NATIONAL QUALITY FORUM

Moderator: Angela Franklin
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9:00 am CT

Operator: Good day everyone welcome to the conference. Please note today's event is being recorded. Please stand by.

Angela Franklin: Hi. Welcome everyone to the Behavioral Health Steering Committee. This is the call for Workgroup 1.

Today's focus is going to be on the tobacco use measures. And I'd like to introduce myself Angela Franklin. I'm the Senior Director for the project.

And I'm joined by Sarah Fanta, Project Manager and Evan Williamson, our Project Analyst for this project.

I'd like to start off with a quick roll call ((inaudible)). First I have Peter Briss?

Dr. Peter Briss: I'm here. Good morning.

Male: Good morning.

Angela Franklin: Good morning. (Carolyn Carney Dubling)? Colleen Barry?

Colleen Barry: I'm here.

Angela Franklin: Emma Hoo?

Emma Hoo: I'm here.

Angela Franklin: (Karen Halflan)? Lynn Wegman? David Einzig?

David Einzig: Yes I'm here. And it's a little bit hard to hear you. Your voice is a little bit quiet.

Angela Franklin: Bernadette Melnyk?

Bernadette Melnyk: Here. And I am also having some challenges hearing you.

Angela Franklin: Okay sorry. Is this a little bit better? Is this...

Bernadette Melnyk: Yes.

Angela Franklin: Okay sorry. We - our phone was not well situated, sorry. And (Vaneeta Pindoya)? I think she wasn't going to join today.

Okay. Well I want to explain a bit about the process for today. We're looking at measures in a preliminary fashion and having - hoping to facilitate a good discussion of the group about each measure.

As you know each of you have been assigned as lead discussant for a measure. And for the lead discussant I'd like for you to tell us a little bit about the measure going through the four criteria and your thoughts about the measure underneath each of those four criteria.

And then we'd like to open it up to the larger group to discuss. And please feel free at any point if you have a question for the developer. We have developers on the call for these measures.

Please feel free to ask the developer to respond to any questions you may have as we go through. And are there any questions about the process?

Sure - who do we - so with that who do we have on the line as measure developers? I thought I heard someone from Joint Commission and NCQA.

Ann Watt: This is Ann Watt, Joint Commission.

Nancy Lawler: Nancy Lawler, Joint Commission.

Angela Franklin: Welcome.

Female: Thank you.

Male: Supporting the Joint Commission is the University of Wisconsin Center for Tobacco Research and Intervention. And on the line from the University of Wisconsin is Michael Fiore and (Rob Adsik).

Angela Franklin: Okay. Thank you. Is anyone from NCQA on the call?

Female: If not if you all have any questions or any follow-up information we'll be sure to communicate that to measure developers after the call and then get back to you with their responses.

Angela Franklin: All right. So looking at your - looking at our schedule here our first measure up is number 1651 TOB1, Tobacco Use Screening, the measure developers the Joint Commission.

And we had Dr. Briss as our lead discussant. Dr. Briss?

Dr. Peter Briss: Lucky me, I get to go first. All right so - this is essentially a tobacco use screening measure so in - among hospitalized patients.

And so it's as everybody here knows this is one of a series of measures that are intended to be used together and this first step of screening is then linked to tobacco use treatment in the hospital and tobacco use treatment provided at discharge and assessment after discharge.

The - so I won't read to you the rest of the details about the numerator and denominator. They're relatively simple on this one.

And sort of this - I sort of had the general sense that we had a relatively easy set of measures to evaluate.

It's easy to make the impact case for - it's easier to make the impact case for tobacco use measures then virtually anything else in public health or health care.

And so as we work down the form so I thought that (Oliver) made a good case that this was a high impact measure.

In the opportunity for improvements column I thought mostly on the basis of the pilot data that's that were provided later down the form that this was - this struck me as more like moderate because the baselines were fairly high.

I thought that they made a reasonable case that disparities weren't such an issue in this measure in terms of evidence...

Female: Okay.

Dr. Peter Briss: ...of evidence the - so this is not a health outcome. And so in terms of quantity, quality and consistency of evidence it scored as BN.

Female: Okay.

Dr. Peter Briss: High, high, and high.

Female: Okay.

Dr. Peter Briss: And...

Female: Before we move on to scientific acceptability does anyone else on the committee want to comment going along with Dr. Briss's assessment of the importance criteria?

Is there any other comments any other members would like to make at this point?

Female: No.

Female: No? Okay Dr. Briss would you like to walk us through the scientific acceptability portion?

Dr. Peter Briss: So the truth is I think I just did. It's this is again the depth of the evidence for tobacco is high, right? You know, so all things considered...

