NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
May 22, 2013
2:00 p.m. ET

Operator: Welcome to the conference. Today's call is being recorded, please standby.

Elisa Munthali: Good afternoon everyone and welcome to the third workgroup call for Phase 2 of the Behavioral Health Project. During this call, the workgroup will discuss their preliminary ratings on eight alcohol and tobacco measure submitted by the Joint Commission. My name is Elisa Munthali, I'm a senior project manager here at NQF and also joining me today are my colleagues Lauralei Dorian, Angela Franklin and Jessica Weber and we also have a committee member and a workgroup member Mady Chalk.

Before I turn it over to the committee's co-chair Peter Briss who will facilitate the call, there are a couple of housekeeping items that I wanted to share with you. First, this call is being recorded and transcribed and it is open to the public. Members of the public will have an opportunity at the end of the call to make comments. Also, we've opened it up and invited the developer, in this case, it's the Joint Commission for all eight measures to respond to questions that the workgroup members may have.

Second, we are using the webinar to show the preliminary ratings on screen and we just wanted to makes sure that everyone can see the webinar at the moment we have the agenda up. But if you have any difficulties with viewing the webinar, please let us know either through the chat box or during – through this open line.

And when I turn it over to Dr. Briss, what he would do is identify the lead discussions for each measure and everyone will be expected to introduce the

measure with the title and description and walk through the preliminary evaluation ratings and particularly noting any areas of discrepancy. And these ratings will help to inform the discussion at the in-person meeting which will be held here in Washington, D.C. at our headquarters at NQF on June 5th and 6th.

And so with that, I will turn it over to Dr. Briss.

Peter Briss: Good afternoon everybody. I'd like to open with thank you's to the committee and staff for a lot of hard work to get us to this point and why don't – why don't we open really briefly with each of the committee members walking around and introducing ourselves. I'm Dr. Peter Briss from CDC.

Elisa Munthali: And perhaps I can do a roll call. Madeline, are you on the line?

Madeline Naegle: Yes, I am. Yes, this is Madeline Naegle. I'm a professor at NYU's College of Nursing. My specialty areas are addiction and psychiatric mental health.

Elisa Munthali: Great, welcome. Michael, are you on the line?

Michael Lardiere: Yes, I am. I'm Mike Lardiere, I'm Vice President for HIT and Strategic Development at the National Council for Committee Behavioral Health Care and social worker by background and in-patient, out-patient management setting then also have a health information technology background as well.

Elisa Munthali: Thank you and welcome. (Lynn Wagner)? OK, I don't think Lynn is with us. David Pating?

Male: Pating.

Elisa Munthali: Pating, sorry. OK, I don't think David is with us, and Mady?

Mady Chalk: Mady Chalk, Director of Policy Research at Treatment Research Institute. Glad to be here.

Elisa Munthali: And I think (Jeffrey Summit) wasn't able to join us today but he's also on this workgroup and so, Peter, I think that's our roll call.

Peter Briss: Excellent, thank you. So and one other sort of housekeeping item as we work our way through the measures, as the committee will recall, we had begun evaluations of all of these tobacco and alcohol measures in phase 1 of this project. Not surprisingly, there was general consensus I think on the sort of in importance to measure and report criteria.

And so, I think that there was general consensus among the committee that both tobacco and alcohol were high burden conditions therefore, which effective but under utilized interventions were available and so, assuming no objection from the committee members today, I think they will suggest that that will those – we'll take importance to measure and report to be given on all of the pool of measures today and move straight to scientific acceptability and the other criteria unless somebody would like to raise an objection for that.

Male: No?

Peter Briss: Hearing no objections, we'll move straight to the measure evaluations starting with 1651 Tobacco-1 and, yes, I will go ahead and do that (inaudible). Since we have a lot of measures to get through today in a limited two-hour time block, I'll ask the committee members to be brief in their summaries and I'll try to open by modeling for – occasionally I'm getting some background noise, so it might be useful if you're listening and not talking to mute your phone, please.

So the scientific acceptability of 1651, the committee generally gave high or moderate marks to both reliability and validity of the measures and suggested that both of these are likely to improve as BHRs continue to come online. Our reliability testing was generally reasonable on agreement rates between two reviewers where in the high 80, 40 measure components. One of us remained concerned about inability to accept the exclusion, the impact of excluding patients based on cognitive status result, measure specs were generally thought to be reasonable via technical advisory, panel, even public comments and then a small number of testing hospital.

Performance results were reported from 19 private hospitals and did show improvements in performance before and after suggesting that the measure

was implementable and could measure change. And so with that in the preliminary evaluations, the reliability and validity were thought to be high or moderate. Anybody have discussion or like to raise concerns about that?

Hearing none, I'll move to usability. So in general, all of us rated the usability high. Rationale was presented, outcome measures were clear, the measure will be reported on the Joint Commission website and is under consideration for the (inaudible) prospective payment system rule, that the measure was rated, outlined into the four and the five-point scale by pilot test users about usefulness for best marking and identifying – benchmarking and identifier best practices and then supporting quality improvements. Respondents scored the measure in the low four with respect to ease of interpretation and usefulness and meaningfulness to stakeholders. And so in summary, we had consensus that usability was high. Any questions, comments, or concerns?

Hearing none, the feasibility, you know, feasibility scored high or moderate and people generally tend to feel that the testing showed that the measure was feasible to use. And so without further ado, any questions, comments or concerns?

