you feel more  
12 positive about these interventions, I'd  
13 encourage you to marshal it.

14 I do think this is going to be --  
15 as a primary care doc, I'm worried about  
16 professional burden of this measure and on an  
17 intervention that's mostly been untested.

18 And then the second thing that I  
19 would say is that there's clearly a lot of  
20 hope around the table about things that might  
21 be tested in measure testing. I'm skeptical,  
22 frankly. So think about what actually gets

1       written in the EHRs.

2                   You're not talking about a cohort  
3       setting. You're talking about real life  
4       clinical information. If you're lucky, you're  
5       going to have somebody say I addressed this  
6       issue, right, or have a checkbox that says I  
7       addressed this issue.

8                   You will not get information about  
9       quality of counseling. You will not get --  
10      you may get information about whether  
11      processes were done, but you will not get  
12      information about whether people's outcomes  
13      were better.

14                  And so we shouldn't over-emphasize  
15      the kind of -- some of the big questions about  
16      these are fundamental efficacy questions, and  
17      you will not get that information from EHR  
18      data, any kind of EHR data in any setting.

19                  CO-CHAIR PINCUS: So I think we're  
20      ready to vote. Oh Mady, last comment.

21                  MEMBER CHALK: I want to point out  
22      to Peter that the same applies to the measures

1 we discussed yesterday, follow-up for people  
2 with SMI on all of those measures and all of  
3 those exams tells you nothing about the  
4 counseling or the follow-up, and we didn't  
5 have big issues about that. So I don't want  
6 this particular composite measure to be held  
7 to a standard that wasn't used yesterday.

8 MEMBER SUSMAN: This is probably  
9 mostly for Helen. If I heard this discussion  
10 during one of our usual conversations, I'd say  
11 well, this isn't ready for anything. I mean  
12 we got all kinds of questions.

13 It seems more like a discussion  
14 with a very smart research associate, who's  
15 got, you know, lots of different ideas and  
16 projects they're going to do, all of which I  
17 find very exciting, and I don't mean to demean  
18 it.

19 But as far as sort of even close  
20 to prime time, I'm feeling really  
21 uncomfortable. So I'm not quite sure what  
22 NQF's intent for this group is at this point

1 in time before we vote.

2 DR. BURSTIN: That's a good  
3 question. You know, I think in our  
4 expectation, we came up with the concept of  
5 doing trial use was the idea that, you know,  
6 these weren't ready for testing, but they were  
7 ready for everything else.

8 So I do think you need to have a  
9 level of comfort about evidence that is  
10 equivalent to any other measure you would look  
11 at. So it's not as if you're going to have  
12 evidence re-examined as part of this trial.  
13 I mean I just -- just to be honest about it,  
14 it's not as if that's going to emerge.

15 We did hear a fair amount about  
16 what they could do in terms of the rates of  
17 the individual components that I think would  
18 give you a great deal more comfort about  
19 validity, you know, as much as we'd like to  
20 try to tease those apart, are so heavily  
21 related to each other.

22 So I think you need to decide is

1       there enough that these measures could move  
2       forward for trial use or, you know, is there  
3       still enough discomfort about the level of  
4       evidence of the four components? That's  
5       really why we have a standing committee. It's  
6       not for us to decide.

7               But again, keep in mind -- the  
8       last thing. Keep in mind that even if they go  
9       through this whole process, they are not  
10      endorsed. They're only approved for trial  
11      use.

12             So there is an expectation that  
13      these are sort of out there on a trial basis,  
14      with not an expectation that somebody could  
15      turn around and say these are endorsed  
16      measures, and let's use them to pay providers,  
17      et cetera. You would expect that other work  
18      to happen first.

19             MEMBER SUSMAN: Then could I just  
20      ask the measure developer, from your  
21      perspective, why do all -- it sounds like  
22      you're going to do this stuff pretty much

1        anyway. I mean does having the stamp of being  
2        an eMeasure for whatever this means, I'm  
3        sorry, the lingo, forget it.

4                    Does that have enough impact for  
5        you as the developer that it really is  
6        important?

7                    MS. HANLEY: You know, I think  
8        that at the national level, there is huge  
9        emphasis on measures, outcome measures,  
10       composite measures, patient-reported outcome  
11       measures. We're working very hard to try to  
12       advance the measurement field towards that,  
13       and this is one stop on that journey.

14                   DR. BURSTIN: And just from a  
15       national perspective, I'd also add, I'm glad  
16       you made that point. There's also just a huge  
17       interest in moving eMeasures out. So I think  
18       some of this is also just trying to put it out  
19       there, see what we learn, rather than waiting  
20       for the perfect, which could take a while in  
21       the eMeasurement space.

22                   CO-CHAIR PINCUS: So Helen, I'm a

1     little bit concerned that your last statement,  
2     you know, what you just said is in total  
3     contradiction of what you said before, well,  
4     you should apply exactly the same level of  
5     expectation, level. Because the reality is  
6     that, you know, there are more gaps in the  
7     evidence base for this measure than there are  
8     for the other measures.

9                 Part of the thing that's  
10     accounting for some of the enthusiasm about  
11     this measure is that we're going to get more  
12     evidence to be able to fill those gaps. So  
13     that if -- so in a way, particularly for this  
14     criterion, you know, it's -- you know so just  
15     talking in my own head, sort of walking into  
16     this, sort of how I was going to vote.

17                I was walking in here thinking  
18     like oh, there really isn't evidence for the  
19     drug abuse piece, and I was, you know, sort of  
20     kind of negative about that.

21                But hearing that this is actually  
22     going to get evidence that's going to inform



1       us in a better way has made me more  
2       enthusiastic and more likely to vote in favor  
3       of it. But now you're telling me that I  
4       shouldn't do that.

5                   DR. BURSTIN: Didn't mean to --  
6       yes. I didn't mean to confuse anyone. Let me  
7       just try it one more time. At least our  
8       initial conceptualization of this, and it's  
9       interesting. When I presented on some of this  
10      at Academy of Health, I got pushback on  
11      exactly the issue.

12                   Is it really just that the testing  
13      reliability and validity will emerge from  
14      testing, or in this world of electronic data,  
15      does evidence actually emerge from the work of  
16      putting it out there? I think that's a real  
17      question, is you know, will there be real-time  
18      evidence collection as a result of having this  
19      out there in trial use that would inform you?

20                   Frankly, that's uncharted  
21      territory. I mean again, it's trial use. So  
22      I think there's a bit more of an expectation

1       that it doesn't have to be quite as clear, and  
2       also at the end of the day, you're not saying  
3       this measure is endorsed. It doesn't meet the  
4       same standard.

5               So I'm not saying -- at least in  
6       terms of evidence, you may want to, for  
7       example, consider the fact that you do at  
8       least have an option of insufficient evidence  
9       with exception, which is specifically  
10      something where you think currently the  
11      benefits to patients could outweigh the harms,  
12      but you're not completely and totally  
13      convinced that it is, you know, right at this  
14      very moment something you could move on.

15             I'm not encouraging that. It's  
16      supposed to be an exception, but I just --

17             CO-CHAIR PINCUS: Well, what does  
18      that mean with exception?

19             DR. BURSTIN: It means with  
20      exception, literally that you would say --

21             (Laughter.)

22             CO-CHAIR BRISS: It means we want

1 to -- we believe that it's a good thing to do  
2 and we want to recommend it without evidence.

3 CO-CHAIR PINCUS: Right. So that  
4 counts --

5 DR. BURSTIN: That counts as a  
6 yes.

7 CO-CHAIR PINCUS: That counts a  
8 yes, okay. I just want to be sure, because  
9 it's listed as a 5, but so it counts as a 1 or  
10 a 2.

11 MEMBER TRANGLE: Why don't you  
12 just allow us to review the evidence when it  
13 comes back later, instead of saying review it  
14 now and never look at it again?

15 DR. BURSTIN: Because in general,  
16 most people will come back with only testing  
17 results that will have no impact on your --

18 MEMBER TRANGLE: I know, but can't  
19 we make an exception that way this time, with  
20 exception? That's how we define exception in  
21 this space.

22 DR. BURSTIN: I think that's --

1       that's essentially what this is, it's  
2       insufficient evidence. Do you believe that  
3       putting this measure out there will have  
4       significantly more potential benefits than  
5       harms?

6                   CO-CHAIR PINCUS: Out there for  
7       testing or out there for --

8                   DR. BURSTIN: Out there for  
9       testing. This is only for testing.

10                  CO-CHAIR PINCUS: Okay, oh. Well  
11       right.

12                  (Simultaneous speaking.)

13                  DR. BURSTIN: When it comes back  
14       -- the question is when it comes back --

15                  CO-CHAIR PINCUS: Let's, let's --  
16       okay. So Connie has a question and --

17                  MEMBER HORGAN: This is a follow-  
18       up to Harold, your question, and the issue is  
19       impact on unpackability. One concern with  
20       composite measures is you get a single score,  
21       and how actionable are the components. How  
22       unpackable is this measure going to be?

1 DR. BURSTIN: (off mic)

2 MR. WALLER: It is unpackable  
3 because they each independently have to  
4 happen. So we need to show that each of the  
5 independent factors happened, and then the  
6 brief intervention was done for any positives.

7 MEMBER HORGAN: Right. How usable  
8 will it be by a health plan to use it in that  
9 way, and why not have paired measures versus  
10 a composite measure, because you know, the  
11 ease of unpacking. I mean you could have a  
12 locked suitcase that's very difficult to  
13 unpack.

14 CO-CHAIR PINCUS: So let me see.  
15 Let me sort of just try to clarify, so that we  
16 can move ahead, because time is marching on  
17 and people have planes. So it sounds like if  
18 we -- that if we move ahead with sort of  
19 recognition of this measure for testing, that  
20 it could come back to us for endorsement  
21 either as separate measures or as a composite  
22 measure?

1                   MR. WALLER: I think that yes,  
2 ultimately. Because we're going to be able to  
3 determine the validity of the approach for  
4 each of those independently, you know, as far  
5 as --

6                   CO-CHAIR PINCUS: Just a yes/no.

7                   MR. WALLER: Yes.

8                   CO-CHAIR PINCUS: Okay, okay. Any  
9 other questions before we go to voting? Okay.  
10 Larry and Bob.

11                  MEMBER MILLER: I'm sorry. Just a  
12 quick technical question. Would this come  
13 back in three years like normal things or just  
14 when would this come back in terms of arguing  
15 this again?

16                  DR. BURSTIN: It has to come back  
17 within three years. It doesn't have to wait  
18 three years. As soon as they're done with  
19 their testing and their evaluation, we  
20 hopefully get it back much sooner than then.  
21 We don't want to wait that long if we don't  
22 have to.

1 CO-CHAIR PINCUS: Okay, Bob.

2 MEMBER ATKINS: The unpackability  
3 question. If somebody screens positive on two  
4 or three of the substance classes, will the  
5 counseling be one counseling for the complete  
6 set that they score a positive on? Or do they  
7 need three separate counseling sessions?

8 MR. WALLER: They would all need  
9 to be addressed, but it could be in one  
10 session.

11 MEMBER ATKINS: Okay. I don't  
12 know what that has to do -- it seems to me  
13 that might be complex, in terms of the  
14 unpacking. But you guys deal with that.

15 CO-CHAIR PINCUS: Yes, okay. So  
16 why don't we move ahead? So okay. So we're  
17 going to vote now on this issue about the  
18 evidence for the importance of the measure of  
19 concept, and just to clarify, that a 1, 2 or  
20 5 would allow the measure to go forward and  
21 for us to review the other criteria. Is that  
22 correct, Helen? Okay.

1 MS. DORIAN: Caroline, are you on  
2 the phone?

3 (No response.)

4 MS. DORIAN: All right. Does  
5 everybody have their clicker and ready to  
6 vote? Okay.

7 MS. BAL: Voting is now open for  
8 evidence. The options are 1 high, 2 moderate,  
9 3 low, 4 insufficient evidence, 5 insufficient  
10 evidence with exception, and as we said  
11 earlier, 1, 2 and 5 combined together would  
12 allow the measure to pass. One more.

13 CO-CHAIR PINCUS: Les isn't here.

14 MS. BAL: Is anyone else out of  
15 the room? We're missing one person on that  
16 side. Let's move forward with 22 then.

17 Okay. So the results for 2597  
18 evidence is high 3, moderate 5, low 0,  
19 insufficient 1, insufficient evidence with  
20 exception 13 and we'll move forward to gap.

21 CO-CHAIR PINCUS: Okay. So let's  
22 move forward, and Peter.



1 CO-CHAIR BRISS: Essentially  
2 everybody agreed that there was a large  
3 performance gap.

4 CO-CHAIR PINCUS: Okay.

5 MS. BAL: Okay. Voting for gap is  
6 now open.

7 [VOTING.]

8 MS. BAL: Okay. The results for  
9 gap for 2597 is high 17, moderate 5, low 0,  
10 insufficient 0, and we'll move forward to high  
11 priority. Would you like to discuss or just  
12 vote?

13 CO-CHAIR BRISS: No issues on  
14 priority.

15 MS. BAL: Okay. Voting is now  
16 open.

17 [VOTING.]

18 MS. BAL: Okay. The vote for  
19 2597, high priority, is high 20, moderate 2,  
20 low 0, insufficient 0, and we can also vote  
21 for the composite importance as a whole.  
22 Would we like to do any discussion or just

1       move forward with it?

2                   CO-CHAIR BRISS:   So it was  
3       articulated, and I think we've discussed the  
4       issues with the composite already.

5                   MS. BAL:   Okay.   Voting is now  
6       open.

7                   [VOTING.]

8                   CO-CHAIR PINCUS:   By the way  
9       Helen, you may want to modify this criterion  
10      for the purposes of e-measure testing, okay.

11                   (Pause.)

12                   MS. BAL:   We're just missing one  
13      vote.   Okay, we got it.   Thank you.   Okay.   So  
14      for the importance composite, for 2597, we  
15      have high 8, moderate 9, low 3, insufficient  
16      2, and we can move forward to the trial use  
17      specifications.

18                   CO-CHAIR BRISS:   So essentially  
19      the work group thought that it was cleanly  
20      specified.

21                   CO-CHAIR PINCUS:   Are there other  
22      comments with regard to the measure

1 specification?

2 (No response.)

3 CO-CHAIR PINCUS: I guess, just --  
4 I think there was some concern that Raquel had  
5 brought up about the specification of the  
6 counseling component.

7 CO-CHAIR BRISS: But as with many  
8 of the measures yesterday, you know, we talked  
9 about it. Sometimes we've essentially  
10 accepted a developer's argument that they're  
11 trying to be flexible, and I think that we've  
12 heard that argument again today.

13 CO-CHAIR PINCUS: Tami.

14 MEMBER MARK: I thought I heard  
15 that the specification is going to allow for  
16 easy billing. I just want to confirm that,  
17 because it seems important to, you know, to  
18 encourage that.

19 CO-CHAIR PINCUS: Could you speak  
20 a little closer to the microphone?

21 MEMBER MARK: I thought I heard  
22 that the specifications that allow for easy

1       billing, and I just want to confirm that,  
2       because it seems like adoption of the  
3       screening is going to be more encouraged if  
4       the specification is linked easily to billing.

5               MS. HANLEY:  As long as the  
6       counseling services provided meet the criteria  
7       to bill for that, it can absolutely be used  
8       for the measure.  But we're not measuring  
9       whether or not what's right to bill or not.  
10      So I'm clear by what you mean by easy billing.

11             MEMBER MARK:  Well, I mean maybe  
12      you could just articulate a little bit how  
13      like checking the boxes would be translated in  
14      a provider organization into something that  
15      would be billable.

16             MR. WALLER:  Yeah.  So basically  
17      you have three levels of brief intervention  
18      billing, and those are connected to the  
19      specification when it's started.  So I mean  
20      you go through the screening if it's positive.  
21      Then at the end, on your billing screen on the  
22      EMR, you can bill either -- you can put non-

1 billable brief intervention which is the  
2 really short version, like you chatted with it  
3 but it's not something that needs billing, or  
4 you can actually code it out as the specific  
5 E&M code for each of those two.

6 And it's literally the way that  
7 it's built into the EMR, check which one  
8 applies. Did you do extensive, you know, and  
9 it's based on time. So it's based on 15  
10 minutes is billable. If you do less than 15  
11 minutes, it's not billable.

12 Now that 15 minutes can be  
13 combined. So if the physician does a portion  
14 and another portion is done by their social  
15 worker or nurse, that can be combined billing,  
16 and that meets specs for reimbursement. So it  
17 can be billed out, even if the physician does  
18 half, and if the other half is done as team,  
19 then that can still be billed out so --

20 MEMBER MARK: So is the screening  
21 part billable or only if the screening leads  
22 to brief intervention is it billable?

1                   MR. WALLER: Screening is also a  
2 billable element. Whether or not it's paid  
3 is, you know, built on different payors.  
4 There is a code that can be levied for the  
5 screen.

6                   (Off mic comment.)

7                   CO-CHAIR PINCUS: Okay. So are we  
8 ready to vote on specifications?

9                   MS. BAL: Okay. The voting is now  
10 open.

11                   [VOTING.]

12                   MS. BAL: Just waiting for two  
13 more. If everyone could please vote.

14                   (Pause.)

15                   MS. BAL: So the trial measure  
16 specification for 2597 is high 4, moderate 16,  
17 low 0, insufficient 2, and we can move forward  
18 to feasibility.

19                   CO-CHAIR BRISS: Okay. So there  
20 are feasibility questions about this measure,  
21 which I think we've already discussed.

22                   MS. HANLEY: Just so everybody is

1     aware, we did do feasibility testing and two  
2     sites, a federally qualified health care  
3     network of clinics, and a solo practitioner  
4     family practice site, and that was included in  
5     your submission materials with the feasibility  
6     assessment.

7                   CO-CHAIR BRISS: And it does raise  
8     some questions though, because the solo  
9     practitioner scored high, and he or she was  
10    presumably motivated. The community health  
11    center didn't implement it very well, as I  
12    recall.

13                  CO-CHAIR PINCUS: Okay. Any other  
14    comments?

15                  (No response.)

16                  CO-CHAIR PINCUS: Okay. Let's  
17    vote.

18                  MS. BAL: Okay. Voting is now  
19    open for feasibility.

20                  [VOTING.]

21                  MS. BAL: Okay. The results for  
22    2597 feasibility is high 4, moderate 14, low

1       4, insufficient 0, and we'll move forward to  
2       usability and use.

3               CO-CHAIR BRISS: I don't think  
4       there's anything to talk about here that we  
5       haven't already talked about.

6               CO-CHAIR PINCUS: Okay. Any other  
7       comments?

8               (No response.)

9               CO-CHAIR PINCUS: Okay. Let's  
10      move to voting.

11              MS. BAL: Okay, voting is now  
12      open.

13              [VOTING.]

14              MS. BAL: Okay. The results for  
15      2597 usability and use, high 10, moderate 9,  
16      low 1, insufficient 2, and we'll move forward  
17      to the overall vote, unless you would like  
18      further discussion.

19              (Off mic comments.)

20              MS. BAL: Do you want more  
21      discussion or no?

22              CO-CHAIR PINCUS: Any further



1 discussion?

2 (No response.)

3 CO-CHAIR PINCUS: Okay.

4 MS. BAL: Voting is now open.

5 [VOTING.]

6 MS. BAL: Okay. So for overall  
7 suitability to be a trial measure for 2597,  
8 the results are yes 20, no 2. So this measure  
9 will be a trial measure -- trial use measure.

10 MR. WALLER: I'd like to thank the  
11 Committee for their time in looking at this.  
12 I know it was confusing, so thank you.

13 CO-CHAIR PINCUS: Okay. So thank  
14 you very much. I think Helen, we were glad to  
15 be a guinea pig for NQF on this process. I  
16 think we learned a lot. I think it's  
17 interesting. I think there's a -- you know,  
18 I think there's a reality that, you know,  
19 almost by definition, you have to apply  
20 different standards, because you're trying to  
21 get information.

22 So it really is not looking out

1       there that, you know, that whether or not this  
2       should be used, but really will this generate  
3       information. I guess a couple of just  
4       recommendations to the developer, just a  
5       couple of things, just comments.

6                   I received an email from Rich  
7       Sates, sort of raising a series of issues,  
8       raising a series of issues, and he had asked  
9       me to bring it up. I didn't do it, because  
10      it's clear that he, not being part of this  
11      interaction, wasn't completely informed about  
12      all the issues. I suggest you might want to  
13      contact him to --

14                   (Off mic comment.)

15                   CO-CHAIR PINCUS: And the second  
16      thing is -- the second thing is NIDA had a  
17      recent meeting that Connie and I were both at,  
18      in which they are sort of actually developing  
19      these common data elements as part of their  
20      clinical trials network, and actually looking  
21      at sort of specifying measures, and it would  
22      be good to coordinate with them.

1                   Okay, good. So now we're going to  
2                   move to Measure 2599, and Peter's going to  
3                   chair and Mady's going to be --

4                   CO-CHAIR BRISS: So this is  
5                   alcohol screening and follow-up. It's  
6                   another, and would the developer like to pick  
7                   this up?

8                   MS. DORIAN: So just to note,  
9                   we're not sticking with the original agenda.  
10                  2605 was up next, but we're going to do 2599  
11                  and 2600, and then 2605.

12                  MS. HUDSON SCHOLLE: Good morning.  
13                  So we're continuing on our journey  
14                  to look at care for people with serious mental  
15                  illness. So this morning, there are two more  
16                  measures that we're going to review, that  
17                  address alcohol and tobacco use, and so these  
18                  are similar to the BMI measure that we  
19                  discussed yesterday.

20                  So again, these measures looked at  
21                  existing measures from the existing NQF-  
22                  endorsed measures. All three of the measures,

1 BMI screening, alcohol screening and tobacco  
2 screening, all three of those measures are set  
3 up as screening and follow-up.

4 So this is not about full  
5 treatment. This is about getting people  
6 connected and doing the first step in follow-  
7 up of a positive screen. The alcohol measure  
8 focuses on people with serious mental illness.

9 So the two changes that we made  
10 were we took that existing provider level  
11 measure, that looked for screening and  
12 immediate follow-up at the time of the  
13 screening, and we adjusted it for reporting by  
14 health plans for the SMI population.

15 So the denominator is now people  
16 with serious mental illness, and the numerator  
17 is looking for two events of counseling. Now  
18 there's a question about what should count as  
19 meeting this numerator, and so we allow two  
20 events of counseling.

21 There was a question, I think,  
22 whether medication use would be consistent for

1 alcohol. We did not -- I'm sorry, and but  
2 that was not included in the original measure,  
3 which focused on counseling, and so it's not  
4 included here.

5 The counseling can occur at the  
6 visit by the provider who conducted the  
7 screening, or it can be other kinds of events.  
8 We increased the expectations to two events,  
9 given that this is a high risk population and  
10 this single event was -- our panel thought  
11 that a single event was not sufficient.

12 Okay. I'm sorry. I'm speaking  
13 right into the mic. Okay, okay, exactly. So  
14 the numerator requires two events of  
15 counseling. It can be conducted at the visit  
16 at the time of the screening, or it can be --  
17 and those two events have to occur within  
18 three months.

19 They can be done by any kind of  
20 provider, including a health plan care  
21 manager, if the health plan can document that  
22 follow-up. I think that's where I'll stop.

1 I mean we based this on evidence about the  
2 prevalence of alcohol use, and this was tested  
3 in a way that was similar, in the same sets of  
4 health plans.

5 I will note that we were -- that  
6 people with an existing alcohol use disorder  
7 are excluded from this denominator because  
8 they have already been identified. This is  
9 about identifying new cases. So a number of  
10 people in this population are already  
11 identified, so that decreases the denominator.

12 It also -- what we found in our  
13 testing was a very low rate of positive  
14 results, which our stakeholder group said  
15 doesn't make any sense at all. So we were --  
16 that's what we found.

17 Now we largely had access only to  
18 medical records. So it's likely that the  
19 alcohol use might have been identified and  
20 addressed in behavioral health care. But as  
21 we talked about yesterday, even though we were  
22 in places where we -- theoretically where the

1 plan had access and their nurses were able --  
2 the plan requested behavioral health records,  
3 they did not always get those in time for this  
4 review.

5 MS. LIU: I'd just add that these  
6 measures are to address the comorbid  
7 condition. So you see that for the SMI  
8 population, we try to address their alcohol  
9 use, screening and follow-up, and also tobacco  
10 use for both SMI and the AOD population.

11 We also reviewed these measures  
12 with the original measure developers and  
13 stewards, and they felt our adaptation of  
14 these measures made sense, given that these  
15 are applying to another vulnerable population.  
16 The results, as Sarah mentioned, demonstrated  
17 that there was a gap in care and there was  
18 disparity.

19 CO-CHAIR BRISS: So let's let Mady  
20 key this one up for the Committee, and then  
21 we'll have a discussion.

22 MEMBER CHALK: Clearly, there's a

1 performance gap that was identified by the  
2 measure developers. However, the data are  
3 very limited, because the alcohol screening  
4 and brief counseling measure has only been  
5 recently endorsed by NQF. So it hasn't been  
6 terribly well used out there.

7 No issue with regard to  
8 reliability. The issue of validity remains,  
9 as we talked about some yesterday. But in  
10 this one, the measure -- I still have issues  
11 with the fact that the measure was not tested  
12 in commercial health plans, but was tested  
13 only in a variety of Medicaid and Medicare  
14 plans, and that the data was shockingly bad.

15 I mean it's much worse than the  
16 data that we saw about the measures yesterday.  
17 I mean it's almost -- there was one -- one of  
18 the plans only screened one person. So  
19 there's, you know, I don't -- it is of big  
20 concern to me that we push, we endorse a  
21 measure like this with those kinds of issues  
22 and lack of testing.



1                   No issues with feasibility,  
2           because alcohol claims are not difficult to  
3           identify and reference. Usability, as the  
4           first reviewer, this is coming just from me.

5                   I have, as I said yesterday, some  
6           major concerns about pushing forward quality  
7           measures such as this, that come with no  
8           action plan to help them be implemented  
9           appropriately and useful and move, related to  
10          improving quality.

11                  I don't have any expectations  
12          personally that this measure will do anything  
13          more than has happened with the screening  
14          measures for alcohol and -- well, for alcohol,  
15          that we have -- that NCQA has currently, which  
16          haven't moved at all. So you can take that  
17          for what it's worth.

18                  There are significant disparities  
19          in the care that was provided, but NCQA talked  
20          about that a minute ago. Only a third of the  
21          people, about a third of the people who were  
22          screened have follow-up in the three Medicaid

1 plans, despite the fact that we know that  
2 alcohol is heavily implicated in major chronic  
3 illnesses for people with serious mental  
4 illness.

5                   There was good face validity.  
6 However, there is one issue that was of deep  
7 concern to me, and that has to do with the  
8 fact that the two events that NCQA just talked  
9 about of counseling, the specifications were  
10 amended to allow self-help services to be  
11 documented in the clinical record, which means  
12 AA, and to this reviewer, that's unacceptable.

13                   MEMBER MAZON JEFFERS: So I'm just  
14 trying to, in my head, reconcile three things:  
15 The intended use of the measure at the health  
16 plan level, the care setting that people with  
17 SMI are normally treated in, and the evidence  
18 of effectiveness for the SBI in that SMI  
19 population.

20                   So I think I understand that the  
21 intended use is at the health plan level, and  
22 that people with SMI would be screened in a

1 primary care setting for the alcohol use.

2 My understanding of a normal  
3 clinical pathway for someone with SMI is that  
4 I don't know how much contact they have with  
5 their primary care physician, and whether the  
6 care setting, screening them for their alcohol  
7 use makes sense to happen in the behavioral  
8 health setting, or in the -- in the primary  
9 care setting.

10 I guess you're going to tell me it  
11 could be used in either, but it's a little  
12 confusing, and then the third thing is that as  
13 was discussed before, screening and brief  
14 intervention is more effective for alcohol  
15 use, in terms of changing outcomes, in a  
16 population that has mild to moderate substance  
17 use.

18 The SMI population really might  
19 not fall into that category. It might not be  
20 the most effective population to engage using  
21 SBI.

22 CO-CHAIR BRISS: I'd like to focus

1       us on what -- try to focus us on one issue at  
2       a time. So if we -- if for now we can talk  
3       about the evidence things, we'll come back to  
4       the rest of the criteria.

5               MEMBER SHEA: This is just a brief  
6       question. Just looking at the specifications,  
7       one of the screeners was the CAGE, but I know  
8       we had a large discussion about how the CAGE  
9       really wasn't a good screener. It's more for  
10      someone who has dependence, and so I was just  
11      wondering about that.

12             MEMBER TRANGLE: This is more of a  
13      technical question. I mean we've been doing  
14      this, and my own perspective is as an  
15      integrated system, we're trying to do it at  
16      the plan level telephonically. We're trying  
17      to do it in primary care and behavioral  
18      health.

19             I heard you say a plan phone call  
20      well documented counts. Is that also true if  
21      it's a nurse or care manager in primary  
22      care/behavioral health? It's documented but

1       they're not a billable provider? Is it coming  
2       from the EMR or is it claims-based I guess is  
3       what I'm asking? Could it be both?

4               MS. HUDSON SCHOLLE: Okay. So it  
5       is plan level. So that's right. It counts.  
6       It doesn't have to be a claim. It could be  
7       either a claim or documentation in the medical  
8       record, or documentation, wherever the health  
9       plan might document that case management  
10      service. So I think what you suggested about  
11      the nurse, that would count.

12             MEMBER TRANGLE: Okay. As long as  
13      it's documented in the EMR, it can be  
14      abstracted somehow.

15             MS. HUDSON SCHOLLE: Right.

16             MEMBER TRANGLE: Whether there's a  
17      billable provider or not.

18             MS. HUDSON SCHOLLE: Right, right.  
19      So we're looking for the documentation or the  
20      screening and the service, okay. So there's  
21      not a requirement about who does it. The  
22      second thing is it is intended to be wherever

1       it happens, right?