Female: Okay.

Dr. Peter Briss: ...you know, high, high, and high.

Female: Great.

Dr. Peter Briss: Oh I'm sorry. And then so I'm ((inaudible)). So in terms of scientific acceptability...

Female: So for this criterion we're basically going to focus on the reliability and validity. So if you found the testing results to be valid and reliable and if you agreed with the way that it was basically set up to be tested?

Dr. Peter Briss: Yes. So I'm sorry I'm...

Female: That's okay.

Dr. Peter Briss: ...trying to move through my electronic scoring, sorry.

Female: Okay.

Female: There we go.

Male: So it should be up on the screen here. We have - this was all of the evaluations submitted for 1651 here.

Female: Now it looks like everyone on the workgroup agreed that it was...

Male: High or moderate.

Female: ...high or moderate. And everyone agreed that it did meet that criterion for scientific acceptability.

Dr. Peter Briss: Exactly thank you.

Female: Great no problem.

Male: So we'll move on to usability and feasibility here. Again it looks like we have a skew towards high and moderate.

Dr. Peter Briss: Yes.

Female: What's...

Female: Did anyone find any - does anyone have any specific comments around the usability or feasibility criterion for this measure, any issues?

Female: They (liked this).

Female: It looks like for the most part everyone rated this as high or moderate on the evaluation survey.

Female: Any other points we'd like to raise about this one?

Female: This measure?

Female: Again if anyone has any questions we do have the measure developers online to answer any questions.

This one does appear to be pretty straightforward. So if there's no other comments or questions I think we can move on.

Angela Franklin: Great. So our next measure up is number 1654 TOB2 second in this set Tobacco use Treatment Provided or Offered and the subset measure 2OB2A Tobacco Use Treatment.

And we have as a re-discussant (Carolyn). Is (Carolyn) on the line?

Female: Okay do you want to...

Angela Franklin: So if we don't have (Carolyn) on we'll just throw it open to the rest of the members. Did anyone have particular thoughts about this measure? And we'll also look at the measure scores a little bit later.

Female: And do we have...

Male: So this was...

Female: Go ahead sorry.

Male: I'm sorry, after you.

Female: Oh I was just going to give a brief. So this is basically TOB2 Tobacco use Treatment Provided or Offered and it's a subset measure of T - and a subset measure TOB2A Tobacco Use Treatment from the Joint Commission.

So basically the numerator statement is the number of patients who received or refused practical counseling to quit and received or refused FDA approved cessation medication for the subset of the number of patients who received practical counseling to quit and received FDA approved cessation medication.

So that's the numerator over the number of hospitalized inpatients 18 years of age and older identified as current tobacco users.

So does anyone have any issues or any opinions on the way the measure was constructed?

Colleen Barry: This is Colleen Barry. I have a question actually that relates to both this measure and the next set of measures which were the measures that I evaluated as a primary, one of the primary folks.

I'm just curious to hear I don't have an issue with it but I'm curious to hear the justification on the part of the designers related to the denominator exclusion related to cognitive impairment?

Dr. Peter Briss: And while you're doing that I also had a denominator question too. This is Peter. I - so I was also and on two through four I wondered about the - essentially the denominator is constructed as people who were screened and screened positive for tobacco use.

And it looked like from the pilot data on tobacco one that that could have excluded as many as 20% to 40% of the people that could have been in the denominator because they weren't screened.

And so - and then secondarily I had the question about cognitive impairment. And so I - my question would have been why wouldn't you construct the denominator for this as a - as either

people that did that were screened positive for tobacco use or for whom tobacco use was unknown the - to try to capture all the tobacco users?

Bernadette Melnyk: And this is Bernadette Melnyk. I was just curious about the rationale to exclude patients for less than 18 years of age?

Female: Okay, Nancy or Ann?

Nancy Lawler: This is Nancy. So let me try and take these in order. I think first we had a question on cognitive impairment.

And I'm not really clear on what the question was related to cognitive impairment. We felt that, you know, if someone was not able to respond to even the screening or and if certainly if they couldn't respond to the screening and they were cognitively impaired you certainly weren't going to be able to do any counseling with those people.

And so we felt that they should be excluded. Now if you have particular questions on...

Bernadette Melnyk: Yes.

Nancy Lawler: ...okay.

Colleen Barry: Yes I'm sorry. Let me be a little bit more clear. Again this is Colleen Barry.

Nancy Lawler: Okay.

Colleen Barry: Can you describe the determination of cognitive impairment for the purpose of this center? How are...

Nancy Lawler: Okay.

Colleen Barry: ...individuals going to be determined as too cognitively impaired to be able to be included in the denominator?