Hearing none, the last general comment that we might want to talk about a little is a concern was raised that this measure was specified for people in and over in which she (inaudible) raised inconsistencies with the Stage 2 Meaningful Use measure which is that's like for allocation setting and then that's like the nature of 13 and over. And so, I wonder if the joint committee (inaudible) would want to comment on the rationale for the rational for the age that's been presented.

Elisa Munthali: (Celeste) or (Ann), are you on the call?

(Celeste): Hi, yes this is (Celeste), I'm on the call. And I might have Rob joined in here. He's one of our coach here as well on our Tobacco Committee. It's my understanding that we were looking at an adult population which begins at age 18. It kind of married the other core measures that we typically evaluate with adults 18 years and older. It kind of also falls into guidelines like it's (inaudible) to become part of the CMS recording program that would be

looking at adults. And I don't know Rob if you want to add anything to as far as what are technical advisory panel felt at that time?

Rob Adsit: Sure, so this is Rob Adsit and I'm actually representing Dr. Mike Fiore today. We both are from the University Wisconsin-Center for Tobacco Research and Intervention and Dr. Mike Fiore was the chair for the clinical practice guideline. So the 18 was based on – there's very little evidence, there's not enough evidence actually on people under the age of 18 for the Tobacco Association Interventions especially the medication but also counseling.

So, the technical advisory panel decided to stay with 18 even though we had a long discussion about other federal initiatives like Meaningful Use being 13. And I wonder, I don't know of the top of my head and I wonder if anybody else knows the NQF, one of the other Tobacco Association endorsed measures for outpatient, it's NQF 0028. Does anybody know the age? I believe that's 18 as well and I think it's for the same reason.

Elisa Munthali: Yes, it's 18.

Peter Briss: Yes, this is Peter, it's 18.

Michael Lardiere: I just have a question with that one, when was it last reviewed?

Elisa Munthali: Phase 1.

(Celeste) I have a problem with – (inaudible).

Elisa Munthali: I think it's background noise. Operator, are you able to identify where the background noise is coming from and if you could please (leave) that line.

Operator: OK, one moment.

Elisa Munthali: OK.

Mady Chalk: Even though 0028, I just came from that meeting, is specified as 18. That involves screening and cessation intervention. This is a screening measure. It's not an intervention measure and as such, if a patient who are hospitalized and this is at the hospital level (inaudible) because it's a Joint Commission

measure. If an adolescent were hospitalized, I would wonder why an adolescent would not be screened.

Now, I know that the Meaningful Use Measures at age 13 and I believe that question will be raised again at the behavioral health committee level and in the (inaudible) schools about why this continues to be specified at 18.

Rob Adsit: Yes, so this – I'm sorry. So this is Rob Adsit and I welcome (Celeste) and (Ann) from the Joint Commission to respond. I hear what you're saying. We understand that. The concern would be if we did lower the, you know, screening to 13 and what would happen if 13 to 17-year-old are identified as tobacco users. What would the action be?

(Celeste): Hi Rob, it's Celeste, you're absolutely correct. This is one of four measures that comprises a measure set and review this as a set. So if they were to have a positive screen in measure one, then the logic would dictate that you would (inaudible) do an intervention and if the guidelines don't support an intervention, the fact, the utility of an intervention at age 13 then they wouldn't be able to necessarily have favorable results for the second and the third measure because then that would be continued outpatient after they're discharged and then of course the follow up fee.

We're not arguing that, it's not a bad idea to screen somebody at age 13 but what we're looking at here is of those 18 years and older, we know there's evidence that states if they have a positive screen that they may be more receptive to the intervention and to the cessation medication. So it's that's why we focused it – so that we're looking at just one population. If we had a different population for measure 1 and different population for measure 2, then that would not work. It wouldn't be able to just select one measure just for adolescents for the purpose of how we develop a measure set to be used to gather their complimentary measures.

Mady Chalk: So, what's the Joint Commission going to do about the 13, 18 year old group? Are you just opting out of measuring that group?

(Celeste): We chose, as Rob indicated, the technical panel, the technical advisory panel itself that there wasn't enough evidence to support doing the interventions and

as I've just stated, if we were planning to do a screening measure for that group, we'd have to have some sort of an intervention measure and there's nothing in the evidence to support that this would make a difference for an adolescent. We can't have a single measure out, there just to look at screening adolescents, that's not how we develop our measures, we develop them in a set, so that's a complimentary.

Michael Lardiere: This is Mike Lardiere, and I guess that my concern was that the intervention doesn't include counseling. It's only a medication intervention?

(Celeste): No, actually there's two types of interventions, depends on the use of tobacco whether they're – I'm just going to use the terms whether a light smoker or a smokeless tobacco user versus a heavy tobacco user. If they're identified and of the lighter groups in such as they don't smoke everyday, they just use smokeless tobacco, the evidence shows that they should receive counseling but if they're a heavier user like they were smoking daily greater than five cigarettes a day and so forth then the evidence shows that they should repeat both the medication and the counseling.

Michael Lardiere: All right.

(Celeste): That's how our logic is set up to identify first in the screening, what is their level of use and their frequency of use and then that would drive how they would be evaluated in the second measure which would be the intervention measure.

Michael Lardiere: I guess maybe the evidences hasn't called it up to what the realities are in the population and is that the not harmonizing the measures across the board in where they're going, you know, throughout the country and then having different providers measure just adults and different providers measure 13 and above. It makes sense for some 13 and above not for others. I don't know how we could support just doing 18 and above, and maybe we need to begin to do that counseling and catch up because we just haven't done it enough to have the evidence and I don't think that's a reason to exclude doing the 13-year-old. It's a huge problem in the country.