2                   It could be in primary care or it  
3       could be in the behavioral health setting.

4       It's just to make sure that it actually is  
5       documented and addressed. The third question  
6       is about which, the CAGE or the audit or what  
7       actually counts.

8                   So in the original measure that  
9       we're building on, anything counts  
10      essentially. The CAGE or the auditor both  
11      listed, as well as documenting frequency and  
12      amount of alcohol use. So it's basically  
13      documentation of any kind of alcohol use.

14                  In terms of is this the right  
15      intervention for this population, I think this  
16      is something that our Committee struggled  
17      with, and again, this measure is mostly about  
18      trying to make sure people get on the pathway  
19      to treatment, okay.

20                  So counseling and it's based on  
21      the SBIRT logic. But the panel felt very  
22      strongly that we needed to capture efforts to

1 connect people to peer support, peer-lead  
2 interventions, as well as other interventions.  
3 That's why this has been a constant criticism  
4 of our existing measures that look at  
5 initiation, engagement and treatment, and  
6 concern about that.

7 Because this is about connecting  
8 people to service rather than evaluating the  
9 completeness of their treatment, then that's  
10 why the panel felt like this measure of  
11 screening and making an active step towards  
12 follow-up, that that was a reasonable thing.

13 The issue is to have it documented  
14 in a record where it could be identified, and  
15 that was a strong recommendation from the  
16 consumer members of our panels.

17 MEMBER ZUN: So as I read the  
18 numerator, it says receive two events of  
19 counseling to identify alcohol abuse; is that  
20 correct? And so the problem I have with that  
21 is we know that many problem drinkers are  
22 recalcitrant to follow-up and treatment. But

1 then you're holding the plans accountable for  
2 ensuring that the patient actually gets that.

3 So you know -- so from my  
4 perspective, you know, you can lead them to  
5 the paper but you can't make them drink. So  
6 if we hold them accountable for leading to the  
7 water, and not necessarily making them drink.  
8 So we can't control them actually going to  
9 those appointments or going to AA, or getting  
10 any intervention.

11 The responsibility of the plans  
12 are to make the referral, to connect them.  
13 But whether they go or not, you know, how do  
14 we enforce that with anyone?

15 MEMBER MILLER: I think this is an  
16 incredibly important issue, the co-occurring  
17 disorders. We were talking about it last  
18 night while we were drinking wine, the work  
19 I've done to really pull this together in  
20 Arkansas, and we've done that to some extent.

21 My concern is, following up on  
22 Raquel's question about the -- and at the CMHC



1 level, for instance, Medicaid in our state  
2 does not pay for alcohol treatment. So even  
3 if there is the screening, there's no  
4 incentive to do it. There's no incentive to  
5 do it because no one pays for it, and I'm sure  
6 there are other plans like that as well.

7 Now in the future we will be,  
8 hopefully starting in January, if the  
9 legislature doesn't push that back. But I'm  
10 concerned about the operationalizing of this  
11 and the evidence that this really going to  
12 happen, and is there incentive to do it  
13 because there's no process for paying for it?  
14 I think that's an incredibly important  
15 consideration that we found already.

16 MEMBER ROBINSON: Last question I  
17 can ask, I guess.

18 CO-CHAIR BRISS: That's right.  
19 This is your last chance. Make it a good one.

20 MEMBER ROBINSON: I'm off the  
21 island, okay. Okay. So obviously there's a  
22 huge problem if the testing only revealed a

1 very small amount of screening that's going  
2 on, and there were substantial research done  
3 in the past that shows 60 to 70 percent of  
4 those individuals with SPMI that were  
5 hospitalized had some type of alcohol and/or  
6 drug use.

7 So we're definitely missing the  
8 boat with this. I'm just not clear, number  
9 one, several things. With this being a health  
10 plan measure, I agree with the gentleman down  
11 the table. Sorry, I can't see your name tag  
12 from here.

13 Okay, Larry, that this could be a  
14 very difficult measure for a health plan and  
15 would be more appropriate for a health system.  
16 Whether it's a facility inpatient, an ER or a  
17 primary care practice or outpatient behavioral  
18 health practice, primarily from the standpoint  
19 of you that -- and I say that from the  
20 standpoint of you, the direct motivation, if  
21 the way of being able to apply this is clear.

22 I agree with the gentleman down

1 the table, that there's so much variation  
2 amongst the states as to how substance use  
3 disorders are paid for, that it really becomes  
4 real complicated to even implement, because of  
5 the barriers just from a benefit perspective.

6 So I guess those are my concerns  
7 about it. My question is is the counseling  
8 that can be counted, are there specific codes  
9 for this that would help differentiate the  
10 counseling from any type of psychotherapy that  
11 this population would naturally receive, and  
12 would this also require in the specifications  
13 the use of a diagnosis if there is a positive  
14 screen, because that's another issue that is  
15 problematic in this regard.

16 CO-CHAIR BRISS: So let's take a  
17 second and let you make some responses.

18 MS. HUDSON SCHOLLE: Okay. So the  
19 last question, does it require a diagnosis?  
20 No, okay. There's nothing where we say that.  
21 It's just a positive screen. So we're not  
22 looking at any diagnostic information. We're

1 really looking at the services codes and all  
2 of that could be billed in the medical --

3 I mean it could be described in  
4 the record or in the care management record,  
5 without actually providing a diagnosis of  
6 alcohol use disorder, right, because this is  
7 for unhealthy alcohol use, not -- maybe not  
8 reaching the disorder criterion.

9 The second question or previous  
10 question was about who's accountable? Where's  
11 the right level of accountability, and so, you  
12 know, in our experience, primary care  
13 providers hate measures like this, that  
14 require them to do things that -- where they  
15 are concerned about whether they have either  
16 the expertise on staff or a connection to the  
17 specialty services that their patients might  
18 need.

19 And in particular for this  
20 population of people with serious mental  
21 illness, what we're looking at is something  
22 that actually should happen in behavioral

1 health. If it doesn't happen in behavioral  
2 health, you want it to happen in primary care.  
3 You want people to be thinking about the  
4 comorbid condition.

5 So that's why, in our view, having  
6 the health plan responsible says health plan,  
7 make it happen and make it happen wherever it  
8 makes sense within your network of providers.  
9 So and I -- and we are cognizant of the  
10 challenges of the fragmentation of services  
11 for mental health, substance abuse and general  
12 medical care, and who pays for it where.

13 I can't -- we started with 50  
14 plans that wanted to test these measures. We  
15 found three that were still able to test the  
16 measures, because we had -- we said you had to  
17 be responsible, and we went through a lot of  
18 states where the states carved things out, and  
19 we had plans willing to test it, particularly  
20 plans that were serving dual eligibles, where  
21 Medicare expects some things and then the  
22 Medicaid program might carve things out.

1                   So if you think about this whole  
2       suite of measures, they're really assuming or  
3       arguing for coordination and integration of  
4       care, and so in an -- so they assume, they  
5       require the sharing of information across all  
6       those diverse settings, and they put the  
7       accountability at the health plan, because the  
8       health plan may be paying for, you know,  
9       multiple pieces of that.

10                  It could be that the state is  
11       really, and the state and Medicare and  
12       commercial payors as well, that create this  
13       kind of fragmentation, these measures, if they  
14       want these measures, they're going to have to  
15       think about well how do we make this happen?

16                  So you know, just saying that  
17       those systems don't talk and we're not  
18       accountable, yes and people with SMI really  
19       should be screened and get some follow-up if  
20       they have an alcohol problem.

21                  CO-CHAIR BRISS: So if possible,  
22       I'd like to quickly come back up this way, and

1       then vote on the evidence, please. Okay,  
2       Jeff.

3                   MEMBER SUSMAN: So just a very  
4       brief comment, and mostly in reaction to Les.  
5       I think we've gone beyond being able to say  
6       oh, it's our job to lead the horse to water,  
7       but not to make them drink.

8                   I think the developer captured  
9       that in her last remarks around, you know, at  
10      a health plan or at system level, I think we  
11      need to figure out ways to get the horses to  
12      drink.

13                  It is our responsibility, and we  
14      used to say that about a lot of things that  
15      we've been able to make substantial  
16      improvement, progress on. So while we may do  
17      a really awful job now and have a single  
18      person, I think that is all the more reason to  
19      go down this path and support development in  
20      this arena, to provide the data and make it  
21      compelling, and to not only lead horses to  
22      water, but find ways to creatively get them to

1 drink.

2 CO-CHAIR BRISS: Michael. Stop  
3 drinking, yeah. Or substitute water for  
4 whatever else they want to drink perhaps.

5 MEMBER TRANGLE: So unlike Jesus,  
6 it's not going from water to wine. We're  
7 going to the other way. But I want to  
8 piggyback on that, in that as a system that's  
9 been doing this and trying to do this better,  
10 we do SBIRT in the hospital.

11 We do it at different places. You  
12 know, not perfectly obviously, but a lot of  
13 people, you know, it's not -- we're in a world  
14 where it's not a total closed system. We're  
15 not a Kaiser.

16 So especially in a CD, people go  
17 all over the places for where they're going  
18 to get their treatment or not, and to have a  
19 measure that ideally -- it would be ideal for  
20 this measure to span health plans and the  
21 joint commission, you know, so that in some  
22 sense, both could be requiring it.



1                   But it's a way of compiling data,  
2                   so that everybody has to share their data and  
3                   kind of work together, to find out where  
4                   they're going and what's happening. If you  
5                   leave it splintered, you know, with the  
6                   hospital world not thinking about it, the plan  
7                   world thinking about it and whatever's going  
8                   on in primary care and behavioral health,  
9                   segmented off.

10                   The more we could have these  
11                   measures cross all systems, the more we're  
12                   going to learn, the more we'll be forced to  
13                   sort of improve what's happening for patients  
14                   in a more coordinated way.

15                   CO-CHAIR BRISS: So I hope we can  
16                   go through Bob and Mady relatively quickly,  
17                   and then try to get to a vote, please.

18                   MEMBER ATKINS: So every one of  
19                   our health plans, our business rules, if  
20                   someone's positive for mental illness, we  
21                   screen them for substance use. Because of all  
22                   the things you talked about, clinically,

1 passionately I agree with you.

2 I think you have two measures  
3 here, not one, and they have different kinds  
4 of issues involved. I think there's a to what  
5 extent do people get screened, which is a  
6 really important question, and then do you do  
7 something about it, and the something --

8 Because we have plan states that  
9 don't cover it, because it's program funded  
10 through the Department of Addiction Services.  
11 But then our care managers are supposed to  
12 coordinate outside of Medicaid to make it  
13 happen.

14 So I think I haven't read in this  
15 that you can capture effectively the work  
16 that's done for the second metric, which is  
17 have you done something to hook them up with  
18 the service, and if I have it in a progress  
19 note in my computer system, I'm not sure that  
20 the metric will very effectively pick that up.  
21 So I think it's two metrics.

22 CO-CHAIR BRISS: So that issue

1 might be -- that issue might be more about  
2 reliability and validity than importance to  
3 measure. So Mady, will you finish us up  
4 please, and then let's go to a vote?

5 MEMBER CHALK: Okay. So while I  
6 agree with Michael about the importance, I  
7 still have to ask the same question I asked  
8 before, which is does follow up for people on  
9 Body Mass Index and screening, is pure support  
10 good enough to count as counseling?

11 CO-CHAIR BRISS: So is the  
12 question you're asking, Mady --

13 MEMBER CHALK: Is it the same  
14 standard that you're using for the alcohol and  
15 SMI measure or not?

16 CO-CHAIR BRISS: So is the issue  
17 that there's really not an obesity-related AA?

18 MEMBER CHALK: No, it doesn't have  
19 -- well, there is as it turns out. There is  
20 as it turns out. Overeaters Anonymous, and  
21 it's across the United States, that group.

22 I want to know if that's adequate

1     care for somebody with serious mental illness,  
2     and are you saying that for alcohol it is  
3     adequate care, but it's not adequate for  
4     people who are obese?

5                   CO-CHAIR BRISS:  So do you want to  
6     make any other comments or extensions?  Fine.

7                   (Off mic comments.)

8                   MS. HUDSON SCHOLLE:  Our panel  
9     recommended that we include it in this step,  
10    because they felt like if four, that this  
11    would -- that that is a reasonable follow-up  
12    step for people with healthy alcohol use.  Not  
13    substance use disorder.  We have a separate  
14    measure that looks at the substance use  
15    disorder and engagement and treatment.

16                  MEMBER CHALK:  Body mass index is  
17    not a disorder.  It doesn't show up.

18                  CO-CHAIR BRISS:  So let's -- this  
19    has been a spirited discussion.  Let's try  
20    moving through the voting on importance to  
21    measure and report please.

22                  MS. BAL:  Voting for evidence is

1       now open.

2                       [VOTING.]

3                       MS. BAL: We're only at 20 and we  
4       need three more votes. If everyone could just  
5       vote please?

6                       Never mind then. All right. So  
7       for evidence for 2599, we have high 7,  
8       moderate 11, low 1, insufficient evidence 1  
9       and sufficient evidence with exception 1. So  
10      we'll go forward to gap, and do we want to  
11      discuss or just start voting for all the  
12      importance ones?

13                      CO-CHAIR BRISS: Does any -- I  
14      think we've likely talked about this already.  
15      Does anybody feel an urgent need to say  
16      anything else that hasn't been said?

17                      (No response.)

18                      CO-CHAIR BRISS: Hearing none,  
19      let's move to a vote.

20                      MS. BAL: Okay. Gap is now open.

21                      [VOTING.]

22                      MS. BAL: Okay. So for gap for

1 2599, we have high 17, moderate 3, low 1,  
2 insufficient 0, and we'll move forward to high  
3 priority. Voting is now open.

4 [VOTING.]

5 MS. BAL: Okay. The results for  
6 high priority for 2599 is high 18, moderate 3,  
7 low 0, insufficient 0. Now we can move  
8 forward to scientific acceptability.

9 CO-CHAIR BRISS: So it seems to me  
10 that we've opened many of these issues  
11 already. Are there other comments on  
12 reliability or validity that haven't already  
13 been made that folks would like to address?

14 MS. HUDSON SCHOLLE: I just want  
15 to clarify that this is set up as a what we  
16 call hybrid measure, right, where we identify  
17 the denominator from claims data, and then the  
18 chart, the numerator can be identified either  
19 from claims data or from medical records  
20 review or other supplemental data that the  
21 health plan has.

22 So the progress note discussion

1 documentation, right, would count or a nurse  
2 in the clinic. But it has to happen twice.  
3 So you can't just say we referred them to the  
4 other clinic. It has to say "referred," and  
5 then there's a visit to the clinic.

6 (Off mic comment.)

7 MS. HUDSON SCHOLLE: Would allow  
8 it to -- the hybrid methodology would allow  
9 the plan to review medical records.

10 (Off mic comments.)

11 MEMBER ATKINS: I'm not the expert  
12 at hybrid methodology, but I've always  
13 understood it means we send people out to  
14 providers, and look at their charts. I didn't  
15 know that we could do an internal review of  
16 our internal plan records as part of hybrid  
17 methodology. So maybe I just learned  
18 something. I just didn't know that.

19 MS. HUDSON SCHOLLE: Trust me,  
20 your plans know how to do this.

21 CO-CHAIR BRISS: So Mike.

22 MEMBER LARDIERI: I'm just

1       confused. So how do you document the peer,  
2       because peers don't have a record?

3               MS. HUDSON SCHOLLE: It would have  
4       to be documented in the record, saying not  
5       that the person was referred to AA, but  
6       "person reports that they are attending AA."

7               MEMBER LARDIERI: Oh, okay.

8               CO-CHAIR BRISS: So other comments  
9       on reliability and validity?

10              (No response.)

11              CO-CHAIR BRISS: Let's move to  
12       voting, please.

13              MS. BAL: Okay. Voting for  
14       reliability is now open.

15              [VOTING.]

16              MS. BAL: So the final result is  
17       high 0, moderate 12, low 8, insufficient 1 for  
18       2599, and that will actually put us in the  
19       gray zone, but we'll move forward, and voting  
20       -- unless you want to speak further.

21              CO-CHAIR BRISS: And any final  
22       arguments on validity before we vote?



1 (No response.)

2 CO-CHAIR BRISS: Hearing none.

3 MS. BAL: Okay. Voting for  
4 validity is now open.

5 [VOTING.]

6 MS. BAL: So the result for  
7 validity is 2599 is high 2, moderate 10, low  
8 6, insufficient 3. So this will also be in  
9 the gray zone. We can move forward to  
10 discussion of feasibility.

11 CO-CHAIR BRISS: Any new issues on  
12 feasibility that haven't already been raised?

13 (No response.)

14 CO-CHAIR BRISS: Hearing none,  
15 let's move to voting please.

16 MS. BAL: Okay. So voting is now  
17 open for feasibility for 2599.

18 [VOTING.]

19 MS. BAL: Okay. So the results  
20 for feasibility for 2599 is high 1, moderate  
21 11, low 8, insufficient 1, and it's also in  
22 the gray zone, and we'll move forward to

1       usability and use.

2                   CO-CHAIR BRISS:   Any final  
3       arguments on usability and use before we vote?

4                   (No response.)

5                   CO-CHAIR BRISS:   Hearing none, I  
6       think we can move to vote.

7                   MS. BAL:   The voting is now open.

8                   [VOTING.]

9                   MS. BAL:   Okay.   The results for  
10       usability and use for 2599 is high 2, moderate  
11       12, low 5, insufficient 2, and we'll actually  
12       pass that criteria, and then we can do  
13       overall, unless you would like further  
14       discussion.

15                   CO-CHAIR BRISS:   And any closing  
16       arguments before we talk about -- before we  
17       vote on overall suitability?

18                   (No response.)

19                   CO-CHAIR BRISS:   You do vote if  
20       it's in the gray zone.   You only completely  
21       reject a measure if it's under 40, not if it's  
22       gray.

1                   MEMBER PATING: Just a question  
2                   about the process. So what does that mean  
3                   though? Did staff work on it or is there  
4                   improvements in reliability and validity or  
5                   how do you --

6                   CO-CHAIR BRISS: I think the quick  
7                   answer, the quick answer is in the spirit of  
8                   transparency for the stuff going forward, we  
9                   highlight more than usual this agreement. But  
10                  it otherwise gets treated in much the same way  
11                  as if we had fully approved it. Is that fair?

12                 MEMBER PATING: Because yesterday  
13                  we had two that were actually -- I thought we  
14                  voted up on, but then we're reporting out that  
15                  they were gray zoned. There was one?

16                 CO-CHAIR BRISS: There was one.

17                 DR. BURSTIN: One from yesterday.  
18                  Yes. So essentially it's just again, as Peter  
19                  said, it's about transparency. These measures  
20                  will go out with a clear indication of which  
21                  criteria had gray zone or overall. So it just  
22                  invites comments specifically on the issues

1       you've already raised.

2                   MEMBER PATING:   If we vote up,  
3       that means that we're letting it go through  
4       then?   There's no next process.

5                   DR. BURSTIN:   It will still be in  
6       the report with gray zone for the criteria you  
7       reported it as for gray zone, so people will  
8       know you had specific issues in these  
9       criteria.

10                  CO-CHAIR BRISS:   And recall that  
11       there are other steps after ours.   So this  
12       flags areas where the Committee had more than  
13       usual disagreements.   So that people like the  
14       CSAC and the member councils and the other  
15       people that look at these measures and  
16       consider them can know what our sticking  
17       points were about the measure.

18                   (Off mic comment.)

19                  CO-CHAIR BRISS:   So this will be  
20       labeled as something like 50 shades of gray,  
21       right, and so overall suitability.   I think  
22       we're probably ready to vote.

1 MS. BAL: Okay. Voting is now  
2 open.

3 [VOTING.]

4 MS. BAL: There's one vote out  
5 there somewhere. Oh, there we go. Okay. So  
6 we have yes 13, no 8 for overall suitability  
7 for 2599, and that is just passing for  
8 endorsement.

9 CO-CHAIR BRISS: So thank you. I  
10 think what we'll do next is we've got two more  
11 measures to do before the lunch break. I'd  
12 like to take a ten minute break. Please be  
13 back in your chairs by right on 11:00 a.m.  
14 We'll get restarted and we'll have two more  
15 measures to do by noon. So we'll have to be  
16 efficient after the break.

17 (Whereupon, the above-entitled  
18 matter went off the record at 10:46 a.m. and  
19 resumed at 10:57 a.m.)

20 CO-CHAIR BRISS: So the next  
21 measure is the tobacco screening and follow-up  
22 measure, and Susan, will you please kick us

1 off.

2 MS. HUDSON SCHOLLE: Sure. Okay.

3 So this measure, like the alcohol and the BMI  
4 measure, this is looking at tobacco use  
5 screening and follow-up. Again, it's adapted  
6 from the provider level measure.

7 This one does -- follow-up for  
8 tobacco use includes either medication or  
9 counseling or both -- and two events. The two  
10 events can be any of those.

11 I did want to emphasize, you know,  
12 this measure, we do have good inter-rater  
13 reliability and trying to get this information  
14 from the records, and we see A, a gap in care  
15 and disparities, and certainly what we heard  
16 from our panel is that they -- in the  
17 stakeholder focus groups, people thought this  
18 was a truly important topic that ---- we asked  
19 them to prioritize things and they put this  
20 one very high.

21 CO-CHAIR BRISS: So the lead  
22 discussant for this one is Constance. No?

1 FEMALE PARTICIPANT: No, it's  
2 Mady. No, I'm sorry ---- Kraig Knudsen.

3 MEMBER KNUDSEN: I think it's me.  
4 There's a conflict with the other individual.  
5 So it's all about me. So in terms of  
6 evidence, obviously there is plenty of  
7 evidence on the harmful effects of tobacco  
8 usage. Individuals with mental illness are  
9 more likely than the general population to  
10 smoke, 31 percent versus 21 percent.

11 Obviously that puts them at risk  
12 of other conditions. Study assessing tobacco  
13 use among individuals with substance abuse  
14 treatment settings showed a prevalence of  
15 smoking, around 77 and 94 percent. Obviously  
16 tobacco use is related to poor health  
17 outcomes.

18 In terms of work group comments on  
19 evidence, the Committee agreed that it  
20 examines a critical issue and is important.  
21 However, it did stress the fact that evidence  
22 indicates pharmacotherapy for smoking is most

1 effective when it is including counseling. So  
2 that's important.

3 Additionally they had concerns,  
4 specifically with the SMI population, that  
5 adding another medication may not be the best  
6 approach, and also that the definition of  
7 follow-up care for this measure did not  
8 require both pharmacotherapy and cessation  
9 counseling. So that's that with the evidence.

10 CO-CHAIR BRISS: So this is sort  
11 of --- this is very -- obviously, this is  
12 very conceptually related to the last measure,  
13 and so some of the issues will have been --  
14 will likely have been raised. It's always  
15 hard to argue that tobacco screening and  
16 treatment isn't an important thing to do,  
17 right?

18 So are there -- I suspect we might  
19 be able to keep this discussion fairly brief.  
20 Are there additional comments that folks would  
21 like to make about the importance to measure  
22 and report on this one? Raquel.



1                   MEMBER MAZON JEFFERS: Could the  
2                   developer just address the issue of why you  
3                   made the measure pharmacotherapy or cessation  
4                   counseling and not both?

5                   MEMBER SHEA: So actually we had  
6                   -- the specific issue is that in thinking  
7                   about the SMI population. So this measure is  
8                   for both the SMI population and AOD  
9                   population, and people were concerned about  
10                  requiring that people with SMI take another  
11                  medication.

12                 And so they felt like allowing  
13                 medication or counseling to meet the measure  
14                 numerator was important to allow the patients  
15                 to have the choice of which approach.

16                 CO-CHAIR BRISS: Any other -- any  
17                 other questions or comments on importance to  
18                 measure and report?

19                 Hearing none, why don't we try to  
20                 move to voting, please.

21                 MS. BAL: Okay. Voting is now  
22                 open for evidence for 2600.

1                   Okay. So for evidence for 2600,  
2                   is high, 18. Moderate, two. Low, one.  
3                   Insufficient, zero. Insufficient with  
4                   exception, zero, and we can move forward to  
5                   gap, unless there's further discussion.

6                   CO-CHAIR BRISS: So anybody want  
7                   to make further comments about a performance  
8                   gap?

9                   MEMBER KNUDSEN: In terms of the  
10                  workgroup comments and also what was  
11                  presented, they did a study that showed 35.8  
12                  percent of people with severe mental illness  
13                  had tobacco use screening and appropriate  
14                  follow-up, which I think is pretty alarming,  
15                  and for alcohol and other drug dependence  
16                  population, the field tests showed that 22  
17                  percent had tobacco screening and appropriate  
18                  follow-up, which I also think is absolutely  
19                  alarming.

20                  There's limited data on  
21                  disparities, and they were not able to assess  
22                  differences by race and ethnicity or language.

1       So that's it.

2                   CO-CHAIR BRISS:   So we have a vote  
3       for absolutely alarming?   Anybody like to --  
4       anybody like to -- it's a call and raise over  
5       absolutely alarming.   Hearing none, why don't  
6       we try to move to vote.

7                   MS. BAL:   Okay.   Voting is now  
8       open for gap of 2600.

9                   CO-CHAIR BRISS:   And the truth is,  
10      for the NQF staff, I think there needs to be  
11      an actual category for absolutely alarming.  
12      Could we suggest that as a methodologic  
13      improvement?

14                  MS. BAL:   Okay.   So the results  
15      for gap for 2600 is high, 18. Moderate, one.  
16      Low, zero. Insufficient, two, and we'll move  
17      forward to high priority.

18                  MEMBER KNUDSEN:   Everybody thought  
19      it was a high priority.

20                  CO-CHAIR BRISS:   Any further  
21      comments?   All right.   Then we'll vote please.

22                  MS. BAL:   Okay.   Voting is open

1 for high priority.

2 We're just waiting for one more  
3 person. If you'll retry it please. So the  
4 result for 2600 high priority is high, 16.  
5 Moderate, four. Low, one. Insufficient,  
6 zero, and we can move forward to the  
7 discussion on scientific acceptability.

8 CO-CHAIR BRISS: So would you like  
9 to tee it up for us?

10 MEMBER KNUDSEN: All right. On  
11 this one, they did an inter-rater reliability  
12 test, and the final sample, it included -- I  
13 believe, let's see here, a few health plans.  
14 The final sample is 756 patients with SMI, and  
15 306 patients with AOD. High inter-rater  
16 reliability, and then in terms of validity,  
17 they did their face validity with an expert  
18 panel of 16 folks, group of 29 and public  
19 comment of 20, and it was found to be valid.

20 So the kappa was .75, and the  
21 overall .57. So there were some other  
22 comments on this. High rates of missing

1 records present, presented a challenge for the  
2 generalizability of the population. Only  
3 about a third of the patients had behavioral  
4 health records available.

5 A Committee member expressed that  
6 the pediatric population should be included,  
7 rather than limiting the measure to those over  
8 18, and the Committee challenged the  
9 limitation of the measure to outpatient  
10 settings, noting that much care is now  
11 delivered in acute settings. So that's what  
12 they talked about.

13 CO-CHAIR BRISS: An issue -- I  
14 think this Committee's talked about this  
15 before. There's a general issue with tobacco  
16 measures in adults and kids. This kind of  
17 measure, where part of the specification is  
18 drug treatment, because there's sort of  
19 insufficient evidence to conclude on whether  
20 drug treatment for tobacco actually works in  
21 kids.

22 So any other comments on

1 reliability before we move to a vote on this  
2 one?

3 MS. BAL: Okay. Voting is now  
4 open for reliability.

5 Okay. So we have ---- for  
6 reliability of 2600, we have high, six.  
7 Moderate, 14. Low, one. Insufficient, zero,  
8 and we can move forward to validity, unless  
9 you guys would like to discuss more.

10 MEMBER KNUDSEN: I already  
11 discussed what the -- any other comments?

12 CO-CHAIR BRISS: Any other  
13 comments? No.

14 MS. BAL: Okay. Validity is now  
15 open.

16 Okay. So the results for validity  
17 for 2600 is high, five. Moderate, 14. Low,  
18 three. Insufficient, zero, and we can move  
19 forward to feasibility.

20 MEMBER KNUDSEN: Everybody thought  
21 it was feasible.

22 CO-CHAIR BRISS: That was

1       admirable efficiency. Any other comments?

2       All right. Voting please.

3               MS. BAL: Okay. Voting is open  
4       for feasibility.

5               Okay. The result for feasibility  
6       is high, seven. Moderate, 12. Low, two, for  
7       2600, and we can move forward to usability and  
8       use.

9               MEMBER KNUDSEN: There were no  
10       comments on usability.

11              CO-CHAIR BRISS: Okay. Would  
12       anyone like to add a comment on usability?  
13       Seeing no cards, let's vote.

14              MS. BAL: Okay. Voting for  
15       usability and use is now open.

16              So the results for usability and  
17       use for 2600 is high, six. Moderate, 14.  
18       Low, one. Insufficient, zero, and we can move  
19       forward to overall vote, unless there's  
20       further discussion.

21              CO-CHAIR BRISS: Any closing  
22       arguments? No. Let's vote, please.

1 MS. BAL: Okay. Voting is now  
2 open.

3 CO-CHAIR BRISS: Oh, I'm sorry.  
4 All right, I see your card. Dodi.

5 MS. BAL: Not open.

6 MEMBER KELLEHER: I just wanted  
7 before we ended --

8 CO-CHAIR BRISS: Please use your  
9 mic.

10 MEMBER KELLEHER: Oh, microphone,  
11 sorry. I've got it. I just wanted to --  
12 because this has come up with other phases as  
13 well.

14 With an SMI population like this,  
15 you really ought to consider, to increase your  
16 validity, sampling from other than just  
17 outpatient, because so many of that,  
18 especially the Medicaid population, do get  
19 screened and treated perhaps more reliably in  
20 acute and subacute levels of care, such as  
21 residential or, you know, subacute locked,  
22 which are quite common.



