NATIONAL QUALITY FORUM

Moderator: Lauralei Dorian
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Operator: Welcome to the Behavioral Health Steering Committee meeting. Please note today's call is being recorded. All lines will remain open throughout the duration of the call.

If you experience any background noise and wish to mute your line, please utilize your Mute button or you can press star 6 on your telephone keypad.

To speak, press star 6 again. Please standby.

Lauralei Dorian: Good morning everybody. Thank you for calling in today. This is Lauralei Dorian from NQF, and on behalf of my colleagues, I would like to thank you very much for your dedication to this project so far and for dialing in today, particularly in light of the last minute the change from in-person meetings to Web-based meetings. And we do apologize for the slight delay at the start time this morning.

Before I hand the call over to our General Counsel, Ann Hammersmith, who will go through introductions on the disclosures of interest, I'd like to turn it over to Gerry Shea who is our NQF interim President and CEO, and Helen Burstin who is Performance Measures' Senior Vice President, as well as our two co-chairs, Dr. Pincus and Dr. Briss, to make some opening remarks.

Gerry Shea: Thanks, Lauralei. This is Gerry Shea, I am the interim CEO and really an exiled board member of NQF. I'm a long time board member of NQF. I'm a long time board member who we stepped in October because of the leadership vacuum that arose suddenly.

And I felt that you deserve an explanation for what's caused the problem with this last minute switch, so I just wanted to briefly go over that. You've heard a little bit about it but I want to go over some more of it and then just answer any questions you might have.

The issue about in-person meetings versus remote or virtual meetings is one that we all wrestle with in all organizations in terms of cost and effectiveness and so forth.

We primarily have used in-person meetings because of the complexity of the issues that we're dealing with. In some cases, actually in many cases, we use Webinars or teleconferences to do some kind of meetings in between major meetings.

But starting this winter, we heard from CMS and other federal agencies that there was a meeting policy in place, to some extent government wide and to some extent with special certain rules within CMS that put a much higher bar on whether or not on having an in-person meeting. And it was an attempt to deal with the financial issues and the fiscal problem that the government face. And also originally had something to do with scandal of the GAO meeting in Las Vegas and the government's reaction to wanting to sort of have a moratorium and get control of things.

And we have been having this dialogue with CMS for the last several months. We have a very good working relationship with the CMS program officials. We talk to them frequently. The meetings are always constructive. They are always involved in our meeting. The chief medical officer of CMS as many of you know is on the NQF Board. This ruling is – or this policy is not their doing and it's not theirs to decide. It's decided in the contract office and then eventually as all things are in the secretary's office but by in large this is a preview of the contracting office and they get to make a decision and pretty much their decision stick.

There are instances where they can be in appeal and so forth but pretty much they run whether or not meeting sampling. And we were told at first, that this meeting should be done by Webinar. And we had a lot of dialogue with CMS

about the difficulty we perceived in trying to process a large number of measures that are complex and extremely important nature on the Webinar series. And as you know, we tried to actually schedule some Webinars and we're not able to schedule Webinars given all the demands on your time, insufficient time to complete the work within our contract period which we're obligated to do.

So we made the decision at that point as we have on just a couple of other occasions that rather than undermining the integrity of this process, we should go ahead and just pay the costs ourselves. We – in addition to our contract money, have significant member dues money and we were able to decide – we were able to put some of that to this.

What happened last week was that we were advised by CMS that we would not be allowed to pay for the meeting. And in fact, over the course of a couple of days, we eventually got a written directive from them ordering us not to hold the meeting in-person.

And the issue here, we could go into it if you like, but it's basically the interpretation of a federal statute which prevents the federal government from receiving voluntary donations from federal contractors. We believe that there is room in the policy for – if they agree that we can sponsor a meeting for us to pay for meeting but they wouldn't accept that interpretation.

So, that's what led to the situation today and (CFO) unfortunately is that this situation has gotten worse even this week, where we understand there is now moratorium on meeting.

So to give you some context, we just finally got request for proposals from the CMS for a number of big projects that we were told or we're going to be asked to do this year.

And because of the lateness, they won't start until this summer, so we lost half a year almost. But they did approve in those – in the context of those contract. A number of meetings and it looks like now even though they were once approved that they're going to be calling this moratorium and so we don't know what to do.

We are going to engage CMS and HHS at a high level in a discussion about this and see if we can work something out. Again, we have a legal interpretation we think would allow this kind of meetings. We're prepared to try to raise money to pay for these meetings, specifically we can't just continue to pay for them all out of our dues dollars because, you know, precious unexpected times. But we think that we – at least we have some chance of raising money for it so, we are not giving up the fight but this is a very difficult situation. And I think it's one that we're all going to have to come to terms with over the next period of months.

The bottom line is we're not going to hold processes that aren't fair to people and aren't rigorous and complete enough to do the job that we're asked to do.

So, but, you know, that's what led us to deciding to pay for this meeting today and then being told we couldn't. So, the situation, it's just not within our control but as I said, we're going to try to negotiate some sort of understanding with the department that would allow us to move forward and hold in-person meeting.

We will be holding as many meeting just effect richly but – we've done a lot of research on this over the past month. We've talked to ION, NIH, ARC and the other agencies, private organizations. We've held literature on virtual meetings which is mostly in the business literature. And it's very clear that you can't replicate in-person meetings by teleconference even if you do high level video conferences which are extremely expensive, then you can't replicate them.

So, but we'll be looking at all the alternatives and just try to work this out as best we can.

So, again, I wanted to thank you for your commitment and perseverance and I direct this time to the committee about are – to re development colleagues as well. You've been extremely patient in understanding about all these.

So at this point, I'll take any questions just for a couple of minutes.

Lauralei Dorian: Any questions for Gerry? OK, I'm hearing none immediately. I'll turn it over to our General Counsel, Ann Hammersmith, and she will go around the table virtually to committee members to have them disclose any conflicts that may have a arisen since phase one of the project.

Gerry Shea: Can I add – I just wanted to add a postscript and that is it would be very helpful to us if we could have a short conversation with you maybe at the end of the day, tomorrow, or the beginning – today or the end – or beginning tomorrow to get your comments on how well this meeting went and to the extent to which you think it is a suitable replacement for an in-person meeting.

It's just very important for us to have sort of fresh data points in our discussion with the ....

(Angela): Thanks, Gerry. This is (Angela Spoke). Actually, if our co-chairs have a few words to say, I'll give them that opportunity now.

Harold Pincus: This is Harold Pincus. And I'd like to also with Peter sort of welcome everybody. We all understand this is not the ideal circumstance in which we like to be meeting but I think if we all try to keep our focus of attention on the discussion. And I know for myself having pretty severe in ADHD, that it's necessary to try to avoid as many destructions as possible. I think we can have very useful discussions and I think we can have really substantive decision making over the course of this.

So I look forward to the discussions and realized that we – it would be nicer to see everybody face to face but under the circumstances, this is a reasonable approach.

Peter Briss: And good morning, this is Peter Briss. I want to add my welcome to everybody else. I appreciate the patience of the committee and the staff as we work through our challenges. And I'm very confident that we'll be able to view our business in and take a good hard look at important measures that are in front of us today and tomorrow.

Ann Hammersmith: Good morning everyone, this is Ann Hammersmith, NQF's general counsel. I'm going to lead us through the disclosures of interest. All of you

are familiar with this process. We want it virtually (inaudible) of course. And we will combine the introductions with the disclosures of interest (inaudible) to save time.

Even though you've done this before, I'm just going to remind you of the few things. We're asking for you to disclose things to the committee and to anyone else who's participating on this meeting (inaudible). We ask you to disclose things irrelevant to the subject matter and it's before the committee to get.

So in other words, please don't recount your (inaudible) educational background and so on. Just when it's relevant to – before the committee today.

And you're particularly interrupted in your disclosure of grants, research ... …

Ann Hammersmith: … I'm talking relationships that are relevant to be working for the committee today.

Just a few reminders before we begin, the disclosures (inaudible). Then on the committee (inaudible) in individuals. You are not here as a representative of higher or anything that's nominated you for service on the committee.

I'm going to remind everyone that you may have disclosures that's not financial in nature. We asked you to (inaudible). I don't have a financial conflict of interest which is great but because of the unique nature of the work I do, we're up the interest in their disclosure – excuse me, any activities made available. Their money may not have exchanged yet. For example, they had been a volunteer on the committee for professional society and perhaps the work we've done next meeting are over to – the committee will work on today.

So in order to make this a little bit easier, I'm going to call on and you can go ahead and introduce yourself. Tell us who you are and if you have any disclosure, and if I mispronounce your name, I apologize. And we're going to go alphabetically and we'll start with Peter Briss.

Peter Briss: So good morning. This is Peter Briss. I have nothing to disclose in the end. Just for your information, you are breaking up a bit.

Ann Hammersmith: I'm breaking up? OK, I'll try to talk louder and more clearly.

Peter Briss: Thank you, that's much better.

Ann Hammersmith: OK, good.

Ann Hammersmith: Peter? OK. Caroline Carney-Doebbeling?

Caroline Carney-Doebbeling: Hi, this is Caroline Carney-Doebbeling and I have no conflict of interest.

Ann Hammersmith: OK, thank you. Mady Chalk?

Mady Chalk: This is Mady Chalk. No conflict of interest. I am a member of the Washington Circle. (Inaudible) identified.

Ann Hammersmith: OK, thank you. David Einzig?

David Einzig: Hi. President Elective in the social society of Child and Adolescence Psychiatry. No other disclosures or conflicts.

Ann Hammersmith: OK. Nancy Hanrahan?

Nancy Hanrahan: Yes, this is Nancy Hanrahan from the University of Pennsylvania. I have no conflicts of interest to disclose.

Ann Hammersmith: Thank you. Emma Hoo?

Emma Hoo: I have no conflicts.

Ann Hammersmith: Thank you. Dolores Kelleher?

Dolores Kelleher: Hi, this is Dothy Kelleher, I'm an independent consultant and I have no conflicts of interest.

Ann Hammersmith: OK, thank you. Michael Lardiere? Is Michael Lardiere on the phone? OK. Madeline Naegle?

Madeline Naegle: Hi, it's Madeline Naegle here. I am at New York University. I represent A&A. I have no financial conflicts but I do serve on the American Psychiatric Nurses Association Tobacco Dependence Council.

Ann Hammersmith: Thank you. Tami Mark?

Tami Mark: Hi, this is Tami Mark. I'm an employee of Truven Health Analytics. I have no conflicts to disclose.

Ann Hammersmith: Thank you. Bernadette Melynk?

Bernadette Melynk: Hi everyone. I am editor of the Mental Health Guide but that is focused on children and adolescence. I also have an MIH fund study to test the cognitive behavioral skills-building program but again that is focused on adolescence.

Ann Hammersmith: Thank you. David Pating?

David Pating: Hi, David Pating. I have no conflicts of interest.

Ann Hammersmith: Thank you. Karlene Phillips?

Karlene Phillips: Hi, this is Karlene. I have no conflicts of interest.

Ann Hammersmith: Harold Pincus?

Harold Pincus: I'm employed by Columbia University in New York-Presbyterian Hospital. I am on committees for the American Psychiatric Association and on the Board of the American Society for Clinical Psychopharmacology.

I have received compensation for consulting with (Land) Mathematica and Johnson & Johnson.

Ann Hammersmith: OK, thank you. Vanita Pindolia?

Vanita Pindolia: Good morning. This is Vanita. I have no conflict of interest.

Ann Hammersmith: Thank you. Jeffrey Samet.

Jeffrey Samet: Morning. Jeffrey here. I am currently the president of the American Board of Addiction Medicine but I really have no conflicts.

Ann Hammersmith: OK, thank you. Lisa Shea?

Lisa Shea: Good morning. Again, I just to – I don't really have conflicts, but I am the second vice president of the National Association of Psychiatric Health System.

Ann Hammersmith: OK, thank you. Jeffrey Susman?

Jeffrey Susman: Hi, Jeff Susman here. I am the dean at Northeast Ohio Medical University and I have no conflicts of interest.

Ann Hammersmith: OK, thank you. Mark Wolraich?

Mark Wolraich: I am the section chief of the Section of Developmental and Behavioral Pediatrics at the University of Oklahoma Health Sciences Center. I have no conflicts although I have do have two paternal and child health behavioral training grants at this time.

Ann Hammersmith: OK, thank you. Bonnie Zima?

Bonnie Zima: Yes, Bonnie Zima, UCLA Child Psychiatry Health Services Research. I received research funding from AHRQ, NIMH, UCLA CTSI, UCLA Council in Research and I'm recently a member of the Council on Quality for the American Psychiatric Association.

Ann Hammersmith: Thank you. Leslie Zun?

Leslie Zun: Yes, I am employed by Sinai Medical Group in Chicago. I sit on the Board of the American Academy of Emergency Medicine and also the American Association for Emergency Psychiatry. I have been the consultant for Alexza Pharmaceuticals.

Ann Hammersmith: OK, thank you. Is there anyone else on the phone who's a committee member whose name I didn't call?

OK. Do you have any questions of each other or with me based upon your disclosures this morning?

All right, thank you very much.

Laurale Dorian: Thank you, Ann. Now I'm going to just go over a little bit about the process for the calls today, the logistics of the call.

First, I'd like to remind everybody to please keep your phones on mute if you're not speaking. It's particularly important because we have so many people on the call today. I'd also like to remind you that as we do for all NQF calls, this call is being recorded, excuse me, and will be transcribed and upload it to the Web within a week.

We are utilizing the Webinar function. So hopefully, all of you can see it.

The steering committee members have received an individualized link that will enable you to vote. So if you don't have that link or you didn't receive it, can you please e-mail me and I can send it to you within a couple of minutes.

Everybody else, members of the public and developers, should be able to see the Webinar now. So if you're having any technical difficulties, please let me know via e-mail and we'll try to get that sorted out.

Again, because there are so many people on the call, we're going to utilize the chat function of the Webinar. If you want to make a comment while we're evaluating measures. So if you could just type in to the chat function that you'd like to make a comment, then we'll keep track of that and call on you when the time come.

We do have measure developers on the line to respond to any questions or comments that you might have. We also have some measure developers in the room with us. We are going to ask the developer to give a brief, I think, one or two minute introduction to their measure before the evaluations begin. And

before we lead it – hand it over to the lead discussing. So we'll be expected to summarize the nature of the work group calls and voting, noting in particular areas of concern or discrepancy.

So I'm going to pause here to see if there are any questions about the process for today's call and tomorrow's call as well.

Harold Pincus: This is Harold Pincus, could you say something about the voting process?

Lauralei Dorian: Yes, in fact, in one moment, I'm just going to turn it over to my colleague, (Jessica) who's going to walk out through how exactly that process will work. So, before I do that, I'll take any other question.

Mark Wolraich: This is Mark Wolraich. The materials that we had when we had the slower group meetings are those available and where do we access that?

Lauralei Dorian: They are – yes, all material is available on SharePoint. That material actually would e-mail to you and updated. I can send it to you again because some people went back in after those calls to revote and we have to summarize the calls. So that's on SharePoint and I can also e-mail that to you.

Mark Wolraich: OK. Yes, please do, thank you. ....

Lauralei Dorian: Was there another question? I heard something.

Mady Chalk: This is Mady. It would be helpful – Mady Chalk – if you would send the work group summaries. Thank you.

Lauralei Dorian: OK. I'll resend that to the entire committee right now. If there are no other questions about the process, I'm going to turn it over to (Jessica who will talk about voting.

And just a reminder, you already know this but – we will be reviewing 24 measures, 13 of which are new. We have two outcome measures, three eMeasures, and the general areas – the general topics of depression and medication management, tobacco and alcohol and general psychiatric care.

(Jessica): So, all steering committee members should have received a specialized link to access for voting. And from that link, you should be able to vote, we'll start with one slide that present the question in the following slide which you see now will allow you to vote. For all steering committee members that logged-in, you should see buttons on your left of the question that you can click with your response.