Nancy Lawler: Okay. So in our data dictionary we have a definition of cognitive impairment which we say for the purpose of the measures that relate to documentation, the patient cannot be screened for tobacco and alcohol use due to the impairment. For example they're comatose, obtunded, confused and memory loss.

We have a question, a suggested data element question that we want everyone to ask to the same question. And it's a yes, no kind of a data element.

And so is their documentation in the medical record that indicates the patient is cognitively impaired?

We have included guidelines for abstraction. And here is where we lift terms if someone were defined as a medical record that might be equivalent to cognitive impairment.

And so those would be things like the word cognitive impairment or cognitively impaired, confused, memory loss, mentally retarded.

We do not exclude a temporary cognitive impairment due to acute substance use. So if someone comes in, they've overdosed or there in acute intoxication and we know that that's going to, you know, it's temporary, we do expect that they will go back and they will work with that person to do the screening and whatever intervention is necessary once that impairment does subside.

Colleen Barry: Is that piece of the criterion placed for the - well it's jumping ahead - but so I'll ask the same question about that last one that you just mentioned in the context of discharge because it seems like potentially those are two different points in the hospitalization in terms of the appropriateness of that criteria. But we can get back to that one in the next measure.

Nancy Lawler: Okay.

Dr. Peter Briss: And this is Peter. My follow-up on that question was it looks like people are in the - I'm sorry, are excluded from the denominator if they're either defined to be cognitively impaired or if that is unknown.

So I was a little concerned about excluding people based on incomplete charting. So can you give us a sense of how many people get lost based on that being coded unknown?

Nancy Lawler: On unknown oh, because it says unable to determine in that no?

Dr. Peter Briss: Yes.

Colleen Barry: Yes.

Nancy Lawler: Oh okay. That's where you're coming from. You know, I don't know the answer to that. I - and because it's lumped with the no so, you know, I don't know the answer to that.

I - we did do a calculation in here to see how many cognitively impaired people when we looked at the exclusion. I - I'm going to have to hunt that up here.

Dr. Peter Briss: Yes for this was in this whole set of measures those were my biggest concerns about, you know, how many people were being, you know, might be left out of the denominator either

because the tobacco status couldn't be determined or the cognitive impairment couldn't be determined.

Nancy Lawler: Right. The denominator on - let me address that. You know, we constructed the measure - to exclude those people who, you know, weren't screened or obviously, you know, were cognitively impaired but who weren't screened because we don't know what the status is and so it's really hard to put them into the denominator and say that you - because this isn't - the measure is constructed as a proportion.

So, you know, anybody who is in the denominator has to have an equal opportunity to flow up to the numerator.

And so when you put those people in the denominator who are, you know, we don't know if they are tobacco users.

And let's say they're not. Then they don't have a chance to flow up to the numerator because they don't need the intervention and so simply because we're constructing this as a proportion type measure it really didn't seem fit to put those kinds of folks into the denominator.

Ann Watt: Okay. This is Ann. And please correct me if I'm wrong but Nancy this is Ann from the Joint Commission and Nancy and I...

Nancy Lawler: Yes.

Ann Watt: ...actually both conducted these reliability studies and went out of the hospitals to re-abstract the medical records that they had already abstracted and to compare them.

I don't recall - now this is just anecdotally. I don't recall running across one case where it was unknown though.

I - my sense is just from reviewing the medical records that this was a small proportion of the patient's. Would you agree?

Dr. Peter Briss: For cognitive impairment or for tobacco use or both?

Angela Franklin: Well for both. That, you know...

Female: Well Ann...

Angela Franklin: Go ahead. I'm sorry.

Female: No you're right. No you're right Ann. And actually the reliability for cognitive impairment was quite high.

I thought we might have a little bit of trouble with that but the reliability for that data element was very high.

And you're right I don't remember ever seeing it either data element, you know, cognitive impairment or it was an unknown that someone was even screened. I don't remember ever seeing that.

Angela Franklin: Okay any other questions around the denominator exclusions?

(Crosstalk)

Female: There was one more question though about the why did we - why the age was it...

Angela Franklin: Yes.

Female: ...18 was of age and older.

And so we really grappled with that question with the Technical Advisory Panel because, you know, we all know that kids start smoking at an early age.

But we decided that it was best for us to stick with the evidence which was largely done on the adult population. And so that's why we stayed with the measure with the adult population.

Michael Fiore: And just to add to that the main evidentiary resources, the United States public health - this is Mike Fiore by the way.