1                   So I think you need to go back and  
2                   look at that the next time around. That's all.  
3                   It's not really an argument for yes or no.

4                   MS. HUDSON SCHOLLE:   Okay.   So  
5                   inpatient would not count, but I believe that  
6                   intensive outpatient would count like at the  
7                   intensive outpatient settings.   No?

8                   MEMBER KELLEHER:   Okay, go for it.

9                   MEMBER TRANGLE:   I mean health  
10                  plans pay for inpatient, straight outpatient  
11                  or IOP services.   But a lot of these patients  
12                  go to group homes.   Some Borden Cares, ACT  
13                  teams, you know, a lot of their treatment,  
14                  including where they reside, is in a  
15                  psychosocial sphere versus the medical sphere.

16                  That's where they're living, and  
17                  you can do a lot of really important key care  
18                  there that we've never thought of as a gap in  
19                  our conceptual continuum of care -- of who  
20                  owns it, you know.

21                  MS. HUDSON SCHOLLE:   So if the  
22                  health plan could track that that service --

1 health plans typically do not look --

2 MEMBER KELLEHER: No.

3 MS. HUDSON SCHOLLE: They don't --  
 4 they typically don't look at care that's  
 5 provided inpatient, but those services that if  
 6 they're provided -- if the health plan can  
 7 produce the record that demonstrates that it's  
 8 done, this is a hybrid measure. If they could  
 9 find it, that it's happening there, it would  
 10 count.

11 MEMBER KELLEHER: You know, if  
 12 you're looking at -- if you're looking at  
 13 quote-unquote medical record or notes, for say  
 14 someone might be -- either for SMI or for  
 15 substance abuse, might be in a 30 day  
 16 treatment residential that's paid for by the  
 17 health plan, and they're much more likely to  
 18 be assessed and given interventions for things  
 19 like tobacco or alcohol or anything else.

20 I think you just might be missing  
 21 an opportunity there, that in the real setting  
 22 it's used --

1 MS. HUDSON SCHOLLE: And I guess  
2 what I'm saying is that if the health plan  
3 could find that has been done and produce that  
4 record, it would count in this measure,  
5 because it is a ---- the numerator is a  
6 hybrid. It allows the plan to produce the  
7 record from wherever it takes place.

8 So the issues, we would just need  
9 to make it clear that it's not just the  
10 primary care medical record that counts, that  
11 they would provide it. So that's a guidance  
12 we might be able to provide. Thank you. But  
13 thanks for that clarification.

14 CO-CHAIR BRISS: Yeah. So I just  
15 want to say that I think you could -- I think  
16 that this is less about this measure today and  
17 more about things that you can think about  
18 going forward. So I don't actually think it  
19 requires much of a back and forth. But  
20 Michael, I'll let --

21 MEMBER TRANGLE: I mean that  
22 essentially was my point. It's not an NCQA

1 issue, because it varies widely according to  
2 state law, whether health plans pay for this  
3 or not. It's an NQF issue, if we're looking  
4 at ourselves as an integrating function  
5 between health plans, primary care, behavioral  
6 health, hospitals, and this is an area that's  
7 not covered by any of them, you know.

8 It's a CMS issue, almost. But it  
9 does get paid for through public dollars, but  
10 maybe we haven't quite engaged with the right  
11 constituency to talk about it.

12 CO-CHAIR BRISS: So any other  
13 comments on this measure before we vote?  
14 Hearing none.

15 MS. BAL: Okay. Voting is now  
16 open.

17 There you go. Okay. So the vote  
18 for overall suitability for 2600 is yes, 19,  
19 no, two, and this measure will be moved  
20 forward for recommendation. Now we can move  
21 forward to 2605.

22 MS. HUDSON SCHOLLE: Sure, okay.

1       This is my last one.

2                       (Laughter.)

3                       CO-CHAIR BRISS: We'll do our best  
4       to make it particularly painful then.

5                       MS. HUDSON SCHOLLE: Okay. So  
6       this measure is really focused on trying to  
7       encourage continuity of care for people who  
8       are seen in the emergency department, either  
9       for an alcohol or drug problem, or for a  
10      mental health problem.

11                      So this is not like the previous  
12      ones, where we've talked about a population of  
13      people with SMI or AOD dependence, right?  
14      This is about care, trying to improve  
15      continuity between emergency care and  
16      outpatient care.

17                      So it's actually modeled off an  
18      existing measure that looks at follow-up after  
19      hospitalization for mental illness. But in  
20      this case what we've done is we've looked at  
21      follow-up after an ED visit. So there are  
22      actually four different rates in this measure.

1                   Two of them apply to emergency  
2     department visits for a mental health  
3     diagnosis and for those, the two different  
4     rates are ---- they're looking at the  
5     proportion of people seen in the emergency  
6     department, with a primary diagnosis of mental  
7     health, and did those people have a follow-up  
8     visit within seven days that also has a  
9     diagnosis of mental health, okay. So an  
10    outpatient follow-up?

11                  FEMALE PARTICIPANT: Primary  
12    diagnosis.

13                  MS. HUDSON SCHOLLE: A primary  
14    diagnosis, right. So what we're trying to do  
15    is see that if you're seen in the emergency  
16    department for a mental health issue, that  
17    there's follow-up for that mental health  
18    issue. Unlike the follow-up after  
19    hospitalization measure, if you're familiar  
20    with that one, we don't have a requirement  
21    that it has to be with the mental health  
22    practitioner. It could be anywhere, as long

1 as the mental health diagnosis is addressed.

2 Likewise, we have two rates that  
3 are for people with alcohol -- who are seen  
4 for an alcohol or drug diagnosis in the  
5 emergency department. We're looking for  
6 primary diagnosis in the emergency department,  
7 and then looking for the follow-up to occur,  
8 either within seven days or 30 days on those  
9 rates.

10 So the reason we focused on this  
11 is because of the literature that shows the  
12 large proportion of people that are seen in  
13 the emergency department for mental health or  
14 substance use problems, and the lack of  
15 follow-up care that has been documented in the  
16 literature.

17 And because we believe that EDUs  
18 represents a failure of access to care, and an  
19 opportunity to try to intervene and connect  
20 people to care. So we've tested this measure.  
21 Unlike the other measures we used, this is a  
22 claims-based measure only. So we're looking

1 at claims data. We tested it using the  
2 Medicaid analytic extract, which is a claims  
3 database that represents a number of states,  
4 and allows us to look at patterns across  
5 states.

6 We saw wide variation across  
7 states. This Medicaid database is primarily  
8 fee-for-service. There are -- the data that's  
9 on managed care plan enrollees is less  
10 reliable.

11 In general, we had strong support  
12 from stakeholders through our focus group,  
13 public comment and our advisory panel,  
14 supporting that this measure's important, and  
15 encouraging the use of this measure.

16 CO-CHAIR BRISS: Terrific, thanks.  
17 Les, can you walk us through?

18 MEMBER ZUN: With or without bias?  
19 (Laughter.)

20 MEMBER ZUN: So okay. So let me  
21 make a couple of preliminary comments, and  
22 then I'll give my ---- or the Committee's



1 critique. I should be on. So yes, this is a  
2 measure looking at really four rates. So when  
3 they present to the emergency department with  
4 one of three diagnoses -- primary diagnosis  
5 mental health, alcohol or drug dependency, so  
6 one of those three, that they get -- not that  
7 they get, but they actually follow-up seven  
8 days and 30 days after the index visit, which  
9 would be the ED visit, to any provider.

10 Was I clear about any provider,  
11 so all those other services aren't part of  
12 that, like AA, et cetera, et cetera. So can  
13 I now give my bias?

14 CO-CHAIR BRISS: As long as it's  
15 fully disclosed.

16 MEMBER ZUN: Oh, all right. So  
17 here -- as far as I'm concerned, the  
18 motivation and desire to get these people in  
19 follow-up is meritorious, but this measure  
20 does not provide for that for -- we'll say  
21 four reasons. So one is they have to have a  
22 diagnosis of mental health, alcohol or drug

1 dependence.

2 In the emergency department, we do  
3 pretty good about mental health diagnoses, but  
4 we don't make a diagnosis of alcohol or drug  
5 dependency. Now that's a whole another issue  
6 about whether we should be doing that, but  
7 that's not frequently -- that's not a frequent  
8 diagnosis that's given, and we don't go  
9 through the screening or diagnostic tools to  
10 do that, and maybe one day we will.

11 So that's issue one. Issue two is  
12 resources. Whether they're Medicaid fee-for-  
13 service or, you know, they're going to be in  
14 a Medicaid HMO, many communities don't have  
15 resources for mental health, alcohol and drug  
16 dependence, and if they do, it could be months  
17 until they get -- until they're able to get  
18 into a treatment facility as an outpatient or  
19 inpatient or anything.

20 So that's a little problematic in  
21 some communities. So as far as I'm concerned,  
22 it's very hard to hold the emergency

1 department accountable for resources that may  
2 or may not be available in that community, and  
3 we know there are many communities that don't  
4 even have any psychiatric services, let alone  
5 substance abuse and alcohol services. So that  
6 was the second.

7 The third is I believe this is  
8 displaced responsibility. The responsibility  
9 should be on the health plan, should be on the  
10 HMO, should be on Medicaid services to get  
11 their folks into treatment, not the emergency  
12 -- the emergency department has nothing to do  
13 with connecting -- you know, we just make the  
14 referral, and sometimes we don't even make the  
15 right referral because sometimes we don't know  
16 what their coverage is, which kind of leads to  
17 my next problem is, you know, some say they're  
18 on Medicaid, some aren't on Medicaid.

19 We don't know. We don't verify  
20 it. The EMTALA requires us to see every  
21 patient in the emergency department and do at  
22 least a medical screening exam. It doesn't

1 say that we need to confirm their insurance  
2 status and ensure that they're Medicaid  
3 covered, and if they're Medicaid covered, that  
4 we provided these services.

5 So now we have a differential of  
6 care between Medicaid-covered patients and  
7 other patients. So that's the fourth problem,  
8 and then the fifth problem I had was -- I  
9 couldn't find in any of the stakeholders or in  
10 any of the people who developed the tool were  
11 emergency physicians or emergency medicine  
12 specialty organizations were represented.

13 Then the sixth -- is that too  
14 many? Can I give a sixth one?

15 CO-CHAIR BRISS: You can have a  
16 sixth.

17 MEMBER ZUN: If we look at the  
18 validity testing, they state, while empiric  
19 testing did not support our hypothesis,  
20 stakeholders generally supported the face  
21 validity. Well -- but if you look who the  
22 stakeholders are, the stakeholders weren't the

1 folks in the emergency department. They were  
2 -- I don't, you know, they were outside the  
3 emergency department.

4 So I'm a little concerned about  
5 even their own statement about validity. So  
6 I would -- so my bottom line is I would  
7 suggest that they rework this and look at  
8 referrals from the emergency department for  
9 Medicaid recipients, and not, per se, that the  
10 patient actually followed up in the prescribed  
11 number of days. Thank you.

12 CO-CHAIR BRISS: Thank you. Yes.  
13 So thank you for ---- to the Senator from  
14 Emergency Medicine.

15 (Laughter.)

16 CO-CHAIR BRISS: Do you want to --

17 MS. HUDSON SCHOLLE: I would just  
18 clarify ---- a couple of clarifications. This  
19 is a plan level measure. So it is not holding  
20 the emergency department accountable. It's  
21 actually holding the health plan, or the  
22 state, accountable for this connection

1       happening.

2                       Now the health plans don't like  
3       having this accountability either because they  
4       say, how are we going to know somebody? But  
5       there are ways that they can make that  
6       possible, to make that connection happen, and  
7       if there's a lack of services available then  
8       that's part of their responsibility.

9                       This is a measure that is based on  
10       claims-only, and the benefit -- the plan would  
11       be responsible for the benefit, for the mental  
12       health benefit. So they're responsible for  
13       making sure that their services are available  
14       ---- that they have a network of services  
15       available.

16                      And when we get to the validity, I  
17       can ---- we presented the validity data. You  
18       want to hold that one? Yeah.

19                      CO-CHAIR BRISS: So maybe since  
20       Harold saved me for last when we last  
21       commented all open -- so I'm going to take off  
22       my Chair hat for a second -- and so, as has

1       been said by others this morning already, I  
2       think you have to take your own temperature on  
3       how you feel about the leading a horse to  
4       water and encouraging him to drink issue.

5                   I agree. As has been said  
6       previously today, I think we're past the point  
7       where, you know ---- there was an old Tom  
8       Lehrer song where he quoted Wernher von Braun,  
9       or he allegedly quoted Wernher von Braun about  
10      -- I shoot missiles up, who knows where they  
11      come down? That's not my department, said  
12      Wernher von Braun.

13                  So I actually think we're past the  
14      Wernher von Braun stage of the world, and  
15      we're at least partly responsible for whether  
16      people get what they're supposed to get and  
17      whether they get better as a result.

18                  I was also going to comment on  
19      that this is a plan level measure. It's not  
20      really holding the ER specifically  
21      accountable. So I'll just go around, Mady.

22                  MEMBER CHALK: I didn't notice

1     what the data were on diagnoses of alcohol in  
2     the ER because we know specifically that, in  
3     at least half of the states, law still exists  
4     to create a disincentive for emergency rooms  
5     -- emergency departments to diagnose alcohol  
6     because they can't get paid for any resulting  
7     conditions that are related to the alcohol.

8                 So that being the case, and it is  
9     the case, I wonder how that affects all the  
10    rest of the data you're going to collect, or  
11    how this measure's going to perform, given  
12    that in half of the states and maybe in every  
13    state for other reasons, they're not going to  
14    diagnose alcohol and drug dependence. Nice to  
15    include it, but --

16                CO-CHAIR BRISS: And I think we  
17    know that for many measures, including this  
18    one, that the problem -- whatever problem  
19    you're trying to solve is going to be -- is  
20    going to be under-ascertained to a greater or  
21    lesser degree. So it's likely that there's  
22    going to be some under-ascertainment of mental



1 health issues and likely a larger under-  
2 ascertainment of alcohol and drug problems.

3 That doesn't mean that the focus  
4 of the measure, which is coordination of care  
5 for the people that you do know about, is a  
6 bad thing to do.

7 MS. HUDSON SCHOLLE: And just to -  
8 --- maybe we're really interested to  
9 understand this phenomenon that you've  
10 described. We actually found people with  
11 these diagnoses, and if you look at the data  
12 in the testing report, it's in there.

13 So we do see variations across the  
14 states, and it's smaller generally than the  
15 mental illness -- the people with the mental  
16 illness diagnosis. But it's present and in  
17 the Medicaid data that we looked at, and this  
18 was not something we heard from others.

19 MS. LIU: The AOD rate would also  
20 require the chemical dependence benefit. So  
21 if plan's responsible for the benefit, then  
22 they should pay for the services.

1 CO-CHAIR BRISS: Raquel.

2 MEMBER MAZON JEFFERS: I had, I  
3 think, two questions about two exclusions and  
4 a question about an inclusion. So pertinent  
5 to the conversation that Dodi started earlier,  
6 I actually think in this particular situation,  
7 it's even more relevant.

8 So someone being referred -- so  
9 excluded from the numerator are individuals  
10 who have been transferred to subacute  
11 residential treatment, and for an individual  
12 with an alcohol use disorder that appeared in  
13 -- that showed up in the ED, in many cases the  
14 most appropriate referral for them is to a  
15 subacute residential detox program in the  
16 community.

17 So I'm not really sure why they're  
18 excluded from the numerator, and it does  
19 explicitly say that only outpatient and  
20 intensive outpatient seven day visits are  
21 possible. It's actually also true for SMI.  
22 Very often the first place you want to

1 transfer someone who showed up in your  
2 emergency department is a short-term treatment  
3 facility for SMI, if they are in fact rising  
4 to that level of care.

5 So that was one question about an  
6 exclusion from the numerator. Also the  
7 measure excludes from the denominator anybody  
8 with a secondary or tertiary diagnosis of  
9 substance use or mental illness.

10 So very, very often, people  
11 appearing in the emergency room show up  
12 because of a trauma injury, and the first  
13 diagnosis is related directly to the trauma  
14 and the second diagnosis is related to their  
15 behavioral health condition.

16 So very frequently the emergency  
17 department coding is in the secondary and  
18 tertiary diagnosis for the behavioral health  
19 condition. The third question I had is about  
20 an inclusion. So included as appropriate care  
21 in the community, seven days out and 30 days  
22 out is a referral to targeted -- is actually

1 an engagement with targeted case management.

2 As far as I understand, targeted  
3 case management is a linkage service. It is  
4 explicitly not, by Medicaid standards, a  
5 treatment service. So I'm not really sure why  
6 that is counted as a referral to treatment,  
7 because it's not -- technically, it's not  
8 actually a treatment service.

9 CO-CHAIR BRISS: So let's hold the  
10 response to that a second, because most of  
11 that is sort of about measure specs and  
12 reliability and validity, and I'd like us to  
13 finish on importance to measure first, if  
14 that's okay.

15 MEMBER GOLDSTEIN GRUMET: So one  
16 question that maybe the ED docs can answer, if  
17 somebody comes in for suicide or self harm,  
18 and it's just thoughts, are they going to get  
19 coded if there's no diagnosis necessarily?

20 I mean I don't -- if not, one of  
21 the concerns I would have is that somebody who  
22 comes in on suicide, it's not a lesson. It's

1       impulsive. It's a relationship issue. It's  
2       a middle-aged man and had some change in his  
3       life -- that potentially some of these cases  
4       would not have a mental health diagnosis and  
5       need to be followed up.

6               Second, when people with suicide  
7       are referred, we know that a really strong  
8       linkage is a crisis line. There's been some  
9       good research that shows that that reduces  
10      readmission rates, and oftentimes crisis lines  
11      can't -- they don't all bill for those  
12      services. Some do and some don't.

13              But in many cases, it can be a  
14      really viable source, to keep the person out  
15      of the hospital and to keep them safe. And so  
16      I just wonder as well, if that's an additional  
17      resource that people are using in some cases  
18      and it's not going to show up necessarily in  
19      billing.

20              It doesn't mean that the hospital  
21      didn't necessarily take on the burden of  
22      making what is a good linkage.

1 CO-CHAIR BRISS: Maybe still  
2 another ---- more about specs and reliability  
3 and that kind of stuff. So why don't we hold  
4 that one too and try to finish on importance  
5 to measure and report. Mike.

6 MEMBER LARDIERI: Yeah. I just  
7 had a question. I should have asked it with  
8 the other ones too. But with a full range of  
9 telemedicine, does that count as a visit. And  
10 then, as very shortly we're going to be able  
11 to communicate, you know, from my home to my  
12 provider, and that will be counted for a CMS  
13 visit. So will those things be counted as a  
14 visit?

15 CO-CHAIR BRISS: So the whole  
16 series of spec questions. I'm going to try to  
17 hold them a little bit longer. Can we try to  
18 finish on importance, please? You okay.  
19 David.

20 MEMBER ROBINSON: I got my sign  
21 back, so I can ask a question. Okay. So this  
22 area's really an area that is a systems

1     problem.  Patients who show up in the ER and  
2     who have a mental health diagnosis, when you  
3     look at the stats, and there is a HCUP study  
4     that was done about four years ago ---- shows  
5     that more than 70 percent end up being  
6     hospitalized.

7                 By the nature of the ER, the way  
8     it's set up, the limitations of what can be  
9     done in an ER, and -- I'll just say, the  
10    liability of releasing someone with a mental  
11    health diagnosis and no setup -- no secured  
12    setup or follow-up.  So I would think this  
13    measure could help in some way ease the  
14    concern of the ER docs in that way.

15                I also see it as a systems issue.  
16    So I do believe it's a health plan issue, and  
17    so I agree with that from that perspective.  
18    I do have some questions about the definition  
19    of emergency department.

20                Since in the mental health world  
21    there are many different kinds of crisis  
22    intervention-type services, and some of them

1 are very well advertised in certain states and  
2 communities, where patients will show up there  
3 as opposed to emergency room.

4 So my question is whether or not  
5 your specifications -- I'm sorry this is a  
6 specification question, whether or not your  
7 definition of emergency department is that a  
8 classic emergency department type, or does it  
9 include some of these other types of services  
10 ---- could be included?

11 The other thing about this measure  
12 is I see it as exceptionally important, and  
13 it's exceptionally important because, as I  
14 mentioned before, people are over-hospitalized  
15 and put in LOC units, and when you talk to  
16 consumers, it's an issue that is high on their  
17 list, where they're inadequately serviced in  
18 the ER because of the structure, the way it's  
19 set up, and are not necessarily referred to  
20 these other crisis-type services, which health  
21 plans try to make those connections between  
22 the classic ER and these emergency services.



1                   And frankly, we could use a lot of  
2                   help in terms of really pushing that as a  
3                   mechanism that comes under the ER, as opposed  
4                   to hospitalization. So this is exceptionally  
5                   important from a consumer protection advocacy  
6                   perspective.

7                   CO-CHAIR BRISS: So I'm going to  
8                   continue to try to keep tabling the spec  
9                   questions until we get to specs.

10                  MEMBER PATING: All right. So I  
11                  have several others, but I think it relates to  
12                  -- I'm concerned with the logic model, which  
13                  I think is Evidence 1A. So I think in the  
14                  logic as we want to get ED -- we want to link  
15                  them, right, to services, whether it's primary  
16                  care or other things in your other various  
17                  measures.

18                  This is obviously linking to  
19                  mental health/substance abuse. Just  
20                  historically in the last session, we looked at  
21                  Joint Commission measures, which tried to do  
22                  this linkage from the hospital, and I think we

1 found linkage from the acute care setting is  
2 just intrinsically difficult.

3 I will tell you, particularly in  
4 parts of California and I imagine in many  
5 states that are more rural, I have areas of  
6 California where the ED is 120 to 200 miles  
7 away from the county where the person is  
8 referred.

9 We have these rural parts of our  
10 state which have 1,000 people in them. They  
11 have to go -- if they have a psychotic  
12 episode, they have an emergency room ride for  
13 100 miles to the ED. They get better and they  
14 go back on the emergency room ride, and they  
15 don't even live where they came from, because  
16 it's rural.

17 The idea of this linkage, it's a  
18 very hard concept, which I guess when I looked  
19 at how you're measuring the linkage, I think  
20 claims data is just like the worst way to do  
21 this. First of all, claims data is really  
22 inaccurate when you're looking at what comes

1 out of the ER and where people are going.

2 The biggest thing I have about the  
3 claims data, particularly when you're looking  
4 at these seven days windows, it's too quick in  
5 order to do quality improvement. You're  
6 giving people seven days from some sort of  
7 diagnosis.

8 There's no chance for a system to  
9 like correct itself based on these claims,  
10 because they're always retroactive billing,  
11 and you're always kind of looking in the rear  
12 view mirror.

13 I would worry that if you're  
14 trying to drive a system that wants to build  
15 linkage, we're always looking in a rearview  
16 window of data from three years ago -- because  
17 the HEDIS cycle is one year, based on the data  
18 two years ago, and that we're not going to  
19 really drive the system.

20 So that there's a fundamentally  
21 kind of logic flaw, and this being the way ---  
22 - the indicator, to make these linkage in a

1 system that is very fragmented. I think you  
2 need to design something that's much more real  
3 time, with a much more realistic sense of how  
4 people get into ERs and out of ERs. So that's  
5 just my thought.

6 CO-CHAIR BRISS: So I think I  
7 agree, that that's -- that that has to do with  
8 the fundamental logic of the measure. Do you  
9 want to comment or respond?

10 MS. HUDSON SCHOLLE: So I try to  
11 think about this like the way Medicare has  
12 thought about how they're trying to  
13 disincentivize readmissions. It seems to me  
14 that a health plan is accountable for making  
15 sure that people who -- get access to the  
16 services that they need.

17 If they're responsible for the  
18 mental health benefit or the chemical  
19 dependency benefit, and they're paying for the  
20 ED visit. So ---- and if they want to avoid  
21 paying for more ED visits and making sure that  
22 their people get into appropriate care.

1                   So then the question in my mind is  
2                   how does the health plan work with the  
3                   emergency department that it is paying and the  
4                   chemical dependency services for the primary  
5                   care providers that it's paying, to try to  
6                   make those things happen?

7                   What's happening on the primary  
8                   care side is by using medical homes, they're  
9                   using ---- working to help -- health plans can  
10                  help to encourage hospitals to notify medical  
11                  homes that their patients are being seen in  
12                  the emergency department.

13                  Can they do that in a special way  
14                  for people with mental health and make that a  
15                  priority and connect -- so that where people  
16                  are going for the emergency department visit,  
17                  it happens before they leave the hospital, not  
18                  based on data that comes to the health plan,  
19                  you know, a month later after the visit.

20                  So I agree with you. It has to be  
21                  proactive. But the responsibility of getting  
22                  somebody from the emergency department, where

1 alcohol or mental illness is their primary  
2 reason for that visit, to getting them into  
3 care, that does have to be proactive,  
4 prospective, based in the ED, and the health  
5 plan's paying for both pieces of it.

6 So I believe there are ways that  
7 they can help their network of providers work  
8 together. It's not easy, but that's the tool.  
9 Making the emergency department responsible  
10 for that doesn't seem reasonable, as Leslie  
11 has suggested.

12 Making the primary care provider  
13 who doesn't know, or the mental health  
14 provider who doesn't know, responsible also  
15 doesn't seem reasonable.

16 It's the place that's paying for  
17 both sets of care that ---- what our measure  
18 is kind of arguing, that's where the level of  
19 accountability is and that's where the systems  
20 for communicating and sharing information  
21 should -- the accountability for developing  
22 those systems should occur.

1                   MEMBER PATING: And I'm just  
2                   saying, I don't think this is the measure  
3                   that's going to drive the system change at the  
4                   level that you're wanting it, because it's too  
5                   distant, too late, too remote and it's just  
6                   not in the logic cycle of what happens in  
7                   emergency rooms.

8                   CO-CHAIR BRISS: Thank you,  
9                   although it seems to me that almost any  
10                  measure for public reporting or pay for  
11                  performance is going to be -- if you expect it  
12                  by itself to move the system, it's almost  
13                  never going to do that, because they're all  
14                  too late and too infrequent, right?

15                 So what these measures are kind of  
16                 doing are highlighting important issues, and  
17                 if you really wanted to do quality  
18                 improvement, you'd have to be building other  
19                 systems to sort of complement the measures,  
20                 right. So Larry?

21                 MEMBER MILLER: I had a quick  
22                 comment and a quicker question, and Susan

1     actually addressed my comment about behavioral  
2     health homes. I think that's an excellent  
3     place for them to deal with emergency rooms,  
4     and actually we have a metric in our system  
5     that deals with that in terms of the number of  
6     folks who are seen within a certain length of  
7     time.

8                     My question has to do with why  
9     seven and 30 days? I mean if you really want  
10    to see them and have them seen, and this is a  
11    problem, they should be seen within seven  
12    days. You give a system 30 days, they'll take  
13    the 30 days. I really think that this is a  
14    concern for my part.

15                    MS. HUDSON SCHOLLE: So we had a  
16    lot of -- so we basically followed the  
17    existing measure for hospitalization, follow-  
18    up after hospitalization of seven and 30 days,  
19    just to be -- make it easy to program frankly.

20                    But I think there were concerns  
21    actually about the seven days, is that too  
22    short? The 30 days allows us to see whether



1 plans are able to make it up. So that's where  
2 the logic came from.

3 MEMBER MILLER: Putting my hat on  
4 as a clinician, I think that's just -- and an  
5 administrator in the system, I think it's just  
6 too long, because what happens, people get  
7 readmitted. They might get lost in follow-up.  
8 So I think it's, you know, an issue again.

9 MEMBER ZUN: Just a few more  
10 comments. So first of all, I can envision a  
11 scenario where the information about the  
12 compliance with this measure being out there  
13 in the public, and a hospital administrator  
14 saying, oh, you guys in the ED only referred  
15 ten percent of those with mental health and  
16 substance use and -- or ten percent of the  
17 patients you saw in your ED actually followed  
18 up in seven days and 30 days.

19 Although you might be well-meaning  
20 in having the health plans and the providers  
21 be responsible, I've got to tell you that it's  
22 going to come back to haunt me as a provider,

1     because this data gets out in the public  
2     domain and the rest is history. So that's  
3     number one.

4             Number two item is there's about  
5     145 psychiatric emergency services in the  
6     United States. Is that considered an  
7     emergency department visit, or is it not? Some  
8     are free-standing, so a psych patient may go  
9     to a PES. Some are next to an ED and go to  
10    the ED and then they go into the PES. So  
11    that's a question.

12            Third is what do we do about that  
13    patient that boards in the ED for a week,  
14    waiting for an inpatient bed and finally we  
15    decide that they're well enough to send them  
16    home? So they've already hit the wall as far  
17    as they're supposed to be getting an  
18    outpatient visit, but in the meantime, they're  
19    waiting.

20            There was actually a study done in  
21    California, where I think it was 20-some  
22    percent of the ED directors say they have

1 psych patients waiting in their EDs for over  
2 a week to get an inpatient bed. I'm sure I  
3 can give it to -- I'm sure David is familiar  
4 with those problems.

5 Then lastly, I wanted to comment a  
6 little bit more about the claims data, because  
7 we know that the claims data doesn't always  
8 accurately reflect what the patient was seen  
9 for in the emergency department. It may be  
10 based on what the best billable rate may be or  
11 those kind of things.

12 So the claims data is somewhat  
13 suspect for that, and we may actually -- I  
14 think some EDs might not put a substance abuse  
15 or mental health issue on there because the  
16 question of reimbursement or payment ---- like  
17 a trauma patient.

18 If you put down on a trauma  
19 patient's chart that the patient has a  
20 substance abuse problem, then we don't get  
21 paid for their services.

22 So I'm not sure we can fix the

1 whole system, but it's a much bigger problem  
2 overall than just, you know, being addressed  
3 in the measure. Thank you.

