NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
May 23, 2013
12:00 p.m. ET

Operator: Welcome to the conference. Please note, today's call is being recorded. Please standby.

Lauralei Dorian: Great. Thanks (Natalie). Hi everyone and welcome to the 4th Behavioral Health Steering Committee workgroup call. This is Lauralei Dorian from NQF and I am joined by my colleagues, Angela and Jessica. And we would like to thank you so much for this time that you've committed to submitting you preliminary ratings and for dialing in to the call today. And thank you to the developer, the Joint Commission who's also on the line and will be available to answer any of your questions.

Just to remind you that today's call is being recorded so transcripts will be available following the call. And also that we will (inaudible) open to the public as with all of our calls, so we'll take (inaudible). Pardon?

OK, so we'll take public comments towards the end of the call. And then also if you could please place your phone on mute when you're not speaking, that would be helpful. And we just want to (inaudible).

The point of today's call is just to discuss your preliminary evaluations of the subset of the Joint Commission's (HBIPS) measure. And each of you has been assigned, it will be discussed in for a number of measures. And can you please introduce the measure's title, the description of the measure and the summary of the ratings of the measure noting in particular areas that's (inaudible) a concern.

You will still be a lead discussant for that same measure during the in-person meeting. And you can also summarize what is discussed on the call today which we will write up and send to you.

So I think that's all from our end. We do have Peter Briss, who is the co-chair on the call today. So I think at this time, I will turn it over to Peter.

Peter Briss: So this is Peter Briss. I'm the Medical Director in the Chronic Disease Center at CDC. I'm delighted to be with you this afternoon. Now, thanks to everybody for all the time that you've already put in on during the preliminary evaluations and the time that we'll continue to put in at the committee on the call today and at the face-to-face meeting.

Since we have lots of measures to get through today, I hope we can be fairly efficient in working through all of them and in highlighting particular areas of interest or concerns for full committee discussion at the in-person meeting. We don't – in the event that there are discrepancies that we care about, we don't necessarily have to come to consensus today. We're just trying to identify potential issues.

And so – so maybe let's open with just identifying ourselves on the phone. I'm Peter Briss. I'm the Medical Director in the Chronic Disease Center at CDC. And maybe if the staff could do a roll call please of the committee members.

Lauralei Dorian: Sure and we have Lisa Shea on the phone.

Lisa Shea: Hi. I'm a psychiatrist at Butler Hospital and a Deputy Medical Director there.

Lauralei Dorian: Great. And (Bernadette).

(Bernadette): Hi everybody. I'm from the Ohio State University. I'm a Psychiatric Mental Health Nurse Practitioner at the University's chief wellness officer and Dean at the College of Nursing.

Lauralei Dorian: Great. And Caroline.

Caroline Carney-Doebbeling: I'm Caroline Carney-Doebbeling. I'm an internist and psychiatrist and have worked in – I have been in academic medicine, still have adjunct appointments at the Indiana University School of Medicine Department of Psychiatry and Medicine. I served as the Medical Director for the Indiana office of Medicaid Policy and Planning prior to my current position as Chief Medical Officer for MDwise, Indiana's largest not for profit health plan.

Lauralei Dorian: Thanks Caroline. And Emma.

Emma Hoo: Emma Hoo. I'm the Director at the Pacific Business Group on Health also care redesign and payment issues as well as reporting our purchases (inaudible).

Lauralei Dorian: Do we have Les or Nancy on the call yet?

Leslie Zun: Les is on the call. I'm Les Zun. I'm a professor and Chair of Emergency Medicine as well as the dual appointment in the Department of Psychiatry at Rosalind Franklin University of Chicago Medical School. And I'm one of those unique emergency physicians that actually has an interest and has done extensive research in the realm of behavioral emergency.

Lauralei Dorian: Great. And Nancy Hanrahan, are you on the call? OK, maybe she'll join us in a bit. And if we want it – the Joint Commission team to introduce themselves as well, feel free.

Celeste Milton: Hi. It's Celeste Milton. I'm an Associate Project Director in the Division of Healthcare Quality Evaluation of the Joint Commission. I'm the clinical lead and I've been with the HBIPS Project since 2005.

Peter Briss: Anybody else?

So hearing none. Let's begin working through these hospital inpatient psychiatric measures beginning with 1922. And I have Lisa to lead discussion.

Lisa Shea: Yes. Thank you. So HBIPS-1, Admission Screening talks – is a measure that looks at the proportion of patients admitted to an inpatient psychiatric setting

who were screened early on in their hospitalization for risk of violence to self or others, substance use, psychological trauma history and strength.