I have the same issue with the one I was reviewing as well that I think they need to be modified and include 13 and above. So we're all in the same page at all cost and we'll begin to do reporting across inventory and inpatient were looking at the same things, otherwise when we're looking at 18 and inpatient, 13 and ambulatory, how are those things ever going to jive. I don't know.

Male: (Celeste or Ann), I would definitely defer to you but maybe we should consider doing the age 13 but then excluding them from medications. So it would just be the counseling.

(Celeste): We can certainly take this under advisement. I'm not in the position to make any kind of statement about that.

Male: Yes, yes.

(Celeste): We can only take it under advisement, that's all we can do.

Michael Lardiere: (Inaudible) practical solution because if, you know, medications are inappropriate for a 13-year-old whether or not at the level that they need medication and you'll just do counseling. I do think the counseling is important and then it keeps us all working on the same parameters.

Madeline Naegle: Hi, this is Madeline Naegle. I just want to comment on what I perceive as a discrepancy because I think it's hard to really puzzle this out in a way that's clear. I think what we believe would be a good idea in what we recognize as a prevalent problem across the county is not the issue.

I think that the question is really about the scientific evidence and we have tried very hard to look at strong scientific basis, we've sent measures back because we didn't have them. And what I'm hearing from the folks that it was (inaudible) we don't have (found) enough science about intervention with adolescents, and that seems to be the sticking point.

Male: Yes. That is correct. That's why the technical advisory panel finally settled on the (AG team) because that's where they were storing enough evidence to build the intervention then.

Elisa Munthali: Peter?

Michael Lardiere: The evidence around providing – so when you counsel adolescents, evidence doesn't show it works. Is that what (inaudible) were saying?

Male: No. So, basically with adolescents, there's just a lack of data. So, we're not saying that it wouldn't work, we just, there is not enough evidence to make a recommendation or create a measure based on …

Michael Lardiere: Well, can you address how do I got to that for Meaningful Use. They had to have some, and I know I've read it way back then. (Inaudible) some evidence instituted for age 13 for Meaningful Use. But that just didn't come out of the air.

Male: That's right.

Elisa Munthali: Peter, this is Elisa from NQF. It sounds like the work group is coming around consensus on perhaps coming to a recommendation for the Joint Commission and that's something you can absolutely do during the in-person meeting on June 5th and 6th. And so, it sounds like this would be a point of discussion for the entire student committee.

Peter Briss: So, maybe it moves ahead but with a discussion at the meeting with the Joint Commission about specifying it for this other population, and maybe in the interim looking at what Mike has suggested about what the studies are that allowed her to get specified for meaning use.

Elisa Munthali: And just as a reminder, today's discussion is preliminary ratings to just kind of get our discussion going to help us inform your decision on June 5th and 6th.

Peter? Other comments? Operator, could you tell us if Peter Briss is still on the line?

Operator: Yes, one moment. He's line is muted. He's line is now open.

Peter Briss: Hey, this is Peter. I'm sorry. I've been trying to get in for five minutes. I was …

Elisa Munthali: I'm sorry about that.

Peter Briss: So, yes, it sounds like, you know, we've heard the arguments on both sides (inaudible) as I think. There are people among the committee that did (inaudible) that for, because of the importance of the problem and because of the potential for inconsistency with Meaningful Use Measures and other things that we should lower the (inaudible) we've heard that from other reviewers that there are concerns about that and that without evidence of effective intervention, the measuring and reporting in adolescents is more questionable in terms of importance of measure and report then – the measure is currently specified for adults.

And so, I agree with the staff that we should – that we should table the discussions here. And when it comes up on other measure – for the full committee discussion in when we need face to face. So, would anybody, would anybody like to add anything to that?

Madeline Naegle: Peter, it's Madeline. I think that the question is not about the importance measure report. I think we have consensus on that. Use seems to be about a lack of a scientific base for effectiveness of intervention even for the brief interventions.

Peter Briss: Yes, exactly right.

With that caveat, so what do at this point? Do we …

Elisa Munthali: So, what we're doing at this point is taking notes. We're writing down all of the comments that are coming from this discussion and we'll also has – this discussion is also being recorded and transcribed.

And so, we will present a draft summary of all of the calls to the entire steering committee so that you'd have, in advance, when you meet in June.

Peter Briss: So, OK, essentially on this measure here, we had – what sounds to me like – like fairly complete consensus on the four criteria uphill, the age limit and that (inaudible) that should be the main, yes, item of discussion for the direct committee meeting.

Elisa Munthali: Yes, I think so. It seems like that that's where the points of contention where and just so that you remember, we're going to have about 24 to 25 measures. And so where you can pull out these areas where there's no consensus, so where there are needs further discussion that would be most beneficial to the steering committee.

Peter Briss: Great. And if there are anybody else – anybody else have main items before we move on? So let's move – and with that, let's move to 1654. And Michael, can you walk us through that one?

Michael Lardiere: Yes, OK. Thank you, Peter. Yes, so that was much the same as the other one and in the scientific acceptability, there was three identified as yes and one is no. On the reliability, it looks 50-50, two of the reviewers identified it as high and two is medium. On the validity, it was three were high and I guess one is inconclusive with the (inaudible). The same issue with the 13.

Now, there were some concern about all the components of the dialogue and recommended counseling being delivered prior to discharge which raised some questions to a reviewer about its reliability.