4 CO-CHAIR BRISS: So we're  
5 continuing to get a lot of questions about  
6 what counts as an emergency department, what  
7 counts as a service, those kind of things, and  
8 I really want to push those into the next  
9 discussion of reliability and validity.

10 So I think I have -- Julie, is  
11 your card still up? So I think we're out of  
12 cards for importance to measure and report,  
13 and I'd like to try moving us to voting and  
14 see how that goes.

15 MS. BAL: Okay. Voting is now  
16 open for evidence for 2605. Now it's open.  
17 My mistake.

18 [VOTING.]

19 MS. BAL: Okay. So the results  
20 for evidence for 2605 is high 9, moderate 9,  
21 low 4, insufficient 0, insufficient with  
22 exception, 0 and we can move forward to gap?

1 I'm assuming we can vote now? Yes. Okay.

2 Voting is now open for gap.

3 [VOTING.]

4 MS. BAL: Okay. So the results  
5 for gap for 2605 is high 17, moderate 5, low  
6 0, insufficient 0. And now we can vote on  
7 high reliability. I'm sorry, high priority.

8 [VOTING.]

9 MS. BAL: Okay. The results for  
10 high priority for 2605 is high 14, moderate 6,  
11 low 1, insufficient 1, and now we can move  
12 forward to scientific acceptability, as  
13 everyone wanted to talk about.

14 CO-CHAIR BRISS: Clearly, we have  
15 lots of questions that have been coming around  
16 about the specifications and the reliability.  
17 So at a minimum, there are lots of questions  
18 that are about what counts as an ER and  
19 there's a lot of questions about what counts  
20 as a service, and there are lots of questions  
21 about how much of all of that stuff can we get  
22 out of claims data. So can you open this up

1       for us?

2                       MS. HUDSON SCHOLLE:   Sure, okay.  
3       So first, let's talk about the denominator,  
4       which is looking for -- what we're looking for  
5       is a particular kind of facility with a  
6       particular kind of billing code.  And so the  
7       specifications that -- we used specifications  
8       from HEDIS, from how we define what an ED  
9       visit is, and so it's the facility plus the  
10      code.

11                    I believe that the -- so if the  
12      psychiatric facility, if these special  
13      psychiatric ED facilities are using those  
14      codes, then they would show up in the claims  
15      data.  There were questions about the  
16      exclusions.

17                    So the way this measure works is  
18      people that are directly admitted to an  
19      inpatient or facility.  So this is really for  
20      people who are discharged home, right?  These  
21      are people who aren't discharged to an  
22      inpatient or residential setting.

1                   If they are, if that happens, then  
2                   they get excluded. From the denominator,  
3                   right. They're not in the measure. This is  
4                   looking at people that get discharged home.

5                   So those people that are sitting  
6                   in an ER and then go -- and waiting for that  
7                   inpatient bed, they'll go -- they're not in  
8                   this denominator if they go directly to that  
9                   inpatient setting, if they go outpatient.

10                  We start the clock at the point  
11                  where they go outpatient. So this isn't going  
12                  to deal with those problems.

13                  I'm sorry, the inpatient? If they  
14                  go -- many detox facilities are subacute  
15                  residential detox. It would be a discharge  
16                  from the hospital ER into the subacute  
17                  service. That would be included as follow-up,  
18                  then, okay. So if they -- the plan has to be  
19                  responsible for the chemical dependency visit.  
20                  So as long as the detox was in there, that  
21                  would count as a -- that would count to the  
22                  numerator, right?

1                   So if they're discharged home and  
2                   then they go to detox, then that would count.

3                   CO-CHAIR BRISS: I think the  
4                   question is if they're discharged straight to  
5                   detox.

6                   MEMBER MAZON JEFFERS: I think  
7                   there's some confusion.

8                   MS. HUDSON SCHOLLE: If it's an  
9                   inpatient or residential setting, then they're  
10                  out of it, because this is only people that  
11                  are discharged to the community.

12                  MEMBER ROBINSON: Right. This is  
13                  a system measurement. So you're saying if the  
14                  system from the ER gets the person to the  
15                  residential, which they're going to get there  
16                  by transportation that is guarded, then it  
17                  doesn't count here.

18                  What you're really looking at are  
19                  the people who actually go home and have to  
20                  show up some place after that.

21                  MS. HUDSON SCHOLLE: That's right.  
22                  Thank you, Rhonda.



1                   MEMBER ROBINSON:   So an ambulatory  
2                   detox would work, but not an inpatient-based  
3                   detox or subacute detox.

4                   CO-CHAIR BRISS:   Do you have a  
5                   follow-up on this point?

6                   MEMBER MAZON JEFFERS:   I think the  
7                   numerator clearly says -- I'm sorry.   I think  
8                   the numerator clearly says that the visit has  
9                   to be outpatient, an outpatient visit,  
10                  intensive outpatient encounter or partial  
11                  hospitalization.   That's what it says.

12                  So then it would mean that these  
13                  other community providers that we were talking  
14                  about earlier, that are part of the ACM  
15                  continuum of care for people with substance  
16                  use disorders that are community.   It wouldn't  
17                  be a direct transfer.   It's not considered a  
18                  hospitalization.

19                  There are subacute residential  
20                  treatment programs that are community  
21                  providers, that may not be paid for by a  
22                  health plan or by Medicaid, but are still very

1 appropriate next steps for the individual who  
2 left the ED to be referred to.

3 MEMBER SHEA: So this is for --  
4 this is a health plan measure. So if those  
5 services are paid for by the health plan, then  
6 the health plan's going to capture them? Is  
7 that what you're saying? It's not now.

8 MEMBER ROBINSON: No. I think the  
9 question is when you're talking about  
10 community-based services, let's talk about  
11 like three quarter houses. Is that what  
12 you're talking about?

13 MEMBER MAZON JEFFERS: Any  
14 residential substance abuse treatment program.

15 MEMBER ROBINSON: Residential  
16 implies that the person lives there at night.  
17 There's a room and board, and that would be  
18 excluded from this measure.

19 MEMBER MAZON JEFFERS: Exactly.

20 MEMBER ROBINSON: What she's  
21 trying to measure is the strength of the  
22 system, to get the person to come from home

1 and to follow-up after an ED visit. Going to  
2 a residential, they're living there. They are  
3 room and board there. That's the issue.

4 MEMBER MAZON JEFFERS: So  
5 nonetheless, it's an -- so the person would  
6 come from home. They would leave the ED.  
7 They would go home, and then they would go to  
8 a residential treatment facility, depending  
9 upon their level of severity of their  
10 substance use disorder, and it would be a very  
11 appropriate step in the continuum of care for  
12 them.

13 So rather than qualifying to be in  
14 intensive outpatient care, the person's  
15 substance abuse disorder might be severe  
16 enough that they require a more controlled  
17 recovery environment.

18 MEMBER MARK: And I think the  
19 specification issue is that a lot of times  
20 those residential will be carried as  
21 inpatient. So if you're only counting  
22 outpatient as follow-up, you wouldn't be

1 capturing them. So can you just clarify if  
2 inpatient follow-up is captured?

3 MS. HUDSON SCHOLLE: Actually, and  
4 people that get admitted within that time  
5 frame, within that next 30 days. So if they  
6 got admitted, they would also be excluded,  
7 because we're looking for the outpatient care  
8 for people that remained in the outpatient  
9 setting.

10 So I think they're either -- I  
11 believe that the description that you have,  
12 I'm pretty -- I know that it is -- it's an  
13 exclusion, because we think if they're  
14 connected and they get into that inpatient or  
15 that residential setting, even if it's not  
16 direct transfer but it's transfer within this  
17 time frame, this time window, then they're  
18 excluded from the denominator.

19 We're really trying to focus on  
20 people that go to the community and are  
21 expected to get care in the community. Okay,  
22 and so let me just continue down some of the

1 other questions that were raised.

2 Would crisis services count? Yes.

3 Mobile unit services are in our codes.

4 Telemedicine.

5 We are working on the telemedicine  
6 code. CMS has just introduced a series of  
7 telemedicine codes that don't -- are not  
8 included here, but it's one of our projects at  
9 NCQA to actually update all of our codings,  
10 all of our measures that require visits to  
11 include telemedicine. So we're working on  
12 that. It's not represented yet.

13 We focused on primary -- so for  
14 the numerator, okay, and the denominator. For  
15 the denominator, we're looking for people with  
16 a primary diagnosis. We had a lot of  
17 discussion with our stakeholder groups and our  
18 advisors about should we include a diagnosis  
19 of mental illness or alcohol or drug  
20 dependence that occurs anywhere on the claim,  
21 or should we look for primary?

22 Well, that actually got into the

1     problem of how quickly should you require? So  
2     if it's a primary diagnosis that is putting  
3     them in the emergency room, then requiring  
4     that there be a follow-up within seven days or  
5     within 30 days with that same diagnosis or  
6     that, you know, mental health diagnosis if it  
7     was a mental health visit, that seems like a  
8     reasonable requirement for the health plan, to  
9     make sure that that visit happens.

10                 There were concerns that if we  
11     said a secondary diagnosis, that you wouldn't  
12     know whether that was really precipitating the  
13     event and that they weren't in care. So  
14     that's why -- that's why we stuck with  
15     primary. We felt like if you said primary,  
16     then it was a lot easier to say and you have  
17     to have a visit within seven days or within 30  
18     days.

19                 So that's why we've combined  
20     those. Others thought that it would --  
21     requiring such follow-up in that time frame  
22     might not be warranted.

1                   So and in terms of suicide, this  
2                   is based on diagnosis. So if they put  
3                   suicide, then they'd have to use a mental  
4                   illness diagnosis for this to count, okay.

5                   CO-CHAIR BRISS: Let's go to David  
6                   and then David.

7                   Let's see if we can finish  
8                   reliability first, I think, because clearly  
9                   there are some complicated issues being  
10                  raised, and I think that it's hard enough to  
11                  deal with one issue at a time. So David.

12                  MEMBER EINZIG: So I think I'm  
13                  putting this in the right place with the  
14                  reliability.

15                  (Laughter.)

16                  MEMBER EINZIG: I'm having a lot  
17                  of trouble with this concept of making it  
18                  happen, making the patients go to their  
19                  follow-up visits. So I like analogies. I'm  
20                  thinking of, you know, making my kid eat  
21                  spinach, right, because spinach is good for  
22                  the kid.

1                   MEMBER PATING:   It's seven days.

2       I doubt that he'd eat it.

3                   MEMBER EINZIG:   Yeah, right.   Like  
4       that's going to -- Mike, you don't know my  
5       kid.

6                   CO-CHAIR BRISS:   I think admitting  
7       parenting limitations is a slippery slope that  
8       I don't want to start down.

9                   (Laughter.)

10                  MEMBER EINZIG:   But so the horse  
11       and cart concept maybe is backwards.   I mean  
12       maybe the system should be the horse and the  
13       patient is the water.   I mean if we want to  
14       make this happen, then let's go to the  
15       patient's home, right?   I mean otherwise gas  
16       in a cop car or a limousine or something, and  
17       transport the patient.

18                  It's just that I have trouble  
19       using this as a quality measure, when control  
20       in this sense I think is a myth.   You can  
21       influence behavior, but I don't think that you  
22       can control the behavior.



1 CO-CHAIR BRISS: Mady.

2 MEMBER CHALK: Question. Am I  
3 correct that you said that this is only in  
4 reference to patients who are going to be  
5 followed in the community, so that the most  
6 seriously ill patients are excluded from this,  
7 who need some kind of other level of care are  
8 excluded?

9 MS. HUDSON SCHOLLE: So basically  
10 they get excluded because they get the care,  
11 right? So the ones that are sick enough --  
12 okay. If they get -- okay, so let me -- so if  
13 people are seen in the ED, and they either are  
14 transferred to an inpatient or residential  
15 setting at that time, through a direct  
16 transfer, or within the 30 day follow-up  
17 period, right, then they've gotten transferred  
18 to intensive care, right?

19 If they are not, okay, so they get  
20 excluded. So what we're trying to look at are  
21 the people that don't get to that -- that  
22 don't have that intensive need and get into

1       that intensive setting quickly.

2                       We're looking at the people that  
3       are remaining, the ones that appear to be  
4       discharged to community and not getting  
5       follow-up, and we're looking to see are they  
6       getting follow-up, but they're not going to  
7       the intensive setting.

8                       MS. LIU:   Yes.   Just to add to  
9       that, you know, the exclusion is about patient  
10      who were directly transferred into the  
11      inpatient or residential setting right after  
12      the hospitalization, or they got readmitted,  
13      which then started a follow-up period into a  
14      residential or inpatient setting.

15                      So they were getting care there.  
16      Therefore, we exclude them from this measure  
17      and health plans are not penalized for those  
18      patients, because those are excluded from the  
19      denominator.   So that's the focus of this  
20      measure, is who are discharged in the  
21      community and need follow-up care.

22                      CO-CHAIR BRISS:   So Raquel.

1                   MEMBER MAZON JEFFERS:    So  
2           interestingly, I think that the individuals  
3           with the primary substance abuse and mental  
4           health diagnosis that appear in the ER, the  
5           sicker population that are more likely than to  
6           be excluded.

7                   So it's the people who show up in  
8           the ED with a secondary and tertiary mental  
9           health and substance use diagnosis, who are  
10          probably more appropriate to be referred for  
11          the outpatient service.

12                   So I'm just concerned you're going  
13          to miss a lot of people by excluding them,  
14          because you're only looking at the primary  
15          diagnosis, and then oh my gosh, there was one  
16          other thing.

17                   Oh. I did want to share that  
18          there are system solutions that have been very  
19          effective, that I've actually seen in New  
20          Jersey, where there are accountable care  
21          organizations that are doing intensive case  
22          management like behavioral health homes, of

1 managing high utilizers.

2 So that that care coordination  
3 team receives a message the second one of  
4 their clients hits the ED, and they are  
5 greeting that person in the ED and able to  
6 link them to needed services.

7 So I actually do think that this  
8 measure, in terms of the horse and the water  
9 and the cart, is a really nice diagnostic of  
10 the system's ability to devise and invest in  
11 a response for these very complex patients.

12 I do think it's possible. I've  
13 seen healthy systems or systems that are  
14 trying to address this be successful.

15 CO-CHAIR BRISS: Rhonda.

16 MEMBER ROBINSON: I just want to  
17 answer you, Raquel. I think you're absolutely  
18 right. There are systems that work when they  
19 have that connection with the ER, and that's  
20 really the critical part of this. So the ER  
21 has to notify that system. Otherwise, that  
22 connection doesn't happen.

1                   So I think there's two things.  
2           One, this measure does belong with the health  
3           plan, but there needs to be a counter-  
4           accountability to the ER at a facility also,  
5           because they have to do that.

6                   The other thing, in terms of  
7           whether or not this touches seriously ill  
8           patients. I think the distinction is do not  
9           assume that people who are hospitalized are  
10          the only ones -- are the ones who are  
11          seriously ill.

12                  There are seriously ill  
13          individuals who don't require hospitalization,  
14          but do require acute ambulatory care. I ran  
15          a system for 18 years, myself as a capitated  
16          provider, and the majority of the patients did  
17          not require inpatient hospitalization.

18                  They really required connection to  
19          treatment and feeling connected to treatment.  
20          And so, you know, there were a lot of things  
21          that we did in order to do that, to cut the  
22          hospitalization rate and improve the

1 satisfaction.

2                   So I don't want you to think that  
3 this is cutting out those who are ill. It's  
4 not. It's just that the inpatient is not or  
5 the residential is not the only solution for  
6 these individuals, and what this is trying to  
7 do is to bring accountability for those who  
8 don't need that, and not encourage the ERs to  
9 admit these patients as the only solution for  
10 these patients, but to use other types of  
11 services instead.

12                   CO-CHAIR BRISS: Thank you. So  
13 I'd really like to get -- to get very quickly  
14 through anything else about the measure specs.  
15 So Les.

16                   MEMBER ZUN: I only have two more  
17 comments. So what happens when I see someone  
18 that's an alcoholic, and I refer them to our  
19 referral source, which is Garden State  
20 Mission, which provides -- it's basically a  
21 shelter, and it provides good services for  
22 those that are alcohol-dependent. So would

1       that count? So that's my first question.

2               Then my second is kind of a  
3       comment, because I think this measure only  
4       hits the tip of the iceberg, because we did  
5       two studies of undiagnosed mental illness of  
6       patients presenting to emergency departments.  
7       In the adult population, you won't guess what  
8       percentage have undiagnosed mental illness.

9               We used a screening tool for 16  
10       diagnoses. Fifty percent of the inner city  
11       patients that we saw had an undiagnosed mental  
12       illness. Second is so we did that on kids,  
13       because there was a kid tool that we used, and  
14       45 percent of the kids who come in with colds  
15       and flus and aches and pains and strains and  
16       nothing psych-related had screened in for a  
17       psychiatric diagnosis.

18              To me, if we're trying to get at  
19       it, there's a better way of getting to those  
20       that need help. Just because we put that --  
21       you know they have to be really sick to get  
22       that mental health diagnosis.

1                   But someone should be responsible  
2                   for screening these people and getting them  
3                   the therapy, and if the health plans want to  
4                   put mental health workers in the EDs, I'm all  
5                   for it.

6                   CO-CHAIR BRISS:   So Mike, I hope  
7                   this can be the last word on the spec stuff.

8                   MEMBER TRANGLE:   Well, in some  
9                   sense I feel it is a little bit of a summary  
10                  in my own mind.   It feels like I'm hearing  
11                  both -- actually, it feels like I'm hearing 12  
12                  sides of the argument, not just two sides of  
13                  the argument.

14                  CO-CHAIR BRISS:   I think the right  
15                  number is more like 22.

16                  MEMBER TRANGLE:   Whatever the  
17                  number is, but and I find myself agreeing with  
18                  the majority of them or at least a plurality,  
19                  you know.

20                  If I try and make sense of what do  
21                  I think and what makes sense action-wise, it  
22                  really is like clearly this is sort of an



1 early stage of a tool, where definitions are  
2 imperfect, and the world is structured in a  
3 way where in terms of cultural issues, the  
4 flow of ED, what's paid for by health plans,  
5 you know, as well as the specs, mean that  
6 we're not going to be capturing everybody.

7 On the other hand, I totally agree  
8 with Raquel, and we have an in-service social  
9 worker who works with these high utilizers and  
10 spends a lot of time getting them connected so  
11 they get insurance, you know, and getting them  
12 connected so they can then start getting the  
13 treatment and other kinds of things.

14 I can see the utility and I can  
15 really see how it does a lot of good. This  
16 doesn't seem like I've heard anything about  
17 competing measures here. It's not like this  
18 is an area people are vying; I want to be a  
19 vendor. It's going to be a high profit  
20 margin, you know. So part of me is basically  
21 saying yes, this is imperfect.

22 I could focus and persevere on

1       imperfections, you know, or I could say God,  
2       this is a new effort in an area where  
3       nothing's being done, and we all agree that  
4       it's crucial to try and get started on this,  
5       and then hopefully see how it works and we  
6       improve the definitions and start partnering  
7       with the states and CMS kinds of stuff for the  
8       psychosocial elements that aren't included by  
9       health plans.

10                       So I guess I'm saying -- I guess  
11       I'm giving you a summary and saying it's  
12       probably worth voting for, even though I have  
13       trepidation, because it's such an --

14                       Well you could argue about that,  
15       whether you know, how it can improve without  
16       stopping it here.

17                       CO-CHAIR BRISS:   So on the  
18       reliability, on the spec side, I keep trying  
19       to close the discussion and cards keep coming  
20       up.  And so what we have here may be a failure  
21       to communicate.  So if there are things about  
22       the specs that haven't already been said,

1 Raquel and then David please. Is your card  
2 still intended to be up?

3 MEMBER MAZON JEFFERS: The only  
4 issue -- are we on validity?

5 CO-CHAIR BRISS: No. It's still  
6 reliability of the specs, and only if it's not  
7 already been said. Okay. So reliability  
8 testing we haven't really talked about. So  
9 Les, can you very quickly walk us through the  
10 reliability testing.

11 MEMBER ZUN: Well, the reliability  
12 testing was a little problematic, in that it  
13 was looking at inpatient follow-up and even in  
14 their application, it said that the -- let me  
15 see if I can pull this up -- the validity was  
16 not there. Let's see. Let me get back to  
17 this.

18 Empiric testing. We did construct  
19 validity by exploring whether states perform  
20 in this measure, related to the rate of  
21 inpatient hospitalization for mental illness.  
22 I'm not sure how we're going to --

1 CO-CHAIR BRISS: We're still  
2 trying to talk about reliability here.

3 MEMBER ZUN: I'm sorry. I'll get  
4 there. Sorry.

5 MEMBER PATING: I didn't really  
6 understand that. I've looked at this now four  
7 times, and I've tried to understand the  
8 reliability, how you did it. You had -- what  
9 you were comparing apples to apples, what were  
10 the apples, and it was a chart review or it  
11 wasn't clear to me.

12 You compared one claims set to  
13 another claims set. That's what it looked  
14 like.

15 MS. HUDSON SCHOLLE: Okay. There  
16 are different ways to assess reliability for  
17 different kinds of measures. This is a  
18 claims-based measure, and so for claims-based  
19 measures, the approach that we used to look at  
20 reliability is something that's -- it's called  
21 a signal to noise reliability metric.

22 So the idea of this metric is to

1 say can you -- can you pick out one health  
2 plan from all the other plans? Is there  
3 really a signal here? Does this measure -- or  
4 in this case we used state level data. So can  
5 you really identify a result for an individual  
6 organization or entity that you're trying to  
7 characterize?

8 So the statistic, the signal to  
9 noise statistic is based on a beta binomial  
10 model, and the numbers are actually shown  
11 right here on the screen. Basically what  
12 influences this measure is how much variation  
13 is there across the different units of  
14 analysis, across the states, and what's your  
15 sample size.

16 When you have a good sample size  
17 and a lot of variation across states, as we've  
18 demonstrated, then you're going to have a  
19 highly reliable measure. What that's going to  
20 tell you is that it's not going to change --  
21 you can really say, you know, this plan is  
22 different from the average of all plans, or

1       this state is different from other states.

2                   You have a lot of confidence that  
3       when you pull this, when you draw another  
4       sample, when you calculate this again, you're  
5       going to get the same result, because you've  
6       got a big denominator, and you've got a lot of  
7       variation across the organizations or entities  
8       that you're measuring.

9                   So these measures are highly  
10       reliable, okay. This measure is highly  
11       reliable based on our testing, because this  
12       statistic ranges from 0 to 100, and we're  
13       presenting reliability results of .9.

14                   CO-CHAIR BRISS: Questions or  
15       comments about the reliability of the measure.  
16       Yes.

17                   MEMBER ZUN: I understand the  
18       methodology you used. I'm not familiar with  
19       that methodology, because if you look at the  
20       definition, reliability describes how one can  
21       confidently distinguish the performance of one  
22       physician from other.

1 I've got to tell you that in my  
2 face, the face reliability to this just  
3 doesn't -- it doesn't make sense to me. I  
4 have two emergency docs and they rarely come  
5 up with the same mental health diagnosis.

6 MS. HUDSON SCHOLLE: This is about  
7 the reliability of the measure, of the  
8 performance of this measure. When you do it  
9 over and over again, and yes, and I apologize  
10 if it says something about -- it says of one  
11 physician or an accountable entity. In this  
12 case, we're looking at the entity, not a  
13 particular physician.

14 This is looking to understand when  
15 you implement this measure, can you really  
16 pick out one entity from everybody else? I  
17 mean does it give you a signal? That's what  
18 we're trying to get at with this statistic.  
19 It's influenced by how much variation you have  
20 and what your sample size is.

21 Any claims-based measure is going  
22 to have a pretty good -- generally, they have

1     pretty good sample sizes, and this measure has  
2     a lot of variability. So that's why you see  
3     really high reliability results from this  
4     statistic.

5                    DR. BURSTIN: This is a pretty  
6     standard approach for almost all the claims-  
7     based measures we've got, in terms of the  
8     signal to noise reliability analysis.

9                    CO-CHAIR BRISS: But it might  
10    help. Can somebody say in simple words what  
11    a .9 means in this context? What does the  
12    number really mean?

13                   MEMBER SUSMAN: High reliability.  
14                   (Laughter.)

15                   MS. HUDSON SCHOLLE: The statistic  
16    ranges from 0 to 100, right, or 0 to 1, and so  
17    we're getting a .99. That means really  
18    reliable.

19                   MEMBER ZUN: Highly reliable.

20                   MEMBER SUSMAN: The chances are  
21    relatively small that this is due to random  
22    variation. There's probably a true



1 reliability here as opposed to -- you can pick  
2 out differences meaningfully on a consistent  
3 basis.

4 MEMBER ZUN: Maybe I'm confused  
5 about it.

6 MEMBER SUSMAN: I think you're  
7 confusing maybe validity and reliability here.

8 MEMBER ZUN: But if you read the  
9 ranges, percentile across states from 10 to 90  
10 percent, and they're all in the 10 to 90  
11 percentile, I'm a little -- that's like the  
12 whole universe of --

13 I mean of course you're going to  
14 have a high reliability if your universe is  
15 from 0 to 100. It says right there 10 to 90th  
16 percentile across states is very, very high.  
17 I'm a little --

18 MS. HUDSON SCHOLLE: This is not  
19 the performance rate that is -- so the way --  
20 it's just the way this measure is calculated,  
21 and this is how you summarize it and the  
22 statistician who does this is not here to

1 explain it better.

2 CO-CHAIR PINCUS: I see you're  
3 cutting off at the outlier.

4 MS. HUDSON SCHOLLE: Yeah. But  
5 basically what it shows you is that we have  
6 very good reliability in the different places  
7 where we've looked at it in the different  
8 states, because you've calculated for each  
9 state, and then you summarize it.

10 If you're asking about how much  
11 variation that we have in performance, we see  
12 a lot of variation in performance, and that's  
13 presented in a different place in this report,  
14 where we do see that the performance rates  
15 range across states, with an average of -- and  
16 that's in Table 8 of this document, where we  
17 see that the median for the mental health  
18 seven day follow-up is 74 percent. It ranges  
19 from 42 percent to 80 -- to 90 percent.

20 It's under Meaningful Differences,  
21 okay. All right.

22 CO-CHAIR BRISS: So we've had what

1 I think is actually a fairly long reliability  
2 conversation. It's clear that people have  
3 different points of view about the specs, and  
4 maybe about the usefulness of the statistics  
5 that have been presented. But does anybody  
6 else have anything that they want to raise  
7 that hasn't already been raised?

8 About reliability, specifically  
9 about reliability. And if not, I think I'd  
10 like to try to move us to a vote on  
11 reliability in particular.

12 MS. BAL: Okay. Voting is now  
13 open on reliability.

14 [VOTING.]

15 MS. BAL: So we're all at 19. Did  
16 everybody get a chance to vote, and did  
17 anybody step out that I don't see perhaps?

18 There we go, thank you. So for  
19 2605 reliability, we have high 15, moderate 5,  
20 low 0, insufficient 2, and we'll move forward  
21 to validity.

22 CO-CHAIR BRISS: So Les can you

1       tee it up for us on validity?

2                   CO-CHAIR BRISS:   Yeah.   We've  
3       already talked about some of this, I think.

4                   MEMBER ZUN:   So I think there's  
5       been a lot of questions and concerns about the  
6       validity of the data, both the numerator and  
7       the denominator, and in the interest of time,  
8       I don't think I'll go much more into it.

9                   CO-CHAIR BRISS:   So there are lots  
10      of cards up, and maybe we'll start with Raquel  
11      and come this way this time.

12                  MEMBER MAZON JEFFERS:   So just  
13      very quickly, the measures were only tested on  
14      Medicaid plans using fee for service claims.  
15      So I was just concerned about the  
16      applicability across the board.

17                  CO-CHAIR BRISS:   So Bob.

18                  MEMBER ATKINS:   I have two  
19      concerns about validity.   One is, as I  
20      understand it, it's a claim-based measure, and  
21      across markets, across states, across regions  
22      within states, a substantial part of the

1 outpatient services, counseling,  
2 psychotherapies whatever, are not provided by  
3 Medicaid providers, and it's totally  
4 legitimate. It's the right thing.

5 So people are getting what they  
6 need, and it's my understanding that we won't  
7 be able to find that with this methodology.  
8 So I question about the validity of that. The  
9 other is the validity of applying this to the  
10 health plans.

11 This is a system measure, it seems  
12 to me. The health plan, the state, the  
13 provider communities, plural, are all part of  
14 the solution. I'm concerned about making this  
15 the accountability of health plans  
16 specifically.

17 I think it's a really important  
18 issue, and there's a way to apply it to the  
19 systems of care or the lack thereof. I can go  
20 on and on about this, but I'll stop right  
21 there.

22 MEMBER PATING: Section 2b2.4 on

1 the validity. So my understanding of how you  
2 tested the validity was that you had a  
3 hypothesis, that if you get people connected  
4 in these states that had various reliable  
5 rates, that you would somehow be able to show  
6 that they had less hospitalization.

7 But your own conclusions were that  
8 there wasn't significantly less  
9 hospitalization, and that the testing didn't  
10 support your ultimate outcome finding. It was  
11 because of the effect size was sort of too  
12 small, I guess, or there wasn't too much --  
13 even though there's this difference between  
14 states, this difference between the  
15 hospitalization rates wasn't significant  
16 enough so.

17 Then you went to -- then you  
18 backed it up by saying well, it's still face  
19 valid, and I think that we're hearing concerns  
20 around that methodology. So can you just  
21 speak to that gap?

22 MS. HUDSON SCHOLLE: So we could

1 have just repressed the data on our validity  
2 testing. So this is -- it's typical that when  
3 we do measure testing, that we would try to  
4 look for correlations among measures and  
5 patterns across states, and try to understand,  
6 you know, how does this measure relate to  
7 something that we've hypothesized that it  
8 might be related to, and it doesn't always  
9 work out, and this is what we found.