There's a lot of – in terms of looking at the different criteria, in terms of the important measure and report, the group reported in, I guess, three felt that the evidence was there to support the rationale and there was one that did not think so and I think maybe this had to do with that. There were many articles but not comments particularly about the study design and that perhaps it was difficult to look at the articles that are specific to these areas.

There was also another question about the, and I think, I this is apropos to the other measure set in the discussion about age, about what age is screened for substance abuse. Because this measure includes everyone from – every person, how ever old they are. So, that – but overall, the group felt that this was important and that they supported it.

Moving on to the scientific acceptability, the group here felt very much that there was – that the measure properties (inaudible) the standards in terms of looking at reliability and validity. There had been studies looking at validity and face validity being used and looking at exclusions as well.

Moving on to usability, here the group really felt that the measure was usable and that it would allow a public reporting on the quality check website, and also noted that the other HBIPS measures in this set have already been adopted by CMS. And then regarding feasibility, again, the group felt that this was feasible and that it's – that this information is necessary to develop treatments and to provide care, that some of the data elements are electronic and that for most part, it's already being done.

So, through all of that, the consensus was, I guess, unanimous that it preliminarily (matches) criteria for endorsement.

Peter Briss: Thank you. That was – that was elegantly made, that was elegantly done and more fully brief. Any comments from the Committee about additional areas of concern or is there that you'd like to highlight?

Lisa Shea: Only, I guess, what I would say, this is Lisa again, is just in terms of, I guess, looking at the meeting in terms of screening for substance use in light of the other measures and how these would go together (inaudible). That's my only thought about that particular thing. This measure is broader than the substance.

Lauralei Dorian: Celeste, you maybe want to respond.

Celeste Milton: Hi. yes, are you – Lisa, are you referring to the other substance, substance 1, the one that was discussed yesterday?

Lisa Shea: Yes.

Celeste Milton: That what I thought, OK. Well, actually, the substance use measures were designed for broad scale use, so we're looking at all inpatients in any hospital…

Lisa Shea: OK.

Celeste Milton: … not necessarily in an inpatient psychiatric setting where HBIPS-1 was developed just specifically to make sure that those patients that were identified having mental disorders were also screened because of the high prevalence of (inaudible) substance use with any of these patients.

Lisa Shea: OK. OK. So this is sort of a subset of the other one in a sense, right.

Celeste Milton: It's very specific just to inpatient psychiatric, yes.

Lisa Shea: OK.

Peter Briss: Anybody else have questions or comments or concerns with this one?

Perhaps none. Perhaps we'll move to number 0640 Hours of Physical Restraint Use and the discussant is (Bernadette).

(Bernadette): This particular measure is tapping the total member (that was) the outpatients admitted to a hospital-based inpatient psychiatric setting were maintained in physical restraint and it is part of their set of seven nationally-implemented measures that address hospital-based inpatient psychiatric services.

Regarding the category of importance to measure and report, our group had two yeses and two nos. Where that the no's came into play in looking at people's comments on impact, two rated high, two rated medium. People did agree that restraint has been related to major adverse outcomes both for patients as well as staff. There appeared to be a little bit of disagreement regarding whether the evidence was sufficient in terms of the way it was presented. One of the group members commented that much of that evidence appears to rest on expert opinion while others also felt that evidence that was presented did consistently support the benefit of reducing restraint and seclusion use.

In terms of the scientific acceptability of measured property, we have three yeses there. On reliability, it appears that the measurement is reliable. There was 100 percent match for the calculated agreement rate, surface data elements which are used to compute measure weights. Face validity was tested by a total of 40 hospitals during May and June of 2006. And use of the measure does show the important variations in the performance among hospitals.

The group, overall, felt usability was good. Three gave it a high, one gave it a medium. And in terms of feasibility, the same thing. The data are generated by, and used by healthcare professionals during the provision of care, and again, this is already being done. So the overall preliminary assessment of criteria met and suitable for endorsement, it was four yes and zero for no.

Peter Briss: Thank you, (Bernadette). Questions or comments from the Committee?

We evidently set records yesterday on speed of getting few measures. We may set a new record today. If nothing further, let's move on to measure

number 3, Hours of Seclusion Use 0641 and the primary discussant is Lisa again.

Lisa Shea: Yes. OK. So I think a lot of this follows from what (Bernadette) said. But the – here again, this is a measure of hours of seclusion adjusted for patient discharge – discharges and it's already being used as a nationally-reported measure set. And this has to do with seclusion. The rationale is that seclusion is associated with major adverse events.