And then another reviewer identified that the measure seems specified for some reliability testing that's been undertaken. It seems reasonable both for overall measure agreement rate between two reviewers and for key measure components, although agreement on whether all aspects of the counseling delivered was still relatively low. That particular reviewer would like to see how often inability to assess cognitive status results and exclusion of the patients from the measure. It wasn't identified? How often that occurs?

And there's some comment in the – from the public comments in a small number of testing hospitals. Performance results reported from 9,038 records submitted from 19 private hospitals doing the six-month period.

On the usability side, it was rated high and three of the reviewers rated it not (inaudible). And on the feasibility, one reviewer rated it high and three rated it as medium. The comment there was the rationale of what (inaudible) in the past has not been routinely collected, the measure steward will collect them

from hospitals and make them public increasing the likelihood that they'll be included overtime as they become specified by the steward.

And then there's one other comment that all components of counseling may not be routinely recorded as part of clinical care through documentation requirements, however, some of the components may be available in the EHRs. So that was a comment around feasibility.

And on the rationale component, we have the same issue around the age 13. So it seems like from this presentation, the reviewers were in agreement to move it forward same as 1651, but the issue of the starting at age 13 seem to be outstanding, too.

Peter Briss: So, thank you for that (inaudible). The age issue is going to be the same throughout the measure (inaudible) we've already handled that. Does anybody have other issue that they'd like to raise?

Hearing none. That's sounds like – sounds like it's one – gets a relatively easy pass through the vote to the full committee.

And let's move to 1656. Madeline, would you like to – would you like to take this one?

Madeline Naegle: Yes, Peter, thank you. So this is a process measure that is – and this one and the following one is three and four of the four measure subset that we're looking at. This one really looks at an overall rate to include patients 18 and over who would provide it (offer) or refused at discharge and intervention, and the second rate which includes only those who receive tobacco treatment at discharge. The treatment of discharge includes a risk for all the outpatient counseling and a prescription.

Just going down response from our group, we – so we had agreed, we all agreed that it was important to measure and report the scientific acceptability of the measure properties. We are all seem to be on agreement on that with a little bit of – a little of variation reliability but not to bad. The science behind this included a number of meta-analyzed studies in the (inaudible) report. So the wide variation in screening practices, it seems to be an issue that was

raised by a number of people in the group. We (inaudible) as a comment but I think that continues to be a concern in the real world.

At the exclusion of people in relation to cognitive results and variation, and I would say that there might be some concern about assessment of cognitive status in that situation as well, seemingly strong enough to invalidate what we felt was strong science to support it. So people were OK on the reliability at high for 4, 1 for moderate. Usability, 2 high, 3 moderate and I think that this is a screening tool which is noted as easily understood by the public. The question as to whether or not we will be able to implement across the board continues to be a concern.

Apparently, there – there were some – one reviewer noted some difficulty in understanding the results. (Inaudible) scores a little bit with a feasibility with only 4 on rating the moderate 1 high, but moderate seems to hangs in pretty well. The rationale seems to be that the discharge process might be complicated and I think some questions about treatment during admission. Some of the data elements that's noted were routinely generated in clinical care and some would be available electronically. For myself in recording my vote, again with feasibility and some concerns about getting up the speed, now we're just updating the EHRs but usability and the transferability of skills with these interventions from the clinical setting to the EHRs.

So the preliminary assessment for criteria that's suitable for endorsement, 3 to 2, yes to no. So I welcome comments (inaudible) additionally. Some of the same points that we discussed obviously related to 13 and above applied to this measure as well.

Peter Briss: I wonder – yes, I guess that's right although this measure is more complicated for 13 and above even if you believe in – that age should be decreased in (inaudible) some of the treatments we're talking about are pharmacologic treatments, too.

Madeline Naegle: Yes, yes.

Peter Briss: Do any of the folks – are any of the folks who gave an overall vote of no on this measure on the line today and it can – can anybody outline the major concerns that caused them to vote no?

Mady Chalk: This is Mady. I didn't vote no but I felt this is the measure and all of these suite measures that I have most concern about, even though the current commission says well, they need all four for this to work. Not sure if I agree with that but that's not my fault.

I don't understand the way it's – that – it says treatment provided or offered at discharge. What does the mean really? You mean you made a referral or somebody was treated in the hospital at the time of discharge? So you wait until they're ready to be discharged and you are offering medications and counseling in the bed on the way out to door. Is that accurate or am I misunderstanding something?

Madeline Naegle: So I didn't read it that way, Mady. I read it that the – that maybe this person wasn't screened. They're all on the hospital and that (meeting) in the hospital treatment were picked up as the person was leaving and that had to be noted, that somebody is going to catch them on the way out the door. That's how I interpret this measuring treatment offered during hospitalization.

(Crosstalk)

Madeline Naegle: It says the rate – it's the rate as they're leaving, right? We're taking the measuring rate as they're leaving.

(Crosstalk)

Male: (Inaudible) we should probably let the Joint Commission answer that. But it seems to me that there are – there are number of treatment options including both counseling and medications that could quite feasibly be delivered on – at the time of hospital discharge. And so, that sounded plausible and reasonable to me with somebody like that – from the Joint Commission to answer that question for us.

(Celeste): Hi, this is (Celeste) of the Joint Commission. As I indicated before this is a complete set. So, first the patient has to be screened before you can even consider offering anything at discharge. So it would be part of tobacco one and would it had a positive screen for tobacco use. Based on that then the next thing that would occur would be to offer that counseling and/or the cessation medications they were eligible during the hospital stay (inaudible) that's what tobacco two, the second measure of the evaluating.