10 So what -- part of the reason why  
11 we think we couldn't find that difference is  
12 that we've not actually varied, you know, a  
13 correlation.

14 If you're looking for a  
15 correlation, with something that doesn't vary  
16 very much, that has a narrow distribution. So  
17 one thing that's narrowly distributed, and  
18 you're trying to find a correlation with  
19 something that's not.

20 If it's not, then you can't find a  
21 meaningful correlation. So that's -- that was  
22 our explanation for our results here, that we

1       presented in Table 3 and Table 4. We showed  
2       these results to others, and they said well,  
3       we're not ready to throw away the measure  
4       based on these validity results, okay.

5               That's basically what we're  
6       telling you is. When we showed this to  
7       stakeholders, we explained our problem. They  
8       said we can't explain the results, but we  
9       still think the measure has merit, and that's  
10      what the base validity is about. It's saying  
11      the measure has merit without this  
12      hypothesized relationship.

13             I did want to respond to one other  
14      validity concern that was raised, about who's  
15      responsible and are claims data going to pick  
16      up the data, pick up these services. The way  
17      that the specifications are set up, we require  
18      that the plans report --

19             That the plans be responsible for  
20      the members' chemical dependency benefit or  
21      mental health or behavioral health benefit, as  
22      well as the general medical benefit, so that



1 we're not in that situation of its care that's  
2 not in the benefit. If it's in the benefit,  
3 then the plan is responsible for that  
4 individual.

5 CO-CHAIR BRISS: So there are more  
6 and more cards up, sort of four more cards up  
7 on sort of any additional comments on validity  
8 that haven't already been made as quickly as  
9 possible, starting with Vanita, please.

10 MEMBER PINDOLIA: So my question  
11 on the validity is I noticed that during the  
12 stakeholder public comment, it was addressed  
13 of concerns of health plans having a lag time,  
14 the ER claim coming to enact upon a seven day  
15 follow-up. So when you were doing your  
16 validity search, did you notice what kind of  
17 gap there was from when a claim gets to a  
18 health plan?

19 The reason I'm bringing that up is  
20 I think it helps address to what Bob has said,  
21 and I think others have said. This really is  
22 more than just a health plan. This is really

1     needing the providers also to be held  
2     accountable for this joint effort.

3                   MS. HUDSON SCHOLLE:   So we  
4     couldn't analyze that in claims, but -- in our  
5     analyses. But it would require a proactive  
6     system, as others have talked about, of the ED  
7     contacting them and the health plan mediating  
8     that in some way.

9                   CO-CHAIR BRISS:   Yeah. I think  
10    we've actually raised this issue already, that  
11    this is a retrospective, you know, sort of  
12    reporting measure. It by itself isn't, you  
13    know, wouldn't be immediately useful as an  
14    internal quality improvement tool. Tami.

15                  MEMBER MARK:   Yeah. I've looked  
16    at the validity of post-discharge follow-up  
17    from psychiatric and substance use  
18    hospitalizations, which is very parallel, and  
19    it's actually hard to demonstrate that it has  
20    an effect in observational data, because you  
21    have such a selection bias.

22                   But if you look at some of the

1 studies that have been done, you know, more  
2 rigorously in terms of randomized trials, you  
3 know, you do see that there's evidence that  
4 post-discharge follow-up does reduce  
5 readmissions, and I would think that, you  
6 know, you can use that evidence since this is,  
7 you know, a similar type of thing, to support  
8 the validity of the post-discharge follow-up  
9 after ED. But I don't think in your  
10 application you cited any of that research.

11 MEMBER SUSMAN: Thank you. I  
12 don't find that this "failed"  
13 association/correlation with regard to your  
14 validity testing is particularly telling or  
15 concerning. I mean I can think of lots of  
16 different confounders in this.

17 So I think as a group, as we look  
18 at this, I'd say yeah, well that didn't work  
19 out. But it doesn't affect me in thinking  
20 about the validity testing overall.

21 I would hope that in the future,  
22 we would have other approaches to validity

1 testing, and also look at some of the issues  
2 that Les and others have raised, when you get  
3 down to okay, does this really reflect  
4 appropriate, accurate data as we're going  
5 forward.

6 CO-CHAIR BRISS: So thank you, and  
7 I'd like to suggest that we try to vote on  
8 validity please.

9 MS. BAL: Okay. Voting is now  
10 open.

11 [VOTING.]

12 MS. BAL: Just waiting for two  
13 more votes. If everyone could please vote,  
14 thank you. Okay. The results for validity  
15 for 2605 is high 3, moderate 9, low 8,  
16 insufficient 1. So this is actually in the  
17 gray zone, yes, and we can move forward to  
18 feasibility.

19 MEMBER ZUN: I think it would be  
20 best that I not directly comment on this,  
21 because I'm afraid I might bias someone in the  
22 room. So with that, I'll close.

1 CO-CHAIR BRISS: So to quote my  
2 next door neighbor, it's claims data. So it  
3 appears feasible on its face. Any additional  
4 thoughts that need to be raised?

5 (No response.)

6 CO-CHAIR BRISS: Let's try voting,  
7 please.

8 MS. BAL: Okay. The vote is now  
9 open for feasibility.

10 [VOTING.]

11 CO-CHAIR BRISS: I told you we'd  
12 be hard on you for a going away present.

13 MS. BAL: Can we get one more vote  
14 please. If everybody could make sure that  
15 they voted and point at me please?

16 Okay. So the results for  
17 feasibility for 2605 are high 5, moderate 13,  
18 low 2, insufficient 1, and we can move forward  
19 with usability and use.

20 CO-CHAIR BRISS: And it seems to  
21 me that we've had a lot of discussion that  
22 sort of touches on the usability of this

1     measure.  So are there additional comments  
2     that relate to usability that haven't already  
3     been addressed?

4                     (No response.)

5                     CO-CHAIR BRISS:  Hearing none,  
6     let's try to move to voting please.

7                     MS. BAL:  Okay.  Voting is now  
8     open for usability and use.

9                     [VOTING.]

10                    MS. BAL:  So we're only at 17  
11     votes.  If everybody could make sure to vote.

12                    (Pause.)

13                    MS. BAL:  So the results are for  
14     usability and use for 2605 is high 5, moderate  
15     8, low 5, insufficient 3 and okay.  Consensus  
16     is reached on that one, and we can move to  
17     overall, unless there's --

18                    CO-CHAIR BRISS:  It's over the 60  
19     percent line.  So any closing arguments before  
20     overall suitability?  Yes.

21                    MEMBER ROBINSON:  I know that  
22     we've looked at a lot of measures and people

1 are tired and all of this, but I just want to  
2 emphasize that this is probably one of the  
3 more important measures that can help improve  
4 the system where there are significant gaps.

5 Again, I want to emphasize the  
6 gaps cause harm to consumers with unnecessary  
7 hospitalizations, because of the way that ERs  
8 function and have to protect themselves from  
9 the liability of releasing someone without a  
10 clear follow-up. So I just really want you to  
11 keep that in mind as it relates to this.

12 It's not perfect, but it's one  
13 that really addresses a huge gap, and one that  
14 has a potential for helping consumers in the  
15 long run.

16 CO-CHAIR BRISS: And I suspect we  
17 may get a counterpoint. Les.

18 MEMBER ZUN: Actually, I want to  
19 agree, that I think we're on the same page.  
20 I think we want to ensure that providers are  
21 making sure that we capture these patients in  
22 care. I'm afraid that this measure does not

1       -- is not suitable, does not meet that basis.

2               I think I would send it back to  
3       NCQA and ask them to revise it with some more  
4       input, to really look at what -- to really  
5       measure and look at what behaviors they're  
6       trying to change in providers. So I think the  
7       intent's there; the delivery's not.

8               CO-CHAIR BRISS: So Mike, I'll  
9       give you the last word, and I think we know  
10      that there's a diversity of opinion on this  
11      measure already. So quickly please.

12              MEMBER LARDIERI: Yeah. I sort of  
13      wrap my head around this as bring it down from  
14      the health plan. I'm going at risk. As a  
15      health system, I want to do this. I want to  
16      do this in real time.

17              So I think it's important, because  
18      we're changing. It's going to be a whole  
19      different payor. It's not going to be the  
20      health plan. It's going to be me. So I  
21      really want to look at this really closely.

22              CO-CHAIR BRISS: So let's tee up a



1       vote please.

2                   MS. BAL:   Okay.   Voting is open  
3       for overall suitability.

4                   [VOTING.]

5                   MS. BAL:   Okay.   The results for  
6       overall suitability for endorsement for 2605  
7       is yes 16, no 6, and this measure will be  
8       moved forward for endorsement.

9                   CO-CHAIR BRISS:   So I'd like to  
10       try -- we're a bit behind.   I'm still  
11       sensitive to the fact that many of us are  
12       going to be leaving for planes.   I think we'll  
13       be okay, because the four remaining measures  
14       are related to each other, and I'm hopeful  
15       that we can pick up some time on the last four  
16       measures.

17                   I'd like to try to set up -- to  
18       grab lunch and bring it back to your desk in  
19       the next ten minutes or so and --

20       NQF Member and Public Comment

21                   CO-CHAIR BRISS:   Oh, I'm sorry,  
22       and we also need to open the lines for public

1 comment please.

2 OPERATOR: Okay. If some of you  
3 would like to make a comment, please press  
4 star and the number 1.

5 (No response.)

6 OPERATOR: At this time, there are  
7 no public comments.

8 CO-CHAIR BRISS: It appears there  
9 are no comments in the room, and so ten  
10 minutes to set up lunch, and then let's  
11 restart.

12 (Whereupon, the above-entitled  
13 matter went off the record at 12:38 p.m. and  
14 resumed at 12:55 p.m.)

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1	A F T E R N O O N   S E S S I O N
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2 | (12:55 p.m.)

3 CO-CHAIR PINCUS: So we're going to  
4 get started now. So, boy, I'm glad Peter was  
5 able to really do an exceptional job in  
6 getting through the stuff in the morning.

7 I had to keep my mouth shut, which  
8 is always very hard for me. I had to keep my  
9 mouth shut because it was hard for me, but  
10 this afternoon we're making a change in the  
11 schedule, so that we're going to deal with the  
12 PHQ-9 measure first, and then deal together  
13 with the 6-month and 12-month one. It means  
14 that we're going to have to like vote twice  
15 each time we do a vote for the second one.

16 But we can do that, right? So,  
17 you know we vote twice for importance on the  
18 six-month one, importance on the 12-month one,  
19 you know, that kind of thing.

20 MS. DORIAN: We might not be able  
21 to, for the voting itself --- we can discuss  
22 them both at the same time but then for the

1 voting we have to go through everything  
2 because of our software. Everything for one  
3 and then everything for another.

4 Depression/Major Depressive Disorder

5 CO-CHAIR PINCUS: Okay, good. So  
6 is the measure developer here?

7 MS. PITZEN: Yes, thank you.

8 CO-CHAIR PINCUS: Okay, good. So  
9 can you tee up the depression utilization of  
10 the PHQ-9, the 0712 measure for us?

11 MS. PITZEN: Sure. This is  
12 Collette Pitzen at Minnesota Community  
13 Measurement. Can you hear me okay?

14 CO-CHAIR PINCUS: Louder.

15 MS. PITZEN: Okay. Is this  
16 better?

17 CO-CHAIR PINCUS: Yes.

18 MS. PITZEN: Okay. The measure  
19 that we're talking about first today is  
20 depression utilization of the PHQ-9 tool.  
21 This is a paired process measure that seeks to  
22 promote frequent use of the PHQ-9 with

1 patients with major depression or dysthymia,  
2 adult patients aged 18 and older, and also  
3 supports the outcome measures of depression  
4 response and remission.

5           So this measure is capturing all  
6 patients who are seen within a four-month  
7 period, who have major depression or  
8 dysthymia, and have a PHQ-9 tool administered  
9 at least once during that four month  
10 measurement period.

11           The difference between this and  
12 the outcome measure, this is seeking to  
13 measure the entire population that has  
14 depression or dysthymia, regardless of what  
15 that PHQ-9 score is. Simply a way to ensure  
16 and promote frequent use of the PHQ-9 tool.

17           This measure has been collected in  
18 the state of Minnesota as part of a suite of  
19 measures. It's also included in CMS'  
20 Meaningful Use Program. Our average statewide  
21 rates on over 100,000 patients is 68 percent.  
22 I'm sorry. I'm a little bit out of -- I was

1 planning on presenting the other measures  
2 first.

3 The statewide average is 65.6  
4 percent, with significant variability among  
5 the clinics. Some of the data that was  
6 presented to you, one of the issues that the  
7 work group had was it seemed like this was not  
8 moving very much. We reported rates at a  
9 medical group level.

10 But even within a large,  
11 integrated medical group, for example, one  
12 group has a range of clinics administering the  
13 tools between 43 percent and 98 percent within  
14 the same integrated system. So there is  
15 opportunity and room for improvement.

16 CO-CHAIR PINCUS: So Dave, do you  
17 want to sort of begin to go through the  
18 importance to measure and report.

19 MEMBER PATING: Yes. Thank you  
20 very much. Well first of all, I'd like to  
21 just announce that I have no conflicts of  
22 interest. I have no opinions about this

1       measure, and so --

2                       (Laughter.)

3                       MEMBER PATING: I'll put the force  
4       shield around me, yes. So this measure is  
5       again looking at the PHQ-9 and what was been  
6       around, a measure that's been around for a  
7       long time, originally tested as part of the  
8       PRIME-MD, and a standardized measure of using  
9       many systems across the country for  
10      depression.

11                      The numerator is that you've done  
12      one PHQ-9 in a four month period, if you have  
13      a diagnosis of depression or dysthymia, and  
14      the documents and the folks in Minnesota were  
15      saying that by national count, 6.6 percent  
16      have a major depression diagnosis in the last  
17      year, and then if you add dysthymia, we're  
18      about up to 9.1 percent of the population.

19                      I'm just going to be very brief in  
20      terms of the Section 1A, B and C. You know,  
21      depression is common and measuring improvement  
22      is felt to be a gap, or that many people

1     because of either being untreated,  
2     inappropriately or inadequately treated, there  
3     is a gap in people that have been diagnosed  
4     getting to the goal line of being, I guess,  
5     undiagnosed, because they've been well.

6                 So there's felt to be again a  
7     commonness, a gap in treatment and then moving  
8     people that have been diagnosed to remission,  
9     and that the overall cost of this, in terms of  
10    life and quality of life and other health  
11    measures is significant.

12                So that's really the reliability  
13    issues and excuse me, the evidence issues.  
14    There was a lot of agreement among our group  
15    as to the basic need and the gap.

16                CO-CHAIR PINCUS: Other comments  
17    on the importance to measure and report?

18                (No response.)

19                CO-CHAIR PINCUS: Okay, wow.  
20    Okay. Seeing none, why don't we move to  
21    voting?

22                MS. BAL: Okay. Voting for



1 evidence is now open for 0712.

2 [VOTING.]

3 CO-CHAIR PINCUS: And Mike, I  
4 think, is conflicted.

5 FEMALE PARTICIPANT: Yes.

6 CO-CHAIR PINCUS: Okay, no. I  
7 want to make sure that that was said.

8 MS. BAL: Actually, I just do need  
9 one more vote. We should be at 23.

10 (Pause.)

11 MS. BAL: Okay. So then the  
12 results for evidence is high 21, moderate 1,  
13 low 0, insufficient 0, insufficient with  
14 exception 0 for 0712. And do you guys want to  
15 discuss --

16 CO-CHAIR PINCUS: Gap. Vote.

17 MS. BAL: Okay. Voting is now  
18 open for gap for 0712.

19 [VOTING.]

20 MS. BAL: We're missing one.  
21 Could everybody make sure that they voted?

22 (Off mic comments.)

1 MS. BAL: Okay. So for gap for  
2 0712, we have high 20, moderate 3, low 0,  
3 insufficient 0, and we can move forward to  
4 high priority.

5 CO-CHAIR PINCUS: And high  
6 priority.

7 MS. BAL: The voting is open.

8 [VOTING.]

9 MS. BAL: Okay. So for high  
10 priority for 0712, we have high 19, moderate  
11 3, low 0, insufficient 0, and we can move  
12 forward to scientific acceptability.

13 CO-CHAIR PINCUS: Great. So you  
14 discussed the scientific acceptability,  
15 reliability and validity.

16 MEMBER PATING: So this was done  
17 in Minnesota, and I actually forgot whether it  
18 was this measure or a previous measure that  
19 was done in response to a lawsuit. Was it  
20 this one that they implemented? Anyway, it  
21 might have been the other measure that we're  
22 looking at.

1                   They looked at 80,000 claims. So  
2                   it's very high utilization throughout their  
3                   system, and they found a reliability of .846.  
4                   I'm actually going to ask the submitters to,  
5                   if they can explain this .846, because I  
6                   wasn't quite sure. Was that a kappa or was it  
7                   a Cronbach's, you know, alpha in terms of the  
8                   reliability? So I'd be liking just a little  
9                   clarification on that.

10                  The group as a whole found using  
11                  PHQ-9 to be on face value, you know, a very  
12                  reliable measure for measuring depression, and  
13                  again the goal of this measure is to document  
14                  severity of depression when the diagnosis is  
15                  made. So those are my comments.

16                  CO-CHAIR PINCUS: Can the measure  
17                  developer just respond to the question please?

18                  MS. PITZEN: Sure. This is  
19                  Collette. I just wanted to share. I know  
20                  there was a little bit of difficulty  
21                  technically with the documents and the  
22                  insertions. But the reliability testing for

1 the measure itself was at .987, and that was  
2 part of the template that was submitted under  
3 282.

4 And then the reliability for the  
5 PHQ-9, the PRIME instrument itself, had a  
6 sensitivity of 88 percent, specificity of 88  
7 percent, an ROC analysis of .95 and Cronbach's  
8 also of .89.

9 MEMBER PATING: So in terms of  
10 reliability, I think we'd consider those very,  
11 very high.

12 CO-CHAIR PINCUS: Any comments on  
13 reliability?

14 (No response.)

15 CO-CHAIR PINCUS: Okay.

16 MS. BAL: Voting for reliability  
17 is now open.

18 [VOTING.]

19 MS. BAL: We're just missing one  
20 vote. If everybody could make sure to vote  
21 please. There we go, thank you. So the  
22 result for reliability for 0712 is high 19,

1 moderate 4, low 0, insufficient 0, and we'll  
2 move forward to validity.

3 MEMBER PATING: In terms of  
4 validity, that the measure measures depression  
5 and that you can tell something about it.  
6 There was strong belief that this was a valid  
7 measure. There were some questions around  
8 what would be considered the exclusions for  
9 the measure from the denominator.

10 The measure, as designed, excludes  
11 bipolar disorder and personality disorder.  
12 This actually goes back to the implementation  
13 of the PRIME-MD literature, which is from the  
14 mid-1980's, I believe, and they were found to,  
15 because of the high correlation of other  
16 symptoms related to those two diagnoses, the  
17 PHQ-9 was felt not to be valid for those two  
18 diagnoses.

19 It was mine and another reviewer's  
20 that there actually may be other diagnoses  
21 that we might want to recommend or consider in  
22 terms of exclusions, but I think the developer

1 will have a response to this. There's a sense  
2 that this may not actually be a valid tool,  
3 PHQ-9 in measuring depression in alcohol use  
4 disorders or substance disorders during an  
5 active phase.

6 I also wonder whether persons with  
7 cognitive disorders should be excluded, if  
8 there's a mood component as a part of a  
9 dementing or delirium syndrome of some sort.  
10 But there is a way that these are -- I'm sure  
11 that Mr. and Mrs. Developer, you could tell us  
12 how this works, but that you average out --

13 CO-CHAIR PINCUS: As you look up  
14 into the sky.

15 MEMBER PATING: --as you average  
16 out these various things. So could you  
17 address the exclusions and perhaps why these  
18 other exclusions, you felt, are not as  
19 significant?

20 MS. PITZEN: Sure, thank you.  
21 Appreciate the discussion today and at the  
22 work group call. We did conduct a literature

1 review for the use of a PHQ-9 for patients  
2 that have depression and alcohol or substance  
3 abuse, because that is not an exclusion from  
4 our measure.

5 The discussion that occurred at  
6 the work group, and we concur also that even  
7 considering the diagnosis of alcohol abuse or  
8 substance abuse might be difficult if one was  
9 to use that in a risk adjustment model,  
10 because of insufficient coding of that  
11 particular situation.

12 But we did thoroughly research the  
13 use of the PHQ-9 utilizing a bibliography from  
14 the tool developer. There were 1,340 studies  
15 cited as using the PHQ-9 or PRIME-MD.  
16 Searching on substance abuse and alcohol,  
17 there were 83 relevant studies that talked  
18 about using a PHQ-9 within this patient  
19 population.

20 Of those 83, only one study  
21 excluded patients with substance abuse. The  
22 rest of the studies included patients with

1 substance abuse, and there were several,  
2 actually seven supportive studies about  
3 comparing depression with and without alcohol  
4 abuse.

5           Probably the most significant one  
6 was by Delgadillo, Payne and Gilbody called  
7 "How Reliable is Depression Screening in  
8 Alcohol and Drug Users," and that was  
9 conducted in 2011. That demonstrated that  
10 with the PHQ-9 tool, that a PHQ-9 score of  
11 greater than 12 had a sensitivity of 81  
12 percent and specificity of 75 percent for  
13 major depression and alcohol, displaying good  
14 retest reliability of .78 and internal  
15 consistency with a Cronbach's alpha of .84.

16           Within this population of people  
17 that were substance abusers, there was a 68  
18 percent sensitivity, 70 percent specificity,  
19 and with modest retest reliability. So early  
20 on in the development stage, we had talked  
21 about the issues surrounding alcohol use and  
22 a patient's depression.



1                   However, the work group at that  
2                   time did not decide to exclude those patients  
3                   from this measure.

4                   MEMBER PATING:   What about the  
5                   persons with cognitive disorder, then, and  
6                   then also -- can you explain the risk  
7                   adjustment and how that may remove any  
8                   systemic error then?

9                   MS. PITZEN:   I'll try.   On the  
10                  first question with the cognitive impairment,  
11                  we do instruct our practices that if it is not  
12                  appropriate to give a PHQ-9 to someone because  
13                  of dementia or mental retardation, to not the  
14                  use the tool.

15                  One of the things that does is by  
16                  not administering the PHQ-9 to those patients,  
17                  you're not coming into the denominator for the  
18                  outcome measures.   In terms of the risk  
19                  adjustment variables, I'm not sure I  
20                  understand your question.

21                  MEMBER PATING:   Well my  
22                  understanding is the way that you had

1 explained to us on the phone call that these  
2 variables like alcohol or cognitive impairment  
3 might be adjudicated somehow statistically in  
4 your risk adjustment of the measure, and I  
5 didn't quite understand that, and I was just  
6 wondering if you can explain the risk  
7 adjustment process.

8 MS. PITZEN: Sure, and maybe I  
9 lead you to some misunderstanding. So our  
10 current risk adjustment model includes the  
11 severity of a patient's depression. It  
12 includes insurance product as a proxy for  
13 socioeconomic status. It also includes age  
14 bounds of the patient.

15 So right now, we don't collect the  
16 existence of alcohol abuse with these  
17 patients, nor cognitive impairment. So we  
18 don't have those available for a risk  
19 adjustment methodology.

20 If they -- if some time in the  
21 future those are determined to be significant  
22 factors by the Development work group, we

1 would consider including that. In fact, we  
 2 recently had a go-round about the impact of  
 3 chronic fatigue syndrome, sleep disorder and  
 4 some of those conditions, and those actually  
 5 demonstrated that they were very, very low  
 6 percentages within the population and they did  
 7 not impact the outcomes.

8 So always a future consideration,  
 9 but not right now part of our model.

10 (Off mic comment.)

11 CO-CHAIR PINCUS: Any other  
 12 comments about validity? Rhonda. Rhonda, did  
 13 you have --

14 MEMBER ROBINSON: Yes.

15 CO-CHAIR PINCUS: Okay.

16 MEMBER ROBINSON: I'm trying to  
 17 get to it. I have a couple of questions about  
 18 the PHQ-9. One has to do with the number of  
 19 languages that it's been translated into and  
 20 has it been tested for reliability in  
 21 different languages?

22 MS. PITZEN: Hi, this is Collette.

1       So I believe the PHQ-9 is available in between  
2       72 and 75 languages. I guess I am not the  
3       owner and developer of the tool, and I don't  
4       have the knowledge about the level of testing  
5       and reliability and validity. But those tools  
6       are available in different languages and have  
7       been translated as such.

8                   MEMBER ROBINSON: Okay. Then my  
9       second question is really one around why one  
10      administration of the PHQ-9 in four months,  
11      and the selection of the four months, as  
12      opposed to a tighter time frame after the  
13      diagnosis?

14                  MS. PITZEN: Sure, great question.  
15      Actually, we get the flip side of that  
16      question quite frequently, why isn't this  
17      measure like other measures? Why aren't you  
18      looking over a 12 month period for the  
19      administration of the PHQ-9?

20                  This dates back to some of our  
21      earlier constructs for the actual ability to  
22      technically collect this measure. A four

1 month time period was chosen. So the purpose  
2 of the measure really is to support the  
3 outcome measures, which are looking  
4 longitudinally at a patient over time.

5 We encourage groups to be  
6 frequently administering the PHQ-9. You know,  
7 we can't dictate that you give that tool every  
8 time you see the patient. But the intent is  
9 that it be used to assess the patient's  
10 symptoms when they're being seen, and used as  
11 a means for follow-up contact with them.

12 So even this measure once in four  
13 months, in my mind you should be administering  
14 it more frequently as they're seeing that  
15 patient.

16 MEMBER ROBINSON: Yeah, I agree,  
17 and I think the reason why I asked that is  
18 that certainly this is an indicator of  
19 treatment and treatment effectiveness. The  
20 sooner that one understands the baseline and  
21 measures frequently, the more likely they're  
22 able to have a successful outcome.

1                   So I think you've answered my  
2                   question. I just think it's unfortunate that  
3                   it's not requiring the PHQ-9 to be done  
4                   earlier in the course, so that treatment could  
5                   be more effectively administered, particularly  
6                   if the person has side effects or is not  
7                   responding in any way.

8                   Data demonstrates within at least  
9                   the first two weeks you can tell with the  
10                  initial treatment whether or not they're  
11                  starting to respond, and your earlier  
12                  responders you treat a little bit more  
13                  aggressively than you do those that don't  
14                  respond, where you may have to change your  
15                  treatment plan later on. So it's just a  
16                  comment.

17                  MS. PITZEN: This is Collette.  
18                  Can I clarify a little bit?

19                  MEMBER ROBINSON: Sure.

20                  MS. PITZEN: So unlike the outcome  
21                  measures, this measure is for all patients  
22                  with that active or diagnosis in their

1 history. So one of the easiest ways to avoid  
2 being in the outcome measure is to never give  
3 the PHQ-9 tool at all. So we use this as a  
4 companion to evaluate that practices are  
5 implementing and using that PHQ-9 tool.

6 We have seen the rates of this  
7 particular measure soar. So the difference is  
8 this is the use of the tool. You could not be  
9 demonstrating a high PHQ-9. You could be in  
10 remission. But the point is to give the tool  
11 and do the assessment.

12 MEMBER ROBINSON: Thank you.

13 MEMBER PATING: Could I ask a kind  
14 of follow-up question and if I could step out  
15 of order, because it relates to the next two  
16 measures, at a six-month and a twelve-month.

17 What starts the clock as the index  
18 for that six and twelve months? Is it doing  
19 the PHQ-9, because you could be diagnosed at  
20 zero, and then do your PHQ-9 four months  
21 later, and then that makes your six-month  
22 measure really a ten-month measure?

1                   So is it the diagnosis that will  
2                   trigger the six and twelve, or will it be that  
3                   when you do the PHQ-9?

4                   MS. PITZEN: I'm sure -- this is  
5                   Collette. It is when you're doing the PHQ-9.  
6                   So actually we are looking for -- the  
7                   diagnosis is a confirming factor, that we are  
8                   dealing with major depression or dysthymia,  
9                   because we wouldn't want to build a measure  
10                  that was based on just the PHQ-9 alone.

11                  But the act of that coming  
12                  together, we call that an index. So the day  
13                  that that occurs, the day that you have an  
14                  elevated PHQ-9 and you also have the  
15                  confirming diagnosis, that starts the clock  
16                  ticking for every patient.

17                  So every patient is going to have  
18                  a different index date, and then that starts  
19                  the clock ticking forward for six months plus  
20                  or minus 30 day remission, and then assessing  
21                  them again at 12 months, plus or minus 30 days  
22                  for remission. So the same patient is



1       assessed at two different points in time.

2                   CO-CHAIR PINCUS:   So in a sense,  
3       this is a balancing measure, in terms of  
4       applying within the suite?

5                   MS. PITZEN:   That is correct.

6                   CO-CHAIR PINCUS:   Les.

7                   MEMBER ZUN:   The question I have  
8       is, and I'm not a psychiatrist obviously.  Is  
9       the importance the delta of the PHQ-9 over  
10      time, or just getting a PHQ-9?

11                  CO-CHAIR PINCUS:   So Les, just to  
12      clarify.  So you know, we're dealing in a  
13      suite of three measures, and this measure is  
14      -- and so we're talking about this measure and  
15      then we're going to talk about the remission  
16      measures at six and twelve months.

17                  This measure is really trying to,  
18      as I understand it, it's trying to ascertain,  
19      of the universe of people who have a diagnosis  
20      that's applicable, how many of them have had  
21      a PHQ-9 within four years, to show that you're  
22      actually sort of reaching the population?  So

1       it's not looking at a delta yet.

2                       (Off mic comment.)

3                       CO-CHAIR PINCUS: But the next  
4       measure will, okay. Other questions? Okay.  
5       So I guess we're ready to vote on validity.