The United States Public Health Service Clinical Practice Guideline which most recently was updated in 2008 and includes a review of almost 9000 separate articles and about 100 meta-analyses that served as the basis for the recommendations, in that 2008 United States Public Health Service Clinical Practice Guideline they concluded that there was not sufficient evidence to recommend smoking cessation medication for individuals under age 18 in large part because they weren't tested in that population but there was also data that said that medications were equivocal in terms of effectiveness.

So on the basis of that the advisory panel recommended that we follow the evidence and use an 18 or older cut off.

Angela Franklin: Okay thank you. Any other questions about the age exclusion?

Dr. Peter Briss: And Mike just -- this is Peter -- just so what - so wouldn't the - wouldn't an appropriate - for younger people under 18 the rationale for not using medication seems clear.

The sort of what about the rationale for - it seems to me that the rationale for kids could be very much like the rationale for pregnant women which is the, you know, you're still supposed to do counseling. So can you comment about that?

Michael Fiore: You're right. There is evidence although equivocal for counseling. And it - it's the case for both of the populations you just mentioned.

A real challenge with individuals under the age of 18 is a very sparse source of data there. There aren't a good - there's not a good evidence base for them and it tends to be equivocal.

But you are correct that there is evidence, some evidence for counseling. But the panel felt that it didn't rise to the level of it being - it should be universally applied in this instance of hospitalized patients.

And that was a particular issue. And that is virtually none in hospitalized patients that counseling was effective.

Angela Franklin: Okay. All right any other questions around this?

Dr. Peter Briss: So I'm still trying to reconcile what I thought I read related to tobacco use? It's on the screening question and the unknown tobacco status. I'm still trying to reconcile what I thought I've read and heard about the measures.

And so what I thought I just heard was that those of you who have actually abstracted charts felt that tobacco use status was pretty close to universally assessed.

And I'm trying to reconcile that with what I think I read in tobacco use one which was in the pilot assessment was done in 80% to 90% of people. And in the background literature it might have been as low as 60%.

And so I'd still like some additional follow-up on are we sure that the unknown tobacco use status exclusion from the denominator in two through four isn't excluding a lot of people who should be treated or followed?

And the other reason that I'm pressing this point a little is that I'm a little worried about the - that what we're doing with incentives with the various measures.

So and if for example a hospital didn't assess that sort of gets them off folks for the various sorts of follow-up while if you made people go back and follow-up on people for whom they hadn't initially assessed you would - you might have an opportunity to catch the assessment later, so any further thoughts about that?

Ann Watt: This is Ann from the Joint Commission. You know, you bring up a good question doctor. I think what we're going to have to do is go back and look at the reliability data to see - I mean your concern is a good one. Are hospitals just not screening people in order to avoid the measure?

And, you know, that's something we can look at the data for. You know, again all I can say is this is not something, you know, I don't recall a huge number of them being excluded from the measure because they weren't screened.

But let us check the data again and we'll report back at the Steering Committee Meeting.

Dr. Peter Briss: Okay. I appreciate it. Thank you.

Michael Fiore: Yes Peter this is Mike Fiore. Just to add to that I, you know, I your point is really well taken and enormously important given the overall goals of this.

There are some temporal trends that are making this more and more the case. Virtually every electronic medical record platform now has is a mandated field usually part of the vital signs an assessment of tobacco use status.

And thus some of the historic data that was down around 60% precluded the evolution of the Electronic Health Record.

And what we're seeing apart from this but just temporarily in the United States is a higher and higher rate at which both outpatient and inpatient settings are tracking tobacco use.

So I just want to share that with you as some reassurance. But your point is well taken. And the larger goal of this is 100% ascertainment of tobacco use status in order to then move through the rest of the measures.

Dr. Peter Briss: Right. I suspected that you might agree about the spirit of the question.

Michael Fiore: Without a question.

Angela Franklin: Okay are there other questions about 1654...

Male: May want to...

Angela Franklin: Additional discussion? Okay so let's go...

Male: We'll go through the ratings right now. And so we have importance. We saw a lot of yes or high and moderate same with the quantity and quality and consistency of the evidence.

And we have a four to one importance. Does anybody have any additional comments about importance?

Okay moving on to scientific acceptability here. We have - here we had a skew towards moderate for the 2B for the validity.

And again it was passed unanimously five nothing. Any comments on scientific acceptability?

All right moving onto usability and feasibility here we have again high and moderate. But here we had - two with - we had mostly moderate for the usability and same for the feasibility.

Do we have any comments, anybody want to make any comments about that?

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Okay so and it passed four to one suitable for endorsement so I think we have a hand in rationale.

Angela Franklin: So okay.

Male: All right, we covered the adolescent feature. Okay.

Angela Franklin: Right.