In terms of the importance to measure, again, the group – the majority – there was evidence based – that it was and one group member felt no. There were gaps documented but I'm not – I'm looking here – I don't exactly see the rationale for the no but I guess someone put the no down there. And then I guess the issue in terms of the evidence was the fact that randomized controlled trials haven't been able to be conducted because of the ethics involved with that.

So some of the group members were accepted that that, you know, that the evidence consistently supported the benefits but other group members commented that there was – that this seem to be based mostly on expert (appointment) having specific (files at).

But moving on to the scientific acceptability, again, the reliability and the validity – the reliability here was split among the group, two high, two medium, in terms of the reliability. Again, there was 100 percent matches but I didn't mentioned in the previous measure when they went back to look at it.

In terms of validity, the group, I guess, there was one high and three moderate for the validity. And again, there was face validity used and there was explanation regarding the patients that were excluded from the measure.

Moving on to the usability and the feasibility, again, the committee like the previous measure itself that the measure was usable and feasible as this are already being done. And the preliminary assessment of the group was to endorse it or to zero.

Peter Briss: Thank you, Lisa. Questions or comments from the committee?

Hearing none, I think, let's move – sorry, go ahead.

Lauralei Dorian: Peter, it's Lauralei here. I'm just wondering since it seems to be throughout the measures thus far, if any – if the person who voted no for importance and evidence is on the phone, if they wanted to address why they might have voted no.

Peter Briss: And so – on the evidentiary question on all of these measures essentially the scientific evidence is generally presented as – in a sort of a narrative review format. And so, if you compare – for those of you who are on the call yesterday and sort of looked at the tobacco measures and the comparison.

The tobacco measure were generally based on a systematic review and it was easy and transparent to be able to determine how many studies were actually addressing sort of specific questions of the interest, and something about the strength and consistency of those studies because these are all presented in a sort of a narrative review format that – I found the ability to – I found that I was actually unable to accept the quality, transparency or consistency of the evidence.

Lauralei Dorian: That makes sense. Thank you.

Peter Briss: Anybody else, questions or comments?

So let's move to – let's move to 552, discharged on multiple antipsychotic meds.

Leslie Zun: Good morning or afternoon everyone. This is Les Zun. So I want to go through this measure that really looks at patients who are discharged on multiple antipsychotic medications overall. And then also it's been grouped by basically children and adults and elderly folks who are older than 65. The numerator being psychiatric in-patients discharged and two or more routinely scheduled antipsychotics, the denominator is the psychiatric in-patient

discharges overall and broken out by age group. It includes basically all those that need mental health diagnosis and excludes those that die, hopefully not too many die on the psych wards these days.

So let me go through the criteria importance to measure and report the impact, four high, one to medium, the performance gap. There were two high, two mediums. And I did not see comments for evidence. There was four yeses, one no. Nobody thought it was – it was not applicable outcome. The quality of the evidence, there were four high, one medium – I'm sorry that was quantity.

Quality was – of the evidence was three high, one medium and one insufficient. Consistency was four high and one inconsistent. Concerning the scientific acceptability of the measure properties or liability, there were three highs, two mediums or moderates. Validity, there were five in the moderate category. Usability, high was four, medium was one. And in feasibility, there was five high. And preliminary assessment of criteria meeting or suitability for endorsement, there are five yeses and no no's in the workgroup.

So, based on this it appears that the group is recommending acceptance.

Peter Briss: This is Peter. I actually have a question on – this one is – this is probably for the Joint Commission. So, as I understand, the general team for this measure and the one that follows is that most people shouldn't be discharged on multiple antipsychotics but that there are certain kinds of clinical situations in which the sort of treatment can be justified.

And so the question is, if we're going to have the measure that looks at the people discharged without inappropriate justification, what does the first measure add?

Celeste Milton: Hi, it's Celeste, Joint Commission. These two measures are what we call (period) measure so would you never view this measure without viewing HBIPS-5 if the patient was a part of the numerator population.

The goal, of course, is not to be in the numerator and only be in the denominator. So what we're trying to achieve with HBIPS-4 is get a feel of what the problems of these practices across the country. So it's briefly to help us understand what is the prevalence and we, of course, have stratified it by various age groups. And as you'll note from some of the information we've provided, that's tend to be higher in adults, less so in children and adolescents and there are some in older adults. So it's just to help understand prevalence.

