NATIONAL QUALITY FORUM

Moderator: Sarah Fanta
March 26, 2012
9:00 am CT

Operator: Okay Sarah, we are now in the main conference.

Sarah Fanta: Okay.

Operator: And I'll just announce everybody as they join you.

Sarah Fanta: Great, thank you.

Operator: You're welcome. And Linda Hanold has joined you Sarah.

Sarah Fanta: Okay great, thank you.

Operator: Nancy Lawler has joined.

Sarah Fanta: Okay great, thank you.

Operator: You're welcome.

Nancy Lawler: Hello?

Sarah Fanta: Hello.

Nancy Lawler: This is Nancy from the Joint Commission. Do you want me to put my phone on mute?

Sarah Fanta: Oh sure, that would be fine.

Nancy Lawler: Okay.

Sarah Fanta: That would be fine. Thank you.

Female: No, we don't have the developer.

Operator: Bob Rehm has joined.

Sarah Fanta: Great, thank you.

Operator: And Madeline Naegle has joined.

Sarah Fanta: Okay, great. We'll just wait a couple more minutes for a few more people to join us and then we'll go ahead and get started.

Operator: Okay.

Sarah Fanta: Thanks.

Operator: Tami Mark has joined.

Sarah Fanta: Okay, thank you.

Operator: Jeremy Gottlich has joined. And Girma Alemu has joined. Mady Chalk has joined.

Sarah Fanta: Hi everyone, this is Sarah Fanta. We're just going to wait a couple more minutes. I see a few more people are joining the webinar. So we'll catch back up with you in a couple more minutes.

Dr. Madeline Naegle: Sarah?

Sarah Fanta: Yes?

Dr. Madeline Naegle: I'm having trouble getting into the webinar using that address.

Sarah Fanta: You are? Okay.

Dr. Madeline Naegle: Yes.

Sarah Fanta: Sorry.

Dr. Madeline Naegle: Well I don't think - it might not be your problem, it could be here.

Sarah Fanta: Okay. Who's speaking?

Dr. Madeline Naegle: Madeline Naegle.

Sarah Fanta: Okay. Madeline, I will go ahead and resend the link to you one more time and...

Dr. Madeline Naegle: Okay.

Female: Thanks Sarah.

Operator: Eric Goplerud has joined.

Eric Goplerud: Hello?

Sarah Fanta: Hello. Hi, this is Sarah Fanta. We're just going to wait a few more minutes for a few other people to join and then we'll go ahead and get started.

Eric Goplerud: Thank you.

Sarah Fanta: Sure.

Female: Hello everyone and...

Sarah Fanta: Danielle?

Female: Hi there.

Sarah Fanta: Hi Danielle. Can you please move us to the conference room?

Angela Franklin: We're going to go ahead and get started.

Operator: And we're now connected and the recordings are going.

Sarah Fanta: Thank you.

Angela Franklin: Great, thanks Danielle.

Operator: You're welcome.

Angela Franklin: Welcome everyone, this is Angela Franklin, and I have here with me Sarah Fanta. And respectively, I'm the Senior Director on the project, Sarah's the Project Manager for the project, and this is the Behavioral Health Project Workgroup 2, our first call for this project. So welcome.

And today we're focusing on the alcohol measures. And I wanted to real quick do a quick roll call, and I'll start with Dr. Robert Robin? Jeffrey Samet? David Pating? Mady Chalk?

Mady Chalk: Here.

Angela Franklin: Madeline Naegle?

Dr. Madeline Naegle: Here.

Angela Franklin: All right, I thought I heard some other folks join? I just wonder - is - have I not called someone who's also on the line?

Female: There are other names on the list that I see in front of me.

Angela Franklin: Michael Lardiere? Tami Mark?

Tami Mark: Here.

Angela Franklin: Jeffrey Susman? Jeffrey Susman? No? Okay.

Female: I see Eric Goplerud's name on it ((inaudible)).

Female: Yes, he's on. He - I heard him call in.

Eric Goplerud: Here. I'm here.

Angela Franklin: Okay. Great, thanks. So if we have - at this time, if we have measure developers on the line, will you please announce yourself and your affiliation?

Nancy Lawler: This is...

Linda Hanold: Linda Hanold from the Joint Commission.

Nancy Lawler: And Nancy Lawler from the Joint Commission.

Angela Franklin: Okay.

Eric Goplerud: Eric Goplerud, NORC.

Angela Franklin: Okay.

Jeremy Gottlich: This is Jeremy Gottlich from NCQA.

Angela Franklin: Any others on the line? Okay, thank you. And I just wanted to see - I wanted to double check to see if we had a Dr. Robert Robin or Jeffrey Susman on the line? Dr. Michael Lardiere?

All right, well we'll go ahead and get started in the interest of time. our first - on our agenda, our first measure is 1661, however we don't have a measure developer - I mean I'm sorry, we don't have our discussant for that one right now. So we're going to skip down...

Sarah Fanta: No we can go - actually everyone did go ahead, even though they're not here on the phone, some people did inform us that they wouldn't be able to make it. We did have everyone fill out the SurveyMonkey link, so we can go ahead, if anyone on the line, I know you weren't assigned it, but if you would fill comfortable kicking off the discussion for measure 1661, at this time I'll also be projecting the scores from the SurveyMonkey. If anyone is having trouble with webinar please let me know.

Female: It's so small I can't read it.

Female: That's right.

Sarah Fanta: Okay. Is it better? Oh, actually on the webinar screen if you want to hit Maximize, which is in the top right hand corner, that should help a little bit.

Female: Yes, it does a little bit. Okay.

Sarah Fanta: Okay.

Angela Franklin: So according...

Female: It's cut off, you only - we only go to Column B.

Sarah Fanta: Oh yes, I'll scroll over as we move through the discussion.

Female: Can we see the whole thing as we have the discussion?

Female: I don't - what are we saying here, "Importance is high..."

Sarah Fanta: Okay, so starting off here, it looks like everyone in your workgroup who evaluated the measure deemed this to be important. Would anyone like to take on the discussion of this measure just to kick it off?

Angela Franklin: Yes. And just before we dive into the discussion, I just wanted to let everyone know that we're on the call today we're going to be going through these as initial and preliminary discussions. And we will be doing our final votes at the in-person, at which time we'd like to lead that discussion.

And then the workgroup lead's discussions about their feelings and recommendations for the measures. So please, with that said, if we could have someone begin discussion of 1661, you may review it at this time. I think...

Mady Chalk: Well this is Mady. So I'm happy to start it off.

Angela Franklin: Thank you Mady.

Mady Chalk: I think this is a particularly important measure, and particularly important for hospitalized patients. At - in any kind of hospital unit, whether it's on a med-surg unit or in a trauma center or elsewhere, we have plenty of data and plenty of research that makes it clear that alcohol's use and unhealthy use and overuse and use at all actually for a hospitalized patient, has an impact on treatment and management of any other condition that they may be hospitalized for or to process measure.

But it's - it can have very - alcohol overuse, misuse, unhealthy use, can have very serious consequences, not only in and of itself, but for other chronic conditions. And I think the research supports that. I understand why the developers left for this measure, and for the rest of these measures, decided to exclude people who are cognitively impaired, but I have questions about that, particularly for this measure. I'm not absolutely convinced.

Angela Franklin: Okay.

Sarah Fanta: Okay and we do have the measure developers on the line if you'd like to respond to that. Nancy?

Nancy Lawler: Yes, we felt that when you're screening if someone was impaired, that you know, they wouldn't be able to respond accurately. And so it was, "I'm not going to be" - you were not going to really be able to get an accurate assessment of...

Mady Chalk: Okay.

Nancy Lawler: ...the use status.

Mady Chalk: All right, I get it.

Dr. Madeline Naegle: So this is Madeline Naegle. The only other thing I would add to that is we do have some concern about older people. And they may have some mild cognitive impairment which really...

Mady Chalk: Yes.

Dr. Madeline Naegle: ...wouldn't rule them out from being screened for this. My sense of the exclusion criteria was that we were concerned about people who were intoxicated, who had some developmental delays, or who were actually psychotic. These are all people who would not be appropriately screened.

Nancy Lawler: This is Nancy. That's correct. And although those that come in that are in acute intoxication, we excluded them from the cognitive impairment because we felt that, you know, they're acutely intoxicated at the time that the come in, and then that's going to wear off and you can go back and you can screen those people.

Mady Chalk: Right.

Nancy Lawler: And so they are excluded from this definition of cognitive impairment. Someone who is, you know, just mildly - you know, like you mentioned, an older person, I don't think that, you know, the cognitive impairment was meant to deal with that type of person.

Mady Chalk: Okay.

Dr. Madeline Naegle: Yes, but of course that's one of the issues with a number of these subcomponents of this measure, and that is that we are not adequately screening older adults. So trying to - we would still like to be able to use a measure with older adults, despite the fact that they may have mild cognitive impairments.

Nancy Lawler: I see.

Mady Chalk: Yes, I would extend that discussion to patients with psychoses. Patients with psychoses may, you know, come in similarly to patients who are intoxicated, and then you know, with

treatment gain some insight and the role that you play in you know, treatment outcomes of patients with schizophrenia and psychoses is so critical.