The third measure is just the continuation of the treatment that's already been initiated or even (inaudible) and refused but still be offered again at the time of discharge. Once they leave the hospital that a referral has been established for them to continue without patient counseling, and/or cessation medication if they're eligible for it.

(Crosstalk)

(Celeste): So it's dedicated on the fact that they have a positive screen for tobacco which would have been the first measure.

Madeline Naegle: So this a referral measure?

(Celeste): Yes. At the time of discharge, they're arranging for them to continue treatment across the continuum of care. Once they leave the hospital, the thought here is that we're going to offer it. They can refuse and that's what the first measure looks at is how many people were offered and/or refused it. The second – the sub measure will be look at only those that actually suggest. I will take this referral, and yes, I will take this prescription for the medication.

It gives you a clear rate of who actually got continued treatment. And the first one basically looks at everyone got that offer either refused it or received it at the time of discharge.

Mady Chalk: No, it doesn't measure who got treatment, it measures who got referred.

(Celeste): Well, what I'm saying is that tobacco treatment at the time of discharge to continue.

(Crosstalk)

Mady Chalk: OK.

Peter Briss: This is Peter. (Inaudible) Some of the treatment that (inaudible) the part of the treatment at least is a prescription that can actually be given at the time of discharge.

(Celeste): Absolutely, that's what they'd be looking forward, the documentation and the medical record that the patient received the prescription for tobacco cessation medication as long as they were eligible, in other words they weren't pregnant or there was a contraindication.

Male: So does anybody on the committee have additional questions or concerns?

Michael Lardiere: I guess this is (inaudible) the question – so this one is just measuring whether they got medication treatment versus counseling to actually go to their referral?

(Celeste): No, it's actually …

Michael Lardiere: (Inaudible) first time?

(Celeste): It's actually looking – they're to be – part of the goal here. This is like again a complete set of intervention. So after the screening, if they are deemed to be positive then the interventions offered in the hospital. Now, they can refuse it or they can accept it but again, they would ask at the time of discharge whether they have refused or accepted during their hospitalization. They're going to be offered the same intervention to occur after the continued treatment or the treatment, in general, to continue after discharge.

So, if they are deemed to be what I – let me just use these terms, heavy smoker, then they should be offered both the outpatient counseling and the cessation medication. And if they're not deemed the, quote/unquote, the heavy smoker, they should be offered the continued counseling or the outpatient counseling after they leave the hospital. That's what the goal of this

measure is, is to continue the treatment or if they've refused it during hospitalization to perhaps initiate it at that point in time.

We're giving two opportunities to try and intervene if we've identified someone that has a tobacco abuse issue.

Female: OK.

Mady Chalk: Yes, OK. I'm clear on that. And I'm fine, it's just that same 13 issue but other than that, I'm OK with the way you described it, that's great.

(Celeste): Great.

Peter Briss: Anybody else has questions or comments or concerns?

Hearing none, so Madeline, I think you may be on the hook again for 1657.

Madeline Naegle: Yes. This is the fourth in the tobacco use measures. This is looking at the patient after discharge. So, these are the people who've been identified through screening. It really focuses on what happens then. So, they're identified as being smokers and they may or may not have received an intervention but the goal here is to follow up and ask them to find out what their tobacco status is.

So, the evidence cited, of course, other clinical guidelines and number of studies report. That is in our previous notes. Again, we all agree that was important to measure and report on this. Scientific acceptability of the measures seem to be strong, good test, retest reliability but and some good feasibility.

So, our reviewers note that the measure seems precisely specified with reliability testing. Again, the issue of cognitive data is touched upon. But the scientific acceptability, we can weigh with a five, reliability high is four with one vote moderate and some, a little variation on validity, three for high too.

Usability, again, not sure why we got a low on this one, but we have one low and four high as you can see before you. They felt that the scientific data presented was not sufficiently strong on usability and its unclear how the

measure will be evaluated in the community, right, and how the activity will take place to follow-up.

Feasibility, again, the question of EHRs but feasibility would seem to be an evolutionary idea. One of our voters rated as high, moderate three, low one. The pilot programs that they note were not held to be strong, potential for operational use is – has to do with the clarity of all the screening components. I think actually that I was the one who noted the provider readiness question and others may have questions about that as well.

The final preliminary assessment as you can all see kind of mixed with three for yes and two for no, although there is strong support for moving it forward the committee discussion.

Peter Briss: So, this one was one on which that in the full committee on stage one, there was a – there was also a fair amount of discussion as I recall about the feasibility of sort of post-hospital follow-up (inaudible). So that strikes me as (inaudible) to be a main area for discussion in the full committee. Do others have additional issues or concerns that they'd like to raise or comments that they'd like to make?

Madeline Naegle: I just speaking from the position of the feasibility issue. You know, I do have some reservations about that but I really feel it's such an important measure to do outreach and that this is something which in time will be able to be improved. So perhaps this question of the timeliness of the measure.

Peter Briss: And this is Peter (inaudible) taking off my chair hat and just making a comment. I thought that the developer did a good job about sort of highlighting the importance of follow-up in this cascade of measures and as a general principle law, everybody in the quality movement is working hard at trying to facilitate care coordination of issues and clinical community linkages.

And so, it just strikes me as being a potentially high value area to try to work some of their difficulties out.

Madeline Naegle: Yes.

Peter Briss: Anybody else have –so maybe that translates so there are – there were important. When we teed this up for the full committee, there are important reasons to be a little concerned about the immediate feasibility of this. And there are – there maybe important reasons to think about whether there are ways that we can enhance the feasibility. So, anybody else, questions or comments or concerns about this one?