Male: So I think that covers 1654.

Angela Franklin: And I just had a note that (Val Pro) was going to respond to us a bit by the in person meeting regarding the exclusion particularly with - regarding age. Is that correct?

Dr. Peter Briss: I think particularly with regarding screening too.

Angela Franklin: Screening, okay. All right, moving on.

Male: Let's see...

Angela Franklin: Sixteen fifty-six. For that one we have Colleen and Emma as lead discussants. And that's TOB3, tobacco use treatment or provided or offered at discharge and also the subset measure, TOB3A, tobacco use treatment at discharge.

So Colleen or Emma?

Colleen Barry: Emma do you want to go first or would you like me to?

Emma Hoo: Either way. I - you know, I think much of this paralleled tobacco too. It's just focused on the point of discharge.

Colleen Barry: Yes, agreed. And I think that the scores will reflect that. In terms of the impact of scientific acceptability I think that at least my comments are consistent with the comments that have been made on the prior measures.

Honestly with reliability and validity and the usability and feasibility measures I rated all of these high myself. Did you as well Emma or did you have some concerns related to some of these dimensions?

Emma Hoo: In terms of the evidence in the front end I thought overall it was high. I had some concerns around the data collection. But we can hold till we get there.

Sarah Fanta: Okay.

Colleen Barry: Okay let me (pause) there then.

Sarah Fanta: Does anyone else have any comments on the importance section of the measure?

There was a lot of agreement based on the survey that I've already agreed with the high impact area. Okay moving along to scientific susceptibility Colleen and Emma?

Colleen Barry: Emma, do you want to go first? I rated this dimension high.

Emma Hoo: Yes, I didn't see any issues here.

Sarah Fanta: Discussion from the larger group about this area?

Dr. Peter Briss: I had a tiny technical question about in some of the reliability and validity testing in - on some of these measures that you were reporting (Kappas) of numbers like .03 and .05 which - so which I would have normally interpreted as very low agreement.

Was that a misprint or am I interpreting the (Kappa) statistic differently from the way you folks do?

Colleen Barry: No I don't think you are. And, you know, I'll have to go back and check. But I don't think it's a misprint.

But let me go back and check on that and we can report. That's another thing we can report back when we're there in person on the 17th.

Dr. Peter Briss: Okay thanks.

Emma Hoo: Peter what page are you on Peter in your - in citing (this)?

Male: Oh, it's the top of Page 16.

Dr. Peter Briss: Yes, top of Page 16 you're reporting .05.

Emma Hoo: Oh yes I missed that. Okay that - yes. And that was for 98 cases for both the originator and the re-(abstructor) agreed that the case was in the population, okay.

Male: Yes so we need to get some clarification on that for the in person meeting so we'll - we will do that.

Female: Okay.

Colleen Barry: Okay.

Male: Do we have any other discussions on the reliability and validity?

Dr. Peter Briss: Oh and actually that (Kappa) question came up on more than one of the measures. There was another one where you reported out a (Kappa) of .03. And so that'll be a general question for several of these.

Emma Hoo: Okay. Will go back and check that - check all of our (Kappas).

Dr. Peter Briss: Thank you.

Angela Franklin: Comments on the reliability or validity testing? And if not we can move on to usability.

Colleen Barry: For the usability I don't know whether this is the right time to bring it up. But I do want to return to that exclusion guideline in the - for abstraction in the dictionary related to temporary cognitive impairment due to substance use overdose, acute intoxication.

And given that this is a discharge measure I wanted to hear a little bit about the thinking with regard to that.

Emma Hoo: Okay. I guess the reason that, you know, we have that is that this data elements spans the entire measure set.

Colleen Barry: Yes, I saw that consistency. I just was wondering whether it made sense in the context of the three...

Emma Hoo: Right.

Colleen Barry: ...the two statements.

Emma Hoo: Right at - in other words what you're saying it is at discharge, you know...

Colleen Barry: Yes.

(Crosstalk)

Emma Hoo: You know what I mean?

Colleen Barry: Yes. No I'm willing to listen to a justification. There might be one there. This is Colleen Barry by the way. But I think that perhaps it's less appropriate in this context in this specific measure as opposed to - you know, and that needs to be traded off with the sort of feasibility of sort of changing the criteria across measures. But it seems like that's done in other cases so...

Ann Watt: This is Ann Watt. You know, I think it's a good point. I can tell you or I think I can tell you -- and I'm sure Dr. Fiore and Nancy will correct me if I'm wrong -- that our thinking behind this was well number one, if somebody's temporarily cognitively impaired they are - they will be eliminated from the measure by virtue of the fact that, you know, that they won't have had screening done.