I wouldn't want to miss those patients being screened, because you know, their admission they will say core, you know, cognitively impaired, but you know, actually at discharge they were able to have a discussion that involves screening.

Female: That's a good point.

Nancy Lawler: Yes you know, this is - can - this is Nancy, can I make a comment? You know, we grappled with that whole issue because you know, cognitive impairment is something that obviously might be transient, can get better just as you've mentioned. And the reason that we specked it out this way was to address the burden of data collection and the implementation of the measure.

And you know, our though was that if you screen the person one time, except for that acute intoxication person, that when you screened them if they were cognitively impaired we were going to exclude you and we weren't going to make the person that is implementing these, or whatever, abstracting, have to go back again and do this and keep doing it until the person resolves that cognitive impairment, or may not.

So it was an issue of sort of trying to balance that with the burden of implementation of this and the burden of abstraction.

Dr. Madeline Naegle: Yes I think there's also - this is Dr. Naegle. I just want to mention that in terms of provider burden, of the person who is actively psychotic, in the setting where these screening measures are meant to be used, which are primarily primary care and hospitalization medical

units, in the emergency room that person is going to be hopefully quickly transferred to specialist evaluation.

In which case the specialist, the psychiatric nurse practitioner, or the psychiatrist, will evaluate appropriately hopefully, for substance use when the individual is stabilized, so I don't know that we would necessarily lose that population from being screened ultimately.

Mady Chalk: That's the question. I mean they may not be screened in the ER but hope - you know, quality of care would that they were screened when they were transferred to a psych unit or a bed.

Dr. Madeline Naegle: Yes.

Mady Chalk: And would that be captured in the abstraction?

Dr. Madeline Naegle: Or seen in consultation. Because the usual order of affairs would be that someone, a specialist would be called to consult and would do a full evaluation.

Mady Chalk: So would that be picked up in the measure or would those folks be excluded?

Female: Would you know that that occurred?

Mady Chalk: That's a question for the developers.

Female: Yes.

Female: Yes.

Nancy Lawler: I'm sorry, what was the question?

Female: Would you know that it occurred? That somebody was - that there was a consult and the person was evaluated by somebody else?

Nancy Lawler: Well in review of the entire record and as your evaluating this for all of the measures in the set, you would come by that information probably when you're collecting the data elements for sub-three, which addresses those people with dependence or alcohol or drug disorder, which really requires more of an assessment than you can determine. I mean it's a diagnosis and so...

Female: Yes.

Nancy Lawler: ...our technical advisory panel felt that screening wasn't going to get to the point of a diagnosis, that you really needed...

Female: Well no.

Nancy Lawler: ...to have a further assessment.

Female: Yes.

Nancy Lawler: And so you would pick it up because we do - we collect all of these data elements together as a set.

Eric Goplerud: Nancy, this is Eric Goplerud.

Nancy Lawler: Sure, sure.

Eric Goplerud: If I can expand just a little bit on that. The denominator is all hospitalized inpatients except for those that are too cognitively distressed. You know, there are some exceptions. So it is a hospital responsibility, not a specific provider responsibility. So if there was a specialty consult or a transfer to a - any particular inpatient unit, the responsible entity is the hospital for making sure that the SPI is done.

Mady Chalk: So how does that cognitive impairment exclusion get implemented in practical terms by the hospital?

Nancy Lawler: Well it is a - the data element itself is just a yes/no data element. So there is a question whether or not the hospital is cognitively impaired in the data dictionary. If you have it and it's printed out for you, there's a definition of cognitive impairment.

And you know, the abstractor makes a decision, or you know, whoever is - this is the abstraction for the data element, but whoever is asking the questions, the person who is screening obviously if the person can't answer the questions, and is so confused or is obtunded maybe they're just - they're totally in a coma, obviously you know, you can't get the answers to them, they can't be screened, and they can document that. And then the abstractor knows and they can answer yes to cognitive impairment.

Mady Chalk: So I think it comes down to what the instructions are to the abstractor, so what do they look for to determine that the person is too cognitively impaired, you know. And I guess so if you had some instructions that said, "If the person, you know, is unable to respond," and that's noted in the record, that's what you would include.

That would be one thing, but if you had another thing that said, you know, any signs of Alzheimer's, or you know dementia, you know excluded, that would be something else that it seems like you could address this in the instructions you gave ((inaudible)).

Female: Do you all have the data dictionary there?

Female: No.

Female: Okay.

Female: I don't think so.

Female: In review of the measure, did you receive it?

Female: Yes.

Female: Yes, we did receive it.

Female: Okay, so there was - and I'm just going to pull out my specks right now, because let me just speak to it. And then you know if there are issues we can address them. But I'm going to look at the Data Element page and let me just read it - would you like me to read you the definition?

(Crosstalk)

Female: Okay it says - well, it - first of all it just says, "Cognition refers to mental activities associated with thinking learning and memory. Cognitive impairment, for the purposes of this measure set related to - the set related to documentation that the patient cannot be screened for tobacco and alcohol use due to the impairment, for example, comatose, obtunded, confused, memory loss."

There are some inclusion guidelines that we give which says, "If you see these documented; cognitive impairment, cognitively impaired, confused, memory loss, mentally retarded, obtunded -

- those would be inclusions." Of course going back to the definition that says, you know, they just can't answer these questions correctly.

And then the exclusion, as I mentioned earlier, was the temporary cognitive impairment due to acute substance use, because you know, we wanted you to go back at least for those folks, and once that got better, do the screening then.

Eric, do you have anything to say?

David Pating: Hi, this is David Pating. Can I ask, "Who goes back and does this screening?" Do you see this as a nursing function? I mean I know the hospital is responsible for this but I am - in some hospitals they might not have the right skill level on the floor to make this - this is a - I mean it sounds like there's almost a diagnostic quality to the impairment.

Female: No ((inaudible)).

Female: No, this is screening and it's to be done with a validated tool. So you use a tool like the AUDIT, the AUDIT C, the ASSIST, the TWEAK, you know, the MAST -- one of those validated tools. And so it can be administered by a nurse. It does not have to be administered by a physician so...

Female: There is no diagnosis at this level David.

David Pating: No, no I think in terms of the issue of cognitive impairment, that's what I - so I get the point...

Female: Oh the...

David Pating: But who makes the assessment of cognitive...

Female: I see.

David Pating: Is it just says that you can't do the 10 - are you adding an 11th question to the MAST basically and then with this, you know, "Is there cognitive impairment and they can't complete this," is that what you're doing?

Female: Well we're saying that if someone is trying to ask someone, you know, what - how they're drinking or what their use is and they're not able to respond, that - you know, and they're obviously cognitively impaired then you know, you would document that that's someone that you can't screen.

Female: Yes, we were - I don't know if you were on at the beginning of the call David. We were - I raised the question about the inclusion of people who were cognitively impaired. That's how we have this - discussed this.

David Pating: You know, I understand that. And - okay, I'll catch up. Thank you.

Female: Were there any other comments regarding the importance of the issue? I'm pretty - of the measure? I'm pretty sure that according to everyone preliminary evaluation, every person in the workgroup deemed this to be important to measure and report.

Female: Yes.

Female: And I think Mady did a really great job outlining the key issues. So does anyone else have any kind of comment around the importance before we move on to the scientific acceptability of the measure?

Female: I would say, "I think it's very important and has high impact and very timely."

Female: Great, thank you.

(Crosstalk)

Female: Any other comments? Okay so we'll go on and move to the scientific acceptability portion as this measure did pass, so far for discussion-wide the importance criteria. So we'll go ahead. Does anyone have any comments on the reliability and validity of the measure properties?

Dr. Madeline Naegle: It's Madeline Naegle, I...

(Crosstalk)

Dr. Madeline Naegle: The science is very strong in support of this measure.

Female: Okay.

Female: I just wanted to say that the Kappa statistic was very low. And it seemed to be, I think the - you know, or it felt that it was not a big deal because once there was training, it was a rise. So you know, that's a little bit of a caveat.

The other issue that I was a little concerned or wanted to hear more about was the fact that in some settings they used a non-validated tool as prescreening. And then if you know, if they're seeing the person did drink at all, then they would use the validating tool and there seemed to be some issue with how to handle that, and whether that would be considered, you know, screening or not. Yes.

(Crosstalk)

Female: so I just want to mention that the National Institutes of Alcohol and Alcohol Abuse in the Clinician's Guide recognize and support the notion of one question about the number of times a month a person drinks more than 5 drinks.

They use one question as a beginning screener, they don't consider it screening, but they then proceed - they recommend proceeding to the AUDIT C or the AUDIT. So it is a fairly common practice to use that. I have greater concern about the level of training to be able to discern the choice about using a validated tool.

So I would agree with the point that you just raised about some concern about asking one question in areas where that is not - it's not generally followed by the use of a validated screener.

Female: Right. And so the issue is making sure that people who are abstracting recognize that that would be considered screening if someone was asked one question and not asked the follow-up question.

Female: Right, that it would not be considered screening.

Female: It would be considered screening if someone would ask the first question and not the second because they didn't need the AUDIT so ((inaudible)).

Female: Okay.

Female: Any other comments around the reliability in the statement, numerator or denominator details?

Female: And again, just to go back into everyone, the workgroup's preliminary vote, everyone in the workgroup did deem this measure to be scientifically acceptable and have adequate reliability and validity results.