So that would be the firs thing that would be evaluated then. We haven't talk about the next measure but were looking there then would be appropriate justification. So if we were comparing two hospitals and (inaudible) that their rate for HBIPS-4, the measure were discussing, is 10 percent. Each one has 10 percent. Then we would go further to look to see, well, what is the appropriate justification for this practice.

And if the hospital – the first hospital had, let's say, 95 percent of the time documented in the appropriate justification but the second hospital only had an appropriate justification 50 percent of the time, then we would be saying, well, the first hospitals is using the more evidence-based practice to support what is happening because we understand that there are going to be some patients that will have to remain on to more antipsychotics for a number of reasons but we know that the literature that the evidence supports that there are certain indication.

So that's the purpose of splitting them out so that we have a better understanding of what's going on with this practice, and then we would file it up with how is it supported when we're reporting it.

Peter Briss: Anybody else have questions or comments on this one?

Caroline Carney-Doebbeling: This is Caroline. I have a question about it. During the comparison between the hospitals, do you take into account the case next that might be seen at a given hospital, for instance, in our city psychiatric facility where more members may be on multiple antipsychotics or falling to it

category of the more difficult to treat person with psychosis versus a community hospital where the cases might look very different.

Celeste Milton: Hi, Caroline, Celeste again at Joint Commission. I understand what you're saying. Whoever a case (inaudible) can't be applied to a process measure, this is a process measure. And they can only be applied if we were looking at an outcome measure. So there is no sort of an adjustment made as the result of that. It's our understanding, too, from reviewing to evidence that there's been a number of – I would call public facility that have been extremely successful in making sure that they have appropriate documentation for these types of patients.

So the key here is really making sure that you're looking across the continued care going to back to try and get this information and documenting that accordingly. Now the way that the Joint Commission has looked at these pair of measures, the measure were discussing now. We're not actually making that what we call an accountability measure because we do understand that some hospitals are not going to have control because they are tertiary facilities taking some of these patients with these chronic conditions.

So when we're looking at actually reporting this out in a fashion that we use for our – some of our accreditation purposes, we would be looking at how they're doing as far as the appropriate justification keys which is in the next measure to follow.

Caroline Carney-Doebbeling: I'm sorry, I thought it was being used or unless I read my measure on because I have the next measure that it was being used as part of the CMS reporting for payments.

Celeste Milton: It is – well, I don't know how CMS is doing except it that they're doing it right now. You're actually getting paid if you report it, not how you perform.

Caroline Carney-Doebbeling: OK.

Celeste Milton: And so that's how it's currently being used by CMS. And it is public reported also by Joint Commission but we're not using it in some of our programs where we're using accountability measures such as standard compliance, our top performers program and for other initiatives related to accountability. That would be where the second measure would come into play for those patients that end up in the first measure.

Caroline Carney-Doebbeling: Thank you.

Celeste Milton: Once again, just to give the public a general feel for what's happening, and, of course, they would have to be looking at two of the measures – that – the measures together.

Peter Briss: This is Peter. As I listened to the discussion, I think this might worth talking about in the Full Committee. I actually wonder about the useful – I'm having some difficulty frankly getting my head around the usefulness of a pure prevalence measure that combines appropriate – and essentially appropriate, inappropriate prescribing – and why you wouldn't just focus on the next measure that tries to tease out the appropriate prescribing.

(Crosstalk)

Caroline Carney-Doebbeling: I would …

Celeste Milton: … Frank on the line. Frank, would care to comment on that?

Frank Ghinassi: Sure. Hi, thank you for the opportunity. This is Frank Ghinassi at University of Pittsburgh Western Psychiatric Institute and Clinic.

Part of the original discussion on separating this into two measures was in part what Celeste had said which was – it was an opportunity try to find out nationally what the current practices were vis-à-vis polypharmacy with respect to antipsychotics. And there really was no good data nationally what baseline levels were. And there was a lot of discussion about acuity issues and patient mix and urban and rural et cetera regarding that. And there was

some attempt to try to do some stratifying along age groups but they point out that that was one of the things that was discussed.

The second point was that there was some concern about some individuals reporting that, let's say, all of their people left or some very high percentage left on multiple antipsychotics, but that there was a rational explanation for everybody. And if you only report one of the data which is that those people who don't need one of the criteria, you don't really get a sense of how many people are actually leaving the institution on two or more.