Colleen Barry: Yes.

Ann Watt: And therefore that sort of flows throughout the whole measure set.

Colleen Barry: Yes.

Ann Watt: If they weren't there for one they're not going to be there for three either. And so I think that's why we just sort of made it a blanket thing like that. But, you know, we could certainly talk about taking out that exclusion for this measure.

Colleen Barry: Yes. Again, I don't know whether it makes sense from the sort of screening standpoint but it occurred to me that it didn't necessarily make sense in terms of actual cognitive impairment at that moment in time. But we can move on.

Angela Franklin: Okay.

Male: All right, any other discussions on the usability or feasibility? I know you are heading into that.

Colleen Barry: I didn't see anything.

Male: Okay I'll pull up the ratings then.

Female: Yes, no one question I had was in auditing parts and processes around discharge, it strikes me that in some of these checklist type measures that it may not necessarily, you know, get the depth, you know, of interaction on treatment and as we, you know, would define it, you know, just because there are so many other things that are, you know, potentially at issue upon discharge, you know, whether it's, you know, medication reconciliation or some of these other priority areas.

Female: Yes.

Female: Okay.

Male: (Krista) here we have the - let's run through the ratings here. We had a very high rating towards the importance and the evidence. So the importance passed six to nothing. Moving into the scientific acceptability here again, passed five nothing. But we had more of a moderate, skewed to moderate for the reliability and validity.

And for usability and feasibility here we were split between high and moderate for usability and then five to one moderate over high for the feasibility.

And do we have any - does anybody want to discuss any of these ratings?

Overall passed six nothing for suitability for endorsement so that's excellent. And if anybody has any further questions we can move on to 1657.

Colleen Barry: Just quickly before we move on, this is Colleen Barry.

Male: Yes?

Colleen Barry: I had told Sarah that I need to sign off at 11:00. And I apologize for that. I had a prescheduled teaching basically that I couldn't get out of.

Male: Okay.

Angela Franklin: No problem. Thanks so much for joining us Colleen.

Colleen Barry: Sure. I'll stick on for the next 15 minutes but I just wanted...

(Crosstalk)

Male: All right.

Female: Thank you.

Male: Great. All right, so follow-up 1657.

Female: We had the lead discussion as (Aaron Houslin). Is (Aaron) on the call?

Okay not hearing it we'll just give you a quick overview of the measure and go ahead and then open it to the group to discuss the criteria.

So the numerator statements, basically the number of discharged patients who are contacted between 50 and 30 days after hospital discharge and follow-up information regarding tobacco use status is collected.

For the denominator, number of discharged patients 18 years and older identified as current tobacco users. And there are 15 exclusions and I'll - you have them there on your screen and in your form.

And we wanted to start with the importance portion of the measure and see if there were comments from the group. Comments around...

Female: Don't we have to report the scores?

Male: ((inaudible)) scores.

Male: Yes will pull the scores up here just so we can have a starting point without a discussion.

Sarah Fanta: Sure, sure, apologies about that. So it looks like we have mostly in terms of importance, the skew is towards the high to moderate level, mostly highs for this measure. Is there any discussion around - any other thoughts about that from the steering committee?

Okay so...

(Crosstalk)

Sarah Fanta: ...could you - scientific - so moving on to scientific acceptability looking at the scores we're skewing more towards a moderate to low which certainly warrants some discussion from the committee members.

Could you give us thoughts? Feel free to jump in about their - your scores on these, this particular portion of the measure. And that's scientific acceptability.

Male: Specifically I had a comment that there was a high variation in the results. So the ease of collection was ranked very low with the type of study environment. So it's again, that does represent a concern for the real world.

Sarah Fanta: There's some comments about data collection, EHR specification.

Male: Do we have any other comments about the scientific capability portion? Anybody want to bring anything up?

Dr. Peter Briss: Not (from) here, no.

Sarah Fanta: Sorry, what was that?

Dr. Peter Briss: No.

Sarah Fanta: Okay.

Male: All right so - but the ratings attached, scientific acceptability still passed five to nothing. So moving on to usability here we have more of a spread here.

We have some highs, moderates and insufficient. And so we had insufficient for both the quality reporting and quality improvement initiatives. If you want to discuss - anybody want to discuss any of that?

Okay so overall it had a mostly moderate rating for usability and feasibility the same. So again there we had more of a spread with these ratings.

And overall, this one had a much closer vote for the suitability for endorsement. This was three to two so I guess this measure - their departure from previous ones. So we have - anybody want to comment about that?

David Einzig: Yes, this is David Einzig.

Male: Yes?