6                       MS. BAL: Voting is now open for  
7       validity.

8                       [VOTING.]

9                       MS. BAL: Okay. The results are  
10      high 19, moderate 3 for validity of 0712, and  
11      we can move forward to feasibility.

12                      CO-CHAIR PINCUS: Okay. Dave,  
13      feasibility.

14                      MEMBER PATING: So feasibility was  
15      easy. People felt that it was very feasible.  
16      While in some systems the PHQ-9 was not  
17      routine, people felt that the burden wasn't  
18      going to be huge, and then in the Minnesota  
19      data, they got 86,000 PHQ-9s. So that's  
20      86,000 feasibilities that they did so --

21                      (Laughter.)

22                      (Off mic comments.)

1                   MEMBER PATING: Yeah, somebody's  
2                   doing good.

3                   CO-CHAIR PINCUS: Any other  
4                   questions that anybody has about feasibility?

5                   (No response.)

6                   CO-CHAIR PINCUS: Okay. I guess  
7                   we're ready to vote.

8                   MS. BAL: Okay. Feasibility is  
9                   open for voting.

10                  [VOTING.]

11                  MS. BAL: Okay. The result for  
12                  feasibility for 0712 is high 18, moderate 4,  
13                  low 0, insufficient 0, and we'll move forward  
14                  to usability and use.

15                  MEMBER PATING: The group didn't  
16                  have a lot of comments on usability, other  
17                  than they thought this would be a good measure  
18                  for quality improvement on an individual and  
19                  a systems basis, as well as public report.  
20                  Again, it's to measure who gets measured.

21                  So using a measure was felt to  
22                  improve quality, and then we'll see in the

1 subsequent when paired, that you'll get the  
2 delta and the change and the improvement over  
3 time. So we thought that there could be very  
4 good usability with a very validated  
5 instrument.

6 CO-CHAIR PINCUS: Any comments on  
7 usability?

8 (No response.)

9 CO-CHAIR PINCUS: Okay.

10 MS. BAL: Okay. Voting's now  
11 open.

12 [VOTING.]

13 MS. BAL: Okay. The results for  
14 usability and use of 0712 is high 20, moderate  
15 2, low 0, insufficient 0, and we can move  
16 forward to overall vote. Unless there's  
17 further discussion, I'll open voting.

18 CO-CHAIR PINCUS: Any final  
19 comments or questions?

20 (No response.)

21 CO-CHAIR PINCUS: Okay.

22 MS. BAL: Voting's now open.

1 [VOTING.]

2 MS. BAL: Okay. The results are  
3 yes 22, no 0 for overall suitability for  
4 endorsement, and 0712 will be recommended for  
5 endorsement.

6 (Off mic comments.)

7 CO-CHAIR PINCUS: Terrific, okay.  
8 So now we're going to deal with these as a  
9 package. We're going to deal with the six  
10 month and 12 month ones, and let's hear from  
11 the measure developer, in terms of teeing this  
12 up.

13 MS. PITZEN: Great, thank you. As  
14 indicated, these outcome measures are  
15 identical, with the only difference is they're  
16 measuring the same patient at two points in  
17 time, assessing a patient for the patient-  
18 reported outcome of remission, the absence of  
19 depression symptoms as measured by the PHQ-9.

20 It's for adult patients aged 18  
21 and older with major depression or dysthymia,  
22 and initial PHQ-9 score greater than nine, who

1 demonstrate remission at 12 months for the  
2 first measure, or six months for the second.  
3 And that is defined as a PH score of less than  
4 five.

5                   It's a longitudinal measure that  
6 is looking over time to determine if the  
7 patient has remission from their depression  
8 symptoms. The beginning point for measurement  
9 is when the patient has both the diagnosis of  
10 major depression and dysthymia, defined by  
11 ICD-9 codes, and an elevated PHQ-9 score  
12 greater than nine.

13                   This is considered the index, and  
14 we spoke about that earlier. Then we're  
15 looking longitudinally forward. Did the  
16 patient demonstrate remission at either the  
17 six month or the twelve month mark, and there  
18 is a 60-day window around that particular time  
19 frame, that we're looking for a repeat  
20 assessment with the PHQ-9.

21                   The measure applies to both  
22 patients with newly diagnosed and existing

1 depression, whose current PHQ-9 score  
2 indicates that need for treatment. The  
3 measure additionally promotes ongoing contact  
4 between the patient and provider, as patients  
5 who do not have a follow-up PHQ-9 score are  
6 also included in the denominator, and they are  
7 assumed to be not in remission.

8 Exclusions for this measure  
9 include death during the measurement period,  
10 permanent nursing home residence and patients  
11 with a diagnosis of bipolar or personality  
12 disorders. In Minnesota, this measure is used  
13 in both primary care and behavioral health  
14 psychiatry settings.

15 The PHQ-9 tool is a patient-  
16 reported outcome tool with strong psychometric  
17 properties, and is validated for both aiding  
18 in the diagnosis of depression and for  
19 monitoring improvement of symptoms and  
20 assessing patient progress.

21 The measure is reporting on our  
22 consumer-facing website in a set of health

1 scores, and the 12 month measure has been  
2 selected by CMS for inclusion in Meaningful  
3 Use, and more recently for inclusion in the  
4 ACO GPRO Program. The measure that we just  
5 talked about was also included in Meaningful  
6 Use.

7 Some of the concerns expressed by  
8 the steering committee included low  
9 performance results, demonstrated by the  
10 measure, which has significant opportunities  
11 for improvement and the use of PHQ-9 tools for  
12 patients with the diagnosis of depression or  
13 alcohol or substance abuse, and we covered  
14 that issue already.

15 The measure is currently collected  
16 for all primary care and psychiatry clinics in  
17 Minnesota, the most recent data set  
18 representing over 350 clinics and 80,000  
19 denominator patients. Granted, it's been  
20 difficult to see movement in the overall  
21 statewide average, which is currently at 5.6  
22 percent, with higher-performing clinics at the



1 20 percent mark.

2 CO-CHAIR PINCUS: That's 5.6  
3 percent for the six-month or twelve-month?

4 MS. PITZEN: At a twelve-month.  
5 The six-month's is a little bit higher. The  
6 six-month is 6.9. Not super-impressive, I  
7 know. But please note that for both the  
8 measures, the number of denominator cases have  
9 increased fourfold in the last four years, and  
10 a subsequent fourfold increase in the number  
11 of patients achieving remission.

12 It's well-recognized that  
13 maintaining ongoing contact with this  
14 population of patients with depression is  
15 critical to their successful remission of  
16 symptoms.

17 It's also very challenging to do  
18 so. Of any patient population, patients with  
19 depression are least likely to be able to self  
20 advocate and require processes and systems in  
21 place for maintaining contact.

22 Minnesota has made small,

1 incremental improvements in the rates of  
2 follow-up PHQ-9 at twelve months and six  
3 months, that are approaching 25 percent for  
4 twelve months and 30 percent for six months.  
5 The low outcome rates are not solely  
6 attributed to lack of follow-up.

7 Additional analysis of the  
8 denominator patients who do have a follow-up  
9 PHQ-9 at six and twelve months demonstrate  
10 that only about 25 percent of the patients are  
11 in remission, and another 25 percent  
12 demonstrate PHQ-9 scores between 15 and 27,  
13 which is severe depression.

14 We covered the alcohol/substance  
15 abuse issues and questions already. So thank  
16 you.

17 CO-CHAIR PINCUS: So just one  
18 other just clarification. It's my  
19 understanding that there's also -- there are  
20 other, two other parallel measures around  
21 significant improvement; is that correct?

22 MS. PITZEN: Oh yes.

1 CO-CHAIR PINCUS: But they're on a  
2 different time frame for reexamination?

3 MS. PITZEN: Right. They were  
4 recently endorsed in the last phase. We also  
5 have two intermediate outcome measures that  
6 are looking at the response for the patients,  
7 and that is a 50 percent improvement at the  
8 PHQ-9 score, again at six and twelve months.

9 CO-CHAIR PINCUS: So let's talk  
10 about importance to measure and report. Jeff,  
11 do you want to say something about the six-  
12 month and I'll say something about the twelve-  
13 month.

14 MEMBER SUSMAN: Yes. So I think  
15 we're already covered the idea that depression  
16 is an important issue, and that this is one  
17 that's worth concentrating on.

18 CO-CHAIR PINCUS: And even for a  
19 whole year it's worth concentrating on. So  
20 any comments or issues with regard to  
21 importance to measure and report, and the  
22 evidence supporting that, or with regard to

1 the gap, or with regard to the priority.

2 Okay. So ready to vote. Now we're going to  
3 vote for the six-month.

4 MS. BAL: So we can only vote for  
5 one at a time.

6 CO-CHAIR PINCUS: Okay. So here's  
7 my proposal, is that we vote -- we essentially  
8 vote on the six-month at each of these stages,  
9 and then at the end, we go through the whole  
10 thing for the twelve-month, okay? Not the  
11 whole discussion thing, just the whole voting  
12 thing.

13 (Laughter.)

14 MALE PARTICIPANT: We'll be the  
15 judge.

16 MS. BAL: So this is the vote for  
17 0711, which is the six-month measure, and  
18 since this is an outcome measure, we'll be  
19 voting on evidence slightly differently.

20 The options are yes or no for if  
21 the rationale supports the relationship of the  
22 health outcome to at least one health care

1 structure process, intervention or service.  
 2 A slightly different decision, and voting is  
 3 now open.

4 [VOTING.]

5 MS. BAL: Okay. The result is for  
 6 evidence for 0711 is yes 22, no 0, and we can  
 7 move forward to gap. The voting is open.

8 [VOTING.]

9 MS. BAL: Okay. The result for  
 10 gap is high -- gap for 0711 is high 21,  
 11 moderate 1, low 0, insufficient 0, and we'll  
 12 move forward to high priority, and voting is  
 13 now open.

14 [VOTING.]

15 MS. BAL: Okay. The results for  
 16 high priority 0711 is high 21, moderate 1, low  
 17 0, insufficient 0, and we can move forward to  
 18 scientific acceptability.

19 CO-CHAIR PINCUS: Okay. So let's  
 20 talk about scientific acceptability. Jeff, do  
 21 you want to make any comments there?

22 MEMBER SUSMAN: I think without

1     going into the detail, the Committee felt that  
2     these were generally reliable and valid.  
3     There were not major concerns. Of course, any  
4     measure can perhaps be improved. But this was  
5     as measures go, pretty darn good.

6                   CO-CHAIR PINCUS: Yeah. I think a  
7     discussion around the twelve-month one, and  
8     I'm not sure whether this fits under  
9     reliability and measure specifications, or  
10    whether it fits under usability, is the  
11    question of whether it ought to be reported  
12    out as in different categories of people that  
13    were in remission, people who had significant  
14    improvement or whatever the term was, a  
15    response, and people who are not followed up,  
16    who did not --

17                   So that that would provide a more  
18    refined way of reporting it. It seems like  
19    the data are there to do it, and it would be  
20    more informative to people. Any response from  
21    the measure developer on that issue?

22                   MS. PITZEN: Sure, hi, this is

1 Collette again. We actually do have a suite  
2 of measures. We haven't put forth all of them  
3 for endorsement, but we are publicly reporting  
4 the follow-up PHQ-9s that accompanies the  
5 outcome measures. So of those patients who  
6 have an index and are included in the outcome  
7 measure, what is the rate of follow-up at six  
8 months and twelve months?

9 We report all of these measures as  
10 well. You can compare groups side to side.  
11 Like you could pull up the depression  
12 remission of the six months measure and the  
13 response measure side by side. But they are  
14 captured as separate measures, and we are  
15 processing --

16 The process is we're getting one  
17 file of information from our clinics and we're  
18 calculating all of the measures that you're  
19 talking about.

20 CO-CHAIR PINCUS: Okay. So I  
21 guess my comment, you know, doesn't go to the  
22 issue of reliability. It actually goes more

1 to the issue of usability, that it would be  
2 good to at least put that together, you know,  
3 in one place, so that individual provider  
4 groups could be looked at in that way.

5 But with regard to the  
6 specifications, you have the capability of  
7 doing that, you know, given the specifications  
8 that you have. Other comments on reliability?  
9 Rhonda.

10 MEMBER ROBINSON: Yeah. This is  
11 kind of a comment and really more of a  
12 question again. I'm just trying to play  
13 through the measurement of doing the PHQ-9 at  
14 four months, and let's just assume someone has  
15 started treatment as soon as they are  
16 diagnosed, and they don't do the first PHQ-9  
17 until four months.

18 Let's assume that person has shown  
19 a response to the treatment and started on  
20 anti-depressant medications, and their PHQ-9  
21 at that point may be nine or may be less than  
22 nine. So I guess what I'm saying is,



1       depending upon when the initial one is done,  
2       in relationship to the actual start of  
3       treatment, could very well skew these  
4       measurements towards patients who are, well  
5       let's see.

6                   You're going to have a harder time  
7       if you use this measure and you delay the PHQ-  
8       9 measurement. You're going to have a harder  
9       time demonstrating those who are a large  
10      portion that would respond quickly and early  
11      if you do the PHQ-9 late, as your initial, and  
12      then when you do it again.

13                   I'm not quite clear what you're  
14      getting. You may be skewing your populations.  
15      I don't know if I'm --

16                   CO-CHAIR PINCUS: So I think  
17      Collette can respond to that, but I think it's  
18      also based on being above a threshold of the  
19      PHQ-9, to get into the denominator, and also  
20      -- this also incentivizes providers to do it  
21      early. But Collette, do you want to respond  
22      to that?

1 MS. PITZEN: Yeah. I can -- I'll  
2 try to clarify a little bit. I mean I've seen  
3 this a lot in the clinics and the records  
4 through validation.

5 Say you have a patient that maybe  
6 you're not quite sure if you have major  
7 depression yet, and you're administering the  
8 PHQ-9, and you then do that a couple of times  
9 before you give the diagnosis.

10 So that is the one confirming  
11 thing, is you need to have that diagnosis  
12 before we would accept a high PHQ-9 to start  
13 the clock ticking. But in terms of when  
14 you're doing the PHQ-9, I think we're probably  
15 mixing up the process measure and the outcome  
16 measures.

17 We encourage our groups to  
18 frequently, especially for patients that are  
19 identified as having an elevated PHQ-9, that  
20 you're maintaining contact with them and  
21 administering the tool on a frequent basis.

22 In terms of are they in remission

1 at four months, we did need to kind of draw a  
2 line in the sand, and actually we're looking  
3 for remission between five and seven months,  
4 is that time window around the six-month  
5 measure. So there's like a 60-day grace  
6 period.

7 But for everybody, the clock  
8 starts ticking at the same time when you have  
9 the diagnosis and you have an elevated PHQ-9.  
10 Does that help at all?

11 MEMBER ROBINSON: So the index has  
12 to be greater than?

13 MS. PITZEN: That is correct,  
14 greater than nine.

15 MEMBER ROBINSON: So the initial  
16 measurement has to be greater than nine, even  
17 if it's --

18 FEMALE PARTICIPANT: And a  
19 diagnosis.

20 MEMBER ROBINSON: And a diagnosis,  
21 which could be still at four months after  
22 treatment has started, could theoretically,

1 right?

2 CO-CHAIR PINCUS: Right.

3 MEMBER ROBINSON: So aren't you  
4 skewing this towards patients who are, how  
5 would you say, perhaps the more severe, and  
6 who are less likely to respond early?

7 CO-CHAIR PINCUS: It would be to a  
8 provider organization's disadvantage to do  
9 that. I don't know if Minnesota Community  
10 Measurement has any data reflecting on that.  
11 But I don't see why someone would purposefully  
12 do this, or systematically introduce this as  
13 an important factor.

14 MEMBER ROBINSON: I've raised my  
15 issue. It's just that patients respond at  
16 different -- those that respond within two  
17 weeks are different than those that are not  
18 responding until eight weeks and those that  
19 don't respond at all.

20 So I guess what I'm trying to  
21 figure out, if one is taking their baseline at  
22 four weeks, what is the patient population

1     that you're actually measuring at that time,  
2     of those who are less than nine?

3             They may have been -- if they did  
4     it before the treatment started, they may have  
5     been a 9, a 10 or 11. But you started the  
6     treatment. You didn't do the PHQ-9, and then  
7     they didn't respond. So when you measure it  
8     at four months, they already are not going to  
9     be in your cohort. So you're really getting  
10    those, if you started treatment right after  
11    diagnosis, but still delay the PHQ-9, then  
12    you're getting the more severe population.

13            MS. PITZEN: This is Collette.  
14    I'm going to try one more time. So, when  
15    we're talking about a time frame of four  
16    months, we're assessing anyone that has the  
17    diagnosis of depression, to just kind of see  
18    where they're at and make sure that the tool  
19    is being given to them.

20            But the difference between the  
21    outcome measure is it's the elevation of the  
22    PHQ-9 that is starting that process, and I

1     guess I can understand what you're talking  
2     about. If a patient is receiving active  
3     treatment, perhaps before a PHQ-9 is given.  
4     But it's been my experience that the PHQ-9 is  
5     really kind of starting that process and  
6     alerting that there's problems or symptoms.  
7     The second thing I wanted to share is we do  
8     risk adjust by the severity of that patient's  
9     initial PHQ-9 score, that's a part of their  
10    index.

11                   CO-CHAIR PINCUS: Other questions  
12    about the validity? Tami.

13                   MEMBER MARK: At the risk of  
14    sounding biased, I love this measure. I think  
15    this is like -- really like maybe the only,  
16    you know, true population-based outcome  
17    measure we have for mental health and  
18    substance use disorder, and it's actually  
19    being used widely and reported in a  
20    transparent way.

21                   So I think it's quite amazing, but  
22    I might be delusional. So maybe that

1 perception is incorrect. So my question is I  
2 just want to make sure I understand, you know,  
3 what the data are showing us. Now this  
4 measure has been used for a number of years,  
5 and I think you talked to this a little bit.  
6 I thought what you said was that it's showing  
7 increases in follow-up rates.

8 But if you break out the people  
9 who were followed up, I wasn't sure what you  
10 were saying there, that the readmission rates  
11 have been going up over time, or have been  
12 flat over time. So if you can maybe just walk  
13 us through again what the trends are overall,  
14 and then broken out by whether the follow-up  
15 rates are going up since you've been using  
16 this measure, and whether the remission rates  
17 are going up, because since being used widely,  
18 and it's been used for a long period of time,  
19 you probably should, you know, assess whether  
20 it's moved the needle somewhat.

21 CO-CHAIR PINCUS: Collette.

22 MS. PITZEN: Go ahead. This is

1 Collette. Did you want me to respond?

2 CO-CHAIR PINCUS: Yes please.

3 MS. PITZEN: Like I had shared  
4 before, the follow-up rates for both the six  
5 month and the 12 month measure have been  
6 incrementally increasing over the years. The  
7 six month measure started in the low 20's, and  
8 now it's at 30 percent. But the 12 month  
9 measure, again it's a little bit harder to  
10 capture that patient one year out. But that  
11 measure has shown increases in the ability for  
12 groups to capture that follow-up rate.

13 But in terms of the -- when I'm  
14 looking at the patients that did have a PHQ-9,  
15 it's a special analysis that we do. We're not  
16 necessarily trending that over time. I know  
17 I have a suggestion. Why don't you just build  
18 your measure just for people that have  
19 followed up, and measure that?

20 Care and practice would not  
21 change, and we would still have 80 percent of  
22 patients lost to follow-up. But when we --



1     when I have done that analysis in the past, of  
2     the people that have had follow-up that six  
3     and 12 months, 25 percent of them are in  
4     remission. Another 25 percent of them are  
5     still at a level of severe depression.

6                 So there's opportunity for  
7     patients feeling better, even in the ones that  
8     we are following up. So the poor performance  
9     of the measure can't be solely attributed to  
10    the follow-up alone.

11                MEMBER MARK: But so you could do  
12    a trending of the people who were followed up,  
13    you just haven't yet, correct?

14                MS. PITZEN: I have not trended  
15    that, no.

16                MEMBER MARK: That would be  
17    interesting to see.

18                MS. PITZEN: This is Collette. It  
19    would be interesting, but -- however we  
20    wouldn't want to promote that as the new  
21    measure.

22                MEMBER MARK: I get that. I

1 understand that. I just think it would be  
2 nice to know if the measure was moving the  
3 needle on improvement in depression outcomes.

4 MS. PITZEN: I think one thing  
5 that helps is that if we look at the numerator  
6 cases over the years, the number of patients  
7 that actually have achieved remission has  
8 improved fourfold. So we know, but we are  
9 making a difference.

10 CO-CHAIR PINCUS: So I think  
11 Tami's also touching on a broader issue that  
12 I think is important. We may come back to it  
13 again when we talk about the process of this  
14 meeting and our new role as a standing  
15 committee, is that sort of getting information  
16 about the performance of measures going to be  
17 really important as this committee continues.

18 So that we, number one, can have a  
19 better understanding of the context in which  
20 we're evaluating measures, and number two, can  
21 think of ideas for how to improve the  
22 measures, and number three, identify where the

1 gaps are, in terms of the measurement process.

2 So I think that that's something  
3 that, you know, we should think about in a  
4 more formalized way, in terms of how to get  
5 the information or feedback about the  
6 performance of existing measures, both in  
7 terms of their uptake as well as, you know,  
8 whether the needle is moving.

9 MEMBER SUSMAN: And I think to add  
10 just another brief thought about that, it  
11 seems to me if we can give feedback to the  
12 field in some of these measures, which are  
13 very strict, and I think, you know, it's  
14 really laudable in my mind that they have  
15 taken a strict approach to this.

16 But there may be a role for NQF,  
17 in demonstrating to the field that while we  
18 still aren't making the improvement in  
19 remission that we might, there are indications  
20 early on that we're at least getting people in  
21 follow-up a little better. We're actually  
22 doing PHQs, and you can't get to documented

1 remission until you do those things. So we're  
2 not there, but there is some at least early  
3 signal that we might be improving.

4 CO-CHAIR PINCUS: Okay. Dodi and  
5 David.

6 MEMBER KELLEHER: Mine is not a  
7 comment on the specific measure reliability or  
8 validity, but to follow up on a very simple  
9 thing that would make more sense to me is if  
10 we could in the future see the whole suite.  
11 I know off cycle it, but you know, it would  
12 probably have more meaning in terms of impact  
13 on quality if we knew, you know, saw it all  
14 the response and the remission at six months,  
15 response and remission at 12, and having it  
16 off cycle. It's sort of a little  
17 disconcerting for me.

18 CO-CHAIR PINCUS: Good point.  
19 David.

20 MEMBER EINZIG: So a question,  
21 just to make sure that we're comparing apples  
22 to apples in terms of clinics and providers.

1     Are we separating out the locations and other  
2     variables, for example, urban clinics, versus  
3     upper middle class suburban clinics, versus  
4     Indian Health Services, or rural areas?  
5     Because I would imagine there would be  
6     differences.

7                   CO-CHAIR PINCUS:   So there is risk  
8     adjustment built into this measure, and but  
9     Collette, do you want to respond to that?

10                  MS. PITZEN:   Sure.   So for our  
11     public reporting website and our consumer-  
12     facing website, we typically will do some  
13     stratification by specialists, versus primary  
14     care providers.   So that is one option.   We  
15     also, for another project that we do, we look  
16     at things in terms of health care disparities,  
17     but we typically are not -- it would be  
18     interesting, but we currently are not doing  
19     that kind of stratification in our reporting.

20                  CO-CHAIR PINCUS:   Peter.

21                  CO-CHAIR BRISS:   And since risk  
22     adjustment in general is a hot topic at the

1 moment, can you review for us the variables  
2 that go into the risk adjustment model, and  
3 how much different they made?

4 MS. PITZEN: This is Collette  
5 again. I'm not a statistician. I'm trying to  
6 find the information that we provided in terms  
7 of that. I'm sorry. I'm just looking through  
8 my notes here.

9 MEMBER SUSMAN: There is an  
10 extensive description, I think, beginning on  
11 page eight of the document and going through  
12 the risk model.

13 MS. PITZEN: Right. So the  
14 variables that we're looking at, we're looking  
15 at age bands 18 to 25, 26 to 50, 51 to 65.  
16 Gender was evaluated. We're looking at the  
17 severity of the depression, based on the  
18 initial index, and then our --

19 MEMBER SUSMAN: And also payor.

20 MS. PITZEN: Pardon?

21 MEMBER SUSMAN: And also payor.

22 MS. PITZEN: Actually, that is

1 captured through insurance product, which is  
2 a roll-up of payors, and that is part of the  
3 risk adjustment model as well. So to just  
4 quote some of the statistics, the Pierson  
5 correlation compares the risk-adjusted and  
6 unadjusted depression outcome rates as .95,  
7 showing a strong correlation between the  
8 unadjusted and adjusted depression measures.  
9 Kendall's tau correlation was at .81, still  
10 strong but not as strong as the .95 with the  
11 other method.

12 So our statistician and the group  
13 that's working on this felt that this was a  
14 reliable risk adjustment model.

15 CO-CHAIR PINCUS: Other comments  
16 or questions about reliability or validity?  
17 Okay. So I guess we're ready to vote. So we  
18 can go through the reliability and validity  
19 voting components.

20 MS. BAL: Okay. Voting's now open  
21 for reliability of 0711.

22 Okay. So the results for 0711

1 for reliability is high 19, moderate 3, low 0,  
2 insufficient 0, and voting for validity is now  
3 open.

4 So the results for 0711 validity  
5 is high 18, moderate 4, low 0, insufficient 0,  
6 and we can discuss feasibility now.

7 CO-CHAIR PINCUS: So with regard  
8 to feasibility, Jeff, do you want to add  
9 anything?

10 MEMBER SUSMAN: I think the  
11 results speak for themselves. Tens of  
12 thousands of participants across the state.

13 CO-CHAIR PINCUS: I would agree.  
14 You know, it's not easy to do it, but it can  
15 be done and you know, it takes leadership to  
16 do that.

17 CO-CHAIR BRISS: And the other  
18 thing about that is that it's been done in  
19 tens of thousands of people. But the follow-  
20 up rates are still like at 30 percent, right?  
21 Isn't that what we heard?

22 CO-CHAIR PINCUS: So I guess the



1 point being that it's not so much that the  
2 measurement's a problem; it's the getting  
3 people to actually do the clinical care is the  
4 issue. Any other comments with regard to  
5 feasibility? Okay.

6 MS. BAL: Okay. Voting is now  
7 open for feasibility for 0711.

8 Okay. The results for 0711  
9 feasibility is high 16, moderate 7, low 0,  
10 insufficient 0, and now we can speak about  
11 usability.

12 CO-CHAIR PINCUS: With regard to  
13 usability and use, I think we've already heard  
14 some comments about displaying it in a way  
15 that you could see the different categories  
16 sort of lined up. But any other comments  
17 beyond that?

18 MS. BAL: Okay. Voting's now  
19 open.

20 Okay. The result for 0711,  
21 usability and use, high 17, moderate 5, low 1,  
22 insufficient 0, and we can move on to the

1 overall vote, unless there's further  
2 discussion.

3 CO-CHAIR PINCUS: Okay. Any last  
4 comments?

5 MS. BAL: Okay. Voting's now open  
6 for overall suitability.

7 Okay. So for the result for 0711,  
8 overall suitability, we have yes 23, no 0, and  
9 we can proceed forward with 0710.

10 CO-CHAIR PINCUS: So now we're  
11 going to go through all of the voting for the  
12 12 month one, and before we do that, is there  
13 any comments? Do people have any issues they  
14 want to bring up in distinguishing between the  
15 six month and the 12 month?

16 MEMBER SUSMAN: Well, first I have  
17 two comments. One is I just want to ask, will  
18 there be at the staff level any harmonization  
19 with this in the NCQA measures, or they're  
20 really just two different sectors of the  
21 world, kind of measuring the same things in  
22 other depressions?

1 CO-CHAIR PINCUS: So we're  
2 supposed to have a harmonization discussion at  
3 the end.

4 MEMBER SUSMAN: I know. But  
5 usually harmonization is within the data, the  
6 set that we have, right? Or is the  
7 harmonization --

8 (Off microphone comments.)

9 DR. BURSTIN: Yes. We have the  
10 harmonization discussion scheduled. We have  
11 them scheduled for later today. If we don't  
12 get to them, we're going to do them on our  
13 December call. But it's not just between --  
14 or within the measure, but it's actually  
15 different measure developers. We want to make  
16 sure that if the measures aren't competing, if  
17 they're just related, that they're harmonized  
18 to the extent possible so there are comparable  
19 results. So we'll definitely have that  
20 conversation.

21 MEMBER PATING: And then with  
22 regards to 12 months, I think there is a

1 question, you know, of the low -- I guess it's  
2 the change, the delta from the six months to  
3 the 12 months. So whether that is  
4 significant, is it enough just to measure  
5 progress at six months or do you want to put  
6 out a second measure again at 12 months, kind  
7 of move the system more incrementally?

8 I know that 12 month outcome is  
9 important, but just the data didn't show that  
10 there was a lot of movement from measuring at  
11 six to measuring at 12. So I guess I don't  
12 know. I don't even know where it fits. I  
13 mean on a practical level, did it make a  
14 difference to do it at 12? So that would be  
15 the question that I would ask.

16 CO-CHAIR PINCUS: I'm not sure we  
17 know.

18 MEMBER SUSMAN: Yeah. I was going  
19 say I'm not sure the state of our evidence is  
20 there, to be able to even answer that. My  
21 sense is that it comes to what is going to be  
22 most effective in the health system over time,

1 to move practitioners and systems to do things  
2 differently, and where does it matter?

3 I mean for example, for some  
4 patients who have more severe depression, we  
5 know certainly that you might have to go  
6 through two or three drugs. There might be a  
7 referral and other processes that would make  
8 it unfair to say at six months has the person  
9 reached remission, or might be anticipated  
10 from the data we do have, that it would be a  
11 better measure of total outcome to say at 12  
12 months.