So maybe before we move on the suite of alcohol measures, does anybody else want to highlight any issues with the suite of measures that haven't – that suite of tobacco measures that haven't already been raised?

Madeline Naegle: I would just comment of having reviewed this recently for other reasons in terms of where we are with statistics in the country. You know I would really, again, go back to the importance of some movement in this area. We are not making great progress meeting our Healthy People 2010 obviously, but beyond that, even towards 2020 goals. And the importance really can't be underestimated in terms of having effective interventions and ways of monitoring them and then working from some measures toward improved intervention.

Peter Briss: And it would be good to make some further progress on the leading cause of death on the States, right?

Madeline Naegle: (Inaudible) You got it.

Peter Briss: All right. So with that, we'll move from the leading cause of death to something like the third leading cause of death and started on the alcohol suites. This one, the designated lead was supposed to be David Pating and I think that David is still not on the phone, is that true?

Elisa Munthali: Yes, it doesn't appear he is but operator, has David Pating joined the call?

Operator: No.

Elisa Munthali: OK.

Peter Briss: Would anybody like to volunteer to walk us through 1661?

Mady Chalk: Well, I can walk us. This is Mady. I can walk us through it. I mean there is nothing – sure.

Peter Briss: Thank you.

Mady Chalk: Since we're skipping importance and moving to scientific acceptability, the ratings for reliability were good. Validity again suffers each time but that's in – that was in the tobacco use measures and in the alcohol measures. While there are good differences in performance before and after implementation, there were some problems as I recall in assuring that this got – that it got done.

Some of the – many of the pilot hospitals didn't seem to improve. It was deemed usable which is good although I will say that the improvement from using the same over time is miniscule, but that's noted elsewhere. (Inaudible) in general has not moved easily as a quality improvement measure. Maybe once – if this is implemented, maybe that will begin to change.

At any rate, it was – the group that weighted it has both highly useful and understandable. In terms of feasibility, not specified again for the electronic health record so that needs to happen at some point. I mean, the experience was (inaudible) for alcohol and most hospitals as far as I know has been – one that's implement in hospital settings, has been that unless it eventually gets into the electronic health record in the hospital setting it doesn't get done.

So specifying it electronically will be important. I don't think there was any disagreement that this was high need and that pilot program demonstrated some improvement with implementation. Applying it to adult population in this instance was fine. The question of the interrater reliability issue was raised, and I don't know what happened there, maybe somebody from the Joint Commission can say something about that because it didn't exactly make sense. If people are saying that it was usable and feasible, what happened with interrater reliability? But it was recommended to move forward pretty unequivocally.

Peter Briss: So thank you for the summary, anybody would like to raise questions, comments or concerns?

So, hearing none.

I'm sorry, there may be a little bit of noise in your background. If you're not trying to speak it might be good to mute your phone. Anybody have any additional comments on this one?

(Crosstalk)

Peter Briss: Hearing none …

Elisa Munthali: Peter, sorry. This is Elisa, would you like the Joint Commission to respond to the issue raised about interrater reliability?

Peter Briss: Oh, I'm sorry, I would. Thank you.

(Celeste): Steven, are you there?

Steven: I am. I'm not sure what the question is though, about interrater reliability.

Mady Chalk: In your documentation, yes. It was noted that interrater reliability was only 75 percent, 96 cases. So I just wondered what that was about. I was surprised. That's all.

Steven: That it was only 95 percent or that …

Mady Chalk: No, 75 percent, 75.

Steven: Seventy five percent?

Mady Chalk: Yes.

Steven: Yes, I think that particular measure was only due to one particular data element that had an issue.

Mady Chalk: OK. Was it corrected?

(Celeste): Hi, it's (Celeste). I can respond to that feed. It's actually about the alcohol use status question and it had to do with whether asking a patient about whether they used alcohol, was it validated during a non-validated question and we've clarified that in our measure specification. So we were all coming up basically with the same answer but it wasn't exactly whether it was validated versus a non-validate tool that was used for the screening. So that was what some of the confusion was.

Mady Chalk: All right.

Eric Goplerud: Mady, Mady, this is Eric Goplerud. And the issue was disqualifying in the initial analysis a prescreening question of – you know, do you drink alcohol?

Mady Chalk: Right, right, right.

Eric Goplerud: And when we got a negative on that we did not qualify that as a negative because we had specified a validated screening tool.

Mady Chalk: OK, I get it. All right. Thanks.

Peter Briss: That's right. That's very helpful. Thank you. So, anybody else have questions, or comments, or concerns?

Eric Goplerud: This is Eric Goplerud again. If I could, we used exactly the same rationale for not including 13 to 18 year olds. There certainly is an awful lot of interesting concern in the field about screening at that level but as you know, the U.S. Preventive Services Task Force has given – has not made a recommendation because of insufficient amount of evidence and that also holds for insufficient evidence for screening in hospitalized adolescent populations.

Peter Briss: Thank you, sir. Thanks for (the addition). So anybody else with questions, comments or concerns about the things that you want?

So hearing none, further we'll move to 1663, and I think that (Jeffrey Summit) is not on the line, is that still correct?

Elisa Munthali: Yes, he won't be joining us today.

Peter Briss: OK. So I will take this one, the ways skipping issues about importance to measuring report, we'll move straight to the scientific acceptability.

So people generally thought that the decision logic was reasonable, the reliability was the center of gravity in our estimates was leaning toward moderate as was the validity. People thought strong (inaudible) agreements, some challenges with data collection as with the counseling measures we've done elsewhere. So I'm not completely clear what's meant by counseling, to all of us at least.