David Einzig: Just in terms of feasibility of this I think it's - in the real world I think it's a lot more challenging and difficult to follow-up with patients after their discharged from the hospital.

I just started thinking in the back of my mind if I were a patient discharged from the hospital would I really want to be receiving phone calls from the institution?

And then as a person making those phone calls I would think it be frustrating because sometimes it's often difficult to try track these patients down, wrong phone numbers or you've got - who knows what, but typical patients with mental illness.

Male: Yes that's a very good point and that's definitely reflected here in the ratings.

(Crosstalk)

(Crosstalk)

Nancy Lawler: ((inaudible)) this is Nancy. If I could - can I make a comment?

Sarah Fanta: Yes.

Male: Yes.

Nancy Lawler: If we do - we did make some revisions to this measure and we do account for people who are lost to follow-up. They will be excluded.

And so originally when tested we didn't have a cap on, you know, how - you know, how often do you have to try to contact someone.

But, you know, if there are incorrect phone numbers, they can't get in touch with someone, you know, there are multiple exclusions here. And if they are lost to follow-up then they won't be excluded. So we do account for that.

Male: And similarly the - it seems to me that the cognitive impairment exclusion from this fleet of measure probably handled the significant mental illness issue.

Nancy Lawler: Right. And, you know, going back to back cognitive impairment and Ann's comment relative to the third measure and the Fed and also you seek cognitive impairment followed through the entire set and, you know, it's interesting because, you know, we're sitting on the other side of the fence when we first developed this measure.

And I had multiple, multiple conversations with our technical staff. And I dug my heels in and said we don't need to have cognitive impairment here.

And, you know, I won the battle. And it wasn't until I ran test cases through our calculation algorithm that I realized that we had to have cognitive impairment in these measure series and to the end. So I just wanted to bring that point forward to just sort of echoes what Ann said.

Michael Fiore: And this is Mike Fiore. Just to give the group a sense of sort of the rationale for this in, you know, in a global way, it really builds on the data.

And there's substantial data now that if we arrange follow-up for tobacco use treatments in the 5A acronym to that's the last of them we actually substantially drive outcomes like quit attempts and ultimate cessation.

So the global rationale for this was to increase the likelihoods that hospitalized patients who smoked would make quit attempts and quit because there's a substantial evidence-based supporting follow-up contact in doing that.

And as - so I - I just wanted - I thought it would be helpful to provide the rationale for this. And we also referred to some other instances where hospitals do regularly follow-up with their patients post-delivery of a pregnant patient often with congestive heart failure, sometimes with antibiotic checks.

So we saw a rationale in it being done in other chronic disease management. And that's very much approaches tobacco dependence treatment. It's chronic disease management and one that might achieve the broad goal of increasing quit attempts and increasing cessation.

Dr. Peter Briss: Peter. And also - it also seems to me that in a world where we're - we - we are trying to move toward better coordinated care in a variety of ways, it seems to me that this might be a - sort of a useful baby step towards that.

Male: We agree.

Male: Great. Do we have any other comments about Measure 1567?

Sarah Fanta: Okay.

Male: Excellent. Now we'll move on to Measure 0027.

Sarah Fanta: And Dr. Einzig if you'd like to give us a brief overview?

Dr. David Einzig: Yes. So this is a pretty straightforward in the numerator advising smokers to quit. The denominator are all patients 18 and over who are current smokers or tobacco users. We already addressed the issue related to the age cut off of 18.

Female: Okay, all right.

Male: Any comments about the importance or the impact?

Female: Any comments from the group, questions? Okay.

Male: We can go to the ratings here. So this one actually it shows there's a lot of - it's skewed toward high but then we - it passed only three to two for the importance.

So I was wondering if anybody wants to comment on maybe why they didn't feel this met the importance criteria?

Okay so video is not known. Call - but she has evidence supporting patient education on smoking cessation, is helpful to quit smoking however asking patients at one time, point in the year irrespective of when recent decision ((inaudible)) occurred.

So they recall having discussion on this topic translates to improved outcome and is not shared in the body of evidence ((inaudible)) submitted. So that's one opinion here on why it possibly didn't pass the importance criteria.

Do we have any other comments on the importance?

Sarah Fanta: Any concerns or comments about the evidence that was submitted?

Okay Dr. Einzig would you like to walk us through the scientific acceptability portion?

Dr. David Einzig: All right. Let me move forward here.

Sarah Fanta: And.

Dr. David Einzig: So on quantity, quality and consistency?

Sarah Fanta: Yes.

Male: Yes.

Dr. David Einzig: All right so quantity it's just referenced measures based on USPSTF guideline. It didn't reference quantity of studies beyond that statement. But this was...