So with that being said, if there's no more comments around the scientific acceptability of the measure, we can go ahead and move on to the usability portion, which is the extent to which the audience says, "Consumers, purchasers, providers and policy makers," and understand the results of the measure and are likely to find them useful for decision making.

Were there any specific comments around the usability of the measure? Going back to the preliminary evaluations, we had three individuals rank this as being High, 1 as Moderate and 1 as Insufficient.

So I believe Tami, you had raised it as Insufficient. Do you want to express maybe some of your concerns around the usability of the measure?

Tami Mark: Yes, I mean I guess it was just an issue of not - it's not clear to me - you know, it's not available in electronic forms, so someone has to go in and abstract the data. And I guess that's part of the Joint Commission process. So maybe it's not a, you know, a big deal to do that.

Nancy Lawler: Well this is Nancy, and if I can make another comment. You know, the Joint Commission is currently in the process of ((inaudible)) the electronic specifications for sub-1 and sub-2. We've already done the modeling, we have the concepts down. We'll be doing the test cases this week, and then following that come the value sets, so this all should be done for these two measures by the end of May.

Tami Mark: Okay, that's great.

Eric Goplerud: This is Eric Goplerud. Also we are finding that many hospitals are building this into their EHRs so that it's being built into - in a number of places it's being built into Epic, which is a really pervasive EHR software, so that the instruments themselves, the scoring and the brief interventions or treatment initiation are all part of the electronic record, and therefore can be abstracted.

Dr. Madeline Naegle: So - it's Madeline Naegle. I'd just again, go back to a point which has come up in other committees for the quality forum, and I think it's an issue that we're continuing to try to deal with.

But we have - when we look at the science base, we have a very weak base for using the measure with what we would consider to be vulnerable minority groups, also older adults and women. So that the sample and the primary sample we're drawing for all four of these, would appear to be in VA certainly predominantly male. And I think we need to continue - we can't really change that right now.

I don't mean that to be - to take away the validity of going forward on any of these initiatives, because I strongly support them. But I think it's important to note that in taking this forward that we begin to communicate to our provider, institutions, that data needs to be gathered in these groups which have disparate access to treatment for alcohol and other drug problems.

Mady Chalk: I - Madeline, I agree with that with one caveat; that's true for the VA. The research that's been conducted on screening measures other than through the VA has included Medicaid and so significant numbers of minority and other groups with disparities, and as well as women. So that is true for the VA, but that is not the only place that this measure has been tested.

Dr. Madeline Naegle: So the developer did not speak to that. I mean we would assume that certainly we've gotten some older folks in the Medicare group and certainly a mix in the Medicaid group.

But the developer doesn't really make a point of that. And I think the more it's in the discussion the more we will continue to have it as something we need to improve in our data collection.

Mady Chalk: I agree with you about that.

Female: Yes, and I would say that the main source of the evidence is this Cochran collaboration review, which I thought was very well done. It includes, you know, 11 randomized trials in hospitals. But they do point out that, as you say, most - almost all the studies are done on men, and you know, we need more evidence on women...

Mady Chalk: ...single piece of research that comes through the NIH.

Female: What? Sorry Mady I didn't hear that.

Mady Chalk: That - never mind, that was a snide comment.

Female: Monday morning snide...

Female: Does the developer have anything additional to say around the populations that were discussed?

Nancy Lawler: You know, this is Nancy, and I don't. I think we decided - I have to go back and look at the submission, but I think we talked about (Whitlock Tanner McQueen) which was in the hospital setting, plus the VA and all of the reviews that were done by the VA, there's just a multitude of individual studies that have been done.

And I guess it was my understanding that what the NQF was looking for was really more of a systematic review of the evidence, so I don't know. Eric, do you have anything that you want to add?

Eric Goplerud: We're in the process of having a systematic review of the evidence of screening and brief intervention for geriatric populations in EDs being done this month. It won't be available till the end of this month.

Female: Great.

Female: Thanks Eric.

Female: Any other comments around the usability of the measure? Okay hearing none, we'll move on to the final criterion, which is feasibility, the extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement.

Looking at the workgroup's ratings, it appears that everyone rated this Moderate except for one person rated this as High. So does anyone have any comments around the feasibility of the measure?

Dr. Madeline Naegle: The only - this is Madeline Naegle again. The only comment I would make about it is, and everybody in the advisory group is aware of it and probably most the people on this call, is that while we see in the abstract it should be feasible, and when we're looking at the studies that support taking forth this measure, we see that it's feasible, but in reality we don't have very good follow-up in the clinical setting.

So I would say, and I think probably I marked this as Moderate, that I think this is something that we hope to gain some momentum on. And I certainly think it should be feasible. We don't really understand the organizational and provider issues that have not supported its wider use.

Mady Chalk: While I consider it feasible, I also consider that the purpose of having these measures and of having - requiring some accountability is something that drives improvements in quality so that I would hope, and I would expect that having a measure like this would drive quality improvement on its use.

Female: Great, any other comments around the feasibility of this measure? Okay, so based on the workgroup's evaluation of this measure, everyone seems to agree that it met all of the criterion and that it would in fact - it would have been recommended for NQF endorsement.

So of course, we'll take this discussion back to the Steering Committee, which you know, they'll discuss it during the April 17th and 18th meeting. So I think we have a really good head start on this measure. So we're going to go ahead now and move on to Measure 1663, which I'll pull up on the screen.

And I don't believe that Jeffrey's on the phone right now, so we may need someone else to give a brief overview of the measure. Let me pull up the - okay, so this is Measure 1663, it's sub-2, "Alcohol use brief intervention provided or offered," and sub-2a, "Alcohol use brief intervention," from the Joint Commission. Does anyone give an overview, or perhaps maybe the measure developer can give us a brief introduction to this measure?

Nancy Lawler: Okay this is Nancy. So since no one is speaking up I guess you're wanting the developer to give you an overview. I guess in your overview I'm not really sure what you want. I can tell you what the measure is and then if you want to launch into a discussion about importance or evidence we can do that. Is that how you'd like me...

(Crosstalk)

Nancy Lawler: Okay. So this particular measure, sub-2, looks at for all of those people who screen positive for unhealthy alcohol use that they are provided with a brief intervention. And in sub-2, those people that refuse, you may try to provide the intervention but they just tell you that, "You know what, I'm not interested, please go away, don't talk to me," whatever. We do give credit and that kind of a case will flow to the numerator because the hospital tried to do the right thing.

What sub-2 does is sub-2 - 2a, excuse - sub-2a, allows only those that received the intervention to go to the numerator so that, you know, you can see when you're looking at sub-2a, only those people who actually received the brief intervention. The refusals are not included in the numerator.

We do have a definition of brief intervention if you want me to go over that before we begin the discussion...

Female: That would be helpful.

Nancy Lawler: ...I'm going to pull it up here. We call this, "A single interaction between the qualified health care professional and the patient following a positive screening for a result of unhealthy alcohol use or alcohol use disorder." A brief intervention focuses on increasing the patient's understanding the impact of the substance of use on his or her health in motivating the patient to change the risky behaviors.

The components of the intervention include feedback concerning the quantity and frequency of alcohol consumed by the patient in comparison with national norms, a discussion of the negative physical, emotional and occupational consequences, and a discussion of the overall severity of

the problem. The qualified health care professional engages the patient in a joint decision making process regarding alcohol use and plans for follow-up are discussed and agreed to.

Let's see, we have several notes for abstraction, but I won't go through those unless you have any questions. But that's really the crux of what we want someone to sit down, we want someone to have an interaction with the patient and talk about the problem and how it's impacting their health, their life, and try to come up with some kind of plan to bring them back into either what would be acceptable use or obviously absent and - or not using at all.

Female: Right.

Nancy Lawler: So I guess with that I'll just turn it back to you all and we can begin to discuss the measure.

Female: Thanks.

Female: Thank you very much. So we will move on then to the impact opportunity and evidence, so part of the importance to measure and report. So was there any discussion around whether or not this was an important area to measure, and whether or not there was evidence to prove that this was an important area to measure? Does anyone on the workgroup have any comments about this section?

Dr. Madeline Naegle: I would simply reinforce that it's a very important area to measure. This is Madeline. We're very aware that many, many of our patients, and it's well cited, never receive any screening or discussion about this, it's well substantiated in the literature. We need to begin to look at this from a clinical perspective.

Female: Other comments.

Mady Chalk: Although it's - this is Mady. Although it's important I had actually some serious questions about its' ((inaudible)) in inpatients that I understand potentially the - what I didn't have about the other measures by the way. I saw the value in some - higher value in some of the other measures than this one.

So it's - I just had some real issues about what's brief intervention if a patient is in the hospital for anything, some diabetic issue, or a heart attack, whether a brief intervention is what is called for. I can - the screening is certainly called for, the brief intervention I wasn't sure.

Female: So I know that some people from our advisory panel are on. I know Eric's on. We do have some research on using brief interventions with tobacco use in this realm. And I'm wondering if we, you know, other than the immediate data that were cited from the studies in hospital based SBIRT samples and the VA, if anyone has any insight into how effectively this has been used across the board for alcohol.

Female: I didn't think the Cochran Review, the McQueen Review was just limited to the VA.