13 CO-CHAIR PINCUS: I mean my view  
14 is that sort of the secret sauce in depression  
15 care is ruthless follow-up, and I think this  
16 encourages that. Any other comments,  
17 questions? Okay. So now we're going to go  
18 through, you know, the voting process for the  
19 12 month one.

20 MS. BAL: Okay. So for 0710,  
21 evidence is now open, and the options are 1  
22 yes, 2 no, since this is an outcome measure.

1 All right. So for evidence for  
2 0710, we have yes 22, no 0. Okay, now voting  
3 for -- sorry, wrong one. Ignore that. Voting  
4 for gap is now open for 0710.

5 Okay, and the result for 0710 for  
6 gap is high 23, moderate 0, low 0,  
7 insufficient 0, and voting for high priority  
8 is now open.

9 Okay. The result for high  
10 priority for 0710 is high 22, moderate 1, low  
11 0, insufficient 0, and we can vote on  
12 reliability now. We are waiting for two more  
13 votes, so everybody please make sure to vote.

14 Okay. So the vote for  
15 reliability for 0710 is high 21, moderate 1,  
16 low 0, insufficient 0, and voting for validity  
17 is now open.

18 Okay. So the result for 0710  
19 validity is high 19, moderate 3, low 0,  
20 insufficient 0, and we can vote for  
21 feasibility now. If everybody could just make  
22 sure to vote, please? We're missing a few.

1           Okay. The result for feasibility  
2       for 0710 is high 16, moderate 6, low 0,  
3       insufficient 0, and we can move forward with  
4       the vote for usability and use is now open.

5           Okay, and the vote for usability  
6       and use for 0710 is high 19, moderate 4, low  
7       0, insufficient 0, and now the vote for  
8       overall suitability is open. If everybody  
9       could please vote. We are missing a few.

10          Okay. The result for overall  
11       suitability for 0710 is yes 23, no 0, and this  
12       measure will move forward for endorsement.

13          CO-CHAIR PINCUS: Terrific. So  
14       now we're on our last measure to consider.

15          (Off microphone comments.)

16          CO-CHAIR PINCUS: Yeah, for this  
17       set. No, we don't have anymore. No, what I'm  
18       saying we're done. Now we're on the -- yes.  
19       Now we're on the last one. Yeah. You scared  
20       me for a minute.

21          (Off microphone comments.)

22          So this is -- so this is Measure

1 No. 2620, Multidimensional Mental Health  
2 Screening Assessment, and we have the measure  
3 developer here to tee it up.

4 DR. DAVIS: Thank you. Can you  
5 hear me okay? All right, great. Hi. So I'm  
6 Steve Davis with M3 Information. So our goal  
7 with this measure, and we've been through  
8 several iterations and, you know, there were  
9 several of you who were on the call, I think,  
10 a week or so ago, and discussed some concerns  
11 about how we wrote it up.

12 I'm a practicing psychiatrist.  
13 This is the first time I've written one of  
14 these things for you guys. I've done it on  
15 EURAC, but not over here. So you know, I  
16 appreciate being gentle with me, if you can.

17 (Laughter.)

18 CO-CHAIR BRISS: We haven't too  
19 much of a capacity for that.

20 DR. DAVIS: That's why I asked  
21 that question. So one of the challenges that  
22 we see in primary care, you know, as all of



1     you know, primary care providers do the lion's  
2     share of treating people with mental health  
3     problems, depression, anxiety disorder, some  
4     milder bipolar disorder, some mild to moderate  
5     PTSD, drug and alcohol abuse.

6                     And those numbers range from 50 to  
7     75 percent of people doing that, and they  
8     don't have psychiatrists in other -- or  
9     psychologists, other people to help them.  
10    They are not using tools, other than maybe the  
11    PHQ-9. In fact, just in the past month, I  
12    interviewed about five FQHCs about this, and  
13    most -- almost all of them were doing the PHQ-  
14    9.

15                    None of them were checking for  
16    bipolar disorder, and we know that 20 percent  
17    of people who screen positive for depression  
18    have bipolar disorder. In fact, even in the  
19    study from the University of Pittsburgh last  
20    year that was in JAMA, about looking at  
21    screening 10,000 women, postpartum women for  
22    depression using the Edenberg, and then doing

1 a SCID on the ones who scored positive.

2 Twenty-two percent of them had  
3 bipolar disorder based on the SCID, very high.  
4 So by just using the PHQ-9 -- and I understand  
5 that these last Minnesota ones excluded people  
6 with bipolar disorder. I didn't see how they  
7 excluded them. I don't know what they did to  
8 make sure people didn't have bipolar disorder.

9 But the challenge is what  
10 everyone's doing is they're pretty much doing  
11 PHQ-9 and figure okay, we're done with  
12 behavioral health, and they're not. In fact,  
13 they're guaranteed to be mistreating some  
14 fifth of their patients who score positive for  
15 depression.

16 Anxiety disorder is twice as  
17 common as mood disorders, and are highly  
18 managed in behavioral -- in primary care  
19 practices, but there's no systematic way of  
20 assessing that. Nobody's doing it. How are  
21 you doing? Okay, fine. Here's your Xanax or  
22 whatever.

1                   So we set out to have a  
2                   multidimensional mental health assessment tool  
3                   that assesses the common domains that are seen  
4                   in primary care practices, and mood disorders  
5                   including bipolar disorder, anxiety disorders  
6                   including PTSD, drug and alcohol abuse.

7                   Screening questions. Now this is  
8                   a process measure. So let me say something  
9                   about that, because in my initial application  
10                  to this, we got it kind of, I think, conflated  
11                  between process and outcome. I think we've  
12                  cleaned that up pretty well, and it's really  
13                  about the process measure.

14                 And that is, I think, a bar at  
15                 which to start, because this is not being done  
16                 at all now in primary care practices, and  
17                 patients are not getting screened and  
18                 adequately assessed, a screening tool like  
19                 ours or any others.

20                 I mean there's the full PHQ. I  
21                 haven't seen anything about the PHQ, the full  
22                 28 question PHQ for years, which looks at a

1 number of different domains. Nobody's using  
2 it, I think because it takes too long and it's  
3 not practical.

4 But there are practical tools.  
5 We've developed one that can be used in  
6 outpatient settings by primary care doctors,  
7 and we've added the proviso, and hopefully --  
8 well, you have on screen, you have the most  
9 recent revision of this, which includes  
10 measuring this in practices that have staff-  
11 supported care, that can help in further  
12 diagnosis, referral and management.

13 Like what's added in the U.S.  
14 Preventive Services Task Force for Depression  
15 Screening. They say well, you should only do  
16 it if you can do something about the result,  
17 and we're saying the same thing.

18 So that's kind of, I guess, the  
19 basic thing that we're trying to do here.  
20 I'll just point out a couple other things that  
21 I think are -- I think I heard Peter, you  
22 talked about let's vote for absolutely

1 shocking.

2 Well, some of the absolutely  
3 shocking things to vote for are that a third  
4 of patients, only a third of patients with  
5 these problems are receiving any treatment.  
6 Of the ones who are, a third of those are  
7 receiving minimally adequate treatment.

8 So we're talking about 12 percent  
9 of these patients getting minimally adequate  
10 treatment, which is just not acceptable and we  
11 could continue to do kind of single  
12 dimensional things, or we could do something  
13 broader, and that's kind of what I'm hoping to  
14 do.

15 The final point, I guess, is World  
16 Health Organization, top 15 causes of global  
17 disease burden in developed countries. Five  
18 of the top 15 are behavioral health,  
19 depression, bipolar, panic disorder, alcohol,  
20 schizophrenia. So we have to pay attention to  
21 this.

22 I think that in my work with

1 patient-centered medical homes, and in fact  
2 we've got NCQA has looked at us and we have  
3 the only NCQA recognition for a mental health  
4 measure in patient-centered medical homes.

5           They have recently added, as I'm  
6 sure many of you know, a greater focus on  
7 behavioral health, and when I talked to  
8 patient-centered medical homes, what they're  
9 focusing on is making sure that they get, you  
10 know, I have to do a behavioral health quality  
11 measure, so let's pick one. They picked  
12 depression. Unless we have something that's  
13 broader, they're just going to keep picking  
14 depression over and over again, and we're not  
15 going to get off the dime.

16           CO-CHAIR PINCUS: Okay. So Mike,  
17 do you want to --

18           MEMBER LARDIERI: Great, thanks,  
19 yes. So --

20           CO-CHAIR PINCUS: And let's focus  
21 on the, you know, the importance to measure  
22 and report this focus.

1                   MEMBER LARDIERI: Right. So the  
2 work group identified that it was important to  
3 screen across multiple dimensions, for some of  
4 the reasons that the developer had identified.  
5 So we were pretty clear that yeah, you should  
6 -- it's important to do this, and then  
7 there's, you know, some issues around the gap.

8                   There's a wide gap around  
9 screening in primary care for multiple  
10 behavioral health disorders, and we were  
11 pretty clear on that as well. There was some  
12 discussion that the -- well, that gets into  
13 the other thing. Some discussion about  
14 whether, as initially presented, it was to use  
15 the M3 specifically.

16                  But I think this revision here is  
17 not specifically to use the M3, but to use the  
18 multidimensional screening tool. So that's  
19 been revised since we had our discussion. So  
20 gaps yes, and importance, yes, was the work  
21 group discussion.

22                  CO-CHAIR PINCUS: So you want to

1     respond to -- anybody have any comments or  
2     questions with regard to the importance to  
3     measure and report?

4             MEMBER ZUN: I'm coming from a  
5     different angle on this. I think that doing  
6     this kind of analysis or survey of patients in  
7     an ambulatory practice is important. The one  
8     concern I have is we never really look at this  
9     overall, you know. There's so many different  
10    requests from so many different groups in an  
11    ambulatory setting that, you know, how do they  
12    have the resources and time and money to do  
13    all these things and make referrals?

14            So and this may be more an aside,  
15    but you know, I really think we should start  
16    looking at alternatives, like could we have a  
17    web-based program, and require them to do a  
18    web-based program, and to document that they  
19    did a web-based, rather than having people  
20    administer all these different tools.

21            So maybe that gets more into  
22    measures. But I think we need to start



1 pushing that agenda, rather than adding more  
2 and more surveys for primary care practices,  
3 ambulatory practices. Thank you.

4 CO-CHAIR PINCUS: Raquel.

5 MEMBER MAZON JEFFERS: I just had  
6 a question. Maybe it's part of the  
7 harmonization discussion, but is this being  
8 proposed instead of other separate screenings,  
9 or -- so we just voted on a host of measures  
10 using the PHQ-9 to screen for major  
11 depression. This multidimensional tool  
12 includes major depression. We also just voted  
13 on a host of other screening tools for  
14 substance use.

15 So I'm just trying to be clear.  
16 Is this -- the use of the multidimensional  
17 tool, is that being proposed instead of the  
18 separate tools?

19 DR. DAVIS: So I could comment on  
20 that. So the last three measures that you  
21 looked at only applied to people with major  
22 depression or dysthymia, not bipolar, not

1 anxiety, not other things. So I think it's a  
2 separate thing, at least compared to those  
3 three measures.

4 CO-CHAIR PINCUS: I don't know if  
5 you want to comment, the developer, about the  
6 web-based comment, because my understanding is  
7 this is web-based, as well as being able to  
8 give it to --

9 DR. DAVIS: Well, it certainly can  
10 be. Our screening tool, which we make  
11 available for free, is in fact web-based.  
12 It's also app-based, so you could do it with  
13 any browser. You could do it using an app.  
14 But that's about screening.

15 The comment, I think, was about  
16 treatment and the overwhelming requests on  
17 primary care providers, as far as making  
18 referrals and so forth. There certainly, this  
19 goes kind of beyond the measure. But there  
20 are certainly already a number of web-based  
21 behavioral health tools that are being used to  
22 manage patients, and to do kind of some lower

1 level treatment.

2 CBT online, for example. There  
3 are a number of those things that are either  
4 online now or coming online, and I won't get  
5 into the evidence about those. But those  
6 things do exist.

7 CO-CHAIR PINCUS: Jeff and Bob and  
8 -- oh. Vanita, you had yours up first? Okay.  
9 Well, Jeff and Bob and Vanita.

10 MEMBER SUSMAN: Could you  
11 describe, measure developer, just a bit more  
12 about what you believe the causal pathway is  
13 here? So I'm trying to link this with  
14 outcomes in patients.

15 DR. DAVIS: Yes.

16 MEMBER SUSMAN: So just strictly  
17 looking at the evidence basis as opposed to  
18 any of the other potential issues that might  
19 be raised.

20 DR. DAVIS: Right. So we know  
21 that, for example, anxiety disorders are  
22 highly prevalent in primary care practices.

1 Yet there's not screening for it, and if  
2 you're only using something like the PHQ-9,  
3 you know, if all you have is a hammer,  
4 everything looks like a nail.

5 So even people with anxiety  
6 disorders have mood disorder symptoms. But  
7 you're kind of blinded by not asking more  
8 specific questions. By doing that, and of  
9 course it's also the case that there's a lot  
10 of comorbidity.

11 So just because somebody has  
12 depression doesn't mean they do or don't have  
13 anxiety. There's a lot of overlap. So you  
14 can't just find one condition and say go home,  
15 we're done. By having a better sense of what  
16 their symptoms are, then you can tailor the  
17 treatment more specifically to that particular  
18 patient.

19 You can make better referral  
20 decisions, because if you find those 22  
21 percent of patients with depression actually  
22 have bipolar disorder, and your practice

1 doesn't feel comfortable or doesn't have the  
2 supports needed to manage that, you're going  
3 to make a referral decision for that patient.

4 So those types of better decision-  
5 making would lead to better management, better  
6 outcomes. I think that without starting  
7 somewhere, and I think this is kind of a lower  
8 bar, starting somewhere to evaluate well,  
9 who's actually doing this, and I think Leslie  
10 what you said about throwing more surveys at  
11 primary care practices, that's absolutely  
12 right.

13 So right now they've got Medicare  
14 asked them to do depression and alcohol,  
15 because if you combine that into one, now  
16 you've got one instead of two. If you can do  
17 several in one, then that's less for them to  
18 do, and they can get more of it, the patients  
19 and the providers.

20 CO-CHAIR PINCUS: Bob.

21 MEMBER ATKINS: We thought about  
22 exactly the same issue, Medicaid health plans,

1     okay, around the country. We thought about  
2     exactly the same issue, what we say is good,  
3     especially from Medicaid numbers, dramatic  
4     over-reliance on the PHQ-9. When we have  
5     people with all kinds of serious mental  
6     illness, serious and persistent mental  
7     illness.

8                     So we use the K-6 as a high level  
9     screener, for exactly the same rationale as  
10    you have, with the idea that if someone  
11    screens positive, we then do a substance use  
12    screen to catch the co-occurring, and then  
13    send them to a clinician and treat them, and  
14    try to make the referral. So we don't need to  
15    drop into the level of detail, because we're  
16    not the treaters.

17                    I would think that as we have  
18    PCMHs and ACOs that are starting to accept  
19    population risk, that would be an exceptional  
20    use for this, because they'd have to find  
21    people and provide the treatment for the K-6.  
22    It's not -- it's too blunt an instrument for

1     that, and yours -- there may be others, but  
2     yours seems pretty -- a better instrument for  
3     that.

4                 So I think that it really depends  
5     on the application, where it would return  
6     value to the entity that's doing the  
7     screening. I think that having it available  
8     for all the reasons you've talked about would  
9     be of tremendous value globally. But I don't  
10    know that it should be blindly said, well now  
11    we have to do this on top of that, on top of  
12    that.

13                I understand that concern. I  
14    think it's a realistic concern. But I think  
15    having it available as one of the critical  
16    tools in our toolbox is where I would see the  
17    value that this adds.

18                DR. DAVIS: Yeah, and let me just  
19    comment. You're right. ACOs and PCMHs are  
20    probably one of the types of groups that are  
21    much more likely to implement something like  
22    this, and the supports that are needed,

1       because they're on the hook for it.

2                       So they're going to bring in  
3       behavioral health. They're going to make sure  
4       that they have programs that can track these,  
5       and you know, if you look at -- of course the  
6       excess cost in medical conditions, because of  
7       poorly managed or diagnosed mental health  
8       problems.

9                       In Maryland Medicaid, for example,  
10       for 2011 adult data, we find that patients --  
11       we looked at 10 different DRGs, and this is in  
12       your report as well, diabetes and CHF and so  
13       forth. People with comorbid, these are  
14       Medicaid patients -- comorbid mental health  
15       conditions had a hospitalization relative risk  
16       compared to those without, of two to four  
17       times across 10 different DRGs.

18                      MEMBER ATKINS: Our data  
19       consistently replicates that.

20                      DR. DAVIS: Substance abuse was  
21       four to seven times. If you had the trifecta,  
22       I call it the triple threat, a chronic medical



1     problem, mental health, substance abuse across  
2     the 10 DRGs, 18 to 15 times the  
3     hospitalization rate.

4             MEMBER ATKINS:   Yeah.

5             DR. DAVIS:    So we've got to do  
6     something about it, and thank you for your  
7     comment.

8             MEMBER ATKINS:   Absolutely.

9             CO-CHAIR PINCUS:   Vanita.

10            MEMBER PINDOLIA:   I think my  
11     question is on the data.   I'm just very  
12     confused, because originally this was  
13     specifically for M3, and that's where all the  
14     data --   And now I heard that they're -- and  
15     now it's not.   So I think my question's going  
16     to come more when I look at that data portion.

17            MEMBER SUSMAN:    Could I just  
18     clarify?

19            CO-CHAIR PINCUS:   Larry is next.

20            MEMBER MILLER:    I think this is a  
21     valuable tool, and I've got more of a  
22     technical question that sort of follows up on

1 Raquel's question about harmonization, and  
2 Les' questions about over-supply of process  
3 and surveys, screening tools.

4 And maybe this will come up with  
5 the harmonization, but I'm just sort of  
6 curious now for the staff or whatever. If we  
7 like this and endorse it, what do we do with  
8 some of the other tools that don't quite take  
9 care of all these global kinds of issues, and  
10 how do we deal with that then?

11 (Off microphone comments)

12 MEMBER MILLER: Right, I'm sorry.  
13 But if we endorse it, then we've got all these  
14 others.

15 DR. BURSTIN: Even prior to the  
16 endorsement decision, if there are competing  
17 measures, we'll bring that before you and  
18 you'll have an opportunity to discuss it. But  
19 for now, we ask you to look at the measures  
20 individually, on their own merit, and then  
21 we'll come to that.

22 MEMBER MILLER: All right.

1 CO-CHAIR PINCUS: So Peter and  
2 then Dodi.

3 CO-CHAIR BRISS: So I had a -- so  
4 I don't recall seeing any actual data  
5 presented about the relationship of using this  
6 screening instrument and the outcomes. I  
7 understand that you've made a conceptual case,  
8 that people are under-recognized. We think we  
9 have treatments for some of the conditions  
10 that you might recognize, and that ought to  
11 result in better outcomes.

12 So I think the logic model is  
13 clear to me, but I haven't seen any actual  
14 data sort of supporting that, the logic model.  
15 Am I right?

16 DR. DAVIS: So that's where I  
17 think things got confusing with the initial  
18 application, because we had a lot of data on  
19 our particular instrument. But the measure  
20 being submitted was a process measure, the  
21 percentage of patients in an adult population  
22 who have had this screening in the past 12

1 months, versus not.

2 And so we took our instrument data  
3 out of that, because it was really considered  
4 to be irrelevant to the process measure.

5 CO-CHAIR BRISS: But as a general  
6 -- as a general rule, if you're submitting a  
7 process measure, you know, you're supposed to  
8 make a case that the use of the process  
9 measure would result in better outcomes,  
10 right?

11 So at this point, I'm not asking  
12 you about reliability or validity of the  
13 measure itself. I'm asking about whether you  
14 have empirical data that links this sort of  
15 screening to better outcomes.

16 DR. DAVIS: Right.

17 CO-CHAIR BRISS: And especially in  
18 the context of -- I think we just rejected  
19 kind of a similar pediatric measure yesterday,  
20 because it didn't have a great link to  
21 outcomes. But it looked like -- based on the  
22 submission, I think it had more documentation

1 of outcomes than this one does.

2 So I'm just trying to -- I'm  
3 trying to get clear in my head, sort of, your  
4 relationship of screening and better  
5 treatments and outcomes, and I'm trying to  
6 make sure that we're handling, sort of  
7 conceptually, similar measures in a reasonably  
8 consistent way.

9 CO-CHAIR PINCUS: Steve, you can  
10 respond, and then Dodi and Jeff.

11 DR. DAVIS: All right, thank you.  
12 So in -- what we took out was sort of, for  
13 example, although I think maybe some of it, in  
14 the appendix there's still, I don't know, a  
15 five page document or so, that describes some  
16 data from the University of California at San  
17 Diego, where across four sites our particular  
18 measure, multidimensional mental health  
19 screening tool was used across four sites, 12  
20 different physicians, and that data showed  
21 that all 12 providers found it to be useful.

22 I forget all the other aspects to

1     it that I had in there, but it should be in  
2     your appendix. So we've used it there. We  
3     have -- there's a large ACO in New York City  
4     that is currently using it. They are  
5     collecting data.

6                 We did get some -- we did not get  
7     any specific numbers out of them, other than  
8     some anecdotal data. They had some pre/post  
9     measures with respect to suicide attempts in  
10    their population, and found that there were  
11    nine suicide attempts in a period of time.  
12    Prior to initiating this, zero; afterwards,  
13    again it's the anecdotal data.

14                CO-CHAIR PINCUS: So I just want  
15    to just clarify something. So you made a  
16    change in the measure, so that you're not  
17    specifying a particular patient-reported  
18    outcome measure, but that there be --

19                DR. DAVIS: Yes, and it calls for  
20    a validated multidimensional measure or tool.

21                CO-CHAIR PINCUS: And do you have  
22    a list of them that are --

1 DR. DAVIS: We do mention several.  
2 We mention ours. We mention the mini. We  
3 mentioned --

4 CO-CHAIR PINCUS: Right, right.  
5 You mentioned them, but what would be -- how  
6 would this -- how could this be uniformly  
7 applied across the country, so to speak, as --  
8 in a reliable way?

9 DR. DAVIS: Right. So for  
10 example, we kind of looked at the model that's  
11 being used for depression now, which calls on  
12 users to use a validated depression screening  
13 tool. I'm wondering how it's different than  
14 that.

15 CO-CHAIR PINCUS: Well we just  
16 talked about using the PHQ-9.

17 MEMBER SUSMAN: Can I clarify just  
18 with staff what our task is, because I'm  
19 really confused about whether we're looking at  
20 the M3 or whether we're looking at the broader  
21 idea of any quote validated tool.

22 (Simultaneous speaking.)

1                   MEMBER SUSMAN: I hear what you're  
2 saying, but I'm not sure --

3                   DR. DAVIS: It's really just about  
4 the process measure. I don't know.

5                   DR. BURSTIN: It has to be about  
6 the measure before you, not the broader issue.  
7 Whatever the measure is before you, what's  
8 included in it is what you need to make the  
9 decision on.

10                   (Off mic comment.)

11                   CO-CHAIR PINCUS: I assume that  
12 the measure has changed since the previous  
13 discussion.

14                   MEMBER SUSMAN: Yes. I mean we  
15 had materials sent to us, and now I'm hearing  
16 -- so do you see what I'm --

17                   DR. DAVIS: Yes. If I could  
18 comment on that. We've had -- when we had our  
19 conference call a week, two weeks ago,  
20 something like that, the committee who were on  
21 the conference call asked for specific changes  
22 to clarify our submission.



1                   We worked for many hours with  
2                   them, with Lauralei and Angela and Sarah,  
3                   helping to make sure that we understood what  
4                   was being requested of us.

5                   I think that we answered that  
6                   appropriately, and that's -- so we made the  
7                   changes recommended by the Committee in what  
8                   you have before you now.

9                   MS. FRANKLIN: Steve, did you want  
10                  to sort of summarize?

11                  (Off mic comments.)

12                  MEMBER SUSMAN: For Helen or  
13                  Lauralei or whoever's the appropriate person,  
14                  I mean, do we do something based on the  
15                  developer that's just before us now, having  
16                  not seen it, or do we use what was submitted  
17                  and we all had the chance to review and I was  
18                  on that small work group?

19                  I guess we could go either way.  
20                  my own sense is that having stuff come in the  
21                  day of the review makes it very hard to give  
22                  it appropriate due diligence.

1 MS. FRANKLIN: So Steve, if you  
2 could give us a quick summary of what exactly  
3 changed. I don't think any of the underlying  
4 material has changed. You have taken out the  
5 tool, the specific reference to the tool and  
6 kept -- retained the multidimensional aspect  
7 of the measure.

8 DR. DAVIS: Thank you. Yes, that  
9 is -- so we took out mention because, again,  
10 it was thought to be confusing about is this  
11 a process measure or is this an outcome  
12 measure. So we took out any of our --

13 (Off mic comments.)

14 DR. DAVIS: So we made it much  
15 more clearly around the process measure that  
16 we had defined. There was a comment as well  
17 about, well, just screening for something and  
18 not doing something with the results, not  
19 having staff to make referrals or better  
20 treatment, diagnosis and so forth was -- was  
21 not very useful.

22 So we added in the definition,

1 both in the numerator and denominator,  
2 language to make it clear that this applied to  
3 practices like ACOs and PCMHs, for example,  
4 that did have those staff supports to be able  
5 to manage the diagnoses that they come up  
6 with. Those are essentially -- I think those  
7 are the main points, changes.

8 CO-CHAIR BRISS: So now --

9 CO-CHAIR PINCUS: Let me sort of -  
10 -

11 DR. DAVIS: I told you I'm a  
12 neophyte at this, and I probably screwed it  
13 all up, but I'm doing the best I can.

14 CO-CHAIR PINCUS: Well, let me see  
15 if I can -- so I think we're talking about two  
16 different issues here. One is we've been  
17 talking about the importance to measure and  
18 report this concept, this focus, and so there  
19 are issues there.

20 But there's a separate set of  
21 issues in terms of the lack of specification  
22 of the information before us, about what it is

1 we would be voting on, and I think that's a  
2 bigger issue. I mean we can talk about the  
3 concept, and I had my thing up because I had  
4 some concerns about the concept.

5 But I'm not sure we're in the  
6 position to be informed and to vote on what is  
7 the specification of this measure that we  
8 would be voting on.

9 MEMBER PATING: I feel like we  
10 just can't take eleventh-hour consideration.  
11 We really need to look at the documentation  
12 and consider these carefully. It's not a  
13 visibly fair process, but also I think there's  
14 still some structural concerns that really  
15 need to work out.

16 In the pre group, there was two  
17 issues. One issue had this concept paper, but  
18 you had no data backing the concept up, and  
19 you submitted specific indicator, the M3,  
20 which is the study that you've done.

21 We asked you pick one or the  
22 other. Either fill out the big picture or

1 give us the M3 indicator, and you actually I  
2 think took out the best part, which is the  
3 data around the M3.

4 But we still have this chasm,  
5 which is the concept, but no data, no  
6 specifications, no trial, no validity or  
7 reliability. So we're really stuck to go into  
8 this detail now, and I just feel like I can't  
9 even give this a vote.

10 I'd like to table this if we can,  
11 if there's such a thing.

12 CO-CHAIR BRISS: Yes. There's a  
13 thing called deferring actually, and so  
14 essentially we could defer to a later date,  
15 which I would recommend that we do. And so  
16 there are -- on the one hand you're to be  
17 commended, frankly, for trying to make a lot  
18 of changes in response to the work group call,  
19 right.

20 So but clearly, it made you and  
21 made us try to react to too many changes in  
22 not enough time. And so what I would

1       recommend is that we defer this one, which is  
2       essentially tabling it for a future time.

3               That would allow you a little bit  
4       of extra time to work with staff and possibly  
5       some members of the Committee about what would  
6       be needed, so that we could actually make a  
7       reasonable decision on this.

8               That saves us and you from -- it  
9       saves us from having to vote it down. It  
10      saves you from having to have it voted down  
11      and we could have a better discussion, I  
12      suspect, at a future date based on better  
13      information and more understanding of the  
14      process. So that's what I think I would  
15      recommend.

16              MS. DORIAN: We actually already  
17      -- no. We actually already have a post-  
18      comment call scheduled for January 8th, and  
19      oftentimes issues that weren't able to be  
20      resolved at the in-person meetings got  
21      discussed there, and measures are voted on  
22      again or for the first time if there wasn't

1 enough information. So that's a potential  
2 solution.

3 CO-CHAIR BRISS: I'd be careful  
4 about that, I think. This strikes me as being  
5 a possibly complicated measure. I don't see  
6 this one as being -- yes. My feeling is that  
7 if we were going to try to handle a measure by  
8 phone, I'd rather have it be a sort of a no-  
9 brainer, and my guess is that this one won't  
10 be a no-brainer.

11 But I think we ought to defer at  
12 this time, and talk about, you know, when and  
13 how we could bring it back up for a  
14 reconsideration is what -- I thought I saw a  
15 fair amount of head-nodding around the table.  
16 Are people generally okay with that? Is staff  
17 okay with that?

18 MEMBER PINDOLIA: One more  
19 comment. I think the discussion of having M3  
20 be the specific tool versus any validated  
21 multidimensional tool, the data you had with  
22 M3 gave a lot of data. The concern was it

1       didn't address the substance abuse, which was  
2       a very important part of a multidimensional  
3       tool.

4                       So I just don't want you to come  
5       back just with all M3 again, I think is at  
6       least my --

7                       DR. DAVIS:   Sure.  Yes, we did  
8       have substance abuse data, but I guess we  
9       didn't present it or highlight it in a way  
10      that was helpful.

11                      CO-CHAIR PINCUS:  So assuming that  
12      we are now going to be deferring this, are  
13      there additional comments that people have?