Sarah Fanta: Okay.

Dr. David Einzig: And quality and consistency rated as high as well.

Male: Okay. All right and we'll move on to the reliability and validity. Oh and...

Male: All right.

Male: Okay so the reliability and validity here, we had a split here for reliability between high and moderate.

And then we had for the validity we had three high and one low. But then it passed four to nothing for the scientific acceptability. Any comments, concerns about the acceptability, the reliability or validity of this measure?

Okay move on to the usability and feasibility here. So it looks like we had - it was high for the public reporting and arrange for the quality improvement. And then looks like we had range for the usability two, one and one. So we had a range from high to low.

Do we have any comments, concerns about the feasibility?

All right.

Sarah Fanta: Any comments?

Male: All right, hearing none we'll move on to feasibility, so the final one here.

And here we had definitely a skewed towards low and insufficient for the 4A and 4B, the by part care processes and the electronic data sources.

Does anybody want to express their concerns over those two elements?

Dr. Peter Briss: Well because it's a - because it's a survey measure it seems to me that it scored below. It seems to me they have to score low on those elements.

Male: Okay. That's a good point.

Sarah Fanta: Any comments from the developer on that issue?

Bob Rehm: Oh I. It's Bob Rehm here at NCQA as well as Dawn Alayon. No, I mean I think that, you know, we're measuring plan performance.

Plans are - have demonstrated over the years significant ability to have interventions focused on their membership.

We find that the survey approach is still valid and very helpful to the community and provides both specific data to health plans as well as larger data that reinforces surveillance that we already know of on interventions around tobacco use and cessation.

Dr. Peter Briss: Maybe...

Male: Okay, great.

Dr. Peter Briss: ...while you're there can you comment on the - so this one has a lot of conceptual potential for overlapped with NQF 0028.

And so do you want to comment about why we need this sort of survey measure in addition to the other conceptually related health record measure?

Bob Rehm: Well sure. I mean where you have - I mean there's one specified for clinician, one specified for health plan.

I think, you know, we understand that depending on which clinician office you happen to be in and, you know, that the dated that's reported there, who's reporting it, how many clinicians are reporting it is really of the question.

I mean currently this - the (Kaps) measure is part of meaningful use and its included another programs.

So I mean I think that's a good result to have a, essentially an aligned measure in the clinician community gathered in one from one data source and to have a - another for different, a level of accountability from another data source. So I think that actually is a strength, not a weakness.

Sarah Fanta: Any other comments?

Female: How about 28 coming.

Sarah Fanta: And as Dr. Briss just mentioned we will be looking at 0027 in the context of a similar related measure which is 0028. So that - it's coming from AMA PCPI.

And that measure actually is still - measure developers are working with them to enter in their testing data. So that measure will actually come before you at the in person meeting. And you'll have a chance to kind of dive a little bit deeper into this discussion.

But we do just want to make you aware. Thank you Dr. Briss for bringing that up that you will be looking at both of these measures just keeping in mind that they are similar.

Male: And on the second day of the meeting there will be discussion of related and competing measures involving several of the measures up for review during this project.

Sarah Fanta: Dawn do we have any questions on either this work group or any of the other workgroup meetings that occurred in the in person meeting or anything at this time that anyone wants to bring up?

If not I just want to thank all of you so much for making the time to be on this call. We really think it's going to help facilitate the meeting April 17 and 18 moving along the discussion just getting the preliminary look at the measures.

Fortunately these measures are pretty straightforward but we're going to have some more challenges at the in person meeting at least based on the other workgroup calls.

But thank you all so much. We'll be sure to follow up with the developers around all the questions that you would ask. And in the meantime feel free to email me. This is Sarah or Angela and (Evan) with any questions. But again, thank you all so much.

Male: And at the same time if you feel that the discussion has changed your opinion on any of the measures feel free to go in and change your evaluation in the survey tool.

And we'll be presenting these again at the in person meeting just as a starting point for discussion just so we saw where the workgroups landed on the measure evaluations.

So if you want to change anything feel free to go back in and we'll make sure those get updated.

Sarah Fanta: And we ask that you just update them about three days before the...

Male: Yes.

Sarah Fanta: ...April 17 meeting. So around April 14 if you could go in and update if need be, that would be great.

Male: Yes, so by the end of this week.

Angela Franklin: Yes.

Sarah Fanta: Any other - or - oh sorry, go ahead.

Angela Franklin: Any other questions or comments? No, hearing none, we look forward to seeing you at the in-person.

Male: Thanks much.

Female: Thank you.

Male: Thank you everybody.

Female: Thank you.

END