Female: No it isn't it is...

Female: Okay.

Female: ...there are several other hospitals. But those were hospitals also where they had been using and been training to use SBIRT. So the sample was somewhat biased, in as much as you had groups that were motivated, interested and incentivized. That is open to discussion I imagine.

Female: So it's more of a fidelity issue than a ((inaudible))...

Female: Yes.

Female: ...issue.

Female: Yes, thank you.

Female: Any other comments around the importance? It seems that everyone agrees this is an important area. Mady, were all your questions about this answered at this point?

Mady Chalk: Yes, they're answered.

Female: Okay great. So we'll move on then to the scientific acceptability of this measure, particularly the reliability and validity. So the extent to which the measure as specified produces consistent, reliable, and credible, valid results about the quality of care when implemented. So this measure must demonstrate adequate reliability and validity in order to be recommended for endorsement.

So this measure was tested, are there any comments around the testing results or the reliability or validity of the measure? It seems as though in this area that the workgroup was left with half believing that this criterion was met and half believing that it was not. So if there's any comments around this stuff feel free.

Female: I'd like to hear from who felt who felt that the criteria was not met.

Female: All right, well I think actually two of them are not on the phone, but I can read their rationale that they submitted.

Female: Thank you.

Female: One of them said - sure. One of them said, "The idea of what a brief intervention is unclear." However Nancy I believe you covered that well in the beginning.

"The ability to measure this in practical terms and the fidelity of such interventions is unclear. I'm not convinced that the measure can be used effectively with large population of differing types of hospitals."

And then we had another one that said, "This seemed to be rather difficult to assess at least in the pilot testing that was performed. There was great deal of variation among hospitals regarding the uptake of this CI among screen positive among patients. Nicely half had EMRs and half did not, more or less."

Female: Okay.

Female: And is reflective of necessarily on whether or not in electronic screening and CI ((inaudible)).

Female: But those things are also more...

Female: CI.

Female: Those questions seem to be more about feasibility than actually about the data that was presented in the scientific studies.

Female: Yes.

Female: There was one more comment actually that was in regards to the low Kappa statistic. Familiarity with the measure specifications and implementation and use of the measure should correct this issue however. On-going validation will be implemented by contracted measure system vendors.

And results sent to the Joint Commission so that validity issues can be addressed. So it seems as though although the Kappa statistic was low, there could be things that could remedy that.

Female: Yes.

Nancy Lawler: I think - this is Nancy, from our pilot testing, again that's the primary issue when you read this was that, you know, because we were so prescriptive about what had to be included in a brief intervention that you know, we didn't, you know, we didn't - when we went out and we, you know, I went out to all these pilot sites and re-extracted the records.

And so you know, when we had a non-match it was usually because you know, the hospital would give themselves credit for doing a brief intervention, but they didn't cover all the things that were supposed to cover. Or at least that we said needed to be part of that brief intervention.

And we just really felt like that was a learning curve thing. That once people get familiar with the specifications they know what we're expecting, that that's - that rate is going to, you know, that's going to come up and people will implement it correctly because they want to get credit for what they're doing. So, you know, I realize that the Kappa statistic is low and that the reliability issues that are there, but we really feel that this is correctable.

Female: Yes, I do have some concern about provider burden on that. Just because it's - because of where we are with the general implementation of ACA and I really think that that is going to continue to be a concern. I don't think that's not a reason - I think that's a reason to not support the measure. But I think the very things that you've cited about the learning curve and the need to get people up to speed and the fidelity of implementation will be a concern.

Tami Mark: And this is Tami, do you also think that this is an evidence issue? That defining, you know, exactly what needs to be done that makes brief interventions effective is not necessarily clear, so we can't ((inaudible)).

Female: I feel that the evidence - so you'll notice that apparently some of the evidence that has also influenced this sub-group before comes from brief interventions again with tobacco. I think that there's a lot of intervention that the elements of the brief intervention can be implemented in three to five minutes by an experienced provider. Or that the individual is not going to participate in one way or another. There is a good bit of evidence in the literature supporting that. So I don't think it's a reason to not go forward.

Tami Mark: So I mean that would argue that, you know, you should have the key elements - ((inaudible)) is the key issue of, yes as you said, some instances it didn't seem like they used all the elements that they needed to for the brief intervention ((inaudible)).

Female: Yes.

Tami Mark: I mean, you know, then that would be consistent with the evidence that you should use all the components to get credit for it.

Female: Yes.

Tami Mark: All right...

Female: And I think that's an innovation issue and something that's characteristic of this kind of organizational change and our expectations about it.

Female: Any other comments around the scientific acceptability? All right, and then we will move on to the usability portion, which is the extent to which intended audiences can understand the results of the measure and are likely to find them useful for decision making.

Looking at the workgroup is appears that the majority voted this criterion as Moderate, and there were two individuals this criterion as well. So one of the individuals who actually again, isn't on the phone, I'll just read his rationale. And it says, "This would require a new check box," and he's skeptical of documenting such intervention without an EHR, and the mindless checking of a box on the EHR does not mean effective intervention occurs.

Female: I think those are realistic points. I just don't see them as deal-breakers.

Female: Then we had one more comment again, an individual who couldn't make it today. And it says again, "The feasibility of capturing this data outside of the score." Am sorry that was for feasibility, go ahead, anyone for usability criterion?

Nancy Lawler: I guess it - this is Nancy again and if I could just make a comment. And I know, you know, how everybody's feeling about the check box issue and we at the Joint Commission feel exactly the same way. And that's why we tried to make these specifications much more robust than what we had seen before when we had our old tobacco cessation measures, because you could just check a box or give somebody a brochure.

This requires that -- and it needs to be documented that -- you know, someone is sitting down and actually having a one-on-one discussion with the patient, and that all of these parameters are discussed. So, you know, even if you're checking a box, you're going to have to at least check the box that, you know, you sat down and talked to this person and that you covered this point, this point, this point and this point.

You know, I don't know how else to address that because outside of you know, doing observational type of studies and work to see whether or not, you know, this is really carried out, I don't know how else we could achieve this.

Eric Goplerud: This is Eric. Also I have seen some of the EHRs that are being built have more than a check box in them. They have - on their check box it says, "These are the characteristics of what you need to have done."

Female: Right, exactly.

Female: Now that's what this decision is for.

Eric Goplerud: Right. I mean it still doesn't say that you couldn't check it off, but at least you've checked off something that says, "I discussed the following issues with the client and we developed a plan and this is what we've agreed to."

Female: Okay, great, any other comments on usability? Okay hearing none we'll move on to the feasibility criterion. And that is the extent to which the required data are readily available, retrievable without undue burden and can be implemented for performance measurements. So we kind of already delved into this topic a little bit with the check box issues and EHRs, but if anyone has any additional comments to add about the feasibility, feel free.

Okay, hearing none, that sounds good. And we will be sure to take all of your discussion points to the Steering Committee and again, you'll all have a chance to present at that meeting.

So based on the preliminary evaluation of this measure it would have actually been equally divided. Half the people said it was suitable for endorsement and half said it wasn't. So perhaps some points of the discussion would have swayed people one way or another.

Okay, then the next one we're going to move onto is Measure 1664. And I believe, Dr. Pating, you're on the line, correct?

David Pating: Yes, can hear me?

Female: Yes we can. Can you give us a brief description of the measure or any overarching issues that you found when reviewing this measure?

David Pating: Well this seemed to be the RT of the SBIRT Initiative, the referral, the treatment, and it was interesting that it was broken into two portions. At the - the measure basically looks at before or at the time of discharge, that there is a referral to either psychosocial or a prescribing of medication.

And then because of high refusal rates to accept referral of treatments they - the developers developed a prescribed medications measure as a subset of that. It had the same numerators and denominators as previous indicators that we saw, so I don't know if we'll need a lot of discussion on that.

The issues are of the reliability and validity. There was a high - there was sort of - there was a problem with the reliability with regards to a referral. That - it was - in terms of the AUDIT, there was 85% agreement around alcohol and drug diagnosis, 78% about the appropriateness or whether they qualified as receiving medications, and then 62% were providing a referral to treatment.

And the issue appears to have been ((inaudible)) was about - was a definition I think of whether people were involved in a continuum of care, might - like my guess is, "What was treatment?"

There also was a question that I had regarding the validity of the measure. The mean scores seemed much less than we typically suspect for this population, there was ((inaudible)) that received brief intervention had a mean score of 5.6% got referred to the non - I think it was 2.9 and the VA got 1.2, so there's kind of like non-intuitive direction of ability to assert a treatment.

And then more importantly that the range between hospitals is quite far. So that to me raised questions about the usability of this measure in terms of - I always think of the (Tom McLellan), "Compared to what?" So what would we be comparing, or you know, in terms of using this. And the usability section did not offer a lot of clarity in terms of how this would be used. Would it be inter-hospital quality programs, or as like a public measure?

And then lastly, usability issues - I did have questions still about the - as far as ((inaudible)) the cognitive impairment. To me that was just sort of a - sort of not part of a typical data set, and so we'd be creating a new data set at a - in a way that seemed rather important.

And then there was also a question raised at the end that it looked like - and I guess I would ask the developers to answer this. And I had probably more questions than I had, you know, definitely landing in certain boxes here, was because 31% did not accept referral, it looks like a second part of the study was waiting to be validated.