14                      CO-CHAIR BRISS:  The other comment  
15      that I would make, as you think about how to  
16      bring this back is so in some ways, I consider  
17      the Preventive Services Task Force to be the  
18      gold standard in sort of making the case that  
19      some intervention or bundle of interventions  
20      improves outcomes, and that's a case that I  
21      didn't really see in the materials that you  
22      presented today.



1                   So you might look to them for some  
2                   examples of how they're marshaled evidence  
3                   about what intervention am I talking about,  
4                   and how do I know that if I do it, it will  
5                   improve outcomes, and you might use some of  
6                   those as examples.

7                   DR. DAVIS: Thank you.

8                   CO-CHAIR PINCUS: And so Dodi and  
9                   David.

10                  MEMBER KELLEHER: Yes. Just  
11                  really quickly. I suggested on the prework  
12                  call, and I suggest again that you might want  
13                  to look at successful measures like the  
14                  Minnesota Community process and then suite of  
15                  outcome measures as sort of an example of what  
16                  you need to get passed and endorsed.

17                  DR. DAVIS: If I can respond to  
18                  that with a question. I appreciate your  
19                  feedback. So what I found challenging in  
20                  doing that was comparing our process measure  
21                  application with those outcome measure  
22                  applications. I continue to get kind of

1 tripped up with the --

2 CO-CHAIR PINCUS: So number one is  
3 you have to decide --

4 DR. DAVIS: Is it just me?

5 CO-CHAIR PINCUS: Well, number one  
6 is you have to decide what the measure is that  
7 you're proposing, and then to think about what  
8 kind of evidence you need to marshal for that.  
9 You know we can't say whether, you know, it  
10 should be a process or an outcome measure.

11 But I will say, going along with  
12 what Peter said, that you know, as a process  
13 measure you'd have to document pretty strong  
14 proximal relationships with outcome, not a  
15 theoretical notion, but actually that there's  
16 a strong causal link between what's done in  
17 the process and there's a relationship with  
18 the outcomes, and not just, like I said, a  
19 theoretical notion, but actual data. So I  
20 think that's a key issue.

21 Okay. So I guess we now move into  
22 some final discussion topics. So do we want

1 to have the harmonization discussion now?

2 MS. DORIAN: I think maybe we'll  
3 do the other two first, I think. Angela? Or  
4 at least maybe we can take a break now and  
5 pick the terms, for a break between, because  
6 that's one thing we have to get done.

7 Additional Discussion Topics

8 MS. FRANKLIN: So our next  
9 activity would be picking terms for the  
10 standing committee going forward?

11 MS. DORIAN: Right. So with our  
12 new process of seating standing committees, as  
13 you've already heard --

14 (Simultaneous speaking.)

15 MS. DORIAN: That's true, right.  
16 Of having standing committees, it's good  
17 because for example on this instance, you're  
18 able to oversee the entire portfolio and  
19 review things on an ongoing basis.

20 So we have terms of two to three  
21 years that are randomly selected, and I had  
22 emailed everybody a while ago to say please

1 let me know if you have any opposition to  
2 being seated for a three-year term.

3 I didn't hear back from anybody,  
4 but if you do, you can let me know now, let us  
5 know now. If not, we'll just go around, and  
6 if you could just read -- say your name out  
7 loud and then read the results, so it's  
8 transcribed, recorded and transcribed.

9 (Off mic comments.)

10 DR. BURSTIN: All of which are  
11 renewable. So we'd love to --

12 MEMBER ZUN: And the answer is Les  
13 Zun, three.

14 MEMBER MILLER: I'm going to be in  
15 Gryffindor House. Three.

16 MEMBER EINZIG: Dave Einzig, two.

17 MEMBER PATING: David Pating,  
18 three.

19 MEMBER JENSEN: Lisa Jensen,  
20 three.

21 MEMBER ROBINSON BEALE: Rhonda  
22 Robinson Beale, three.

1                   MEMBER KELLEHER: Dodi Kelleher,  
2     three.

3                   MEMBER PINDOLIA: Vanita Pindolia,  
4     three.

5                   (Off mic comments.)

6                   MEMBER ZIMA: Bonnie Zima, three.

7                   MEMBER MELNYK: Bernadette Melnyk,  
8     two.

9                   MEMBER LARDIERI: Mike Lardieri,  
10    three.

11                  (Off mic comments.)

12                  MEMBER SUSMAN: You know, for a  
13    bunch of scientists, the fish bowl is very  
14    scary.

15                  MEMBER GOLDSTEIN GRUMET: Julie  
16    Goldstein, two.

17                  MEMBER MAZON JEFFERS: Raquel  
18    Mazon Jeffers, two.

19                  MEMBER MARK: Tami Mark, two.

20                  MEMBER KNUDSEN: Kraig Knudsen,  
21    two.

22                  MEMBER SHEA: Lisa Shea -- oh.

1 Lisa Shea, two.

2 MEMBER SUSMAN: Jeff Susman, two.

3 MEMBER HORGAN: Connie Horgan,  
4 two.

5 MEMBER TRANGLE: Michael Trangle,  
6 another two.

7 MEMBER ATKINS: Bob Atkins, three.  
8 I'm a ringer. I belong over there.

9 (Off mic comments.)

10 DR. BURSTIN: Can we just explain  
11 to some people why we did twos and threes?  
12 It's just that -- so since we're starting the  
13 standing committee, we don't want all of you  
14 guys to rotate off at the same time. So the  
15 idea is just that half of you will be on for  
16 the two years and the other half, and it's  
17 still renewable.

18 So we're hoping that you'll  
19 actually come back for another two years. So  
20 after that, the terms will be two years. But  
21 at least we won't have everybody rotate off at  
22 the same time, and then we're stuck in the

1 same boat.

2 CO-CHAIR BRISS: Just to make  
3 everybody feel better -- sorry. Just to make  
4 everybody feel better, this side of the chair  
5 got the three. So we balanced it out a  
6 little.

7 (Off mic comments.)

8 MS. DORIAN: And the acceptance  
9 letters went out three months ago at this  
10 point.

11 So we have a discussion on gaps  
12 and sort of areas for future recommendations  
13 and more high level policy discussions, which  
14 we began yesterday.

15 CO-CHAIR BRISS: Could I make a  
16 comment? Yes. There were excellent comments  
17 on the gaps issue over the lunch break that I  
18 just wanted to put on the table. So we've  
19 approved most of the measures that we've seen  
20 over the last couple of days, but we approved  
21 nearly all of them with a bunch of important  
22 comments about ways that things, that might

1 evolve.

2 And so especially in a world of  
3 standing committees, it might be good to sort  
4 of try to figure out ways to capture what was  
5 said, and follow up with NQF and the measure  
6 developers about trying to more systematically  
7 evolve the measures, to kind of continuously  
8 improve the measures, so that, you know, over  
9 time maybe in a more systematic way than we  
10 perhaps have.

11 CO-CHAIR PINCUS: And it might be  
12 worthwhile actually, and maybe we should  
13 circulate this to the Committee. At the end  
14 of the last two Phase 1 and Phase 2, there  
15 were a series of gaps identified, with  
16 recommendations for future measure  
17 development, that we may want to sort of  
18 distribute to people.

19 (Laughter.)

20 CO-CHAIR BRISS: Do you always  
21 have that signal at the end of a meeting? You  
22 know, it's a good one for the group, right.



1 CO-CHAIR PINCUS: Dodi.

2 MEMBER KELLEHER: Yes. I want to  
3 second what you just talked about, and in fact  
4 maybe even recommend that there be a much more  
5 formal way that we document the sort of  
6 consensus recommendations or guidance, get  
7 that back to the developers, and maybe even  
8 have a strong expectation that unless those  
9 are addressed, and I think we --

10 CO-CHAIR PINCUS: It's almost like  
11 a study section, like you know --

12 MEMBER KELLEHER: Yes. If you  
13 don't address these, then your ability to get  
14 your maintenance endorsement may not be as  
15 strong, as an incentive for them to really pay  
16 attention to I think the very good comments.

17 In some of those gray zone sort of  
18 measures that got passed, I think that's  
19 especially important.

20 CO-CHAIR PINCUS: Vanita? Oh,  
21 Michael and Raquel and Vanita and David and  
22 Bob.

1                   MEMBER TRANGLE: Can you hear me?  
2       Okay. I'd like to follow up, and Peter, this  
3       is sort of the comment or the question I was  
4       asking you during one of our breaks, but it  
5       wasn't in the general meeting.

6                   It had to do with who are the  
7       parties that are really key or crucial to  
8       potentially look at the gaps, that just aren't  
9       part of our realm of thought or discussion?  
10      So you know, we've got our Joint Commission,  
11      you've got health plans.

12                  But another major player that's  
13      especially important in the mental health and  
14      the substance use disorder world really is  
15      CMS, and what's going on, either that the feds  
16      are paying for with Medicare or MA, however  
17      it's configured, the role of the states, and  
18      some degree of accountability and sort of  
19      harmonizing that things kind of match.

20                  CO-CHAIR PINCUS: Not to mention  
21      consumers.

22                  MEMBER TRANGLE: And consumers,

1     you know. But -- because it just feels like  
2     we sort of talk about it, and then we kind of  
3     wring our hands and sort of go on to something  
4     we can deal with and take action with. The  
5     other thing I mentioned way back when, but I  
6     think it's come up here periodically is, you  
7     know, I think you guys --

8                 Helen, you were very correctly and  
9     proudly kind of pointing out that we added 60  
10    measures and reduced 60 measures, you know.  
11    But I think for us to sort of somehow in a  
12    more formal, reliably kind of actionable way  
13    is to look at what's the whole portfolio, and  
14    how does it play out in the real world of a  
15    primary care/behavioral health clinician?

16                When we're adding something,  
17    what's the burden of time and money that it  
18    might take, and factoring that into our  
19    discussions with feasibility would be good,  
20    versus just technical feasibility with an  
21    instrument, you know.

22                CO-CHAIR BRISS: At least just to

1 perhaps make you feel slightly better, you  
2 know, HHS clearly knows that this general area  
3 is a gap. There have been HHS people at most  
4 or all of this meeting sort of listening in,  
5 and HHS is the funder of this particular  
6 exercise.

7 So the fact that behavioral health  
8 is a huge issue and that sort of it still  
9 represents -- it still includes lots of  
10 measure gaps is not entirely lost on the HHS  
11 family.

12 CO-CHAIR PINCUS: No, but I think  
13 Mike is getting a little bit more specific  
14 than that, because I think what's important is  
15 that CMS is doing stuff, but we're not aware  
16 of it, you know. So that's -- you know, there  
17 are things that are in the pipeline from CMS  
18 or issues that have come up, for example, in  
19 the MAP, yes, in the MAP that --

20 Like, you know, we had a  
21 discussion last time about reviewing the  
22 measures for the health exchanges, and noting

1 the lack of behavioral health measures, and  
2 particularly about sort of access to specialty  
3 care.

4 CO-CHAIR BRISS: Would anybody  
5 else from the family like to comment?

6 MS. POTTER: Hi. I'm D.E.B.  
7 Potter. I've been here the whole time,  
8 except for when I had to run to another NQF  
9 meeting.

10 I work at AHRQ three days a week  
11 and at the Office of the Secretary two days a  
12 week, and I've been working with NCQA and  
13 Mathematica on these measures that Sarah  
14 presented to you, that were developed with  
15 money from the Office of the Secretary and  
16 SAMHSA, in partnership also with CMS.

17 So HHS is very aware of all that  
18 you're doing, and we take what you say and I  
19 write it down and I think about it. I  
20 appreciate all of your contribution and your  
21 volunteering to this effort. But knowing  
22 where the important gaps are is something that

1 helps the Department in general.

2 So you know, please make that  
3 known. I'll just leave it at that.

4 CO-CHAIR BRISS: And the other  
5 thing that I would say on this topic is that  
6 there's sort of in the -- among the people  
7 that are at HHS working on measure development  
8 or measure development and testing and the  
9 sort of other key players like NQF and NCQA  
10 and others, there's been an increasing amount  
11 of cross-talk.

12 We haven't reached nirvana yet,  
13 but there's an increasing amount of attempts  
14 to get the left hand knowing what the right  
15 hand is doing in a way that we perhaps none of  
16 us, public or private sector, have done  
17 ideally to date.

18 CO-CHAIR PINCUS: So Vanita.

19 MEMBER PINDOLIA: My comment is on  
20 I agree with what's been said about what to do  
21 for measure developers, to understand where  
22 our concerns were. But yet I think I would

1 challenge NQF to take maybe a different stance  
2 for those that are gray zone, maybe making the  
3 developer understand.

4 I know right now that's not what  
5 NQF does. But to take this back for NQF to  
6 consider, that they would be able to say these  
7 were approved in the gray zones, understanding  
8 those aren't their committees.

9 But if it passes, and then they  
10 have limitations of what they can be used --  
11 and specifically understanding if they can be  
12 used for pay for performance, when we had so  
13 many concerns.

14 It passed between a 40 to 60  
15 percent, and maybe at the next round, if they  
16 have everything resolved, it can then move to  
17 that next level. It just puts a real hardship  
18 on the providers and health plan, when we had  
19 all those concerns and they weren't, you know,  
20 discussed or -- they were discussed, but they  
21 weren't resolved.

22 CO-CHAIR PINCUS: Okay, Dave.

1                   MEMBER PATING: I actually would  
2     like to second that, and actually I wanted  
3     just to say, in terms of this process, this is  
4     my third NQF meeting, and I just think  
5     actually this has been the best and most  
6     thorough discussions that we've had.

7                   I actually want to commend our  
8     chairs for getting expert in leading us.  
9     We're an unruly group. But I also think that  
10    we're learning as a group.

11                  This continuity idea, I do think  
12    that it's an advancement, because we're always  
13    finding we're bringing up other stuff that has  
14    been raised in other measures, and the  
15    continuity of this process over time has great  
16    value.

17                  So I think it goes to what Vanita  
18    is saying, in terms of, you know, us remaining  
19    as a thinking body and taking a look at these  
20    measures. But I again want to commend our NQF  
21    leadership, our leaders and then everyone here  
22    for a wonderful meeting.



1 CO-CHAIR PINCUS: Thanks.

2 (Applause.)

3 CO-CHAIR PINCUS: Dave.

4 MEMBER EINZIG: So ditto. Thank  
5 you, everybody on the NQF, and if anybody has  
6 a Sharpie, if we can change this to a 3-0, I  
7 wouldn't be opposed.

8 CO-CHAIR BRISS: You can always  
9 re-up. You have plenty of time to re-up.

10 (Off mic comments.)

11 MEMBER EINZIG: And building off  
12 of what Michael was saying about  
13 representation at the table, especially as  
14 we're moving more towards integrative models  
15 of care, I'd love to see more social  
16 work/mental health case managers, maybe  
17 education representatives, as we are moving  
18 more towards putting psychology and psychiatry  
19 in the school systems. So let's make it a  
20 well-rounded conversation at this table.

21 CO-CHAIR PINCUS: Bob.

22 MEMBER ATKINS: A couple of sort

1 of disparate thoughts. In terms of some gaps,  
2 I see on here, I just scanned it quickly,  
3 there's something about recovery, and that  
4 certainly connects to me with recovery-  
5 oriented metrics, in terms of what consumers  
6 are looking for and also something I'm just  
7 recently sort of learning more about, is the  
8 difference between disease-oriented evidence  
9 and what people refer to as POEMs, patient-  
10 oriented evidence that matters.

11 So the stuff that matters in  
12 people's lives, rather than disease state  
13 metrics. I think that's a really interesting  
14 and important issue to look at, because so  
15 much we look at disease states and things that  
16 matter to us.

17 I also would ask us to think about  
18 the concept of community tenure, because we  
19 used this when I was at Magellan. I'm  
20 introducing it now in Aetna. But it's not  
21 something that seems to be in common use. It  
22 has to do with people that frequently readmit,

1 but they readmit longer than 30 days.

2 So they might have eight  
3 admissions a year, and it has to do with how  
4 long people stay out of the hospital on  
5 average between admissions. For many of our  
6 people with serious and persistent mental  
7 illness, that community tenure concept, but  
8 it's not well-defined. Every company defines  
9 it differently, it seems.

10 The other thing, and this goes  
11 along with another comment, I'd say, is there  
12 were a lot of sort of cases made that this is  
13 really, really important, and we have really  
14 bad care, and we want to put this metric out  
15 there because it's better than nothing, which  
16 I totally agree with.

17 My concern is with unintended  
18 consequences, that once these metrics go out  
19 there, there are people, for example, state  
20 government, Medicaid, leaders who are largely  
21 uninformed about the concerns that we talked  
22 about here, and they use them to create

1 incentives and penalties for health plans.

2 As all of us know who are  
3 clinicians, punishment produces behavior to  
4 avoid punishment. It doesn't produce the  
5 desired outcome.

6 So I'm really concerned -- I'm  
7 old enough to remember Skinner. I'm really  
8 concerned that for people doing -- we want  
9 these metrics for all the right reasons, but  
10 the unintended consequences of them are really  
11 scary to me.

12 And if we get follow-up, what --  
13 how are they used, you know? Who's using them  
14 for what purpose? I think that's a really  
15 important consideration.

16 CO-CHAIR PINCUS: And Mike.

17 MEMBER LARDIERI: Thanks. I'm  
18 thinking that it would be helpful if we had,  
19 you know, for those consumers and other folks  
20 to participate, like the HIT community. So I  
21 would think it would be very helpful if we had  
22 some EHR vendors in, and if you look at EHR

1 vendors, you look at -- need to look at  
2 medical and behavioral health, because they're  
3 two separate groups, and they're not  
4 necessarily talking to each other now.

5 Or maybe from the Health  
6 Information Exchange area, and the other area  
7 under ONC, there's a Quality Measures Work  
8 Group, which is the work group that's talking  
9 about passing all the data. Once we decide  
10 what measure, they're figuring out how to pass  
11 that data around.

12 So somebody or some combination  
13 from those groups I think would be very  
14 helpful, because they're going to have to  
15 implement this stuff once we decide on it.

16 CO-CHAIR PINCUS: Jeff.

17 MEMBER SUSMAN: Helen, I think you  
18 hinted at this earlier. It seems to me there  
19 should be a higher standard for accountability  
20 measures, and I hear this in your remarks,  
21 Bob, about how either when we do pay for  
22 performance or we're looking at comparisons of

1     one plan versus another, I think many of the  
2     measures we talked about today seems like they  
3     will help to improve care.

4                     Quality improvement efforts, I  
5     think, are really a very important part of our  
6     mission. I get real queasy about some of the  
7     measures we approve, because I think there is  
8     this transformation from improvement to  
9     accountability and potentially unintended  
10    consequences, where our evidence basis doesn't  
11    really, in my mind, connote.

12                    And an easy way to operationalize  
13    that might be to use your gray zone sort of  
14    concept or something. That would be a two-  
15    stage process, where we vote for one level and  
16    then yet a higher standard level, or to rework  
17    your criteria around evidence and so forth, to  
18    be staged.

19                    DR. BURSTIN: So I feel like Dave  
20    was just asking about the timing of that. We  
21    have a Consensus Task Force on the Board that  
22    meets actually next week, and this is one of

1 the proposals we're bringing to them. And  
2 after that, we will convene an expert panel to  
3 help us think that through.

4 It's interesting. There's not a  
5 lot of science that helps you figure out which  
6 criteria help you decide a measure for  
7 different intended uses. It's interesting,  
8 you know, when you speak to consumers and  
9 purchasers in particular, their perspective  
10 is, you know, in some ways if I'm going to use  
11 this measure to pick a doc for my family,  
12 that's just as important as how much the  
13 provider gets paid.

14 So you know, I think that's where  
15 you have to sort of think through those  
16 concepts. So part of what we've been thinking  
17 about is maybe not getting into the issue of  
18 saying this is for payment, this is for the  
19 different uses, but instead to almost have a  
20 -- I've been referring to it affectionately as  
21 sort of a bond rating.

22 You know, this is a Triple A

1     measure, this is a Double A measure. This  
2     one's still in its evolution, and sort of  
3     buyer beware, as opposed to necessarily saying  
4     use this for payment. But obviously when  
5     those decisions get made and you pick an A  
6     measure that's not been in use and isn't at  
7     the highest levels of reliability and  
8     validity, it should give pause, particularly  
9     when it gets to the MAP and they help select  
10    programs.

11                   CO-CHAIR PINCUS: So you're  
12    talking about developing measures of measures?

13                   DR. BURSTIN: You got it. Measure  
14    rating system, yes.

15                   CO-CHAIR PINCUS: Okay.

16                   MEMBER TRANGLE: If you think  
17    about that in terms of sort of the Triple AIM,  
18    you could almost sort of like do the measures  
19    by patient satisfaction, by quality and by  
20    cost/affordability, the three different  
21    perspectives, depending on who's looking at  
22    it.



1 CO-CHAIR PINCUS: Peter and then  
2 Larry.

3 CO-CHAIR BRISS: So this is a  
4 thought about process and proven. So I've  
5 been struck many times over the last couple of  
6 days about the divergence between what I think  
7 was in the -- what I thought I read in the  
8 materials, and what gets discussed around the  
9 table, right.

10 You know, so I won't pick  
11 particular examples, but it appears to me that  
12 unless my reading has gone completely awry in  
13 my old age, that there were some times when we  
14 had significant divergence. It might be worth  
15 thinking about whether there are process  
16 improvements that would allow this to be --

17 I'd feel better about the  
18 transparency and reliability of the process if  
19 you treated it more like a grant review, and  
20 if it's -- if the material isn't in print in  
21 front of everybody, it doesn't count, right?

22 CO-CHAIR PINCUS: Larry.

1                   MEMBER MILLER: Well, this was my  
2 first rodeo in this arena, and when I got  
3 appointed, I was very happy, and then when I  
4 started looking at the data, I got very  
5 anxious. I didn't need a screen to tell me oh  
6 my God, what have I gotten into, you know.  
7 And so I know what I know, and there are other  
8 things I have no clue about, and I'm the first  
9 one to admit that.

10                   So I listened very intently on the  
11 calls, and we were the first group to get  
12 assigned and I think we had about a week to do  
13 it. I go oh my God, and then I've learned a  
14 lot just sitting here and listening and sort  
15 of getting the process.

16                   I think between Peter and Harold,  
17 I've really gotten a lot of input into sort of  
18 what this is all about for the next rodeo. I  
19 think in terms of some of the process, I think  
20 I like the idea of the work groups having more  
21 time to sort of process things and begin to  
22 talk about things, rather than just the one

1 call.

2 I know we're all very busy and I'm  
3 sure people won't be happy about it. But I  
4 think it helps the process to really think  
5 more intellectually about it, and really do a  
6 good job on those kind of things. So I would  
7 really be in favor of that.

8 The other sort of -- one of the  
9 other points is that I concur about the gray  
10 zone, because I think that even though they're  
11 documented, a measure is a measure when they  
12 get out there in many ways, and people don't  
13 know that all measures are created equal, and  
14 I think that's a problem.

15 One of the content areas that you  
16 may have addressed in previous iterations or  
17 not is the whole other spectrum of the  
18 population, the graying population, the  
19 elderly population in terms of behavioral  
20 health issues.

21 The population is aging, and I  
22 think that that would be another area that

1 many of us struggle with, in terms of the  
2 interface between what's intellectual, what's  
3 behavioral and how that all works together.

4 I think that would be an important  
5 piece to get, and I had a great time, thank  
6 you.

7 CO-CHAIR PINCUS: So Raquel, Tami.

8 CO-CHAIR BRISS: Mic, please.

9 MEMBER SIDDIQI: Oh, you can't  
10 hear me? Sorry. As we were chatting, I was  
11 chatting with Dr. Susman yesterday and Leslie.  
12 But my primary interest is behavioral health  
13 and elderly, and with all the regulations that  
14 are coming down with, you know, Department of  
15 Health and Medicare in terms of psychotropics  
16 in elderly, I have to say very honestly the  
17 tertiary psych facilities don't know what to  
18 do with these people.

19 Now they are stuck at our  
20 facilities like long term facilities or acute  
21 care hospitals. Really nobody knows what to  
22 do with these patients, and then there's

1 regulatory issues in terms -- and then there's  
2 quality of life issues.

3 I think there has to be a little  
4 better guidance, because they're regulations,  
5 but they don't make sense in certain  
6 populations. The intent is good, yes, but it  
7 doesn't apply to everyone. That's my dilemma.  
8 So I agree with you. Thank you.

9 CO-CHAIR PINCUS: Raquel.

10 MEMBER MAZON JEFFERS: I also want  
11 to say what an incredibly rich learning  
12 experience this has been for me. So thank  
13 you.

14 But I wonder if it's worth taking  
15 maybe a very small group of people, to look at  
16 the -- in terms of process improvement, to  
17 look at the documentations, the documents,  
18 because I found myself struggling and tripping  
19 over and re-reading and searching to find.

20 My guess is that there might be a  
21 way to streamline that. I mean eventually I  
22 found everything I needed. But it seems like

1       it might be -- it might be simpler. There  
2       might be a way to simplify it.

3                   MS. BAL: And then just feedback,  
4       that we are in the process of updating those  
5       work sheets. Could you give a little more  
6       detail, like what exactly you found difficult  
7       to find just so we can know?

8                   (Off mic comment.)

9                   MS. BAL: Okay, thank you.

10                  DR. BURSTIN: Poonam's our lean  
11       person, so she's the right person to work with  
12       on this. So we'll make sure that we get a  
13       group of you together.

14                  CO-CHAIR PINCUS: Tami.

15                  MEMBER MARK: Basically it was  
16       just said, yes. If we could --

17                  CO-CHAIR PINCUS: There's a couple  
18       of things, as kind of homework. One is that  
19       we do want people to think about, and we're  
20       going to have this follow-up call in January.  
21       But people to think about it, and actually  
22       even before January, actually to respond to

1 the staff, I think, with regard to number one,  
2 recommendations for future measure  
3 development.

4 So this is -- what's up here is  
5 what was actually in the report from Phase 2,  
6 and obviously we didn't fill everything today  
7 in terms of those gaps, and to sort of look at  
8 that and think about how one might refine  
9 that, but also add to it based upon what  
10 you've observed and both here, but also what  
11 you observed back home as well.

12 CO-CHAIR BRISS: In addition to  
13 that, sort of -- so in every measure  
14 discussion I've ever been in, people come out  
15 with a very long list of additional needs.

16 It would be great if you have  
17 thoughts about the highest priorities. In  
18 addition to lengthening the whole universe, it  
19 would be good to give some thoughts about what  
20 are the highest priority things.

21 CO-CHAIR PINCUS: Right. I mean  
22 to really think about this, so that we just

1 don't add, but we actually, you know, do it in  
2 a refined way. Then also come back with a  
3 different set of recommendations, in terms of  
4 process improvements, what we had here.

5 A number of things have already  
6 come up, like the notion of having a different  
7 kind of template for patient-reported outcome  
8 measures that need to be transformed into  
9 performance measures, to think about how we  
10 frame the segmentation kinds of issues that  
11 we've talked about, in a way that, you know,  
12 can make the process proceed more efficiently  
13 for segmenting existing measures, you know,  
14 things like that, you know, to think about  
15 that.

16 And so you know, speaking for me  
17 and Peter can speak for himself, as he does,  
18 that it's really been delightful working with  
19 all of you and with the staff. Now we're  
20 supposed to hear from public comment.

21 CO-CHAIR BRISS: And while we're  
22 waiting for public comment, thanks. I'll add



1 my thanks to everybody, too. Thank you.

2 NQF Member and Public Comment

3 OPERATOR: Okay. At this time, if  
4 you would like to make a comment, please press  
5 star then the number 1.

6 (No response.)

7 OPERATOR: There are no public  
8 comments at this time.

9 Next Steps

10 MS. DORIAN: Okay, wonderful.  
11 Well, gosh. It's been -- these two days have  
12 actually gone by really quickly. We just --  
13 we have one last slide for Next Steps. So of  
14 course this first one that we've just  
15 completed.

16 We will work on drafting the  
17 report with your recommendations, and being  
18 careful to concisely and clearly articulate  
19 the areas where we were in the gray zone so  
20 that we can solicit comments from members of  
21 the public and members of NQF.

22 That will be posted for a 30-day

1 period, from November 7th through December  
2 8th. Then we do have a call scheduled, it  
3 should be in your calendars, to review and  
4 respond to those comments, and we may use that  
5 call, if there's any additional time, if we  
6 don't end up getting, you know, a vast amount  
7 of comments, to discuss maybe gap areas or  
8 something else. We can think about that as it  
9 gets closer.

10 We will then draft the report for  
11 NQF member vote. That's for a 15-day period  
12 through February 6th, and then we have our  
13 Consensus Standards Approval Committee review  
14 your recommendations at a pretty high level.  
15 They sort of review them as a whole group and  
16 pull out any that they wish to discuss.

17 Then we have endorsement by the  
18 Board, and finally an appeals process. You  
19 also did have an optional date held in your  
20 calendar for I believe this Tuesday, and that  
21 was if we were unable to get to all of the  
22 measures in time. So you can release that

1       date. We'll cancel it.

2                   I'm sure you'll heartbroken about  
3       that. Don't cry too much. So yes. Just on  
4       behalf of myself and my colleagues, I'd like  
5       to say thank you so much. It's been a  
6       wonderful two days. I've really enjoyed  
7       getting to meet all of you, and I think it was  
8       a wonderful, rich discussion.

9                   MS. FRANKLIN: I'd like to add my  
10       thanks to Lauralei's and thanks to our co-  
11       chairs for shepherding us through these two  
12       days, as well as all the hard work you all put  
13       in, and the good recommendations that you gave  
14       to everyone, including developers and NQF.

15                  CO-CHAIR PINCUS: Okay. Thanks,  
16       everyone.

17                  (Whereupon, the above-entitled  
18       matter went off the record at 3:12 p.m.)

19  
20  
21  
22

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C E R T I F I C A T E

This is to certify that the foregoing transcript

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Standing Committee Meeting

Before: NQF

Date: 10-02-14

Place: Washington, DC

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