So they were seen as companion measures that both allowed us to see some level of prevalence, but also allowed us to take a look at, replace the saying that most if not everybody left on to but we've got a good reason for everybody, or where there are some places where only a few percent were and they, you know, didn't have it. It felt like both pieces of data were something that the original technical expert group that (inaudible) or nine years ago felt would be useful in understanding the phenomenon. Hope that helps.

Peter Briss: Anybody have any additional questions or comments or concerns on this one?

Hearing none, let's move to the companion measure, 560 and 560 is Caroline.

Caroline Carney-Doebbeling Thanks Peter. So 560 is the companion measures to the measure we just discussed looking at justification for discharge from psychiatric inpatient hospital for two or more antipsychotic medications. Initially it was reported in 2008 baseline prevalence of 18.9 percent up to a concurrent rate – not prevalence rather but a rate of 18.9 percent with two different reports of concurrent rate around 40 percent. One was 39.5 and the other was 41.

When looking at the overall impact of the measure, there were three yeses and one no. The impact of the measure in large part was reported by issues regarding medication safety, the potential (Q) effect, large numbers of people with the potential for downstream morbidity and mortality from that. The evidence supporting that also was three yeses and one no, and there were four

of the persons who rated this with the quantity and consistency and quality of the evidence rated variably throughout the group.

The evidence largely rested upon clinical practice guideline and review studies with showing of monitoring of practices potentially being important. However, in my review of the evidence, I'm not sure yet given other issues this week but in my review of the evidence, there's no evidence that's actually (targeting) this information leads to downstream changes and prescribing patterns or outcomes for the member which I felt was a weakness of the evidence supporting doing this measure.

Overall, the scientific acceptability of the measures, there were four yeses and no no's with the reliability split, two and two, and the validity split, two and two. The initial reliability and validity studies were done at the onset of the measure in 2007, 2008. And only face validity was conducted. There were repeat assessments in 2011 showing high agreement at a 100 percent on the category assignments agreement rate. Face validity with tested by 36 hospitals back at 2006 which ranged quite substantially between 17 and those facilities reporting good or very good, and the remaining of the 30 percent reporting average to very poor. No other testing has been done of the measure.

The usability of the measure was three high and adding my vote to that would be two medium. Some of the concerns about the usability of the measure weren't voiced except that it was noted that the measure is currently a publicly reported measure and that CMS has adopted the measure.

The feasibility of the measure was two and two also by those who reported their review of this measure. And the rationale for this was that some data could be an electronic versus others where that it was to be generated by healthcare personnel and that the healthcare personnel specifically the clinicians prescribing had to do the bulk of the documentation and whether or not much of this could really be put in the electronic medical record if wanting to sit in the inpatient setting to support the documentation or the ease in getting this done leads to some questions about the feasibility. However,

despite the somewhat mixed review, the panel overall shows four to zero to endorse this measure.

Peter Briss: Thank you. Questions, comments or concerns?

Lisa Shea: This is Lisa. I just had a comment on in terms of the property measures itself and I'm just having – I'd been working with this measure for a while and, of course, as good as you can be on four, that can sometimes make it harder to hit it on five because you're – and it's much smaller. But the issue has to do with the – in the specifications of documenting other rationales that might not meet the three that are acceptable and I was just wondering if any information (inaudible) because the other rationale isn't allowed as an acceptable thing but it is specified to document that. So I was just wondering about that.

Celeste Milton: Right, Celeste, Joint Commission. Lisa, the purpose of that allowable value is to get hospitals to understand what's happened of one of the first three justifications. Why isn't selected? There may be another justification written in the medical record or there may be complete lack of documentation. So this allowable value would be that there is no documentation whereas the fourth would be that they've documented for example, I'll use, they're prescribing Seroquel for sleep and…

Lisa Shea: Right.

Celeste Milton: … from our studies, there was nothing that – in the evidence that would support that but it would help the hospital then further understand, are they just not documenting a reason or they're documenting a reason that is not supported by the evidence. That's for …

Lisa Shea: Yes.

Celeste Milton: … internal performance improvement purposes.

Lisa Shea: OK, right. One – one thing and I – and I, you know, it's a dilemma and I – I don't know when people are in the hospital for four or five days and they

come in on a panoply of these medications from the community and one tries to work as best as you can but not your – not – they're not actually coming in because of that issue. And that – that's the issue that we struggle with.

I don't necessarily disagree with the measure or the intent of it. It's just the – the reality on the ground is how to – how to handle those situations where – where you might not have the opportunity to sort – taking people off of medications because they're not – they're not going to be in the hospital long enough to evaluate that.