I wasn't quite clear about that when I read that out of the ((inaudible)), and those are my overall highlights. So again, starting from real validity measures that just weren't apparent in the other two that we reviewed so far so.

Female: Okay, thank you so much Dr. Pating, for that overview. So we will start again with the importance to measure and report. Is there anything that anyone else would like to add about this criterion? Again, it's the threshold criterion that must be met in order to recommend the measure. So if there's anything anyone wants to say around the population or the measure specifications, feel free, or any of the evidence that was presented, go ahead.

Mady Chalk: This is Mady. Regardless of all of the issues about studying this and some of the things David said, which I really resonate with, I really don't see how one can, in an inpatient hospital setting, in which a patient receives a diagnosis because according to the specifications this is patients who are diagnosed with dependence or abuse I believe, I can't remember.

I don't see how you cannot either offer medication or - and/or a referral to treatment, whether or not it was turned down or accepted. Somehow or other that - not doing that - not offering would seem to me almost to border on malpractice, I just don't see how one can do that with a diagnosed patient. So that's where I'm at.

Female: So this measure is designed to improve the precision of those identification and interventions. I think the questions that Dr. Pating raised are more about the feasibility of getting an accurate capacity to - an accurate measure of the follow-up and referral.

Mady Chalk: Because the follow-up is the next one.

Female: Well referral - but referral, even getting measure of referral.

Mady Chalk: You mean...

Female: I think it's what you...

Mady Chalk: ...or more medication, prescriptions...

Female: Yes.

Mady Chalk: ...you can't - that you can't get that measure.

Female: That's one of the questions, yes.

Mady Chalk: ((inaudible))? Okay. Well that's a usability question...

Female: Yes, yes.

Mady Chalk: ...down the road. I thought we were still back in the measure, but okay.

Female: Yes, I'm sorry.

Mady Chalk: Talking about usability, I suppose somebody could not do it and check the box that they did do it. But that's true of all the measures, isn't it? Isn't it true of screening or brief intervention or?

Female: I think we'd have to - we'll all have to agree with that.

Female: They could lie, that's true.

Female: So going back to what the workgroup said, back to importance, it was - the majority did agree, deem it to be an important area to measure and report. So it would have passed this criterion.

So if there's no more comments around the importance then we'll go ahead on to scientific acceptability. Okay so going on to scientific acceptability, particularly reliability and validity, the

extent to which the measure as specified produces consistent and credible results about the quality of care when implemented.

Did anyone - I believe that Dr. Pating did make a few excellent points, so I don't know if you want to speak to those again Dr. Pating or if anyone would like to comment on what he mentioned about the liability and validity?

Nancy Lawler: Well this is Nancy, and there were so many comments that perhaps, you know, maybe it would help me too if we could just kind of maybe go through each one of the issues.

But the one that I can speak to at least right now as far as the reliability, related to the referral for addictions treatment, had to do with you know, this measure we want to make sure that that referral is made for the person before they leave the hospital. That they're just not, you know, given a number to call, and you leave it to the patient to do themselves...

Female: Right.

Nancy Lawler: ...because we know that that's probably not going to happen. And so we expect that the provider will do that for the patient before he leaves the hospital.

And that was the main issue with the reliability on the referral piece, that oftentimes hospitals would say, "Yes, you know, we referred the person but that referral was not made before the patient left the hospital." So that was the piece, that's why the reliability there is a little bit lower.

And then if we could just go - walk through the other issues because I had a hard time following them and I couldn't really - if I can address them where I see what I've written then maybe I can address the concerns.

Eric Goplerud: Nancy, this is Eric.

Nancy Lawler: Yes.

Eric Goplerud: One other issue I believe that you had reported was that the technical advisory panel did not feel that a referral - simply a referral to go to AA or go to NA...

Nancy Lawler: Yes.

Eric Goplerud: ...was a sufficient referral for follow-up treatment...

Nancy Lawler: That's correct.

Eric Goplerud: ...therefore some hospitals recorded that they recommended the patient go to AA and that was considered non-compliant, even though they had measured it as compliant.

Female: Yes.

Female: That's correct.

Female: But I think that that's - the notion that AA as treatment is widely held in the community, even in the health care provider community. So I - Nancy, do we have - and I don't have the definitions ahead of me, do we actually - have we spelled out what a referral should - the elements to be included in the referral?

Nancy Lawler: Yes, we do. So let me take this...

Female: Okay.

Nancy Lawler: ...to (element) and read it to you.

It just says, "The documentation that a referral was made at discharge for addictions treatment by a physician or not a physician, such as nurse, psychologist or counselor, a referral may be defined as an appointment made by the provider, either through telephone contact, fax or email. The referral may be to an addictions treatment program, to a mental health program or a mental health specialist for follow-up for substance use, or additions treatment or to a medical or health professional for follow-up for substance use addiction."

Female: Okay, thank you.

Female: Yes.

Nancy Lawler: And the - again the exclusion is - the AA is an exclusion to this.

Female: Yes, good.

Female: So I mean I think it - you know, as this conversation is playing out, the devil is in the detail here in terms of, you know, people are doing some kind of - some kind of referral, but it's not good referral. And that's - this measure can move us in the direction of better discharge planning and...

Female: Absolutely.

Female: ...that would be terrific. And then so we're trying to understand I guess, "Is it going to do that," because again it depends on if you're requiring them to do the things that we think they have to do. So you mentioned making a telephone call or fax or email. So does communication have to happen with an outpatient or a subsequent provider in order for this to be considered a referral?

Female: Actual communication.

Female: Yes, does the person have to like communicate with another - and you know, and transfer the record and setup the appointment?

Female: No.

Female: Or is it enough just to say, "Okay, here's a doctor in your area?"

Female: No, you can't just say, "Here's a doctor in your area." You have to really - you have to setup the appointment for them so that, you know, that's all set before the patient leaves the hospital.

(Crosstalk)

Female: Now, it can be - and here's another interesting thing in this measure that, you know, we're referring them for continuing treatment. Now that treatment, even if you refer to, you know, another mental health specialist or whatever, that specialist could come into the hospital and begin that - those treatments while the patient is still in the hospital and continue after the patient leaves.

Or it can happen - you know, the appointment is made and the additional counseling takes place after the patient leaves, either way. Just as long as that referral is made and something, you know, is going to get started for the patient.

Eric Goplerud: And this is Eric, something...

Female: And I think that's very important.

Eric Goplerud: Something I think is particularly strong in this, speaking as a developer is that we also specified that it can be a medical or other health care provider for the purpose of providing addiction treatment.

Female: Yes, ((inaudible)).

Eric Goplerud: So it would cover Buprenorphine or other...

Female: Right.

Eric Goplerud: ...medical treatments.

Female: Yes. That was particularly good.

David Pating: Hi Eric. So what if you see your - you know, you actually see a psychiatrist or a counselor in the hospital and the - you know, the person says, "I'm going to follow-up with my sponsor and that - I'm okay, don't worry about," is that a refusal or is that a positive because they're going to go to AA or is that even an appropriate referral when it's - if the consult says, "Okay, why don't you get back to your program and do what you need to do?"

Female: I don't - I think AA was considered excluded.

Male: Okay.

Female: Well, it's not so much that - in AA was excluded because it's not considered best clinical practice as treatment, but a...

Female: Right.

Female: ...very helpful adjunct.

Eric Goplerud: Right.

Female: Sure. Yes, we all agree with that.

Tami Mark: And to what extent are you going to capture whether the medical record or some summary of it was transferred as well? Is that part of this? Can you do that?

Female: I'm sorry, I can barely hear. Could you state the question again?

Tami Mark: Okay, sorry. This is Tami Mark. I'm wondering about the issue of the transfer of the medical record or some summary of it, whether...

Female: Oh I see, yes. Yes, interesting. That's not really part of this measure. But certainly an important issue and maybe one that, you know, when you think about the continuum of care, another measure that probably could be (splunned) off from this to make sure that, you know, all the appropriate information gets to the next provider. But this measure just simply deals with the - that the referral is made.

Tami Mark: Okay, thank you.

Male: So can I just ask, in terms of the reliability of the referral to addiction treatment at 62%, do you have suggestions of how that could be improved? Is that just really a question of the instruction set then, you think that needs to go out with this, that that needs to be modified...

Female: Yes I think...

Male: ...over time?

Female: I think it's going to get better over time. I think that people are not used to, you know, making these referrals to begin with. And it's easy, you know, to just give somebody - we've seen it in a lot of our measures, like the VTE measures and others where we expect there to be a referral, you know, following discharge to get some type of treatment or care afterwards.

And so the expectation to actually make the appointment is something that they're not used to doing. And so I think that again, like any measure, this is going to drive people to actually begin to do this.

Female: Yes.

Female: So that you know, there is better follow-up and you know, these people will get into treatment, and are not just left to their own devices to get this done. I just think it's going to take time. And we are prescriptive about it in the specifications. The problem I think that you have with these things is that, you know, a lot of people just don't read the detail of the specifications and so it's a learning curve.

Female: Yes, once measures get put in twice and some accountability and public accountability is required...

Female: Right.

Female: ...that shifts things considerably.

Female: It does.

Female: Okay.