And you can change that if you clicked the wrong box. You can only do this from a desktop or a laptop, you can't use it from an iPod. And members of the public should see the voting response but not the ability to answer the question.

So right now, we have 22 I believe that voted.

Male: After we click the box, does that automatically vote or is there something we have to do?

(Jessica): No, there's nothing you have to do after you click the box. And if everyone could just stop so we could – stop clicking the boxes that we can get a number count on how many of you voted to make sure everyone was able to access the link. But it appears that everyone was. And we'll run through all the questions for the criteria somewhere to the slide. So we'll start with the question of the criteria and then we'll advance the slide and you'll be able to vote.

And just a reminder, you will be able to change your vote after you voted if you accidentally click the wrong box.

Male: It appears as if I can vote for more than one item?

(Jessica): You shouldn't be able – that might be just in the example question, but I know the actual voting for the measures, you can only vote for one thing. And maybe, if you're changing your vote, you might see it moving back and forth.

Male: No, I actually, I just clicked at all four, there are all four checked.

Female: I can't figure out on how to do this.

(Jessica): I know that they made sure that couldn't happen for the actual – for voting on the actual measures. So hopefully, it's just because of the sample question but we'll make sure.

Female: Going to go private.

(Jessica): And were any steering committee members are not able to vote?

Mady Chalk: This is Mady. I don't think I was able to vote. At least if I was, I can't figure it out. I couldn't see anything that said vote.

(Jessica): OK. And did you use the specialized link sent to you?

Mady Chalk: Yes. I'm going to try it again right now.

(Jessica): OK. We'll follow up with you offline to see if we can fix that.

Male: As we definitely want to make sure that we can't vote twice because it looks like this is an example of vote early, vote often.

Male: Although, presumably people want to vote Yes and No.

Male: Depends on how may of them, I believe.

Mady Chalk: I'd see, I enter the ....

(Jessica): OK. So I think, we're going to go forward and start reviewing measure 1880. And we'll work with you, Mady to resolve the issue with the voting.

Lauralei Dorian: So measure 1880 was submitted by FMQAI. It's the adherence to move stabilizers for individuals with bipolar I disorder. The lead discussing is (Dave), the lead discussing are David and Parinda. Parinda is now in Wisoncsin. David, it will be up to you. And I don't know if Kyle and (Elizabeth) and (Natalie) and (Cherry) are on this call from FMQAI.

I think – David do the introduction of your measure

Kyle Campbell: This is Kyle, I can do the introduction?

So, thank you. Good morning, my name is Kyle Campbell. And I'm project director at FMQAI for the CMS medication measure special innovation project. The measures submitted for your consideration today is NQF 1880, adherence to mood stabilizer medication for individuals with bipolar disorder. This is part of a set of measures developed by FMQAI, RAND Health in the University of Florida for CMS related to medication management and the ambulatory setting.

The development process followed the standard CMS measure management system blueprint. And included a review by a multi disciplinary technical expert panel as well as the national public comment process. Dr. Kate Watkins who's the practicing psychiatrist and researcher a RAND served as the team subject matter expert to this measure. And the methodology used to calculate the adherence is harmonized with four other CMS endorsed adherence measures and one other NQF endorsed measure for which Pharmacy Quality Alliance served as the measure steward.

Under the behavioral health phase I project, we had a related measure which received endorsement NQF 1879 which is adherence to antipsychotic medications for individuals with schizophrenia.

Specifically, to the measure and their consideration today, the measure denominator is individuals 18 years of age and older with a diagnosis of bipolar disorder and at least two plans for a mood stabilizer medication during the measurement period

And the numerator is individuals identified in the denominator that have a proportion of days covered or PDC about at least 0.8. The measure is very important intermediate outcome measure for individuals with bipolar disorder as the evidence is demonstrated a clear association between increased adherence and reduction of primary outcomes of mental health related hospitalization which shares approximately for symptom relapse and suicide.

We proposed that implementing this measure will allow providers to design interventions that have been shown to improve adherence with this patient population. And there by improved patient outcomes. I'd also like to note

that following the work group review, we submitted a briefing document to address some of the question. And I understand from NQF staff that this briefing document was uploaded to your SharePoint site. We appreciate your consideration on this measure today.

David Einzig: OK. This is David Einzig. Shall I ahead and start.

Kyle Campbell: Yes.

Dave Einzig: OK. So, as he mentioned – measures looking at bipolar type I adults, looking at medication adherence rates over a one year period, looking at the proportion of days covered with a new stabilizer of at least of at least 0.8. Assuming that folks who are compliant with medication are less likely to end up back in the hospital most likely to commit suicide and improve outcomes and improve quality.

Most people on the group rated the impacts – rated impacts and performance as significant. There's a wide variability of adherence rate recorded at anywhere between 16 and 76 percent across studies. Patients – referenced patients with low adherence rate associated with higher rates of recurrence and hospitalizations and suicides. And also concluded that there were some discrepancies with age related discrepancies with folks 18 to 64 has been less likely to be adherence as oppose to folks older than 64.

Should we stop there and move forward with (inaudible) or should we just…

Kyle Campbell: Well, I guess that what other comments related to the importance to measure and the report that people have.

So, I'm hearing none. We should vote on that criterion.

(Jessica): System committee members, please go ahead and enter your votes.

Male: Oh, I just lost the whole thing.

Vanita Pindolia: This is Vanita, just so you know you can do multiple votes on the screen.

Male: And therefore we should avoid doing that.

Vanita Pindolia: Yes, I'm just letting you know. That's all.

(Jessica): Thank you. We'll try to fix that on the back end over here.

Male: Yes. So vote only once. Only vote for only one category.

Female: Yes.

(Jessica): OK. We have 20 votes right now, 18 yes, one no, one insufficient.

Female: I am having problems.

Male: OK. Criterion two?

David Pating: OK. Criterion, criteria 2A. Looking at reliability, looking at the various reliability scores. The group thought that the reliability was sufficient. And the measure it's a – they come at as far as reliability goes, a strong support from the technical expert panel. I'm not sure what else to say beyond that for reliability.

So we had addressed validity now too or do we vote separately?

Female: Dr. Pating if you could speak up just a little bit. We're having trouble hearing you.

David Pating: Oh can you hear – can you hear me?

Female: Still – it's still pretty soft.

Male: I can hear your tone.

Female: OK.

David Einzig: This is David Einzig. Can everybody hear me or people having trouble hearing me?

Female: I can hear you fine David. I think it might be on the conference room and the National Quality Forum.

Female: OK. Sorry about that. Go ahead then please.

David Einzig: OK. So we – do we vote on reliability now or it's – do I go on and discuss the validity?

Female: We actually have three votes for importance. So we've done the first vote and now we're on performance gap before we discuss the scientific acceptability.

David Einzig: Oh, I see. OK. And our performance gap is significant in the measure. It's – it was reported as high adherence rate was variable anywhere between six – 16 at 76 percent where view this adherence with medications, so there's room for improvement.

Male: Any comments for those performance gaps?

(Jessica): OK. So we can go ahead and vote on the performance gap.

Male: What is this? They're not (inaudible) of vote that we should expect?

(Jessica): We should expect 20 votes.

Male: OK. So we have 19.

(Dr. Jenkins): So we're now at 19 votes, 10 high, nine moderate.

Male: You know if somebody is having a problem with the voting process or should we move on?

Female: Hi, Mady are on the call?

Mady can you hear me?

David Pating: Dr. (Jenkins), this is David Pating can I make a small request?

(Dr. Jenkins): Sure.

David Pating: Is it possible that we could hear the work groups overview first. Go all the way through the – the indicator with, you know, major issues that were

identified in the work group. I mean, I have everything here and I've read everything and I'm putting between multiple screens to get documents up. And we're just wondering if we can hear the big, picture get refreshed and then dive back in and back to vote or to discuss.

(Dr. Jenkins): Sure. Yes. That's no problem at all. We've done that before.

David Pating: OK. You know what, when we did it last time, yes.

(Dr. Jenkins): OK. Sure. Let's go ahead that way then.

David Einzig: OK. So, one of the issues, one of the questions that was brought up from the group is while those measure looks at the proportion of this covered as greater than 0.8, it did not necessarily look at or present studies that saw defective ways to influence providers or hospitals from trying to get patients to become compliance with the medications. And so that was one of the addendums that was sent a couple of days ago.

I'm trying to come up with the other questions or issues that the group have from the conversation. Let me page through here.

In terms of quality, the measure looked at information that was largely obtained from guidelines from 2002 for American Psychiatric Association Guidelines for treatment of bipolar disorder. And so then, we looked at 2005 addendum to that health 2002 and 2005 recommendations were fairly similar with the exception of 2005 adding lamotrigine and (eaton) as psychotics, using those medications in addition to some of the older mood stabilizing agents.

And then the other issue that was raised was where the 0.8 come from. Was it some arbitrary number that somebody just pulled out of the air? Why 0.8 and the factors of the measure presented some data, why 0.8 was selected for proportion of days covered.

Is that fair? Does anyone else have comments about that?

Kate Watkins: Hi, this is Kate Watkins. I'm sorry, I can't figure out how to use the chat screen. Actually, I just want to clarify that the 2005 addendum didn't had lamotrigine and the atypical antipsychotic which was added additional evidence for them. Those were recommended in the 2002 guidelines that there was more evidence that was provided in 2005.

Male: One question that I had is that if between now and the next time this is reviewed, that another drug get indications for use in drug polar disorder, how would that be handled?

Kyle Campbell: Hi, this is Kyle Campbell from FMQAI. The measure undergoes an annual update process that's reviewed by our technical expert panel and our subject matter experts. And during that time, any new medications that could potentially be added to the measure would be evaluated and then added to the National Drug Code list for the measure stratification.

Male: And so, that automatically go – gets transferred into sort of the NQF endorse list, that change and specification?

Kyle Campbell: Yes, every year, we submit during the fourth quarter of the year an annual maintenance update to NQF which provides any coding changes as well as any changes to medications.

Male: OK, thank you.

Kyle Campbell: Yes, you're welcome.

Male: So, just to clarify, the – how the discussion will go going forward is that the measure developer will present first then the lead person who reviewed the measure in the workgroup would present both summarizing all of the information that has gone through the workgroup going in order of the criteria. And identify any kind of issues that came up. And then we'll have discussions and then we'll go through the voting across all of the criteria. Is that the intention?

Female: Yes, precisely.

Male: OK...

David Pating: And I think you were going to send because I haven't received yet the forms to refresh my memory.

Female: Yes, it will be sent to you just in one or two minutes. We're putting together the e-mail now and I did want to let everybody know that to use the chat function where it says chat on the left hand side, if you click the box with the purple and blue arrow to enlarge it and then you can click where it says special messages and announcements, and can either send it to us, the leaders of the NQF or to the entire committee if you wanted to ask a question. And it looks as though Lisa Shea has a question regarding exclusions.

Lisa Shea: So, yes, and I don't know if this is the right time and the sequence but I was just wondering about how pregnancy was handled and it's measure given that that's a controversial area?

Kyle Campbell: And so, we didn't – this is Kyle Campbell again from FMQAI. And we don't have any exclusions when we looked at pregnancy and some other measures because we are looking in a Medicare populations in terms of the administrative claim. It was a fetch low frequency that we didn't consider it as a potential exclusion.

Male: Although medicare population includes younger disabled populations as well?

Kyle Campbell: That's correct, yes. But when we did an analysis of – we used age stage of data for administrate claims and we looked for, you know, pregnancies within that population of the eight states that we had. It has much less than 1 percent. And I don't know Kate, if you want to speak to anything else with regard to pregnancy?

Kate Watkins: No. I mean, I think there is, in general, the clinical recommendations are – that you weigh the risks and the benefits. And certainly for lithium, many people will continue lithium in someone who's pregnant. You know, judging that's a risk of a bipolar relapse is more detrimental to the fetus than to the mother than the risks of continued lithium therapy.

So I think there are certainly situations, it's where a woman may choose to continue on her mood stabilizers but that's a decision between her and her physician.

Female: It looks like we have a question from Tam Mark.

Tami Mark: Hi. My question concerns how one takes into account potential changes and diagnoses and whether there's any research about the extent to which apparent non-adherence might relate to a change in a diagnoses from an initial diagnoses with bipolar I to something else in which mood stabilizers might not be indicated.

Male: OK. I would let you address that first and then I can discuss it from a coding perspective.

Kate Watkins: Well, in general, the way bipolar I is diagnosed, you need to have evidence of a mania. So, it would not there – if you have evidence of mania, there wouldn't be any situation where you would then go to a diagnosis of major depression. I think the only way the diagnosis could possibly change would be going to – possibly to a diagnosis of schizoaffective disorder in which case, mood stabilizers would continue to be recommended or possibly to a diagnosis of schizophrenia where they wouldn't be contraindicated.

They may not be sort of first line choice but it wouldn't be wrong to use them. The only other time I could see it would be if the clinicians subsequently found out that the person, the mania was drug-induced or substance-induced. I think we deal with that pretty well by requiring to actually (inaudible) in terms of – it's not a single (inaudible) who are identified as being in maintenance or a long-term treatment.

Tami Mark: You've cut out a little on that last point but I think you were saying you required two ICD-9 diagnosis sub-bipolar I?

Female: Kyle, can you speak to that?

Kyle Campbell: Yes. So, what Kate was saying is we actually require two claims for a mood stabilizer which would indicate the intent of the physician, you know, to

prescribe. And then in terms of diagnosis coding, we do require an outpatient setting, at least two separate encounters with the diagnosis of bipolar disorder and in the acute inpatient setting just one instance of that.

And I would point out that that would reset every year so this measurement period is a year – year-long measurement period. So, in order for the patient to qualify in the following year, they would have to meet all the illegibility criteria that would include those diagnoses.

Tami Mark: OK, thank you.

Kyle Campbell: You're welcome.

Male: Are there other comments or questions? And this is with regard to all of the criteria, the importance to measuring report, the scientific acceptability, the usability, and the feasibility. Any other comments or questions?

Male: Well, hi, I just – are we – should I comment in the chat or just open line…

Male: Either way.

Male: OK. So, I still have concerns of these data meeting about the bipolar diagnosis. And many patients where – particularly public sector patients, they – you look at their chart and they've been given multiple diagnosis which change over time. I guess, what's your remedy, you know, for that even if there's two – single entries with it's (inaudible) go into the hospital and suddenly, you're on methamphetamine. Somebody doesn't know that and they call you manic and you get an outpatient. On the first visit, they repeat the hospital diagnosis.

So now you fall into the denominator but the third physician decide this is all a mistake. I mean, it happens a lot. So – interested in hearing around a lot about that. And then, I'm still not clear on the construct of the indicator and the PDC. I've read it like five times and maybe I just can't understand the PDC interval issue.

So, I'm a little concerned about the reliability of the measure as it's constructive.

Male: OK, (Kate) do you want to address the diagnosis issue and, I'll discuss the methodology and the algorithm for CDP?

Kate Watkins: Yes. So it sounds like you're concerned about the reliability of the diagnosis? If I'm understanding you correctly.

Male: Yes.

Kate Watkins: And I think that I don't know – we would have – I don't know research on the reliability of the diagnosis, I would have to go back and look at that, but it's my understanding that even in the situation where someone does have a methamphetamine-induced psychosis that presumably, the inpatient position would be ordering a urine toxicology screen which would be standard of care with any inpatient admission and would find out that there was methamphetamine in the urine.

Male: Well, maybe that's not a good example, I mean, the issue is…

Caroline Carney-Doebbeling: I actually think – this is Dr. Doebbeling, I think that is good example. I review charts regularly for quality failures and the lack of a drug screen is a very, very common occurrence with folks presenting either on PCP methamphetamine, cocaine and other substances that get completely missed in the process.

Male: Sounds like an opening for somebody to develop a quality measure.

Caroline Carney-Doebbeling: Yes, I agree. I'd like that.