Celeste Milton: Lisa, so once again – we understand what you're saying about that and they can certainly document recommendations for a tapering plan for next level of care provider if you can't begin the tapering plan.

Lisa Shea: OK, thank you.

Caroline Carney-Doebbeling: This is Caroline. I'd like to jump in with just seeking your opinion about a couple of issues that I have regarding the measure. The first Lisa just alluded to which is in the often short-term stay of this measure or of – of folks who are coming in to the hospital, whether or not they may or may not know enough of the history to understand what was happening in the out-patient setting that led to more than one antipsychotic being used and the (inaudible) are for members who are – patients who are discharged over weekends where they may be covered by someone who is coming in to check – to check and make sure they're stable, not suicidal, whatever that might be and may doing – may be doing the discharge without kind of knowing the whole case. Not that that's justifiable not to do the right thing but it's something that I definitely commonly see happening in clinical practice as I review cases.

The second concern that I had about the measure just is that I mentioned earlier which is documenting this doesn't necessarily lead to long-term change. We see that some of the facilities that were tested or where this measure was implemented and that documenting better or they may go to monotherapy. But whether or not that leads to change, once that patient is back in the community setting, back in the community treatment, whether

they get another medication added back on in that setting or whether there are any changes in their health outcomes due to this, I think it's largely unknown at this point. So there's a lot of documentation burden for outcomes that are unknown.

I just would love to hear your opinions about this.

Celeste Milton: Frank, would you try to comment?

Frank Ghinassi: You know I – Frank Ghinassi again. I share the same concerns and, you know, I mean I've been involved in inpatient and outpatient treatment with psychiatric patients for just about 30 years and I think one of the concerns that's risen to the top for me has always been that frequently when people are in outpatient settings, teams are afraid to fiddle too much with complex regimens because they're worried about destabilizing the patient and often that leads to inaction about that, and sometimes when they're an inpatient settings, we all have precious little time and we're concerned about stabilizing acute symptoms and the need to then move them out because being pressured to do so.

And I understand the pressures on both sides but, you know, I felt like this measure has helped us at least. I can speak for our facility here and it helped us to make this a conscious effort on our part to try and bring some decision making to the table and I agree for many other people we see, they come in on relatively complex often inexplicable combinations of medications that had been accumulating like barnacles on a ship and – and we often can't solve that in a seven or eight-day stay.

But I think making a firm recommendation to the follow up team that we're going to recommend that this person be considered for that kind of tapering and can we help in providing information. It's been useful on our system to kind of communicate that message. And my hope is that ultimately some of this same measures are going to find their way in the ambulatory levels of care because I do think that with the side effects, there are part of the profile of these very helpful medications, you know, metabolic syndrome being only

one of them. That I think for us to be sure that when we are doing this kind of polytherapy techniques, that it really is a treatment of last resort. And I think this was a place to begin that thought process.

We've seen impact in our own system both in terms of our inpatient levels coming down which I think had been good, and it certainly hasn't gone to zero but it has come down. And the good news on our side is although we have a very large ambulatory system, we've seen an impact in that system as well. So I think this is the beginning of a good movement but I agree with you, it's not the total answer yet.

Caroline Carney-Doebbeling: Frank I'm just curious. What you were seeing with regard to the transmission of that clinical recommendation to the outpatient setting especially if the patient is not seen in the same facility as where they were an inpatient but are seen in anyone of the variety of community settings, is that information giving transmitted to the next group of outpatient practitioners?

Frank Ghinassi: Well, I can speak for our facility and in fact it is. We tried to do that verbally with social work when and if we are lucky enough to catch the next level by phone and as you know those of you who are involved in the stats, you know, often that's (fraught) with difficulty so you do phone tag (inaudible), and it's certainly communicated in writing in the recommendations where we'll say that the person has begun on taper. Maybe they've tried to taper down one medication and we're recommending that that taper be continued so that, you know, if somebody comes in, it's not uncommon for us to see people coming on five especially when you count PRNs or you count people who've begin, let's say, under 200 milligrams of Seroquel for sleep, just to take one medication.

And we'll try to start that process and say, "Look, we began that by changing, moved to a hypnotic for sleep and we'd like you to continue to pack away at this week. I think it's in the patient's best interest." And so yes, I think we've made an impact with the places we can see.

I can't speak specifically when we send patients to other community resource sites but I am slightly comforted by the fact that if we're doing it inpatient

here, you know, it's my belief and hope that good nature and well-intentioned clinicians at other inpatient facilities are sending the same message.