Male: Also, all of these can be built into an EHR where you have...

Female: Yes...

Male: ...into it.

Female: Okay, any other comments around the validity or reliability?

Male: The issues of validity, the question of the - one second I'm going to try and find it here, caring of the hospitals and the ranges of the results, you have a mean of 5.6 and a range of 0 to 15, so I'm just wondering how does that, you know, play out when you have a range of three times the mean, in terms of inter-facility comparisons and stuff like that? I guess that's more of a usability ((inaudible)) at a later point.

Female: Are you on a...

Male: ((inaudible)).

Female: What section are you on, if you can tell me the section. Is this the testing results for validity?

Male: Yes the testing results.

Female: Okay, I'm just looking at...

(Crosstalk)

Female: So the measure ratings here with respect to; clarity, usability, interpretability, is that what you're talking about?

Male: One is testing till results - hold a minute, find it, and I didn't make this up, 2b5.3 results.

Female: 2b5.3 I'm going to - okay...

Male: And it's in the section Identification of Meaningful Differences in Performance.

Female: Oh, meaningful difference is important. Okay, and then there - you're probably talking - are you talking about the dot plot? The dot plot analysis?

Male: There's two - well there's two parts; one is the - your - these baselines that you...

Female: Right, right.

Male: ...had which seem to be counter-intuitive. One is the that the spread is not that great, and the rates are so low I mean...

Female: Yes.

Male: ...and then the VA rate just seems really counterintuitive. So I'm wondering is there something in systems, the way they're capturing this, that would really throw a big confound? So I just assumed the VA as a - you know, because they have the DoD protocol right? That's what...

Female: Right, yes.

Male: They should have the highest referral rate, but they had the lowest here at 5.2. And then you - then between the hospitals, you just have this huge range and so you're going to have, you know, a scatter plot that just looks like a mess when you try to compare, you know, apples to oranges.

Female: Yes, although you know, the good thing - well, not the good thing about it, but there is tons of variability so lots of room for improvement here.

Female: Yes.

Female: And I think that's, you know, basically what I was trying to show with the dot plot is that, you know, obviously we have a lot of room for improvement. And so I guess I looked at it a little bit differently.

Female: But I do have to agree that that does weaken the reliability somewhat, that ((inaudible)), all those responses.

Eric Goplerud: And this is Eric. There may be a need to - at some point to do risk adjustment once we have more experience with the measure. There is reasonable evidence from literature reviews that the prevalence of alcohol use disorders varies substantially by type of condition of inpatients. So the trauma care is going to be much higher than general med-surg, which will be higher than OB/GYN.

Female: Yes and I think that you're actually underlying an important point that maybe we didn't discuss in the full salience of it. And that is, this is really any alcohol or drug use disorder, not just what we would consider to be - if we put risky drinking in there, we - or we look at it simply as abuse or dependence.

Female: Right.

Female: We're going to see wide variation right along - among the three. So it's...

Male: Let's hope it's discussed on the dependence - abuse and dependence.

Female: Abuse.

Female: Yes, the risky behavior isn't included in this, but the abuse and dependence is.

Female: Yes, okay.

Female: Okay, if there aren't any other comments from the reliability and validity, we'll go ahead and move onto the usability section which I believe...

Male: Can I just ask a question about the abuse because - issue because this is actually my system with regard to HEDA. I mean, not all abuse requires a referral of treatment, you get one DUI and you do get in an accident, but there may be a reason so that doesn't require a referral to treatment for abuse.

So I could see this as dependence, I have real questions about where they were lumping to broadly there. But my belief is for strict abuse, I mean when you look at - you have to look at something that qualifies for the SBIRT, the screen and brief intervention might be adequate without the formal referral if they didn't meet, you know...

Female: Criteria for dependence. Yes, yes.

Male: ...some sort of ((inaudible)).

Female: But if they meet criteria for abuse, if they meet the DSM criteria for abuse, best clinical guidelines would require that they be referred, if you're talking about incidents of binge drinking in which case DWIs might emerge, that's not really meeting the criteria for abuse.

Male: Problem? You don't think they are? Well, the problem is clinicians are coding that as abuse.

Female: Yes.

Female: Binge drinking.

Male: It's more complicated when DSM5 comes out, right?

Female: Yes.

(Crosstalk)

Male: ...whatever, one to ten. Does everyone get a referral, you know, based on the ((inaudible)). I do think we, you know, it's not now, but that's a later thing that we would have - that we should consider when we start to look at what's at - what the numerator or the denominator is.

Female: Okay, any other comments around the scientific acceptability? Okay, so the usability criteria and the extent to which intended audiences can understand the results of the measure and are likely to find them useful for decision making. And it appears that we had - the majority had ranked this as Moderate with two Highs and then another Low, any comments on the usability? I know we talked about it a bit with the use of the check box, but if there's any other comments?

Okay, and if there's nothing else about usability, we'll move on to feasibility, the extent to which the required data are readily available, retrievable without undue burden and can be implemented for performance measurement. I know we also talked about this a little bit, but does anyone else have any comments around the feasibility?

And it appears for feasibility that the majority of the workgroup rated this as Moderate with one High and one Low. Again, for someone who wasn't - oh, David I believe that you had made a comment about this on your survey tool. Is there anything you wanted to add ((inaudible))?

David Pating: No, you know, it's really that cognitive impairment question...

Female: Okay.

David Pating: ...that's been kind of plaguing throughout. And I mean I'm satisfied with that and yes, the hard part was doing - was you know, basing this on the data that was provide in the application - these conversations ((inaudible)).

Female: Okay, great. Any other comments on the feasibility? The majority - oh sorry, go ahead.

Tami Mark: Might be kind of a naïve question but how does this relate to the hospital base inpatient psychiatric core measures? Is that something...

Female: Fair question Tami.

(Crosstalk)

Female: I don't know that much about them, but I was reading recently that there are some measures related to Post-Discharge Continuing Care Plan has been created and that the Post-Discharge Continuing Care Plan has been transmitted to the next level of care upon discharge.

Female: Nancy can you speak to that or?

Nancy Lawler: You know, I am not that familiar with the HBIPS measures but I'll tell you what I'll do is I will, you know, get with the lead for that measure. We'll - your question is, "How does this measure relate to that measure set in general or similar measures in that set," right?

Female: Yes.

Nancy Lawler: So why don't I come to the meeting in April prepared to address that for you?

Female: Yes that's important.

Female: Okay, that would be terrific.

Female: Okay.

Female: That'll be important.

Eric Goplerud: This is Eric. The HBIPS hospital discharge planning, the data gathering that would be necessary to do for that would immediately and easily fit into the sub-3.

Female: Yes, I mean there seems to be some potential intervening.

Female: Yes, there does.

Female: Okay now this is...

Eric Goplerud: And the other measures frankly, can be pulled from the administrative data, "Did you have a diagnosis, did you have medications or a psych service that was provided inpatient?"

Female: Right.

Male: Can I have one last question on the feasibility? On 4d it says, "31% of numerator refused," and then, "Refusals were not ((inaudible))."

But then there's something about, I didn't quite understand what this was referring to, "Sampling was not allowed during the pilot test so sufficient data collected during the six months pilot test." What is that - what's that referring to exactly? Why these people refused or what was needing to be followed up on here?

Female: I'm just - oh, this is in 4d? Describe what we learned, let me see. Oh it's just - you know, I'm just talking - I was just talking in general about, "What did we learn during the pilot test." And you know, one of the things that we like to look at if we can is a sampling methodology, especially in a global measure set where it applies to all patients.

And that's something that's been new for us as we've moved from targeted diagnosis, specific measures, in to more global - measure sets that are more global in nature that apply to all patients. And so sampling is something that, you know, we would have liked to learn something about in the pilot test, but we just really weren't able to do that. And so that's all that comment meant.

Male: Okay.

Female: Okay.

Female: Any other comments before we move on to 1665?

(Crosstalk)

Female: And just so that the Steering Committee has a context, there is also another measure that is discussed in the forum, it's 004. And that's the alcohol measure that we'll be discussing at the end, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment. And we'll be discussing that in full at the In-person committee. But we want to make sure that you have that in mind as we pick up the rest of the measures.

Female: Okay, and just a brief time check, we have about 1/2 hour left and two more measures to go through. So we'll go ahead and get started on 1665. That was assigned to Mady and Tami. So I don't know which one of you would like to go ahead and lead that off.

Mady Chalk: Tami, you want to lead it off?

Tami Mark: Okay, sure. So this is looking at the number of patients who were discharged with - who screened positive unhealthy alcohol use, or received a diagnosis of alcohol or drug use disorder, were contacted within 30 days. And I guess I'll just focus quickly on some of my concerns about this measure.

(Crosstalk)

Tami Mark: One, I thought the evidence of the effectiveness of this post-discharge 30 day contact was weak. They cited a study by Jackson and Booth & Bennett that found that telephone reminders

increased the likelihood of keeping first appointments. The evidence wasn't graded. I didn't - maybe I missed it, but I didn't see direct evidence, you know, looking at this intervention and its outcome in improving ((inaudible)) outcomes.

Mady Chalk: Can I add to that Tami?

Tami Mark: Yes sure.

Mady Chalk: I just wanted to add on that particular one; the evidence is generally, that I've seen, is related to other kinds of conditions, not necessarily substance use.