Kate Watkins: And other thing to remember is that the comorbidity between by polar disorder and substance used is extremely high. And so, again, in those situations were someone does have a comorbid disorder, it would – long-term treatment with mood stabilizers would be still be indicated.

So I think that the amount of sort of these situations where there would be few situations where you would not want to consider might be some but there

wouldn't many situations where you wouldn't want to continue with long-term treatment with bipolar – with mood stabilizers on someone who had a comorbid disorder.

Again, I don't think the issue is that their diagnosis would change to a major depressive disorder, I think the most likely is that it would – the other possibility would if – is that it would move up to a schizophrenia diagnosis because the measure does exclude bipolar II disorder.

Male: Now that's a fine line to draw. Also, I mean, if you have a depressive episode with some kind of slightly mixed state and that you're relying on the 20-year old past history of the manic episode, and there's no collateral data, I mean – I think in under served populations, you just see multiple diagnosis that's all over the chart and you take your best guess sometimes at any urgent situation. I just think clinically, bipolar diagnosis is something that have to proven with a longer duration of observation to make a really – to do really good job on it.

Female: Well…

Male: I don't want to (inaudible) and I kind of let people know ....

Male: And certainly, it's very clear research criteria that in a clinical situation, although a lot of people quote bipolar disorder, often get changed many, many times ....

Female: Again, it would not get by requiring that it be bipolar I, not bipolar II, there must be evident – a clear evidence that, you know, there has to be a manic episode. And, by requiring two separate episodes where the diagnosis is made in a single calendar year and to prescriptions for mood stabilizer were restricting the population to people for whom, on different occasions, either one or multiple physicians have made the diagnosis of bipolar I.

Now, again, if the diagnosis were to change, as Kyle mentioned, in the subsequent year, then that would be taken – that person would either be in the population or out of the population depending on that, you know, pertaining on that year.

What I think you have to go with what the, you know, if a physician is making a diagnosis of bipolar disorder, you have to – you have no way of knowing whether or not that's diagnostic truth. You know, all you can go is with what is recorded.

Male: Well, looking at the reliability data, I was a little bit confused, and we look at your very high statewide – state level reliability measures in the point in the 90 percent, but then when you got them with some other plans that's (come) into the 40 and 50 percent. Could you explain what that variation change (inaudible)? Was this a test-retest reliability, is that a possible ...?

Kyle Campbell: And this is Kyle Campbell at FMQA. This is a signal to noise ratio equation proposed by Adams at (Brent), and it really looks within practice variation and compares it to external variation. And so, one of the things that it's sensitive to is sample size and when we look across states which, you know, with largest unit of analysis, it allows us to have much higher reliability scores.

And as we go down through various levels from part D, to ACOs and to physician groups, you'll note that there is variation and there are denominator threshold sizes for which we would consider the measure either reliable for a mean denominator or an even tighter threshold would be where we would consider reliability at a 100 percent of all of the measured entities.

I will say also that, you know, under consideration and how we're considering benchmarking that's measured would be that compares a number of providers to the mean. So we don't actually have to discriminate between individual providers, we just have to discriminate between their differences with the mean. And that is presented in the meaningful differences and performance section.

So what you'll find is there is a denominator threshold or cutpoint at which either for that mean of units that are being measured or for all of the units being measured, they do achieve the right only threshold of 0.7 with the exception of the ACOs which approach it, appoint them into work. And we

have a very limited sample of ACOs which were the convenient sample of 32 ACOs.

Vanita Pindolia: This is Vanita. I have a question in regard to the reliability, and dividing it by state was helpful. These questions come up – I know at last years meeting, I also had voiced it and I've also written letter to CMS voicing the concern. Because these measures will also be used part of the Medicare Five-Star which – $10 million and this is weight of three that will have obviously added a one, two, three, one of the higher weights that will contribute to what star measure and then you're compared nationally to everybody.

So having it statewide is fine, is there a way – is CMS considering to breakup by zip code or socioeconomic or understanding what's urban and that – and the reason I'm asking is, now, with antipsychotic similar to antidepressant, pretty much all of them are generic and they all are available in the $4 Generic Program. So we don't get claims as much as we used to before when it was more than just Abilify, with Seroquel, with Zyprexa and everything else. But now, it's just Abilify that's available as a brand, and Seroquel's price, everything has dropped drastically and they're available there.

I know in the Detroit area, we just did it for a one year period and that was four years ago, and 12 percent are Medicare members were not showing the claim but we're truly taking their drugs. Because this will be a comparison of health plans from across the nation regardless of where their population is, it would very difficult for an area where there is socioeconomic burden where more people would probably relying on the $4 Free Program and showing a lower score. How is CMS taking that into account? Or are they going to moving forward?

Kyle Campbell: I appreciate your comment on that. Let me address the two separate issues. And one, with regard to CMS policy, so, if this measure were be – to be endorsed, and it were to be considered or any of this CMS reporting program, it would go under the measures under consideration process where it would be reviewed for a specific program, and then prior to it being implemented into a program, it would undergo another public comment period of a specific application within that program.

So at this point, we don't know if and which program CMS could potentially select this measure to be used, and certainly, I can't say that they would select it as an indicator or the star rating programs specifically, even though some of the other adherence measures are, you know, in the star rating program at this point. And I will say that we'll take your comments concerning the star rating program and adjustments in terms of the geographic diversity into consideration or back to that specific program.

The second thing is, we did look at the potential impact of the $4 Prescription Program. We did limited sensitivity analysis and also just looked at a proxy at the discount formulary available from Wal-Mart, for example. And we didn't see any type of major impact to the measure. Again, remembering that folks will be the way we have proposed the measures, if folks would be, you know, compared to a mean. So we're – we don't think that there will be a major impact from the discount formulary but we do appreciate that concerns and that would be something that – if the measure is implemented, we would monitor closely during the evaluation period prior to the next comprehensive review.

Male: And presumably, that would affect all measures. Not just this one. ... looking at medication in here.

Kyle Campbell: Right, that's correct. That could potentially affect any medication-related measure that relies upon claims data. And for which, you know, many of the medications would be available on this formulary.

Harold Pincus: Other questions and comments?

So we're ready to go to the voting process?

(Angela): Yes, and Harold, this is (Angela). When we resume voting, I'll just remind everyone will be resuming at high priority, and that would be the last piece in our importance vote. And then we'll move on to the remainder of the criteria for this measure. And then I'd like for us to kind of reset when we get to our next measure, Harold.

Harold Pincus: OK.

(Angela): Thanks. And maybe if you're on, you can do your vote by voice or chat.

(Jessica): So, please go ahead and vote.

And we're going to stop at 19 votes so I'm going to go ahead and read them, we have nine high, eight moderate, two low, and one insufficient. And we'll continue on to the scientific acceptability voting. We'll vote on reliability next. Please go ahead and vote.

So we have 19 votes. Mady, would you like to cast your vote? High, moderate, low, or insufficient?

Mady Chalk: It's on moderate. I'm back on so I'm able to vote.

(Jessica): OK. Great. So we have…

Male: So we have 19…

(Jessica): So we have 15 moderate, and five low.

Female: OK.

(Jessica): Now, we'll vote on validity. 14 moderate, six low.

Next up, usability. OK. One high, 16 moderate, three low.

Next, we'll vote on feasibility. Feasibility vote is three high, 16 moderate, one low.

Next, we'll vote on the overall suitability for endorsement. 15 yes, five no.

And that concludes our discussion on measure 18 ED.

(Angela): Thanks (Jessica). This is (Angela) and I – and Harold, pardon me for breaking in. I want to just clarify something, and Harold let me know if you agree. As we're discussing each measure, I understand the developers going to introduce their measures in the lead discussion – can introduce the measure

and give a full overview so we have a full picture of the measure, work group discussion. And also, as we start to talk about the criteria, if each person who have question could frame it as – I'm talking now about evidence, I'm talking now about importance, and so on and so forth so that we can track this a little bit better here at NQF before we go to the vote.

And Harold, any thoughts?

Harold Pincus: Yes, I know – I think that's helpful because that, I think, it keeps people sort of on the MAP.

(Angela): Great. So I'm handing it back to you.

Harold Pincus: Folks, are there any other suggestions given our first discussion that you would have with regard to how we run the discussion periods?

Jeffrey Samet: This is Jeffrey Samet. There was a request for clarification in which maybe my own ignorance, but, this clarity on the low versus insufficient when we rate things that way. So…

(Angela): Sure. I'm going to have Karen Pace answer that question.

Karen Pace: Hi, this is Karen Pace. Good question. I think, generally just think of it that insufficient evidence generally means that there wasn't enough provided for you to actually use our rating scale, versus low would really indicate there's information but it is really is not adequately meeting the criteria. So, for example, on reliability and validity, insufficient would mean that they really didn't do testing or didn't provide enough information to even rate it against that criteria versus low would mean the informations there and that doesn't meet criteria to say it's reliable or valid. Does that help?

Jeffrey Samet: That helps. I just – is it really inconsistent to say one thing might be low? It doesn't – it means it (fall) with very low threshold and yet the other stuff maybe good so that the end you actually say it make sense to move forward or is that…?

Karen Pace: Well, the way our criteria is set up, and generally, low means that the informations are there but it doesn't really meet our criteria. So, you know.

Jeffrey Samet: So the quick response of thing in that way is more like a moderate. I think that…

Karen Pace: Right. And so, you know, for – and we can – there's a little bit of a distinction with the evidence particularly about low because, as you know, we're looking quantity-quality consistency. So, you might have low quantity but, you know, it could still need our threshold on the evidence. But, if you think it's minimally acceptable, then you should rate it moderate.

And again, on reliability and validity, things that are only eligible for a high rating as they've tested that, both the data elements and the performance measure score levels so most measures will be in that moderate category. But, you know, the low would indicate, for example, they may have had testing but the reliability coefficient is really too low that you don't think it really meets the threshold for being considered a reliable performance measure.

Jeffrey Samet: That's helpful. Thank you.

Karen Pace: OK.

Harold Pincus: Are there questions other than the interpretations of the criteria or the (inaudible) Webinar discussions?

OK. So now we move on to the next measure on antidepressant medication management. 0105, I believe. And the measure developer I believe is NCQA.

Jeremy Gottlich: Thanks Harold. Can everyone hear me?

Female: Yes, we can hear you.

Jeremy Gottlich: Yes. Great. I'm Jeremy Gottlich. I'm a Senior Healthcare Analyst at NCQA. I've worked on the behavioral health (inaudible) measures for last few years, both in measure development and measure reevaluation. So I will introduce the antidepressant medication management measure, I think that's NQF

number 0105. This is a health plan measure that was previously endorsed in 2009 and it's part of NCQAs (inaudible) of behavioral health measures. This fall under the review of our Behavioral Health Measurement Advisory Panel, this was the group that reviews all of our measures, we also take these measures to a multitude of panels that look specifically pharmacy or coding. And so we really have a lot of groups that review our measures, and this is because we rely on our measures being feasible, scientifically found and reliable which is important for NCQA since we focus on the health plan as like accountable entity that can influence quality of care access and utilization and coordination of care.

This is one of NCQAs longer standing measures and was developed in I believe 1998. It's the most recently reevaluated this past year which is the measure presented in the NQF submission in front of you. The intent of the measure is to look for health plan members who are being newly treated with an antidepressant medication and to then see and measure their experience rate at two different points of time in their care, that first being the acute phase which we say at 84 days or 12 weeks, and then the continuation phase which we say at six months.

We also allow for gap due to some changes in treatments or due to medication washout period. We are specifically looking at people 18 years of age and older who are enrolled in commercial Medicaid or Medicare advantage health plans. And so, to get a little more specific denominator, we first looked for a diagnosis of major depression, we then look for prescription around that index diagnosis event and then – so that's how we find the denominator event. And then we looked for the numerator which is again the adherence of the those two points in time, the acute phase at 84 days and the continuation phase at six months.

I'll turn it back over to the panel.

Vanita Pindolia: Hi, this is Vanita. So, I took the lead for the measure 0105. So I'll just going to walk through our discussion that we had in our conference call. Is that the correct process?

Male: .... The discussion according to the different criteria groups.

Vanita Pindolia: OK. So the first discussion was on the importance to measure and report and the impact at performance gap. (Inaudible) that right, I'm sorry, one minute.

Right. So, in that one, there are four that agreed, four that importance and one that did not. So the main question was revolving around the – and so the diagnostic code of 311 to be included because this is depressive order but not elsewhere classified. This is supposed to be a measure for major depression so there was a question from the group of – does that include people that do not have major depression possibly?

So that was one concern that was raised. And the evidence – the level of evidence that was provided, it was again four agreed that there was enough level of evidence and one that there wasn't. And it has to do with looking at adherence rate of 80 percent or just adherence – I guess it was adherence rate of 80 percent, sorry, but just adherence in general. Is there a correlation of non-adherence to antidepressants in having a poor outcome? I think in our discussion, everyone came to agree that there was enough evidence out there in the literature, but I don't want to speak for the individual who led that concern, because they want – if they still have that concern to still raise that.

The scientific acceptability, everyone agreed but it was – there was scientific acceptability, reliability was four high, one medium. And again, the individual – and it has to do with the statistics and using the binomial model. I'm not familiar with that enough to make a comment of what the concern was on that. I know there's also the concern of –in question five in the report of using tricyclics or SSRIs, should that be excluded or included as well? And we can further discuss that with the individual.

Usability, three high, one medium and one low. And again this was –this comment probably was more for me and it was looking at the two phases, there's an acute phase of the three months and the continuation phase of six months. And the three – in the acute phase of three months, we can see about the measure being in place for two year or three year or four years that it's achieving about 60 percent, and then there is a drop off to about in the 40 to

45 percent when you do continuation. And the question I had for the individuals making this, so for NCQA was, I know if you just get a 90-day fill you're good and it's done. However, most of these patients do need a titration in between and is that – is there any analysis to look at why there is that huge drop off at the six months? Is it just that the first fill is 30 with the 90-day fill but it didn't really mean that they were adherent, there's another issue of just not having a titration. That was just more of a comment to understand years ago, they used to have – that you had have a 30-day follow up and it did seem to make an impact on that, but that measure was removed.

Feasibility, three high, two medium. Majority of the – again, this is my comment about the $4 programs that we've already discussed. The preliminary assessment of criteria and endorsement, four yeses.

So that was the discussions primarily, that we had on the phone, if we want to go from here.

Harold Pincus: Are there comments and question to the people when they comment, could identify which of that sort of a criteria bucket they're commenting would regard to?

Tami Mark: Hi, this is Tami Mark. I think this is a comment on impact although it maybe a comment on (inaudible), I'm not sure. I guess that what I'm weighing is the, you know, benefits versus the risk of providing an antidepressant in someone who may not benefit. So if you look at the meta-analysis that they've cite from (inaudible) here, they conclude that there maybe minimal or non-existent on average benefits on people with mild and moderate symptoms which maybe the, you know, in a NOS 311 categories. We also know the anti-depressive use in the population in general in the U.S. is very, very high and, you know, about 11 percent of the Americans 12 and over taking antidepressant in any given year, and 60 percent take it 40 years or longer. But if we're not really concerned about prescribing people who don't have major depression or encouraging over prescribing, then I guess those issues are (inaudible) in my mind in terms of impact and validity.

(Jodie): And this is (Jodie). I was on this workgroup as well. My – you know, and use of that code by – in my experience, especially in the primary care wherein it's pretty common, it's almost like a default for some. So to eliminate it, exclude it would (inaudible) error leaving it in.

Male: I think you had been cut off at the end of the last sentence, could you repeat that?

(Jodie): I think because of it's use in clinical practice, that it would be more of an error to exclude that diagnostic code than to leave it in. So I don't share the – I understand Tami's concern but I don't agree that it should not be in there.

(Crosstalk)

Caroline Carney-Doebbeling: This is Caroline. I was on the same workgroup and I do share that concern and voiced it during our earlier meeting about leaving that code, especially if we're looking at people needing to say adherent for six months or more. If they truly don't have it in their (memo) at first place, then they have something that's more reactive or any of the other kinds of things that might get thrown into the basket of 311 if not appropriate for them. Perhaps, even to be prescribed to in the first place or continued for 90 or 180 days.