So my hope is that that message is going to be one that's consistently heard from discharging physicians at hospitals across the country and that ambulatory sites even those who weren't affiliated necessarily with a particular inpatient sites are getting the same message from everybody.

Peter Briss: I have to say that – describing – medical regimen is complex and inexplicable and like barnacle is one of the best descriptors I've ever seen. Anybody else have – anybody else have comments on this particular measure?

So let's move to the last pair. And I had a – I had a question on the last sort of similar to my question on the previous pair. If presumably the goal of the processes to have post discharge continuing care plan and to get it transmitted to the next level, do we really need the first measure, and if so, what for? I wonder if the Joint Commission could help me with that.

Celeste Milton: Hi Peter, it's Celeste again at Joint Commission. Just like the – two that we just discussed, they were actually one measure. The same thing was true with this last two, they were combined into one measure. But what we found that there were several steps that you had to complete in order to actually pass the measure. So we've felt that was important to split these up so that first, that they're actually creating the care plan that they're actually getting this information documented in the care plan and that they would at least get credit for that even if they weren't able to get it out to the next level of care provider within five days of discharge, and that's second piece.

And as we've looked at our actual performance with these two measures, we are finding that they are getting the information into the record more than they're getting it transmitted. So this allows the hospital to see, yes, we're making progress as far as getting all these information documented but we still have a little ways to go as far as actually getting it out to the next level of care provider which is ultimately what we want to achieve with this period measures.

Peter Briss: Thank you. So, with no further ado, 557 is the next one. And if – is Nancy on the phone?

Celeste Milton: I don't believe Nancy ever dialed in actually, Peter.

Peter Briss: OK. Since I was on the hook for 58, maybe I'll do the pair. So, on 557, again, it's a post discharge continuing care plan created, importance to measure and report. We were actually split on this one with two yeses and two nos. Impact was generally high, thought to be high or medium. Performance gap was split between highs and lows.

So, people generally thought that continuity of care is an important issue. Affects – so, it really affects large numbers of people frequently performed. There appears to be a variation in performance documented.

So, in the – so although the votes were fairly split, the rationale statement seemed reasonably positive, and so I don' know if anybody who had questions or concerns about this would like to add something about importance to measure and report.

Hearing none, on the evident side, generally thought to be – when, most of us thought reasonable with three yeses and one no. Quantity, quality – quantity, quality and consistency was generally moderate, I would say.

So the structure process outcome relationship seems logical but the studies in support of these were intended to be of – what would generally be considered to be relatively low quality. Thus explaining a lot better than moderate, great quality of evidence overall. And so, but – and then again, the votes were split on importance.

On the scientific acceptability of measure properties, four yeses and one no. I'm sorry, four yeses and no no's, precisely specified. In practice performance has improved overtime. All of us thought that not – perhaps not surprisingly for a measure that's currently in use (inaudible) that this was a usable measure.

And similarly, generally thought high feasibility. And so with that, I'll open it to the group for additional questions or comments.

And hearing none – I'm tempted on the issues on the transmittal to the next level of care are essentially exactly similar to the issues on the previous measure, I think. And so, the – I won't – unless somebody has specific issues, I won't repeat what I just did on the previous measure and we'll just get out of the way and ask if anybody has additional questions or comments on measure number seven.

Emma Hoo: This is Emma. You know, couple of points I would add is that in terms of the evidence, it was striking to me that, you know, the several vote was favorable to quantity and quality were generally viewed as medium. And I thought that one of the more compelling data points was actually what was sighted in the section on the data summarizing the performance gap around the work that was done at Boston University and the observations that the difference between the groups measure compared to the control was about, you know, 30 percent lower rate of readmission, you know, after the intervention and that over the course of the three years in which the data was reported. The improvement had confirmed about 60 percent to 82 percent compliance. So, you know, I think those seemed, you know, favorable even though the specific evidence sighted were, you know, more around interviews and survey as you noted in your comments.

Peter Briss: Thank you, Emma, I think that's a great comment. Anybody else with questions, or comments, or concerns, or addition?

Emma Hoo: You know – this is Emma again. You know one question I have for the Joint Commission folks is given, you know, the large focus on readmission and use of this measure in the care coordination space, could you describe the differences between the structuring of this measure for the behavioral health, psychiatric, inpatient services versus its general use? Is it primarily just in the denominator exclusions and the processes are generally the same?

Female: Emma, are you referring to what is actually comprising the continuing care plan, what we have selected as the minimum to be in that care plan? Is that what you're alluding to?