Good phase validity and the pilot testing showed some improvement before and after implementation. In terms of usability, we were split between high and moderate for the most parts. We got a (inaudible) great for improvement from baseline, the rationale seems incredible, the scores on usability were generally high. It intended to be reported on the Joint Commission's quality check website and being considered for the IPPF rule again and overall, generally high moderate as I've said already that on the feasibility scale leaning toward moderate with some concerns about data elements not being standard. E-specification would be good as often happened.

And so overall, people thought that six – all six of us (inaudible) this measure, we've thought that it was suitable for endorsement, although each one of us thought that it was a close call. So …

(Crosstalk)

Peter Briss: Sorry?

Mady Chalk: Is that person on the call?

Peter Briss: So, the general overall score was pretty positive. When everybody liked to express concerns that (inaudible) are well reflected on the information that we've written out.

Mady Chalk: What you wrote down was right.

Peter Briss: Anybody else have additional questions, or comments, or concerns about this measure? And we're getting very efficient as we're moving through the call. Let's move to 1664.

Mady Chalk: That's me. I have 1664 and 1665. This is the third and fourth in that suite of measures for alcohol. (Inaudible) In the – some of the issues that got raised and the reason that you see a lot of two moderate in validity and reliability was the whole question about what happens with the validity because in the implementation pilots, the way it's dropped compared to what had happened the last time around. The measures seem properly specified from what I could tell.

I think, yes, reliability improved because there was a change in the skip logic and there was some refinement of data definitions but there's still a question that remains about what happened in the implementation pilot. It seems to be that there was the – that the low rate of performance of this measure in terms of usability and I suspect feasibility as well, has something to do with healthcare professionals being reluctant to make referrals prior to discharge. At least that's what the pilot data shows in the submission. They don't tend to make referrals prior to discharge for alcohol treatment.

In the feasibility ratings, there were some concerns about the high refusal rates of patient for at least one of the treatment. And so, one of the – at least one of the reviewers raised a question about whether there should be – a study should be done on cost-benefit prior to this being implemented on a national scale. That is – that's not my opinion, that's what was in the reviews.

It is publicly reportable. I think there's going to be huge variation among hospital settings. I would be surprised if there wasn't and I think it – pretty much folks felt that it was a high impact measure.

Peter Briss: Yes. And – so this is …

Mady Chalk: Go ahead.

Mady Chalk: So this is Peter. The only – I'm sorry, go ahead.

Mady Chalk: Go ahead. No.

Peter Briss: Yes. So, this is Peter. The only, the only other thing I would add to that is in the kind of feasibility and usability discussion where some of us were concerned about the variability between hospitals and some of us thought that that was a (inaudible) demonstration of a performance gap. You know, I was saying that this might be a useful thing, so.

Mady Chalk: Yes. That's exactly right, Peter.

Peter Briss: So, would anybody else like to raise additional questions or comments or concerns?

Hearing none, Mady, do you want to walk us through the last one?

Mady Chalk: OK. The last one is the assessing status after discharge. And again, you know, there were – even though there was very high interrelated reliability on this one, there was a decrease in performance, a follow-up and it wasn't – that wasn't addressed in the write up from the Joint Commission about what happened. The reliability being retested in 2012 with a greater flexibility and specifications for the measure probably improved things but proved the validity but – and maybe even the usability.

The issue of poor data acceptability and use of the data collection was raised by a number of reviewers of this measure. People felt it was very useful for quality improvement. The question about public reporting given how difficult it's going to be to reach a patient and I think, you know, I hesitate to say but I will say it. There is a difference between reaching patients for alcohol and drug use issues and reaching patients for tobacco use, they're not quite the same.

It needs to be specified for inclusion in the electronic health record and the majority of the committee thought it ought to move forward. The follow-up time period is something I had a question about. I don't recall whether there was one specifically mentioned in the write up.

Peter Briss: So would the Joint Commission like to answer that question, please.

(Celeste): Yes, this is Celeste of Joint Commission. Yes, there is a specified timeframe. I hope I get this right, it's 7 to 30 days, right Eric?

Eric Goplerud: Yes, that's correct.

(Celeste): OK. So tobacco was 14 to 30.

Peter Briss: Thank you.

Mady Chalk: And why is that different?

(Celeste): This again has to do with the evidence. They're more likely to relapse within the first week of discharge for patients with substance use issues.

Mady Chalk: Oh, OK. But not with tobacco?

(Celeste): With tobacco, apparently, for longer period of time.

Mady Chalk: OK. So, that's it.

Peter Briss: So, anybody else have – this one has many of the same issues, the (inaudible) as with the fourth tobacco measure, and as have already been said, it may have even, even more of the feasibility question and so there will be a specific issue to highlight for the whole committee. Are there other questions, or comments, or concerns that the committee would like to raise about this one?

So, hearing none, it sounds like we've now teed up all eight of the measures, right? I appreciate the work of the committee and would the staff like to tell us what happens next.

Elisa Munthali: Yes, thank you so much. That was record time. We are quite impressed. We would like to open up the lines, (Natalie), our operator, to our members in the public for comments if they have any.

Eric Goplerud: This is Eric Goplerud. I would like to comment.

Elisa Munthali: Oh, please go ahead, Eric.

Eric Goplerud: OK, maybe was absolutely correct about the importance of e-specification and there are several hospitals that have built all four of these measures into their EHRs and are, you know, getting great success rates. Those that have not built them into their EHRs have miserable rates. So, these measures can and have been successfully integrated into EHRs, into Epic, for example. But if they're not e-specified, boy, you get low rates.