Harold Pincus: Are there comments on this issue with regards to the inclusion of that code?

Male: What happened to that code with DSM-5? This is ICD 9, right, but is there an NOS category and ...?

Caroline Carney-Doebbeling: We have the same issue with the ICD 10, a similar issue I believe.

Male: Yes. ICD 10 has NOS codes also.

Female: Did we have a response from the developer?

Male: Yes. I would say that regarding the code 311, this has been an issue that has come up with our Behavioral Health Measurement Advisory Panel as well. And we've also tested this code – this code's prevalence and use within health plans. The most recent testing showed that around 33 percent of the people diagnosed with depression were diagnosed using this code of 311. And based

on the high prevalence of this code, the Behavioral Health Measurement Advisory Panel felt that the benefit having – of possibly – of including the code and so maybe that there would be more people wrongly excluded from the measure than people that might be correctly include or I'm sorry, might be incorrectly included using that code.

And so, based on weighing those two, the MAP felt that is more important to include this code and make sure that we weren't dropping people out of the measure that belonged in the measure.

I'd also say, regarding the comments about the use of medication therapy for people with major depression, this measure again is based on adherence not just that use of antidepressant treatment. So to get into the measure, you need a prescription. If a member does not fill a prescription for an antidepressant, they are not included in this measure, and once they're included, we look at adherence.

Male: So the notion is that it captures that there's an intention to treat with medications?

Male: And I think that's the key point that if you've selected to treat something, then they should get a full course of therapy. Certainly, there are many patients with depression NOS who may not be treated with medication. But if you're going to treat them, I would be comfortable with saying "Yes, you should treat them for a full course of achieving the continuation therapy."

Female: That, I agree is the case. However, the measure is specified for major depressive disorder. So, perhaps, this is semantic issue and the name of measure should change to any depressive disorder or just depressive disorder in general, because if we're talking about major depressive disorder, certainly, the prevalence I would believe, a major depressive disorder in society is not 33 percent as mentioned earlier about the cons of the 311 code in the population that was studied. So, I think the way to resolve it would be to change the name of the measure or to limit your major depression.

Jeremy Gottlich: This is Jeremy at NCQA. I just wanted to clarify the 33 percent. That was the percent of people with major depression who were diagnosed of major

depression using a code 311 so that's not the percent of the prevalence of major depression.

Male: It was the frequency of that code appearing amongst the entire code sets that we have 33 percent for 311 and then 66 percent for...

Female: How is it then – help me understand the rest of that validation. How is it validated that 100 percent of that sample of which 33 percent were coded with 311, had major depressive disorder?

Jeremy Gottlich: So that analysis was not the validation of major depressive disorder, it was just a...

Female: A code frequency.

Jeremy Gottlich: A code frequency. Correct.

Female: Right. So we can't say that ...

Female: We don't know.

(Crosstalk)

Female: What I'm trying to get to is that you say that 33 percent, right.

Male: I'm sorry, they cutoff those comments.

Female: My comment was, if it was simply a frequency of that code in a data set, that did not confer that those 311s were actually people with major depressive disorder. So what's the intent?

Male: ....

Female: If the intent of the measure is to look at major depressive disorder, then that doesn't support the use of this measure for 311.

Male: No, but I – with regards to the title, the title of it is Antidepressant Medication Management so it doesn't mention major depression in the title.

It's basically saying, if you're intended to treat depression with medication, you know, have you - it follow the full course.

Female: But the measure brief description is specifically saying diagnosis on major depression. I think that's where…

(Crosstalk)

Female: Yes, that's where the issue is.

Male: Yes, so that should probably be adjusted since that's not accurate.

Female: Right. I'm sorry. I said the title instead of the description. But that's what I'm referring to.

Jeremy Gottlich: This is Jeremy at NCQA. The intent is to focus those measures on major depression. The frequency of the 311 code is important because that is the frequency of people that might fall out of the measure if we exclude the code. And it's, you know, like I said, this is an issue that's repeatedly comes up with our Behavioral Health Measurement Advisory Panel. And one day .....

Male: Jeremy, I think what's being proposed though is not to eliminate the code. I think what's being proposed, if I understand it, is that you make some modification of the brief description, because ...…

Female: Yes, that's correct. That would be one way to resolve this, or the other way to resolve it would be specifically to change the measure and limit it only to the most pure diagnosis of major depression.

Male: Right.

Female: At which case you lose the 33 percent. So, to me, it seems like it would make sense if you wanted to include those folks who would be at risk and should be treated and have an intention to be treated to change the description and the title of the measure.

Male: Right. And on brief description.

Male: This is all (inaudible) on the (ABP) of performance measurement at NCQA. Thank you for your comments. Again, your comments really do reflect the range of opinion on our Behavioral Health Measurement Advisory Panel as well as our committee on performance measurement. You know, we've looked at, you know, semantics is important, I think, what we're trying to get at this that we don't want to – we actually had to lead the coast around depression that is, you know, short order and related to, you know, life issues that – so, you know, we try to frame this measure the best we can, balancing the issues that you have all raised.

Again, this is the population health measure for health plan. Maybe it's a little less precise that we did with (inaudible) condition level of measure. But we feel that this is the best way to strike the balance. And so, in terms of renaming the intent of the measure, you know, we have taken – you know, we'll certainly bring this feedback back to our Behavioral Health Measurement Advisory Panel and get their feedback. I think their feedback will be are intended to try to get at, not situational depression, but depression of – it reflects what we understand to be a major depression.

So, again, we do appreciate the feedback and we'll take this back to our Behavioral Health Measurement Advisory Panel.

Harold Pincus: Yes. I think there's probably a way to phrase it so that it's not – it doesn't get into the specific diagnosis but it talks about, you know, the – in which the provider's intention to treat depression with antidepressants.

So, other comments about other issues?

Nancy Hanrahan: This is Nancy Hanrahan. It seems to me that the measure is really targeting problems at the continuity of treatment. Or if you want to have major depression or depression NOS, but the real issue is continuity of treatment. Am I right about that? Is that – that people's sense of it in that regard, if it were simply in that – of targeting that particular aspect of treatment, the continuity of it, the measure seems to work.

Harold Pincus: Other comments?

OK. All right. Hearing none, I guess we're ready to go to the voting process?

(Angela): Yes, let's begin voting.

Male: All right. I just wanted to add (inaudible). It's my understanding also that the performance on this measure has not been high and has not been increasing, is that correct?

Jeremy Gottlich: This is Jeremy. The performance is a bit different across this three (inaudible) so we'd see highest performance among Medicare Advantage health plan, which for the acute phase is between 66 and 78 percent depending on HMO or PPO. For the acute phase for Commercial, a little bit lower in the mid 60s and then for Medicaid, we're at around 51 percent. The rates are lower for the continuation phase, still Medicare Advantage is the highest between 53 and 58 percent, followed by the Commercial plans just under 50 percent, and then Medicaid plans at 34 percent.

Over the last – many years of trending that's done on this measure, we've seen a consistent increase around 1 to 2 percent, and we've also recently looked at the significance of that increase and we've seen that the – even though it sounds small but still 1 to percent for a long-standing measure actually is very meaningful and that it's showing continuing improvement in the performance.

Male: Just to point out, if you look at the tables that we've included, the first data on your left is the most recent followed by 2011, 2010, 2009, sometimes people are looking at the other way and they think performance is declining. We're also seeing gaps in performance between in the (inter core) trial range or between 10 percent to (inaudible) 90 percent health plan. So the gap in care continues.

Harold Pincus: Has everyone voted for the – on the evidence issue?

(Angela): We have 16 people who have voted. So we're still waiting on four.

(Jessica): Four.

(Jessica): So if you've not already voted, please go ahead and vote.

So we have 16 yes, three no, one in insufficient.

We'll vote on performance gap next. Four high, 15 moderate, one low.

Jeffrey Samet: This is Jeffrey Samet again. I'm just trying to get right calibration here. If we were swayed by the argument about the – what constitutes depression, major depression or not, would this be the grading that would suffer as a result?

Male: I think it could – I mean, in (principle) you were – you felt strongly that it can hit at a number of different points.

Karen Pace: This is Karen Pace. I think if you're concerned that the measure is capturing the wrong people, that would be a validity issue in terms of what the results of that measure is going to tell you about quality. So I would factor that into your vote on validity. Does that make sense?

Jeffrey Samet: Yes, thanks.

(Jessica): So for the performance gap, we have four high, 15 moderate, one low.

Next, we'll vote on high priority. Please go ahead and vote. 13 high, 6 moderate, 4 low.

Next, we'll vote on scientific acceptability and reliability. If you've not already voted, please go ahead and cast your vote. All right, we have 17 moderate, 2 low.

Next, we'll vote on validity. We have 12 moderate, 8 low.

Usability.

Female: Can I ask a question about this? Can you have high usability and low validity?

Male: Karen?

Karen Pace: I think that's a good question and I think, you know, as an individual, you know, I mean and that's one of the reason we have usability follow your

discussion of scientific acceptability so that, you know, in terms of (inaudible) hierarchy that if you don't think it's reliable and valid, it's really meant to make it (reasonable). So I think your individual vote will probably flash with your thoughts about reliability and validity in terms with how you vote individually. But I think, you know, that's the reason for hierarchy that if you don't have a scientifically-sound measure, is it really going to be very useable in the context of what we're endorsing measures for.

Male: Right. But it is – but it also adds to it certain other elements to consider. (Inaudible) they're correlated but they're not (as well).

Female: So it's necessary but not sufficient?

Thank you.

Female: OK. So, what was the comment about the correlation? I'm sorry.

Male: I said that, so the concepts of correlated but not identical so that...

Female: Exactly, exactly.

You know, I think it will be more at the individual level than, you know, it could be consistent with your own thoughts.

(Jessica): So the usability vote was three high, 12 moderate and five low.

Feasibility. Four high, 16 moderate. Overall suitability for endorsement.

Female: OK.

(Jessica): We have 16 yes and three no. Measure 105 has been recommended by the steering committee for endorsement.

We'll continue on to measure 1922.

Male: So, Peter you're handling the (TJC) ones?

Peter Briss: Yes. So, what if – this is – this begins a series of hospital-based inpatient psychiatric services measures. And the – if the joint commission would –

would key this up, maybe if you tee up the whole series of measure followed by any specifications with 1922?

Celeste Milton: Thank you, Peter this is Celeste Milton. I'm an Associate Project Director in the Division of Healthcare Quality Evaluation of the Joint Commission. I have Anne Watt, Associate Director also in the division with me. And also the chairman of our technical advisory panel, Dr. Frank Ghinassi. We're available to answer any calls today.

Just to give you a background on this measure this is one of seven measures in the Hospital-Based Inpatient Psychiatric Services also known as the HBIPS core measure set.

This came about as a collaborative effort with the joint commission and the National Association of Psychiatric Health Systems, the National Association of State Mental Health Program directors and their research institute back in 2003 and we have been working collaboratively with a technical advisory panel following the launch of this project in 2004. We held a several meetings with our advisory panel, we've gone through pilot testing activities which involved over – almost 200 hospitals over a 12 month period where we launched the measures and they were tested both for reliability and validity throughout this period of time.

Following our testing activities, our technical advisory panel recommended final specification changes which resulted in the seven measures which are up for consideration today.

The first measure that you'll be evaluating is HBIPS-1 and that's looking at admission screening. And what you're looking at with this measure would be of those hospitalized psychiatric inpatients. We're looking at those that receive an admission screening within the first three days of admission. Specifically, we're evaluating size components of this admission screening.

We're taking a look at violence risk of self, violence risk to others, substance use, psychological trauma history and patient strength. These five areas were selected by our technical advisory panel because we felt that it was important that they were incorporated into the patient's treatment plan. In many cases,

there are co-occurring substance use disorders on the history and other things that can impact the patient's recovery.

And also, patient strengths are based on the recovery model as far as how we would be evaluating these patients.

These measures also have been in used as an entire set since the Fall of 2008. So we have couple of years worth of experience with these out in the field. And more recently, these measures were adapted by CMS as part of their Inpatient Psychiatric Reporting Program beginning in October of last year.

Male: Thank you. I think Lisa Shea was going to do a report on this for the committee?

Lisa Shea: Yes. So, we'll start with our measure 1992 that each – just one admission screening. And this workgroup matched and there was some expectancy in the work group's assessment of the importance to measure and report. The impact – the group pretty much agreed these are high impact issues in terms of the burden of violence, substance use, trauma, and suicide. There was just some disagreement I guess on terms of the amount of gap.

And just – And off since the measure has been in place, there has been improvement in the field from baseline of 79.2 percent moving up to an aggregate of 89.7 percent but there's still room to improve at a100 percent.

Regarding, the evidence, again, the group pretty much though that the evidence, the quantity was high and the (inaudible) moderate. There were just issues in terms of some of the studies provided really talk about the importance of these things, but they're might not have been a direct correlation between this specific measure and the amount of articles that were sited in the literature.

There – in terms of the scientific acceptability, the group agreed that it was a reliable and a valid measure in terms usability. Again, the group agreed it was usable and also feasible.

Male: Thank you, Lisa. The floor is now open for comments from the rest of the committee.

Any comments or questions? Or are we ready to move o – move straight to voting?

Lisa Shea: This is Lisa. I just had one comment and again, I think in the idea of not excluding any populations that the strength of the measure. One issue does come with the screening of substance use in children ages one through 12. And in terms of what – you know, in terms of how young can one reasonably screen toddler or something, for substance use, but that, you know, that being said, I think in the spirit of the overall measure, it make sense to not have exclusions that – I just wanted to say that.

Male: So with that, anybody else with comments or questions or are we ready to vote?

Male: Yes. This is a comment. Not so much related to voting but one thing in terms of as performance on this sort of goes up and continues to improve, I would hope that the Joint Commission would look at how am I develop measures that would look at more about how the screening affects the actions of – at a clinical level after the screening during the hospitalization. And then looks towards developing measures that look more closely at those issues.

Ann Watt: This is Ann from the Joint Commission and we appreciate that comment. And actually these measures sect matures, these are issues that we are discussing. So thanks, it's very timely.

Male: So one more time, anybody else would comments or questions?

I'm hearing none, maybe we can progress right to voting.

(Jessica): Please go ahead and vote on evidence.

And if you've not already voted, please go ahead.

(Angela): Looks like we only have 17 votes. So, if you're not sure if you voted, you can just go ahead and try again because only the most recent one show up on the screen. So…

Jeffrey Samet: This is Jeffrey Samet. I just make an observation. No one said it but this – I'm talking about the quality of the evidence. Someone tries to do many things at the same time and, you know, the committee guide into that, looking at lots of screens, and you know, it's very hard to do but it's all on together.

Peter Briss: Yes. This is Peter. I shared some of that (inaudible). It's less and the issue of the evidence and about the communication of the evidence. But I think that might be something that the Joint Commission could take back and think about as they review with another measure. I know the presentation made it hard actually, but I don't – the quality, quantity and consistency of the evidence.

(Angela): And Leslie, you're on the line. It looks like you have a question?

Operator, are you able to unmute Leslie Zun's line?

Operator: Your line is open.

Leslie Zun: Hello? Hello. Can anyone hear me? Yes.

(Angela): We can hear you, Leslie.

Leslie Zun: OK. I'm so sorry for the confusion on my part here. Actually, I had two questions about this. One is, I was looking for which tools were being required, whether they were validated tools or not. And two, whether screening actually provides – is there any evidence that says screening will improve care or reduce the incidents of this disorders we're looking into?

Male: And would the Joint Commission like to comment.

Celeste Milton: Yes. Thank you. This is Celeste at Joint Commission.

We don't specify specific type of tool to be used further screening since there are variety out there. And perhaps Dr. Ghinassi would like to make a comment as far as how the panel came to that conclusion.