Emma Hoo: Yes, and so also the transmission and the extent in which work has done to assess the acknowledgment and context on the provider side.

Celeste Milton: OK. Well, the first criteria to do that is to make sure that outpatient referral to a next level of care provider takes place. So, that's the first piece that we want to make sure that the continuum of care moves out into the ambulatory setting once they're discharged or if they're going to another facility so that there is a smooth transition.

So, once that's been established, then our technical advisory panel felt that in a minimum, when this patient arrives, many times patients aren't able to give good history as far as what happened.

So at a minimum, that we would provide to them the reason for the hospitalization, the principal discharge diagnosis, and then a list of all the medication along with their doses and indications for use and then any other recommendations that needs to be followed through in their treatment plan, maybe tending AA meetings, meeting with their probation officer, whatever it might be.

So, we're not saying that you can't provide more than that but at a minimum, we felt for at least psychiatric inpatients, these were things many times that the providers on our panel felt were lacking when these patients would come to their office for, you know, follow up. So that would be the first piece of it. And then as far as the transmission piece, what was the question there?

Emma Hoo: Measuring it on the back-end in terms of acknowledgment. You know, I think one of the challenges that we have found in the ambulatory setting, you know, relative to discharge process, you know, something is (faxed) or sent but it's not actually read on the back-end.

Celeste Milton: I understand. It's kind of the adage of leading the horse to water but you can't make him drink. And really, all that we're looking at is that the hospital has tried their part to transmit that continuing care plan and if there's documentation on the record that support that they've completed the transmission. We don't have a separate measure that looks at whether the receiving facility actually acknowledge that they got it and that they're using it.

In a perfect world, that would be wonderful but we felt first step was to make sure that this was a provider to provider report so that you're not relying on the patient to provide this information and that they're getting this information directly transmitted to them. And hopefully, the clinics and physicians are the – clinicians that are seeing these patients understand the importance of what we're trying to do nationally here by making sure we're communicating this treatment plans to the next level of care.

Peter Briss: Anybody else with questions or comments or concerns about this measure?

Hearing none – I'm sorry, go ahead.

Emma Hoo: This is Emma. I think the last note was that, you know, the validity ratings were pretty moderate with the majority of the 35 hospitals cited as good or average. So, more than half, you know, we're more in that middle bucket as opposed to very high.

And just to note Lauralei, that there was just an inconsistency in the 36 in the summary form versus the 35 in the detail.

Peter Briss: OK. Anybody else? Questions, comments, or concerns about this measure?

Hearing none, let me – now that we've been through the whole slide of measures, does anybody else on the Committee want to raise anything that hasn't already been raised?

Hearing none, so for the staff, are we ready for public comments?

Lauralei Dorian: We are, indeed, yes.

Peter Briss: So, we'd love to invite public comments, please.

Lauralei Dorian: And Natalie, all lines are open, correct?

Operator: Yes, all lines are open.

Lauralei Dorian: Great, thanks. It sounds like there is no public comment.

So, we at NQF, would just like to thank everyone very much for dialing in today. We appreciate your participation. We think there is a lot of really good discussion that will be carried over to the in-person meeting.

Thank you also to Celeste and Frank and the Joint Commission representatives and to Peter for leading the call today. Just one note that if any of the conversation that took place during the call today made you feel like you wanted to change your vote, you can go back into SharePoint and reenter a new vote if you desire to do so. Just put a 2 after your name so that it's new vote.

In the meantime, you should have received earlier this month a logistics e-mail from our meetings department giving you instructions on how to book you flight and your hotel accommodations. So if you haven't received that or haven't finalized those details, please let us know and we can put you in touch with the appropriate people.

The meeting as you know, hopefully is taking place here at headquarters here in Washington D.C. on June 5th and 6th. So, that's coming up quickly. The first, the day starts at nine. Well, both days start at 9 a.m. but we do have continental breakfast served at 8:30. The first day ends at 4:45, and the second day end 4:30.

So, let's us know if you have any questions about any of that. We will – what we'll do now in the next few days is summarize all the workgroup meeting

and ratings and send it to you so that you can introduce your – the measure for which you are lead discussant during the in-person meeting.

Are there any questions about? Any upcoming steps?

Peter Briss: I just like to thank everybody for their pre-work and their active participation today. And I thought today was a breathtakingly, efficient great call. Thanks so much.

Lauralei Dorian: Yes, it was. Thank you everyone. Thanks, Peter.

Male: Thank you.

Male: Take care folks. Thank you.

Female: Bye-bye.

Female: Thank you.

END