Kathleen McCann: This is Kathleen McCann from NAPHS. And since our interest is in this use of these in psychiatric hospitals because that's where, you know, CMS is looking first. On the uptake of the electronic records in psychiatric hospitals is far below that of general hospitals and would be a major, major issue for most of them.

Peter Briss: Can you give us a little bit more about why a major issue, please?

Kathleen McCann: It's just, I mean, and following on to (Eric's) comment about the usability is so much better if it's specified in an electronic record and I know these have not been e-specified but the reporting that the analysis will all be by hand, the – things like that. I mean there are major, I think, issues around the feasibility of actually implementing these in every psychiatric hospital and in-patient psychiatric units in the country which is what would be required if they go forward and are taken up by the, you know, the in-patient psyche quality reporting system.

Peter Briss: Thank you.

Mady Chalk: I as a committee member am more concerned that they'd be taken up by all the general hospitals in the United States.

(Celeste): So I would go back as psychiatric nurse and say that I'm exceedingly concerned that we're having such a hard time moving this agenda in psychiatric hospitals where psychiatric patients have the highest smoking rates than any health subpopulation across the board. And I think, I certainly agree with Mady that we're going to catch to 25 percent of excess drinkers in general hospitals. But when we think about feasibility, I'm hoping that if we are able to endorse the detection of smoking within psychiatric hospitals, it will have some push to get the system up to speed and the providers as well.

Mady Chalk: I support that completely, completely.

Michael Lardiere: Me too, this is Mike.

Mady Chalk: We also know that there are a very high percentage of psychiatric patients in hospitals and in community mental health centers that use alcohol at a very high rate and that has compromised, significantly compromised the management of their problems and their treatments.

(Celeste): To add to that, Mady, the subpopulation were our concerns about violence and having a psychiatric diagnosis, the most – the violent incidences do occur seem to be highest in that population when it's among – when the individuals are both diagnosed with a psychiatric disorder and a substance use disorder. So there's great concern about that particular segment of the population.

(Lisa Shay): Hello, this is (Lisa Shay) I just like to weigh in as a psychiatrist that works in an inpatient psychiatric hospital that does deal with a lot of patients who do suffer from these comorbidities with addictions of nicotine and other substances. And I certainly think screenings for that and trying to do an intervention while they're in the hospital. The issue that I'm having some difficulty grappling with is where the – what the return on trying to reach these people after they leave our doors when they're in someone else's care and just in terms of who those people are that reach out to them, when they detect that there is an issue, how they mobilize the system.

It's a lot of resource that will need to go into, track all these people down. And a lot of our patients don't have homes, they don't have coverage that will allow them to get these medications or these nicotine replacements and so forth. So there's a lot of barriers. I'm not saying that these aren't great ideas but to put them on the back of a hospital without looking at the whole system, I think is a setup.

(Celeste): I disagree with that (Lisa). I don't think it's a setup, because I think the large urban hospitals in this country, most notably Montefiore Hospital in New York City which is in a relatively poverty stricken neighborhood and discovered that its readmission rate had almost – 80 percent of them had to do

with substance use or psychosis, has figured out ways to follow people up, find them, work with them, get them into treatment, manage where people want or need management.

There are models out there and I think we're finally going to have, you know, I'd get off my soapbox, finally have to bite the bullet in this country about what has to happen.

Peter Briss: So this is Peter, I do want to make sure that we on the committee are going to – have had some chance for our soapbox and we'll have an additional tent for our soapbox so I do want to make sure that others from the public who would like to comment have an opportunity to do so.

So it sounded like that, (inaudible). Actually, I'm sorry. I wasn't trying to be a conversation stopper. Are there – so maybe I'll send it back to the NQF staff about whether there's anything else that needs to be done.

Elisa Munthali: Yes, absolutely, thank you so much. And what we'll do is as I mentioned before, I'll capture all of this discussion in our staff notes, and the transcription and in the recording and make sure we not only share it with the entire committee but also online on our website so that members of the public and NQF members are privy to that information as well.

And so, after this discussion, if you want to change your votes, please feel free to do so. We'll be sending out a link or you can use the same survey you are using and just indicate by like having maybe a two or whatever next to what your new vote is. And we'll leave that open at least for a few days, a few days from now. We'll send out an e-mail to let you know when we're closing it. And we'll compile the final votes and discussion points as I mentioned before and we'll circulate it to the entire steering committee.

As you did today, lead discussion, it will be asked to lead discussion at the in-person meeting and you did a great job highlighting all of the issues and similar to what you did today, if you can highlight those issues for your colleagues on the steering committee. But we do ask that you, even though you're not taking a deep dive in all of the measures that you review all the

measures so that you can have an informed vote on the overall endorsement recommendation on June 5th and 6th.

And speaking of June 5th and 6th, you should have heard from our travel and meetings department and if you haven't, if you can please send an e-mail to Lauralei Dorian and let us know. They should be finalizing travel arrangements. I think they should be finalizing the hotel within the next couple of days.

We just wanted to thank you very much, Joint Committee members and developers of the Joint Commission and also members of the public for joining us on this very important discussion and we look forward to seeing you all next month. Thank you.

Peter Briss: And thanks for making this great. This was a very – it was a very constructive discussion and I'd like to also thank everybody for the time. Thank you so much.

Elisa Munthali: Thank you.

Michael Lardiere: Bye.

Mady Chalk: Thanks for your time.

Male: Bye, bye-bye.

(Celeste): Bye.

Mady Chalk: Bye.

END