Frank Ghinassi: Yes. Sure. I'm happy to help. Frank Ghinassi here at University of Pittsburgh Medical Center.

We had discussed at the initial development of this a number of years ago whether to specify a specific tool. And Celeste pointed out there or numerous once for each of this. Most – the focus was mostly on making sure that individuals documented clearly that they were screening for these four elements. They came out of the experience of that group and then from further looking at the data. And all the places felt this were important for treatment planning as Harold pointed out before.

But many places were performing very variably on this, especially around trauma and restraint. And I think that all recent events in the media over the past months have pointed to the fact that while many places have routinely screened for suicide, there has been a lot more variance around how people screen for violence toward others and indications around that.

So it was originally designed to make sure that those where a part of screening process. No specific tools were delineated, there is a need for that to be evidenced in the initial assessment documentation by the institution based on their policies and procedures. And that was how it was developed.

Male: And the second part about evidence that once they're screened doesn't actually do something.

Frank Ghinassi: No. We completely with that. And I think that as Harold pointed out before, that was a robust part of the initial discussion that it'd be linked to then specific measurements within treatment plans. I think that the wisdom around the table – again, this is a number of years ago, was – this was a first step in a build block toward what would be a more comprehensive linkage between initially screening, secondarily probably treatment planning progress which is more of a process measuring.

And then ultimately, the ability to look at how those treatment plan steering the inpatient impacted ultimate outcomes. So, you're right, it is a part, I think of a larger plan the Joint Commission has in placed to kind of grow this measure.

Harold Pincus: This is Harold. Just a common related to Jeff's earlier point that these measures a lot of stuff. When this is reported out to – does it look at each of the individual assessments or to hospital have an ability to look at the specifics or they judge as one single, (yes or no).

Celeste Milton: Hi. This is Celeste with Joint Commission.

The hospital will receive a report on how they did with each one of the cases that they've submitted. And if they don't pass that particular case, they have the ability to break it down to identify which one of the components that they didn't do the screen for.

So, a hospital can see if they're consistently not screening for psychological trauma history for example. Or one of the areas in the measure, then they know that that's where they need to focus their performance improvement efforts.

Harold Pincus: The public reporting would not get to that level.

Celeste Milton: No. The public reporting doesn't go to that level. It's either they pass the measure or they didn't pass the measure.

Harold Pincus: OK. Thanks.

Celeste Milton: The (aggregate).

Male: So, and – anybody else would want to enter a vote on the evidence?

Vanita Pindolia: This is Vanita. I'm sorry. I'm just trying to review the – actual the number that we're reviewing. And I had a question because I'm confused on under validity, and then looking at the need for this measure and what's been found. Could you please explain of how many or what is the percentage right now of patients doing or institutions implementing the screening.

Am I reading that correctly under 2C or 2B, where it's 90th percent held at a 100 percent and – I mean, it's average of 92 percent is completing this? Am I misinterpreting that data?

Because I'm trying to figure out is there something wrong right now where we're not getting a good performance of the measure already.

Male: Would the Joint Commission like to respond?

Vanita Pindolia: Specifically looking at 2B 5.3 results.

Female: OK.

Vanita Pindolia: I'm trying to understand if you could help me. What that does mean if somebody says in 90 percent, have 100 percent of the scores being measured and the mean is 92.1 percent?

Celeste Milton: .... Oh, I'm sorry are you – I'm unmuted. You know what? Our statistician had to step away for a moment but my understanding is that the mean for this is 92.1 percent and the 10th percent tile is at the 78.9 percent and the 90th or 100.

So there is a gap of 1.6, you know, between where we are now and the idea. I guess the one thing that I would point out to you is that because for the most part, hospitals reporting on this measure are self-selected that we feel that the performance in the population as a whole is not that high.

Vanita Pindolia : Based on what data?

Celeste Milton: These are our actual measure result that has been reported to the Joint Commission.

Vanita Pindolia: I'm just saying, if a measure is already achieving 92.1 percent mean and, you know, 50 percent of that are already percent held at 98 percent. I don't know what MCQA used as to retire a measure when it achieved a certain percentage, but to introduce a new measure that has already achieve such high, I'm trying understand is that – is this an important measure or do we do

– do we go to the next step, I think someone suggested instead of just testing if there correlation with then the outcome to go with that because it looks like the testing is happening 92 percent of the time.

Anne Watt: This is Ann with the Joint Commission and I would like to point out to you that these are – this is not test data, this is actual performance data. Although, this measure has not been NQS endorsed, it has been and used by the Joint Commission since 2008 and it's being publicly reported.

And what we feel is that, you know, we have seen a definite improvement overtime since we began implementation of this measure because of, you know, QI 101 that we all know and that is what is measured as manage. And we feel that there is still room for improvement in performance for this measure. ....

Male: I was just going to say it's just that when the organizations reporting on this measure, very self-selected, I suspect. And the data counts for the high performance. And I would assume that your hoping that there will be greater use of this measure picked up by organizations that might have greater opportunity for improvement.

Peter Briss: Yes. And I mean – this is Peter. Either workers did note that current average performance, it's really high and this measure as the Joint Commission has already said. There are (waggers) that aren't performing after that average and as the Joint Commission has also said that – this volunteer sample of (resetting) hospitals likely overestimate typical performance.

Are there any questions or comments before we continue with the voting.

Male: These measures include emergency rooms in it? Or only hospital admissions?

Celeste Milton: Celeste with Joint Commission. If they come in through the emergency room and they're hospitalized and the screen is performed in emergency room and becomes part of the permanent medical record, it would include. But they would have to be actually admitted to an inpatient psychiatric care setting in order to be included in the measure of populations.

(Jessica): So continuing on with the voting, the votes for one 1C evidence was 18 yes and one insufficient.

We'll now vote on performance gap. One high, it appears you're still voting.

Seven moderate, 13 low.

High priority?

(Angela): So this (Angela). It looks like we have 13 low which means this measure doesn't pass that 1B performance gap. Is there further discussion?

OK. We will move…

Jeffrey Samet: This is Jeffrey Samet. Just on that discussion part. Just on the face of it, I've – every time, I know, I saw that they hit 90 percentile on that. But I'd like I'm believing it, well considering all of things they have to achieve to get a check box here. It end up others were struck by that.

Mady Chalk : This is Mady, I am. ....

(Madeline): Yes. And – this is (Madeline) here. So one of my questions, well since this is optional for reporting to Joint Commission. Do we have any percentage of hospitals eligible to report who have reported – saying 90 percent of those who report.

Peter Briss: This is Peter – I would, I'd be careful about just looking at the average performance in the 90s, remember the 10th percentile was still on the 70s.

Female: Wow.

Female: Could it be because there's no specific tool and so that's why it might be easier of there's certain tool that are more simple to administer. I'm not aware, I'm not – obviously, that's not my expertise but just curious if that's why we're hitting so much 90th percentile, 75th, 50th even a .7 percentile?

Female: And Celeste, did you want to respond here?

Ann Watt: This is Anne. I was actually curious as to whether or not Dr. Ghinassi could respond to that because he has first hand, you know, knowledge and experience would these measures and has talked to a lot of people in the field.

Frank Ghinassi: I'm happy to. Frank Ghinassi here. Was the question whether or not, if they were more specific tools, it might demonstrate different variance levels ....

Jeffrey Samet: This is Jeffrey Samet. ...…

(Madeline): … we narrowed it down to just a few tools. And that way everybody had to use the same type if that was considered a higher caliber or something versus somebody might be administering a more simpler tool and doesn't have – same result and I'm not sure. So I'm just asking if that might be causing such a high percentile but everyone in the, you know, people who are familiar with the population feel that percentile doesn't really represent the true testing.

Frank Ghinassi: Well, I think there are a couple of variables. Number one, I think that it's always tricky when you ask an institution to select a specific tool especially when many tools exist. And so for, things like substance abuse, we have people on a call like maybe and they're a number of tools that can be used that people in placed, you know, hundreds of different electronic medical record systems, paper systems, systems are already in placed. And it sounds like a small thing to me in data single tool but it can be – it can offer it's own challenges. And again, remember this is developed seven, eight years ago.

Number two, some of the other measures, things like violence to others or violence to self, you'd have to search a little harder to find specific tools that measure that. They're seen as nationally acceptable kinds of tools. Same thing too for patient strength. And I also think the idea of trauma, there are again scales for that. But again, picking one among a pool that of many.

So I think that, you know, we've seen that places have in place measurement systems that they used that are part of their initial screening tool. This often include choices that they've built in. And, you know, our sense has been that people have seen movement on this. I do think you're saying a bit of secluded population as people pointed out for many, many places to across the country until CMS brought this on board.

This was a voluntary measure and when you think about the large number of psychiatric beds that lived within general medsurg hospitals. Many, many, many of those beds which constitute a very large proportion of psychiatric beds, have not elected to use this measure prior to the CMS mandate, primarily because they've satisfied their Joint Commission requirements using other core measures mostly in medsurg realm.

So I do think that as you see those opening up wider to a larger population, the variance on this is going to change dramatically. That's my suspicion.

Ann Watt: This is Ann with the Joint Commission. And as much as I hate to tell it – to admit, this actually – this measure is actually not part of the CMS measures that involve those hospitals who are collecting it are still volunteers only.

Jeffrey Samet: So this is Jeffrey, again. So just – sort of synthesize what was just said. That's OK. It's said, the 90 percent achievement really doesn't reflect with overalls going on and on psychiatric beds. It reflect a particular small subset that report and then do it well.

Ann Watt: Right.

Jeffrey Samet: So I'm not sure our gap scores which were just done saying there isn't a gap, reflect that reality…

(Crosstalk)

Male: That raises the question of – then there is one – doesn't think it's low, does that then move you to insufficient evidence?

Male: Exactly. Exactly.

Female: Right.

Male: I mean, if we don't have the data because you got a self-elected variable (inaudible) for an organization.

Female: Right… You only have data on the people who are voluntarily doing this. You have now data on what would happen if it was a much different population of hospitals.

Peter Briss: And even – this is Peter. And even in – even among these highly self-selected samples, again the (laggards) are still performing in less than 80 percent.

Female: Right.

Karen Pace: This is Karen Pace. I guess one question to the developer and to the steering committee if you're aware of data from the literature that would speak to these different elements. I'm sure there's probably nothing that has it all together, but perhaps on the specific elements.

And then the other thing, I think which you all have been pointing is when you make your decision on this is, is to consider the representativeness of the sample in which the data are being provided.

So if you think that's not a representative sample based on your experience and perhaps other evidence, you know, we could have you revote on this. So, I'll stop there and see if anyone wants to address either of those.

Male: Would the Joint Commission like to comment about the availability of data from other sources?

Ann Watt: This is Ann. And these are the data that are reported to us. We included in the discussion of the literature, the gaps that have been identified – I don't know, Frank if you have additional comments.

Frank Ghinassi: Well, the only thing that might be helpful to the group right now, you know, I think that while this is – in some way to self-selected group. It might be helpful. I don't know if we have this at the ready, but the data that's currently been reported over the past several years.

Can you give folks on the call a sense of how many institution that is. And roughly what the number count is of that. I think they're maybe some thought here perhaps based on what I said or what other's are thinking that this, you

know, it's a very small group of maybe a 100 or so, or 200 or so hospitals and that maybe incorrect.

Roughly, how many folks are currently? Do you know what off hand are reporting? How many institutions are reporting to you on these measures?

Female: We believe that there's about 400 in the vicinity of 400 measures reporting to us now.

Male: Hospitals?

Females: Hospitals.

Frank Ghinassi: 400 hospital systems reporting?

Female: Correct, sorry.

Peter Briss: So this is Peter. This has been – it's been a long discussion about this point. And, yes, I think if I understands the rules correctly and staff should correct me if I say this wrong. But if we decide that the performance gap is low, then the measure won't pass on this criteria and the measure won't pass. And so, slide – yes, I sort of like us to consider revote this one and make sure that we're ....

I'm sorry, if you're – you may want to mute your phone but I'd like if – we try to revote this measure. It's criterion rather and makes sure that we're all in agreement and such. ....

Female: (Sean), could you address that line?

Operator: We are having it pulled now. Thank you.

Female: Go on, Peter.

Peter Briss: So – if the measure doesn't pass on this criteria and they won't pass on an important kind of and it won't pass, so – so, if we just had a long discussion.

Let's revote this criterion please. And make sure that everybody still – is where they were 10 minutes ago.

(Jessica): And we'll just need a moment to cue up the voting.

So, you can go ahead and vote now. High, moderate, low, or insufficient.

We have 10 moderate, four low, and one insufficient – five insufficient.

We'll continue voting on this measure.

You can have it on high priority. Eight high, 11 moderate.

So it appears that we're counting someone twice. So we are going to redo this if you'll just give us a moment to clear out the vote.

Male: No voting early off.

(Jessica): So you can go ahead and vote now for high priority.

And we have three high, 16 moderate

And we'll announce it on the liability. And we have 11 moderate, seven low.

Well, now vote on the validity of the measure. And we have one high, 12 moderate, six low.

Usability. And we have three high, 16 moderate.

Feasibility. And we have two high, 13 moderate, four low.

Overall suitability for endorsement.

And we have 15 yes, four no. 1922 has been recommended for the steering committee, recommended by the steering committee for endorsement.

Peter Briss: Thank you. And so, at this point, I have (inaudible) at the new (narrow) when we were scheduled to break. We're one measure behind but I'm hopeful that the hospital inpatient measure, the remainder of the set of the hospital

impatient measure will go faster this afternoon as we, yes, we get to into our rhythm and a set of measures. I think I would suggest that we go ahead and break for public comment and break for the new (narrow) as we have previously scheduled unless staff or committee members would do with objective and then we'll try to make up the time this afternoon.

Lauralei Dorian: Peter, that sounds good to us. We'll have the lines open to see if anybody is on the call who would like to make a public comment. OK, hearing nobody. We will adjourn for a lunch hour now.

And I would ask that you please keep your Webinar running as possible rather than exiting out and than logging back in. I think that will just make the process a little bit easier and faster. And we will reconvene at 1:00 and continue with the rest of the H this week. Thanks.

Peter Briss: Thanks everybody.

Lauralei Dorian: Thank you.

Male: Thank you.

Lauralei Dorian: Enjoy your lunch.

Lauralei Dorian: Good afternoon everybody. It's Lauralei here from NQF and the rest of the team and we hope that you had a good lunch although it's pretty short. But we are ready to begin reviewing the Joint Commission's second H book measure. So, and I also wanted to note that I think I'm pretty certain that the voting issue about being able to vote more than one time has been fixed so that's good.

So with that, I think I'll turn it over to Harold or sorry, to Peter and to Bernadette who's to lead discussion.

Peter Briss: So welcome back everybody. So we're one measure behind. We've got about an hour and 40 minutes to finish six more measures in this week. So, I'd like to encourage just to try to be efficient in our comments. And so we're back now to the hospital-based inpatient psychiatric measures, the physical restraint

use, this is number 640. So would the Joint Commission like to make any further comments to kick us off?

Lauralei Dorian: Do we have any representatives from the Joint Commission on the call. OK. Well, why don't we get started and I'll send them an e-mail to make sure they're – they'll be on in the next couple of minutes.

Peter Briss: OK. And Bernadette, would you like to walk us through the measure, please?

Lauralei Dorian: Oh, I wonder if we haven't been pushed over.

Operator: Yes, you're in the main conference, ma'am.

Lauralei Dorian: Yes. OK, Bernadette, are you there on the call?

Operator: Your line is open, Bernadette.

Lauralei Dorian: Maybe she is not back from lunch yet. I'm wondering…

Harold Pincus: I think -– can we hear other people too just to make sure?

Lauralei Dorian: You know.

Male: Yes. Is anybody else out there? Hello is anybody there?

Harold Pincus: Yes, I'm not sure we're connected.

Lauralei Dorian: Yes. Operator, are you able to look into that?

Operator: Yes. Everyone's line is open. You're in the main conference with your other participants.