Female: Yes.

Mady Chalk: So we don't have the evidence yet in substance use. There are some people working on it.

Female: I think we had some - I just want to ask and maybe Eric can jump in. I think we have some of that evidence and follow-up in relation to tobacco dependence.

Mady Chalk: Yes, we have the backup, but we also have it with regard to other conditions, like diabetes...

Female: Yes.

Mady Chalk: ...and other chronic conditions. Whether that transfers is another question.

Female: Right.

Mady Chalk: But...

Tami Mark: Yes I mean my second concern had to do with the fact that in terms of net benefits, and the state's idea for ((inaudible)) task force indicating no harms were found in screening or behavioral health interventions, what I'll call them issues. I guess I was a little concerned about the harms of, you know, contacting someone post-discharge who may, you know, have some privacy concerns around that substance abuse...

Female: That's a good point.

Tami Mark: ...admission. And then there was an issue about feasibility. In the quote they say, "During the pilot test it became clear that a limitation of follow-up measure was difficult to achieve for a variety of reasons; it had to be done by hospital employees, it must be done by phone or discharge clinic visit."

The staff - and staff agreed that it was necessary to allow more flexibility in final classifications. So it could necessarily not have to be done by the hospital staff but could be done from a contract service, so ((inaudible)).

Female: That was my biggest concern about this measure.

Tami Mark: Yes, so there's some - you know, and then you get a letter saying, you know raising a privacy issue so. Those are my three.

Female: Yes.

Female: Mady, do you have any additional comments before we move on to the specific criterion or do you want to just?

Mady Chalk: No, go ahead.

Female: Okay, great. All right, so we'll move on to the evidence and importance, so whether or not this measure was important to measure and report. It was almost unanimous that this was an important area to measure and report. I don't know, Mady or Tami or anyone else, do you have any additional comments around - I know you spoke a bit about the evidence, but is there anything else regarding the importance or additional pieces about the evidence you wanted to add?

Mady Chalk: Not about the importance...

Female: Did the developer want to say anything about the concern that they mentioned about the evidence, how it was more related to other conditions?

Female: No. Eric, do you have anything you'd like to say?

Eric Goplerud: Well I think that - I - this is a measure where we're trying to do two things with one measure, which you can see in the inclusion criteria. So that those persons who are identified at high risk for alcohol use are being followed up, as are those people who are dependent or who have a substance use disorder...

Female: Yes.

Eric Goplerud: ...who are being followed up. So I think the evidence splits along both lines. The evidence on the follow-up comes from work on screening brief intervention which finds that a second contact, which could include a telephone contact, increases the effectiveness of the intervention over...

Female: Yes.

Eric Goplerud: ...a single contact.

Female: Yes, that's true.

Eric Goplerud: So that's - that was the evidence base for that. For the follow-up with treatment, there I think we were more going with best practices and with analog to other conditions. And perhaps Nancy you could - might want to talk a little bit about the differentiation that we are suggesting go into the follow-up data gathering.

Nancy Lawler: In the revised measure?

Eric Goplerud: Yes.

Nancy Lawler: Okay. And I guess I have a question for all of you and the measure that you actually reviewed. I'm not sure whether you received the most recent version of the measure. Just before these were to be handed out to you all, they did - NQF opened up the site so that I could put in the revisions that we're going to make to this measure beginning in January 1, 2013.

And so you know, currently the measure is - the patient is to be contacted within 30 days from the point of discharge, and we've changed that. We've made several changes. We've changed that to within 7 to 30 days, and that's because we defined a - what we call a Quit, where you've quit using or whatever, as being free for at least the 7 days prior to the point in time where someone is talking to you.

So if you've contacted the person early on in this process, you know, you never would get any information about whether or not they quit or not because, you know, you're just contacting them too soon. That's the first step. So we changed the timeframe for contact.

And then we've - the original version of the measure only calculates on the fact that the patient was contacted. And the use status and compliance with treatment program doesn't play a part in the calculation of the measure at all. And we really wanted to change that.

And so we have replaced the current data element for alcohol status post-discharge with four new data elements that are much, much easier. The old one had you know, 14, 15 allowable values, and probably more than that, and it was very complex, but it didn't play a part in the calculation.

Now, with the four new data elements, we want to know really three things, you know; is the patient - if he was given medication is he taking that medication; and if they were referred to treatment are they going to the outpatient counseling; and then thirdly, if they have an alcohol dependence issue, you know, well not - that or a misuse, what is the current use at this time for alcohol and then what is the current use for drugs, if they were using drugs.

And so we'll get information on the compliance with the treatment program as well as status. And then how that plays into the calculation of the measure is that the patient has to be contacted within the appropriate point in time and the hospital must collect the data on all of those data elements or they don't pass the measure.

So the crux of it is, and you know, we can't hold the hospital accountable for whether or not the patient is complying with treatment or going to the outpatient addictions treatment or taking his meds or really with a use status, but we do want to hold the hospital accountable for at least collecting that information. And you know, I think it's kind of like our first step into trying to move this more to a true outcome measure.

Hopefully in the future we'll be able to begin to - when we get more experience with this, to begin to collect some true outcome data relative to this measure. So that's where we're headed for January 1, 2013.

Female: Any questions for Nancy about the revisions in the measures?

Female: I actually just am looking at the form right now and the one that is up on the screen is actually not the one that has been modified.

Female: Okay.

Female: So just make sure that you have received the proper and updated measure. I will be emailing that out to you all today - later today, just to ensure that we're all on the same page.

Female: Yes there's the measure, and also the data dictionary, we'll include those four new data elements as well, so you can read about those data elements. And you'll see the calculation algorithm. So the algorithm is a little difficult to understand, but there are some - they're not flags, they're counters that we put on them so that we know that you have addressed all of the data elements that need to be addressed in order to pass the measure.

Eric Goplerud: The reason I suggested - this is Eric, that I suggested that Nancy describe this is that the measure that you see is a process measure, which the committee and the Joint Commission see as kind of an intermediate measure to gathering outcome data. So the NCQA - or I'm sorry, NQF in earlier behavioral measures panel, had approved a depression follow-up measure that was depression...

Female: That's right.

Eric Goplerud: ...that was depression assessed within six weeks following initiation of treatment with antidepressant medications or counseling, that was an intermediate measure to the measurement of, "Has there been a 50% or more change in symptomology as measured by that follow-up measure?"

And so what the committee's orientation to this measure is, you have to have data collection in place in order to be able to assess the outcome. So the process measure itself is admittedly a fairly weak one on the basis of evidence of, "What's the evidence that doing a follow-up within 30 days improves outcomes for patients with dependence?"

That's in the context of where we're really going is, "Are they in treatment, are they reducing or have they stopped drinking or drugging, and are they taking medications?"

Female: Right and I think that we'll be able to get there, you know, Eric in a point in time. And you know this is - these are our steps - our beginning steps to get to that point in time. I mean we're all very excited about this and we think that it's - it is a good measure and it's going to - it's really going to help us to understand more about the - how the patients are really doing in relationship to the treatment that has been provided to them.

Female: You know, I think those are all excellent points. I think that the concern that was raised about privacy and ethical concerns is one that we can't discount totally because of the weakness of the evidence in this area, which truly we haven't adequately explored in order to have a body of evidence that's strong. But when this does come up in the large group, I hope we can revisit the points that were made by Tami and Mady around that.

Female: Thank you very much everyone. Just in the interest of time, was there any major issues around the scientific acceptability, including reliability and validity, usability or feasibility that Tami and Mady haven't brought up yet or if you would like to add anything on to what you've already

mentioned? And keep in mind, we're going to be reviewing all of this, you know, more in-depth at the in-person meeting.

(Crosstalk)

Female: Then we'll get that new measure out to you as soon as we can - or later on today. So we'll move on to the last measure for today that's under review, which is 004, Initiation and Engagement of Alcohol and Other Drug Dependence Treatment. Madeline, I believe that you were in charge of reviewing that measure?

Dr. Madeline Naegle: Michael and I were. I don't know - is Michael on the line?

Female: I don't believe Michael's on the line right now ((inaudible)).

Female: This is a process quality measure put forth by the national clinic for quality assurance, really looking at access to treatment. If we look at a new episode of alcohol or other drug dependence being identified and then we want to try to measure initiation of treatment, which would have to occur within 14 days of the diagnosis.

And engagement which would be defined as, "Two or more additional services received under the diagnosis of alcohol or other drug," would be abuse or dependence, right, since we're dealing with diagnoses here. I think that this is within the HEDA's system, pretty dependable and I would have to say, "Being a health services researcher I think a means of really following the process quality measures and patient outcomes on a number of other fronts."

The concerns that I had about it were less about things like the need, obviously that's - it's high. The performance gap is high. Looking at the evidence we have the evidence of the use of this

measure over time. And I would be interested in hearing people's thoughts about that. This was examined in terms of both initiation and engagement within the public and commercial systems.

I think that for me the feasibility, usability issues remain, especially in institutions that are not yet moved over to electronic health records, "How do they actually participate?" And maybe Eric can help with this - with HEDA's generally if we don't have compliance with EHR. Does anybody know?