Harold Pincus: How come we can't hear, they don't respond when we say anybody there?

Peter Briss: Hello is anybody there?

(Crosstalk)

Female: I'm here.

Male: Yes, I'm here.

Male: I'm here

Female: I'm here.

Female: I'm here.

Male: I'm here.

(Crosstalk)

Peter Briss: That makes me feel a lot better. So has anybody from the Joint Commission joined?

Celeste Milton: Well, actually yes. Can you hear us now?

Lauralei Dorian: Yes.

Celeste Milton: All right, yehey. We've been here all along.

Lauralei Dorian: Oh, good.

Peter Briss: Just makes me feel so much better. So, has the full committee heard my preamble already?

Female: Yes.

Harold Pincus: Yes.

Peter Briss: OK. So Joint Commission would you like to take the next measure, please.

Female: Is Bernadette there also? Bernadette?

Lauralei Dorian: Let me propose to the Joint Commission to see if you wouldn't mind because each but three and two in my understanding are quite similar. One is about seclusion use and one is restraint use. Maybe we can do the seclusion use first if Lisa is on this call?

Lisa Shea: I'm on the call.

(Crosstalk)

Bernadette Melynk: This is Bernadette. I'm back on the call.

Lauralei Dorian: Oh, OK.

Peter Briss: Good.

Lauralei Dorian: Never mind then.

Peter Briss: So let's review them with the restraint use measure. So Joint Commission, would you like to kick us off?

Celeste Milton: OK. Yes, this is Celeste of Joint Commission, hopefully you can hear us now. I'm going to just talk a little bit about (HBIPS-2). This is the second measure in the series of seven measures in the hospital-based inpatient psychiatric services week.

And what this is looking at is the total amount of time that any patient spent in physical restraint and is the ratio measure. And it's going to be divided by all of the inpatient days for all patients that were on the census for the reporting period. And the rate then is multiplied by a thousand and is expressed as a rate per thousand hours of patient care.

Ann Watt: Do you want us – Peter, this is Ann. Do you want us to talk about (HBIPS-3) too just in terms of it also is a ratio measure but it looks not at restraints but at seclusion. And these are – these two measures are so very similar.

Peter Briss: So Ann, what's – in order – they are similar but what – I think it's easier to manage the discussion if we really take them one at a time. So let's stick to the restraint measure for the moment.

Ann Watt: OK, good enough.

Peter Briss: So, Bernadette can you walk us through?

Bernadette Melynk: Sure, I can. Our workgroup agreed that restraint is related to major adverse outcomes to both patients as well as staff. We had one member (inaudible) the evidence was not quite sufficient in the terms it was presented. But the majority of workgroup members really felt that the evidence did support the benefits of decreasing and measuring restraint use. Performance staff is good. According to the literature, there really is a gap that is just in that particular area. In terms of scientific acceptability, this measure has good reliability, face validity has been established. It has good usability, the feasibility is high. And our workgroup are preliminary so five of us voted yes in terms of endorsement and none no.

Peter Briss: Thank you, Bernadette. So with that, I'll open it up to committee discussion ....

(Audio Gap)

Peter Briss: So hearing none…

Leslie Zun: This is Les. I have a couple of questions if this is a good time.

Peter Briss: Please go ahead. Please go ahead.

Leslie Zun: So a couple of questions I have about the – some of the importance to measure and report, restraint is related to major adverse outcomes and harms of restraint are well documented. I'm wondering if they – the Joint Commission has the literature for that because since CMS and join commission put in all the requirements years ago, I have not seen any study, a current study about adverse events and harm caused major adverse outcomes and I have not seen any studies about that. So, can the Joint Commission provide a little bit more input?

Celeste Milton: Hi, this is Celeste of Joint Commission. We do know that we have reports of either death or permanent loss of function in the Joint Commission's Sentinel Event Database and that is as recent as 2012 so we do know that there are still adverse outcomes out there. We basically did a complete review of the literature and we do know that SAMHSA put something out in 2011 that took a look at how hospitals can reduce their restraint and seclusion use by putting

in prevention or into the alternative, and that's really what the aim of this measure is to reduce the use by doing behavioral intervention. And it can result in significant savings in cost, you know, reduced injuries to staff and staff turnover related to any injuries that might occur as result of a patient being physically violent.

Leslie Zun: But what you're saying is different than what's in the measure. You're saying that there are other things that they can do but that's not what's being measured here. It's just total amount of time.

Ann Watt: This is Ann. The point behind the measure is to enable hospitals to understand the prevalence of their restraint use so that if it is higher than they would wish or higher than in the peer group for example or something, they can investigate the feasibility of introducing additional interventions for alternative intervention.

(Audio Gap)

Leslie Zun: Thank you.

Peter Briss: So, it sounds like somebody may be typing in the background, you may want to mute.

Leslie Zun: This is Les again. And the numerator is going to be self reported, how is that data going to be obtained?

Celeste Milton: Hi, Celeste again at Joint Commission. All of our hospitals have what we call a data collection tool that's provided to them so that they can manually extract the records to get this information. It's been a long term standard for Join Commission to be tracking your physical restraint use, so this is something that hospitals are acutely aware of. And typically have been keeping track of that information and many of them monitor in real time as the physical restraint event begins and ends so that they can track it concurrently during the reporting period.

Peter Briss: Anything else from your end, Les?

Leslie Zun: No, thank you so much.

Peter Briss: And would anybody else like to make a question or comment before we move to voting? So hearing none, can we move to voting please?

Female: Let's go ahead and vote on evidence.

(Audio Gap)

Female: And if you've not voted yet, please go ahead and vote now.

(Audio Gap)

Female: Fifteen yes, two insufficient.

Lisa Shea: Excuse me, this is Lisa. I'm not seeing the voting on my screen anymore. Did – happen?

Female: This is a representative from ...…

(Shawn): I've got it. Thank you. Lisa, let's have you go ahead and refresh your screen just in case you had a problem during the break. So let's go ahead and have you refresh by pressing the F5 on your keyboard. Have you seen any of the slides move up to this point?

Lisa Shea: It's stuck or something.

Female: (Shawn), if we could have you do that offline…

(Shawn): Sure.

Female: …I think we'll continue voting on the measure.

(Shawn): Let's have Lisa's line please.

Lauralei Dorian: And then Lisa if you could maybe text your – not text. Use the text box function to let us know what your vote is, that would be great.

Female: OK. So let's go ahead and vote on performance gap.

And we have one high, 14 moderate, one low, 15 moderate. And just to confirm, are there any steering committee members that can't see the voting the way it appeared this morning? All right. Great.

And it looks like we have several more votes so the vote for performance gap is one high, 17 moderate, one low. High priority: seven high, 12 moderate. We'll continue on to reliability. One high, 18 moderate. In validity. Seven – we have 16 moderate, three low, one insufficient. Usability. And we have five high, 14 moderate. Feasibility. 15 high, four moderate. Overall suitability for endorsement. And we have 18 yes, zero no so measure 640 was recommended for endorsement by the steering committee. We'll move on to measure 614 (HBIPS-3).

Male: No, no, no. Take them off.

Peter Briss: So in 641, Joint Commission, any comment about our seclusion use?

Celeste Milton: Hi, Celeste of the Joint Commission again. Really, this is very similar to the measure that you've just evaluated acceptance of looking at physical restraint use. We're looking at seclusion, the time that patients spent in seclusion.

Harold Pincus: And this is Harold, just one question, it's not so much. Just curious as to when you went to and developed this measure earlier on. The choice of doing it as the amount of time rather than instances of and what went into the thinking about that.

Celeste Milton: Hi, it's Celeste again at Joint Commission. Dr. (Kanazi), are you on the line? Could you comment on what the technical advisory panel's thoughts were (inaudible) that we've developed it?

(Frank Kanazi): Yes, Celeste. I am again (Frank Kanazi). You know, this was an issue of considerable debate. And we went back and forth probably half a dozen times about this. And I think in the end people were concerned more about finding one variable that was going to cover major variance differences. There were some proponents who were looking more at incidents of restraint. But some of the people who were concerned about that were folks who worked a lot

with children and who had kids under the age of, you know, let's say 10 or 11 where kids might be held manually for as little as maybe 30 to 60 seconds and that would be counted as restraint. And the numbers would come up fairly quickly for certain populations and people had concerns about that. There were concerns the other way.

I think at the end of the day, total amount of time was chosen as a variable. People felt that at least that was going to give them a sense of the total number of hours per thousand patient hours which they felt might be more useful in the long run. But I can certainly hear and see arguments in that direction now.

Harold Pincus: And I just wondered because I could also see your arguments both ways that, you know, more from the – I think for the restraint issue, it makes more sense in terms of hours seclusion is, yes, in some ways the instances – these instances that, you know, requires health procedure in itself but maybe more reliable kind of measure. But it's, you know, it's not a huge difference. I'm just curious in sort of the thinking.

(Frank Kanazi): You know, I agree. People did have feelings both ways.

Harold Pincus: All right. OK.

Peter Briss: So with that, I think Lisa was our lead discussion on this one.

Lisa Shea: Yes. And again the discussion I think is fairly similar to the one that we just reviewed with the subgroups. So in terms of the importance to measure, in terms of impact and gap, there was consensus among the subgroups that this was impactful and that there was a gap.

Regarding the evidence, three of the subgroup members felt that the evidence was there in terms of the quantity and quality and consistency but there were two that felt that the evidence wasn't necessarily there just in terms of relied on a more expert opinion. And also, it is – the fact is though that random controlled trials couldn't be conducted because of the ethical nature of it. So there was a divide in the group on that point, 1C.

The rest of the measure in terms of the reliability and validity of the group, there was consensus that it was scientifically acceptable. There was consensus in terms of it's usability and feasibility. And the committee did preliminary rated five to zero in terms of suitability for endorsement.

Peter Briss: So with that, the floor can be open for comments or questions.

(Audio Gap)

So perhaps hearing none. We can move to…

Harold Pincus: What's been the experience so far? Have people identified any issues or problems coming up or successes as a result of it's implementation thus far?

Peter Briss: Would the Joint Commission like to answer that one?

Ann Watt: This is Ann, and I'm not sure that we know particularly about the successes. I, you know, I open it to Dr. (Kanazi) who again, you know, in more on the implementation side if you're (inaudible) with anything, Frank.

(Frank Kanazi): Well, I think, you know, again from the implementation, from the provider side it's given places like our shop and shops that we've – who were in organizations with opportunities to discuss numbers apples-to-apples. And certainly, that's happened a lot over the course of the time this had been out there and every time we go to national meetings, these are some of the things that we talk about. Also, when we notice blips I'll be transparent about this. We have certain blips for example in our institution in numbers around seclusion. And a lot of that relates to the balance between how we approach behavioral programming in an attempt to do everything that we can to avoid anything in the way of hands on seclusion. I'm sorry hands on restraint.

And looking at the balance between those two has been – it's been very useful for us to have both of those numbers and to be able to compare those apples-to-apples with places in, you know, in Baltimore and in Washington and in New York and in Boston and other places. So it's been a very handy tool for us and those people I've spoken with. We've just never had these kinds of apple-to-apples comparisons before. So it's helped us to spark changes and

also, you know, ask questions internally about what the individual rates are but also the balances between the two and how strategies might affect that balance between seclusion and restraint.

Peter Briss: Additional questions or comment?

Female: It sounds like we're ready to move into voting.

Peter Briss: Yes.

Female: So let's go ahead and vote on 1C evidence.

And if you haven't voted yet, please go ahead and cast your vote now.

We have 16 yes, two no, one insufficient. Thanks.

And we can go ahead and vote on performance gap.

And we have 19 moderate, high priority.

...

Male: I'm on a conference call, that's OK. Do you need anything?

Peter Briss: If you're able to – if you're able to keep your phone muted when you're not trying to talk, that would help, I think.

Female: And we have six high, 13 – 14 moderate.

We move on to reliability.

(Audio Gap)

Female: We have 19 moderate, one low. Validity.

(Off-Mike)

(Audio Gap)

We have 18 moderate, two low. Usability.

And if you haven't voted yet, please go ahead and vote now.

We have four high, 15 moderate. Feasibility.

And even if you haven't voted, please go ahead and vote now.

Seven high, twelve moderate. Overall suitability for endorsement.

And if you haven't voted, please go ahead and vote now. Nineteen yes. Measure 641 was recommended for endorsement by the steering committee. 20 yes. And we'll move on to measure 552, HBIPS-4.

Peter Briss: So, and so would Celeste or Ann like to kick us off again?

Celeste Milton: Hi, yes. This is Celeste again at Joint Commission. HBIPS-4 is looking at patients that are discharged on multiple antipsychotics – prescribed multiple antipsychotics at the time of discharge and this is to give us an idea of the prevalence of the practice. That's actually appeared with the HBIPS-5 which is going to – you would do both of those when you're looking at hospitals rate for measure four. You would then look at measure five to see if there was an appropriate justification for the practice.

When we originally tested these measures, we felt that it was important to be able to get a handle on exactly what the prevalence of this practice was so our technical advisory panel suggested that this would be one measure and that we would have a peered measure with it to take a look then at appropriate justification. So, you would always look at both of these together. You'd never look at one rate on one measure without including the other measure.

Peter Briss: And I think Les is the discussion on this one.

Leslie Zun: Yes and our group discussed this and there was a couple of questions about if there was a need to have more – more than two or more antipsychotics and how would that be then explained in a data and there was some question about that as well. So, there was – they thought – the group thought that the importance to measuring report was there. The evidence was there. We weren't sure about the issue about that how could someone explain that

problem if they needed to be on more than one. It was thought to be usable and feasible to do. Any other comments from the group?

Harold Pincus: This is Harold. I wasn't on the workgroup but I – I've, you know, when this first came up, I had a sort of an issue and a problem with this in that it's not clear to me why you need to have this as a separate measure. and not have it just, you know, the basis for the denominator in the paired measure because the problem is that most – as a measure of quality for a hospital, I think it's inadequate because given the short timeframe of hospitalization nowadays, the reasons why people are on multiple antipsychotics is that they came in on multiple antipsychotics. And if the hospital is attempting to reduce the prevalence among the people coming in of multiple antipsychotics, it's not going to happen during the hospital stay. It will happen post-hospital and it will be captured under the HBIPS-5 that they've actually either have it justified or they have a plan for titrating and they've communicated that to the next level of care. Whereas if this measure by itself and being separately reported, it's largely a function of the kind of referral base of complexity that hospitals are likely to get.

Female: Yes.

Male: I agree…

...

Harold Pincus: …rather than the actual measure of their quality of care. So I like HBIPS-5 but I have a problem with HBIPS-4 being reported as a separate thing rather than just a denominator of HBIPS-5.

(Crosstalk)

Leslie Zun: I was just going to say and in fact I think you'll select out people who are more likely to be on more than one antipsychotic and those are the people who get hospitalized and they're in and out quickly and you don't have time to manage this issue in the hospital.

Peter Briss: This is Peter. For the record, the same issues struck me. I'm not completely convinced about the new sort of measure given that you have number five.

Mady Chalk: This is Mady. I have the same comment and question about the need for four.

David: Hi, this is David. I just couldn't find anywhere in the report that there was gap of priority on information. I mean other than that multiple drugs is not good. How big is this problem? That said, I agree that I think it burdens urban and certain racial/ethnic populations.

Ann Watt: This is Ann from the Joint Commission, if I might make a few comments?

Peter Briss: This is Peter, please do.

Ann Watt: Thank you. You know, when we initially tested this measure, these measures, actually, it was one measure. And part of the feedback that we received from our pilot test sites was that first of all, they wanted to know the prevalence of the problem of multi anti – multiple antipsychotics and which is one of the chief reasons why we broke them into two measures. And then secondly, there are a lot of things, data elements in that combined measure and they felt that it was very complex to collect the data when it was a combined measure.