Mady Chalk: I believe there have been a variety of ways of getting around the whole issue of electronic health records, with regard to initiation and engagement. I know in the public sector research that we've done on these - this measure or this - these combined measures, they were able to get the data...

Female: Good.

Mady Chalk: ...despite the problems we're having with electronic health records and with getting that level of data.

Female: Yes, thank you Mady. And that would reinforce my points that I feel that this is at an acceptable level of precision, that we can endorse this measure. I'd love to hear other people's ideas about that, other points.

Female: Needless to say, I agree but.

Female: Thank you.

David Pating: Hi this is David Pating. So I just would tell you I'm still struggling. I very strongly like the HEDA's direction, but I struggle with the actual measure itself. The devil's in the details. And my

system - well we found that 50% of our diagnoses are - and this is like thousands, 20-30,000 diagnoses you know, of people - individuals being - that were just - have abuse. And the other half have dependence.

And we just don't feel that - it runs counter to the SBIRT's implementation because it - and it says that, "We should screen and do brief intervention," and in the other end it says that, "It mandates a referral." So I think that there's some conflicting values here with some of our national indicators don't line up properly because our - some of our diagnoses at certain indexes are unclear. I just want to kind of...

Female: I think in most of the recommendations for SBIRT, SBIRT is not recommended when alcohol abuse or dependence is clearly a diagnosis. SBIRT has the best outcomes with risky drinking. So one of the things which seems to be - that you seem to be describing in your system David, is confusion about where the appropriate place for the SBIRT intervention would be. Is - do you think it's...

David Pating: No, but you still put alcohol with some sort of - any consequence is that you know, that's sort of like the classic (Larry), you know, (Gentinello) kind of thing where you give them a - ((inaudible)) and somebody comes in and provides SBIRT.

Female: But I think that's not - that that is not - if you look at the literature in terms of how - and things have been presented here and takes his word, that that is - dependence and abuse are a rule out referral to treatment then is the dominant mode of intervention. Screening referral to treatment, even bypassing brief intervention. Does that...

David Pating: Well but then already you're - you know, with the abuse that you're saying you're going to rule out, with the HEDA's you're already engaging - you're already committing that one abuse referral to an engagement - to two additional sessions of engagement because...

Female: Okay.

David Pating: ...initiation and then engagements.

Female: So this is an inpatient alcohol or drug admission and outpatient visit?

David Pating: Well this - yes outpatient, yes. Outpatient, HEDA's is only out.

Female: Okay.

David Pating: Did that make sense?

Female: I think it clarifies a little bit what we're trying to deal with here. I think you're raising some good points.

David Pating: Yes. For dependence it makes perfect sense. We need to - all dependence need to go be seen in specialty care, and then not only get initiated but engaged. But I think there's a question about the assumption that all abuse needs specialty referral, particularly if a primary care doctor can - you know, it feels very comfortable with making those interventions or whether it's - it requires, you know, that counts as an index whether it really still counts - requires the extra two engagement follow-ups.

Female: Oh I see which way you're going.

Female: Yes, yes.

David Pating: So you're saying all abuse should be evaluated. I don't disagree with that. With a SBIRT program that's full, that evaluation can actually be done in primary care with...

Female: Right.

David Pating: ...if you raise your primary care staff, because I think it actually works against the primary care integration strategies that we're trying to implement for again, abuse, low level abuse which can...

Female: Well wait a minute, wait a minute, wait a minute. David, what if engagement could occur in primary care? What if we end up with - in a more integrated system where you do identify and then you initiate with brief counseling or brief treatment, or whatever it ends up being called, in primary care setting?

David Pating: Well that's where the billing codes don't quite work out when you get down to the auditing level.

Female: Yes.

Female: I understand that. I understand that that's a usability issue.

Female: Yes.

David Pating: Yes.

Female: But I'm talking about initiation and engagement being able to occur in a primary care setting, that's where I'm going.

David Pating: That would be great. Yes, that would be great. But there just - I just want to say that there's still issues I think. But HEDAs is a great concept, but then when we get down to these implementation issues sometimes...

Female: Yes well, yes you do have those. And you're right about the billing issues.

Female: Yes.

Female: So I'm wondering if in fact we went ahead with attempting to - if this measure were in place it would sort of force some more definitive clarification of all those issues.

(Crosstalk)

Female: In other words, would improve - would more precise implementation and use follow from the application of this measure?

Female: I believe we have the developer on the call. Is there someone from NCQA who would like to make a comment?

Bob Rehm: Sure, this is Bob Rehm, I'm the Assistant Vice President for Performance Measurement, and Jeremy Gottlich is our Team Leader on our Behavioral Health Measures. And again, the question was specifically?

Female: Around the distinction between abuse and dependence and how it can be greater provided for or more precisely addressed in the measure.

Bob Rehm: Right. Just before Jeremy responds more technically, you know, this is a broad population measure focused on health plans and their ability to help improve both provider performance and

also patient engagement. And so from that context we do have a broad definition as has been articulated.

And so from that vantage point, for the purpose of the measure intent, there are advantages to that, broader if you will, circle that we're drawing around a patient population. Jeremy, who participates in our measurement advisory panels, our Behavioral Health Measurement Advisory Panels, can speak to getting at more detail maybe downstream.

Jeremy Gottlich: Thanks Bob. And that was a great summary. I would only add that this came up, the issue of abuse verse dependence in our reevaluation of this measure, which actually is occurring right now. We met with our Behavioral Health Group in December of 2011 and a measure that was approved to go forward in the next HEDA publication as it is.

We did - and we have continued to talk about the new ICD-10 coding which will structure these codes by use, abuse and dependence, and that issue will go to our Behavioral Health Expert Panels actually this week. And so that's where we'll have the forum to see if these measures can be more specific - more precise in their coding.

Female: Because one of the issues...

Female: Great.

Female: One of the issues that was identified in the previous use of this measure is that it didn't move. And part of the reason it seems - at least one of the reasons that it may not have moved is precisely this issue. So I'm glad it's going to come in for some discussion. I mean the measure may not move because so many people are diagnosed with abuse that it isn't relevant in some fashion.

(Crosstalk)

Female: ...feedback.

Female: So thanks Jeremy. Are - will you be able to feed that information back to us when you complete your discussions or will it be possible?

Jeremy Gottlich: Yes, just in terms of our measure development cycle, our discussions with the Measurement Advisory Panel around ICD-10 codes would be for the following year, 2014.

Male: Right, when ICD-10 would be implemented in all of our HEDA measures.

Jeremy Gottlich: Right. So currently the measure was recently approved and then supported by CPM for inclusion in next year's HEDA data set. So again, we'd be looking at making recommendations around ICD-10 later this year for potential inclusion, what we refer to as HEDA 2015, which is the next opening cycle.

But yes we would - you know, if and when that happens, then we would articulate those either in a measure update, which we do annually, and then NQF would take a look and see whether that's simply an update issue, whether it needed an ad hoc review or some other level of review. But yes, obviously we would share that immediately.

Bob Rehm: Yes, we'll add that. We do have a public comment period for ICD-10 coding specifically. And I believe that opens up in the next month or so, and so we can make the committee aware of when that opens and how to access the materials. So if you wanted to provide feedback on the coding and precision, you'd be more than welcome to.

Female: Thank you very much.

Female: This is all very helpful. Thank you.

Sarah Fanta: Just in the interest of time, it looks like we have about 4 minutes left. If there's any lingering questions or comments you want to make prior to the April 17 and 18 meeting, if it's brief you can do so now. If not, feel free to email me, I can pass it along to any of the measure developers, and surely we can get into greater discussion of this measure during that in-person meeting. Is there any last comments anyone would like to make about this measure?

Female: My only comment is I wrestle with whether the numerator should include mental health treatment as well as substance...

Female: Yes, so do I.

Female: ...((inaudible)) treatment. Given that you know, the fluidity of those diagnoses and the, you know, the Cigna issue, the coding payment issues. So I'll just throw that quickly out there.

Female: Okay, we'll make a note of all of that to bring it up at the meeting.

Female: Right.

Sarah Fanta: Any other?

Female: No.

Dr. Madeline Naegle: I - this is the first time I have worked with this group. This is Madeline. I just wanted to say that, "It was a pleasure and I look forward to meeting people when we all come together in April."

Sarah Fanta: I'm sorry, I just wanted to echo what Madeline said. This is our first workgroup and I think it went very smoothly. I just want to thank all of you. I know all of you are extremely busy, but for taking the time to fill in those evaluations, taking the time to have this discussion today, I think that it will all be extremely useful when we meet with the larger group, to have you represent these measures in addition to the measure developers. I think you all did a great job.

And just again, we're having the other two workgroup calls on April 9. It's going to be kind of a marathon day for us because we're meeting with both those workgroups. I believe I already sent out the agendas for those two calls, if you want to listen in feel free. If not, we'll have the meeting transcripts and recordings that we can send to you prior to the April meeting if you review it.

Female: Right.

Sarah Fanta: And again, the meeting is April 17 and 18, and if you've had any trouble booking anything or any logistical questions, feel free, again this is Sarah, just email me about anything. And just thanks everyone so much.

Female: Thank you.

Sarah Fanta: I hope you have a great day. We'll give you 2 minutes back of your day.

Female: Bye, thanks.

Female: Bye-bye.

Female: Thank you.

Female: Thank you.

END