We understand that hospitals want to know the prevalence but we also understand that the juice and the squeeze here is the number that are not appropriately – don't appropriately have multiple antipsychotics and that is what five tells us. And for your information, we would never expect to see the rates for HBIPS-4 reported independently of HBIPS-5. And in fact, when we publicly report, we report only the proportion of patient who has inappropriate use.

Harold Pincus: I guess that – but once it's endorsed, it can be used by groups to be reported together. And I guess as a separate independent measure. It's not something that hospitals can necessarily control. So…

Ann Watt: Absolutely true and…

Harold Pincus: So it worries me that it, you know, it (inaudible) fled out to the world. They can and often might be reported publicly. And I guess I don't really understand the argument about it being more complicated. I mean to compute HBIPS-5 you have to do HBIPs-4. So it's going to happen anyway.

Ann Watt: This is Ann and you are absolutely right and I just think, you know, having abstracted a lot of these medical records, I think that what the pilot sites were telling us is that they want to look at more finite group of data elements and hence that because the data collection tool becomes very busy and that kind of a thing.

Male: And this is…

Harold Pincus: …never going to report these separately, why have two measures?

Ann Watt: Yes.

Harold Pincus: It doesn't make sense to me at all.

Ann Watt: Well…

...

Peter Briss: Ann, this is Peter. Can you help us with – Ann, can you help us with the rationale that your hospital gave you for initially wanting the two measures that they were trying to get a (inaudible). I guess you could use HBIPS-4 as a sort of an acuity measure. You could – you might find that your hospital, you know, if your prevalence of this was 20 percent among people coming in, it might be quite different from hospitals that had a prevalence of 2 percent or something like that. So it is that they're trying to get a sense of how they stack up on degree of difficulty with other hospitals or what's the rationale that made people tell you that they wanted to have this?

Ann Watt: All right. This is Ann and I think that basically, they just wanted to know where they stood, you know, in the continuum and as it's reported out of the separate measure, you know, they get comparative data, you know, comparing their practice with other hospitals practices. The other thing that I like to

point out is that there apparently is some usefulness to this measure in and of itself because the rates have improved in that they have gone down since we have implemented it. So it looks like people are really taking a look at their practices.

Lisa Shea: Yes, this is Lisa. I guess I wanted to say, echo that just being a provider in a psychiatric hospital that in fact, even though there are the challenges that Dr. Pincus mentioned about being able to get people off. The fact that if you do a good job and try to streamline that, you get the – you can get credit in that in HBIPS-4 where the better you get in four. Then sometimes if you were just reporting five and you weren't looking in context, you could look not very good for a very number of patients. So I think it really helps you understand the scope of the issue at your facility.

Leslie Zun: This is Les Zun and I had a question. The Joint Commission was saying that it is a measure of appropriateness of use and I'm trying to understand how we got there. Who – how are we deciding what's appropriate and what's not appropriate? How are we deciding which patients meet it and which don't? But I'm not sure it's truly a measure of appropriateness of use.

Celeste Milton: Hi, Celeste of Joint Commission. Actually, the peer – there were peered sets. So the second measure is looking at appropriate justification. So once again, you determine which patients are on more than – for more routinely scheduled antipsychotics at discharge and then in the second measure, then you're evaluating why they're on that. And that's where we're looking at the appropriate use piece. But as Ann pointed out, we have noticed that just by monitoring the practice, we have seen improved ....

Harold Pincus: So you don't know that – if it's totally related to that?

(Crosstalk)

Harold Pincus: I guess my concern is that it's not actually a quality measure. It's something useful and I would hope that those hospitals would try to figure that out and look at this as – but there are many different sort of utilization and descriptive kinds of variables that hospitals might look at. But this by itself, by calling it

a quality measure, having it being endorsed by NQF, we're giving it stat status as a measure of quality.

Mady Chalk: Right.

Harold Pincus: And I don't think it is.

Mady Chalk: And this is Mady, nor do I. I don't think somebody being on multiple antipsychotics by itself is a quality measure.

Harold Pincus: And I think ....

Mady Chalk: …prevalence of that in your own hospital, you should just go find out.

Peter Briss: So it sounds like there are some of the committee has some skepticism about the utility of this measure as a standalone measure. It sounds like there are others who are, you know, are more in favor of HBIPS-4. So are there additional comments at this point that hasn't already been made?

Jeffrey Samet: This is Jeffrey Samet. Can we get maybe a summary of, I mean I think the last session has been kind of persuasive, the summary of the group that reviewed it and gave it pretty high endorsement. Can we get to hear a brief summation of that perspective again?

Leslie Zun: This is Les and I'm not sure that I'm understanding. You're saying that we as a group had a high recommendation for it. I think that kind of – there's kind of two issues in here. I think that the value in this discussion has kind of clarified some of the reservation that was expressed by the group at that time, kind of clarified where the Joint Commission was coming from. I think we were just looking at an – the issue of the, you know, high level. Does giving multiple antipsychotics and reducing the number of antipsychotics given to patients, is that a quality issue? And I think the workgroup had some questions about using this as a standalone measure but thought there was some value in it.

Peter Briss: So anymore questions or comments on this particular point? And if not, are there additional comments on the – questions or comments on the measure and more broadly that haven't already been made?

(Frank Kanazi): (Frank Kanazi) here. Am I able to comment at this point?

Peter Briss: Yes, please.

(Frank Kanazi): Just – I can just reflect on our use of it and I certainly understand and hear all the points have been made and understand some of the concerns. I mean, our experience with this phenomenon in general has been that while – and we're a tertiary facility and so receive a lot of people coming in on multiple meds. You know, our sense of it has been that it has been important for us to both capture the raw number of people who are coming in on multiple meds and the people for whom within our own institution, the 60 or 70 practicing psychiatrists showed fairly wide variability about their own choices about starting people on multiple meds even once they're here.

And I do understand how the states have become briefer and for many of the folks who are severe and chronic. Those days can be, you know, 20 days and sometimes 10 days, five days and fewer. That said, our ability to be able to look at both of those numbers are standing numbers of people coming in and existing on those meds. And then, the ones that we offer acceptable rationales for heading on to – those two measures together had helped us change dramatically even at place like ours.

We started back when this began. We started with numbers that were up in the high teens or 20s and we've always had people coming in on multiple meds and those numbers now hover. When they leave the institution, with the raw numbers hovered down around 12, 13. So they've dropped fairly dramatically even within in-house practice and I think a lot of that's been because people are aware that these are now things that the whole institution is looking at and the different methods that have become possible within the hospital.

I also think that again and I'll end with this, just simply that I think this has a major, major impact on decisions that get made between levels of care and the

consciousness about what's happening on one level of care gets communicated either physician to physician or a social worker to receiving sites about wanting to continue tapers that have began. And I understand how that can only happen, I mean might only be able to happen by looking at the second number but I do believe that having those with those numbers nationally comparable so the places can call and speak to each other about baseline rates and acceptable variation rates with exceptions. It gives people two tools to move this process. And again, I'm just speaking now from, you know, having worked with this infield for five, six, seven years. I just wanted to add that.

Peter Briss: So thank you…

...

Caroline Carney-Doebbeling: Could I ask a quick question, a follow up of that please? Given your experience ....

Peter Briss: May I ask who is speaking at the first comment, the gentleman?

Caroline Carney-Doebbeling: This is Dr. Doebbeling.

Peter Briss: No, no. Who made the comment around the hospital?

(Frank Kanazi): I'm sorry. That was (Frank Kanazi). I'm at the University of Pittsburgh.

Peter Briss: Oh, thank you.

(Frank Kanazi): Oh, thank you very much.

Caroline Carney-Doebbeling: (Frank), this question arose in our small group when we evaluated the next measure that is related to this. But given your five to seven years of experience, what are – what is your impression about this measure in particular about keeping people off of multiple antipsychotics in the outpatient setting and how many then returned back to you on multiple antipsychotics?

(Frank Kanazi): You know, I wish could give you…

Caroline Carney-Doebbeling: I just want – what I get caught on is doing this documentation or putting a measure in place that would appear to make it be that fewer antipsychotics is better so we should try to get them off of antipsychotics while in the hospital. Does that really translate into any long-term better status for that individual?

(Frank Kanazi): I cannot speak to that on a national level. I wish I could. I can speak to it on a local level. We – because we're a large system, a fair number of people to whom we refer, we refer about half people, we send to ourselves. I realized that's fairly unique and a lot of places don't do that. We have seen impact on the people who are – passed along to the next level of care. Primarily because when they come out, we somehow – even if they're coming in on five and that's not uncommon. You folks know that people who often come in four or five, if you count sleep medications or low-dose of (inaudible) or whatever you want to reference. But even leaving on one or two fewer gets a ball rolling and I think the frustration that many of us felt was that for many, many years and I've been in the field for almost 30 now, for many years, people in inpatient always say we don't have enough time to do it, at least more recently in the last 10 or 15 years. And people on outpatient have always said, we don't want to try it because we'll destabilize them. And as a result, nobody did it. And I think that what this has done was it created a dialogue at least for us between inpatient and ambulatory. Look, we're going to start this work on inpatient, we're not going to finish it. It's impossible for us to do that but we're going to start it because we believe it's the right thing to do. Metabolic syndrome is killing people, 25 years younger than their peers if you believe the studies that have come out and we're going to start seeking the moral – sort of the moral imperative is, we're going to ask you to continue the work that we've started.

We've seen impact within our own system but I really wish I could speak to you about impact on that nationally. I would hope that the same is true. I guess I believe that people want to do the right thing and it's always been a matter of where's the kindling point, sort of where do you started and think you started in a setting where you're able to watch them carefully. You start doing the right thing and then you pass along that kind of moral imperative to the next level.

Male: (Frank), I think, it's great that you can able to utilize this information but I guess you don't need to have an NQF-endorsed quality measure in order to assess your own institution's level of discharge on multiple antipsychotics. I think that that's something that I would encourage us just to do, but calling it a quality measure, you know, giving it that name grant I think gives the wrong impression and it's something – you know, it's clearly information that you would want as part of your quality and proven enterprise so at your hospital. But as a basis for national comparison, I'm not sure that – and calling it a quality measure, at that sort of criteria.

Peter Briss: So this is – this is Peter. It sounds to me, it still sounds to me like we've – we sort of have done a pretty good job of airing this issue so there are pretty clearly differences of opinion among the committee about the utility of having HBIPS-4 sort of in addition to HBIPS-5 as something the one might publicly report as opposed to using for local quality improvement purposes. If staff want to – for the people that have concerns about four – sorry – should they vote against four or is this a measure reconciliation problem or something else? Are there any discussions or advices about how you might handle this methodologically?

Karen Pace: This is Karen Pace. So I think this has been some good discussion and I'll just summarize a couple of things. So, I think, you know, one of the things you have to think about is, you need to know it's good information from quality improvement as Harold said, is it a national quality performance measures where you can make conclusions about quality of care.

On the other hand, if it's useful and at least supposed to be used in the context of the other measure, one option is to say that they have to be paired, meaning that this measure could never be reported or I should say, should never be reported without the other measure. That's an option that they would specifically be denoted as a pair and always would have to go together.

If you are feeling that, you know, this measure is unnecessary, the question is at what point would you, you know, register that in your voting so the first item is about evidence so is it about the evidence, is it about – sounds like it's

either about evidence or validity in terms of does the evidence really support having this as a performance measure, simply the prevalence, or is it about the validity of this measure as indicator of quality. I think if you're feeling you'd want to vote against this measure that those would be the two potential criteria that you would register that with.

Female: How would you go about saying that they should be paired, where would you put that?

Karen Pace: Well, that's an option for the developer when they submit measures and the pairing or grouping is specifically for measures that should always be reported together, that they should not be a stand alone and so I guess we can ask if Joint Commission wants to make a statement about why they didn't put it through as a paired measure or what their feelings are about that.

Peter Briss: Or – this is Peter, would there be any problems from the – if the committee wanted to recommend reporting these as paired measures, would there be any problem from the Joint Commission's perspective at stipulating that?

Karen Pace: Right, it is something that the committee could stipulate so, but you want to see what the Joint Commission said first?

Peter Briss: Yes, please.

Ann Watt: This is Ann and we do consider these to be paired measures and I believe that we stated that in our submission form at the very beginning in the brief description.

Karen Pace: Yes, there's a specific way in the – so this is just maybe a technical glitch. There's a way in the submission form to pair them so that they are paired in the group and it will show up that way. So that was their intention then we can have the steering committee proceed with that in mind that you really do and we can fix that in the system so that they are paired, but again this – you know, the steering committee can still – even though they're paired, you know, you still will be looking at each measure individually and still have the option of being in favor or not in favor of this measure.

Male: I'm getting confused now. We're either going to look at them as a paired measure in which case we're voting on the vote where we going to consider each independently. At least a lot of my reservation is about using this measure independently.

...

Karen Pace: Go ahead.

Peter Briss: This is Peter. I'd like to suggest that based on the discussion that we probably should stipulate that if we improve both four and five that we'd like them to be treated as paired measure, there may still be people who finds four problematic enough that they want to vote against it even in the context of paired measure but maybe as we're voting, if we can stipulate that (inaudible) if we stipulate that we want to treat these as paired?

Karen Pace: Yes, I think based on what the Joint Commission said, I think you should do all your voting in the context that these are paired measures but you would still vote on each one individually because, you know, even if they're paired, they are supposed to meet our criteria so but I think it's important for you to do your voting in the context that these would be paired measures.

Male: OK, so we're just (inaudible) about procedure question? If one of those measures pass and the other one didn't, then what happens?

Karen Pace: Then just one that passes would be recommended for endorsement.

Ann Watt: This is Ann from the Joint Commission and I'm sorry to interrupt but actually, I have a technical question then. In the unlikely event that HBIPS-4 didn't pass, HBIPS-5 is not collectible as is currently specified. So does that mean that an endorsement vote of HBIPS-5 couldn't be made today?

Karen Pace: No, it – I don't – I don't understand why it would not be collectible. You would be getting the same data that you would be for number four.

Ann Watt: The numerator – it starts– the denominator of five starts with the numerator of four. They really are paired measure.

Karen Pace: Well, I think you would have to just re-specify the denominator to be the identification of the patients that are on two or more antipsychotics.

Ann Watt: OK, so that's my question then so that that's not done today. Would that render five on reviewable today?

Karen Pace: No, no.

Ann Watt: OK. Thank you.

Emma Hoo: This is Emma Hoo. I'd like to ask a question. If it's possible to also recommend that the measures be recombined, would that be a consideration?

Karen Pace: Well, actually I think the point's been made that measure five is actually using the data that are – that are in both of these measures so I don't think you need to make that a specific recommendations. It's – I think what you're looking at is having two separate measures that would be paired versus measure number five. I bet someone else has the different thought about combining.

Peter Briss: No, I think that that's what's – what's currently being discussed. So, if we frame the question like that, let's vote on four. There (inaudible) only be a vote on five. Let's stipulate that – assuming that they both – if they both get endorsed that we would stipulate that they get recorded as a pair. And I think with that, does anybody else need additional question or (inaudible) before we vote on for?

Female: OK, let's go ahead and vote on evidence.

(Audio Gap)

Female: We have five yes and no, 16. So this measure is not recommended for endorsement.

We'll move on to HBIPS-5.

(Audio Gap)

Female: So HBIPS-5, I believe (inaudible) was Caroline and if the Joint Commission would like to introduce the measure.

Celeste Milton: Hi, yes, this is Celeste Milton at Joint Commission and as we have indicated this was the other measure to be paired with HBIPS-4. And what this looks at are patients then that are on at least two or more routine schedules antipsychotics at the time of discharge have appropriate justification and they found the evidence. There are three appropriate justifications looking at previous failed trials of monotherapy that across (inaudible) has either been initiated or recommended or that clozapine is being augmented with another antipsychotic agent.

Peter Briss: And with that, Caroline, would you like to walk us through the workgroup's discussion, please?

Caroline Carney-Doebbeling: Absolutely. The workgroup met and discussed this measure and had similar questions and concerns raised related to the discussion that we just had. However, during the evaluation of this measure and our preliminary finding for the impact of the measure, the group was somewhat split with two believing this was a high impact measure and three moderate. Similar issues were found for the evidence based on the quantity and quality of support for this measure moving forward.

The scientific validity and reliability also were split by the group with reliability found high by three, moderate by three and the validity, high by three and moderate by two. Some of the concerns that brought – were brought up in this measure had to do with the original testing being done back in 2007 and only one followup data element assessed in 2011 based on the agreement rate and only face validity being conducted for the measure.

The hospitals that completed this actually were split also and their belief about the measure was seven stating that it was very good, 17 good but 12 of the 36 assessed relayed that this measure was average or lower for them.

The usability of the measure was felt to be good for the most part. The Joint Commission said that endorsement would allow public recording of this in their quality check and these were adopted by CMS in the final rule for

inpatient psychiatric hospital quality reporting for fiscal year 2014 payment determination.

It is a publically reported measure that CMS has adopted. And so, if it is endorsed the financial stakes for hospitals related to this measure may be high. With regard to feasibility, our group was also mixed half and half between half thinking it was highly feasible to use and three, believing it was moderately feasible to use. While the measure is standarized, all of the elements that are required for these are cumbersome in recording and require a significant amount of clinician time in doing the reporting.

The workgroup agreed that the measure would have a high impact in prescribing more than one psychotropic medication. And noted that variation is noted in the performance of the hospital to date has been reporting this. However, the long term outcome of reporting this and the communication of this information to the outside setting, especially in non-university based settings where integrated care may be more likely to occur is a question.

Peter Briss: So thank you, Caroline.

Caroline Carney-Doebbeling: Thank you.

Peter Briss: So with that the floor is open for questions or comment.

Harold Pincus: This is Harold. I actually think this is a very useful measure. Essentially, it's a – it's kind of a medication reconciliation measure that looks in a reasonable way at A, whether it was – whether the use of multiple antipsychotics is clinically justified and in any case that justification or explanation is conveyed to the next level of care.

It seems to that's a critical issue because the most common kind of rationale is that either that there is some evidence of some problem relapse previously when taken off this medication or that there is an intention to titrate and getting that information out to the next level of care is the key issue. So I, you know, I'm strongly in favor of this.

Caroline Carney-Doebbeling: And I just want to be clear. I think our group was in favor of if were the same reasons. However, there wasn't evidence that creating a care plan, a discharge care plan in and of itself was proof that any of that information was actually conveyed to the next level of care. That actual piece is not part of the measure, just the creation of the care plan.

Harold Pincus: Oh, really? I thought that it was a – and I thought what initially…

Caroline Carney-Doebbeling: Those are next level of care recommendations.

Harold Pincus: And so, an expectation that is conveyed to the next level of care?

Caroline Carney-Doebbeling: The expectation is that it is but that's not a requirement in the way that I understood the measure. If others on our committee would like to weigh in, that would be helpful.

Harold Pincus: Perhaps, the Joint Commission can explain is it a requirement or isn't it.

Female: Hi.

David: Hi, this is David. So with the question that whether the 557 measure is linked to 560, are they linked or are you asking this is a separate element in this measure?

Caroline Carney-Doebbeling: 560 in and of itself is the measure under review. And that's what I'm saying doesn't have a specific…

Celeste Milton: Hi, it's Celeste Milton at the Joint Commission.

Caroline Carney-Doebbeling: A justification is there, but the measure itself does not require that justification to be linked.

Peter Briss: This is Peter. Let's talk to the Joint Commission comment please.

Celeste Milton: Hi, Celeste at Joint Commission and for the data element appropriate justification for multiple antipsychotics, there is a requirement that the tapering plan be documented in the continuing care plan to the next level of care provider. That's specified in the data element.

Harold Pincus: So does that mean that it is in fact conveyed to the next level of care?

Caroline Carney-Doebbeling: That's a next measure. As I'm understanding 0560 itself, HBIPS-5 which is that five requires the documentation but it's a later measure that requires the transmission.

Harold Pincus: Well, and the Joint Commission say what was in fact is the case.

Ann Watt: Yes, this is Ann and we're trying to bring up the actual data element definition. But just to clarify, for this measure it's a requirements for the measure that the tapering plan or the justification be included in the…

Harold Pincus: Continuing care plan.

Ann Watt: Thank you. Continuing care plan and then the existence of the continuing care plan is the subject of the next measure.

Harold Pincus: And does the existing and does that continuing care plan – we will get to that obviously in the next measure, but in the next measure is it required that it actually be conveyed?

Ann Watt: It's actually requirement for the data element – it's actually requirement…

Male: I'm sorry. Harold, that will be two measures from now into the one that's actually conveyed.

Male: OK.

Female: I have that.

Male: So, you know – my sense of this that we're splitting all these things into the least common denominator.

Female: Right.

Male: Rather than having an effective process of care that's holistic. And maybe it says depends on whether you're a lumper or a splitter but I get worried when

we reduce a complex clinical process into each little process or part and don't link it to an effective carry forward throughout the whole process of care.

Female: As do I. This is…

Karen Pace: And this is Karen Pace. I think you can see on your screen now the numerator details for this measure and Joint Commission might want to comment but this specifically says the medical record, it's not using the term continuing record. So…

Female: And actually, I have a concern on that too and I was waiting to have the discussion on the other part but how actually are we documenting this is appropriate. Because in this – in the numerator, if you look at number five that kind of catches all that basically say the medical record didn't have appropriate documentation.

And I assume, in many cases we won't know number one medical record contains a documentation of the history of minimum of three failed therapies in an inpatient setting. It'd be hard to get that, that's mostly going to be done in the outpatient. And same with number two as well with the titration. My concern was more – just the essence of how are we actually saying this is appropriate or not or how the hospital saying that.

Female: Yes.

Male: Could the Joint Commission answer that question please?

Celeste Milton: Yes, we precisely specify this data element which is called appropriate justification for multiple antipsychotic medication. I want to find out that the continuing care plan is indeed a part of the medical record. It's a requirement that it is a part of the medical record. And we do specify for the first allowable value which is considered appropriate that there's documentation of a history of a minimum of three failed multiple trials of monotherapy. And then we further specify that the medication should be named and what the issues were as far as the failure. So, that's what we're looking for, for the first appropriate justification.

The second would be that a recommended plan to taper to monotherapy start to take place during the hospitalization or that there's a recommendation that a tapering plan be initiated upon discharge. And at further more, states that the medication that would be increased should be specified in the medication to be decrease should be specified and further specified that it should be part of this continuing care plan.

The third would be that the medical record contains documentation that Clozapine is being augmented with another antipsychotic agent. Those are the three allowable values which allows the case in to pass in the numerator.

Female: So what does number five do?

Female: Number five means that there is insufficient documentation. You cannot tell from documentation that there is an appropriate justification for the patient being discharged done with multiple antipsychotic medications.

Female: So, that case would fail the measure?

Female: Would it fail or would it just not be qualified?

Female: It fails the measure because it wouldn't be part of the numerator population that allowable value would not pass the measure.

Female: OK. And where – what – and from having this done through (inaudible) so far how many hospitals or how many institutions are we having that they actually have this medical record documentation of three failed therapies. And – I'm just amazed, I know from the hospitals that I worked with, we wouldn't have that kind of data unless we started calling the physicians and trying to get family members involve. So…

Female: So, could you just clarify – can you see the – from the measure submission form the numerator details because you have four and five.

Male: Probably list again.

Female: Are listed as part of a numerator that that would be an allowable value for the numerator.

Celeste Milton: Hi, yes. Celeste again. And you're right, four and five are additional allowable values but they do not pay as the measure. We have allowable values that either pass or do not pass to be a part of the numerator population.

Allowable value four was put together primarily so that hospitals could understand if they're documenting for other reasons that are not considered appropriate, for example prescribing Seroquel for sleep instead of an hypnotic agent.

Hospitals also can further receive a report that indicates which one of the allowable values they answered the question with, so that they can get a better understanding of how they're performing relative to the allowable values.

Female: And I just wanted to clarify that if you look at the measure logic calculation algorithm, that's where it's very clear that this allowable values fallout of the numerator and therefore if they go to the denominator they do not go to the numerator, and so they actually lower the rate if you will.

Male: Yes. Now, that's clear from what's written under the numerator now.

Peter Briss: So, wow. Are there – this is Peter again. Are there other questions or comments or concerns that we want to hash out with it's measure?

Male: I guess I'm still confused. So, there is no requirement here because it doesn't say within a numerator details, anything about it being in the discharge information transmitted to the next level of care.

Ann Watt: This is Ann from Joint Commission. And in the submission materials that we included is our data element dictionary and that – actually, Celeste just read it to you from the data element definition for the state element. That's where that detail is included.

Male: OK, could you start on the overall form that's what's confusing us?

Ann Watt: Yes, I'm sorry our data dictionary is like many, many, a couple hundred pages. And so we included that as well as the measure calculation algorithm as attachment to the submission. As I believe we were requested to do.

Celeste Milton: Yes, and we're pulling that up now to have it in your screen in a minute.

Tami Mark: This is Tami. I have a question about – around this discussion and I'm trying to process a little bit I'm wondering if there's any concern that this measure might have negative impacts on the way patients are treated or patient outcomes. Or as more as the concern about the measure doesn't go far enough and it may create, you know, burdens on providers. But is there any issue around a negative potential effect on patients or patient treatment?

Male: I'm not sure that I fully understand that question. The – I thought that really what we were talking about four, it seems to me that that people talk about the rationale for the measure and the affects for the measures – the polypharmacy in this context is generally a bad thing and that the use of the measure has tended to reduce the level of polypharmacy. So, does that answer your question or are you – you have additional?

Tami Mark: Yes, no I mean if that's what -– that's what I I'm taking away polypharmacy is generally bad and this reduces it and the discussion seems to be a little bit more about, you know, it would be better to have a measure that transmitted the information to the next level of care and maybe, you know, we specified a little differently but the big picture – I'm not saying as being impacted by this discussion that's to the usefulness of the measure or the validity of the measure. I just want to make sure I wasn't missing something.

Male: I want to get back to Jeff's comment about, you know, and this maybe something more back to NQF staff which is sort of whether you have like specific little measures, I would say little but specific measures that are looking at different components. And then the – and then there is some important one that sort of then sort of that blink to it that follows it up.

So, the example here is, it sounds like this is going to be an important element of a continuing care plan. The next measure is all about that there is a continuing care plan with certain functionality. And then the next measure is going to be that it's actually transmitted to the next level of care.

And the desirability of having those as sort of separate processes, whereas a single process because I know that earlier, we reviewed the initial screening piece and that was a kind of combined of a lot of screening thing.

So, is there a preferential way of how one cuts, you know, slices up, you know, a complex measure?

Anne Watt: This is Ann with the Joint Commission. If I might interject a minute, you know. One thing that I would like for the steering committee to understand is that the way we develop measures is in (inaudible). And as we indicated, you know, first thing this morning, these measures are what we consider to be a set. We require hospitals to collect data every measure in this set. And the whole point of that is so that if you look at the result of all these measures, you can get a sort of like puzzle pieces, jigsaw puzzle pieces. If you look at the answers to all of them, you can get a pretty good idea of the overall picture of the quality of care. That is a basic tenet of Joint Commission Measure Development. We don't ever intent for these measures to be use as independent indicators, just want to clarify that. ....

Peter Briss: This is Peter for the record. I'm going to take off my chair out for a second and just make a comment. It strike me that you could always make a difference, one thing or leading decision. And so – so there are potential advantages. It's more lumping in terms of efficiency, I suppose in whole as – there are potential disadvantages to lumping about making measures harder to calculate and harder to explain. And perhaps not – not communicating well about specific components of care. And so – and so as for me, I could have lump or split these measures differently but I don't personally have much difficulty with the fact that they've reported them as I said and didn't do more one thing.

(Crosstalk)

Jeffrey Susman: To the fact that the Joint Commission has said that they would expect all these measures to be corrected. And that the individual measures help find where there potential opportunities for improvement in the process, it makes great sense. But here we are at the NQF, considering endorsement of each single

measure. And that's what I think doesn't make sense, and isn't really consistent. So, we're taking a fundamentally different approach.

So what the Joint Commission's – I'm hearing they say, it makes total sense to me. What were doing, not so much because we disarticulated this measure and considering them one by one by one.

Helen Burstin: Yes. And this is Helen Bursting for the NQF. Just to weigh-in briefly on this question. And it is something that has come up to certainly before when developers tend to think of some of other measures being used in more of a set fashion. And we have not today, have the capacity to review and evaluate measure sets. And I say that won't be something potentially possible in the future, but in general we have not had issues, for example with measures that are paired or put together understanding they are part of a broader set.

And so that, you know, the real question would be, is there any real, you know, assuming that the data needs to be collected to kind of move one to the next measure. I think that they're more nested than anything else, is there really a downside to having this data collected when they essentially are building block towards the ultimate measure and the data that are being collected. So, just a perspective.

(Jeff): I mean, I guess my response would be one, we really should be able to look at a suite of measures that are collected together are part of a larger clinically process and consider that on suite rather than breaking it down into the element.

And then this particular area, it's hard to interpret one signal portion of this process without knowing more. So, there are potentially some unintended consequences. You know, you might try to reduce antipsychotic use in people who've already failed multiple times on the single or two antipsychotic.

Female: And who is just speaking…

Jeffrey Susman: You know, maybe not so likely but certainly possible.

Female: Who was just speaking? Who was just speaking?

Jeffrey Susman: This is Jeffrey Susman. Thank you.

Female: Thanks Jeff.

Male: So, understanding that is intended to be part of this week. So, can the Joint Commission sort of explain to us, A, is this information that is written here is being part of the medical record. Is it in fact an element – a required element of the next measure about a continuing care plan? And B, as part of that continuing care plan, is it also going to be in the numbers seven measure that is has to be transmitted?

Anne Watt: This is Ann. I'll start and then I'll hand it over to Celeste who's better at the technical details than I am.

This measure HBIPS-5 NQF 0560 looks at whether or not there is documentation of one of these acceptable reasons. And if it's – if the patient is being titrated, you know, off of one and with another, that the be included in the continuing care plan that's defined in the data element definition for this measure.

The next measure HBIPS-6 looks at the presence of a continuing care plan that is intended to be a provider-to-provider communication vehicle. And then HBIPS-7, looks to see that in fact that continuing care plan actually was transmitted within five days to the next level of care provider.

Male: So for the middle one, is this component with regard to how a pharmacy a required element of a continuing care plan.

Celeste Milton: Hi, it's Celeste. As we begin our discussion with the continuing care plan measures which will be coming up soon. One of the requirements is that all medications that the patient is order to take at the time of discharge be lifted along with the dosages and indications. So based on that, the next level of care provider can ascertain how many antipsychotic medication the patient is on at discharge.

Male: No, no, see that's not the point. The point here is that it's also (phase) an explanation of why they're on those and intent to – and the intent to titrate.

Celeste Milton: Yes as we've stated it, in order to select that allowable value, it's a requirement that it'd be documented in the continuing care plan. They can't select that allowable value if it's not documented in the continuing care plan.

Male: Ok. So that is referred to in HBIPS-6?

Celeste Milton: In HBIPS-5.

Male: I understand that. But when somebody is computing HBIPS-6, do they then…

Celeste Milton: … Calculus.

Male: Huh?

Celeste Milton: Is that part of the calculus?

Male: Yes, exactly.

Celeste Milton: A requirement for the continuing care plan is that the medications, dosages and indications that the patient is discharge on be included there? So yes, it would be included.

Male: Well no, but that's not the exactly the same thing as the items we just looked at in the numerator for a HBIPS-5. That it's similar to but not exactly the same.

Jeffrey Susman: This is Jeff. I don't think we're going to resolve this. So whether we should…

Male: Yes.

Jeffrey Susman: … move on and do our voting and let the results speak for themselves.

Male: So with that, does anybody else – OK. Let's go ahead and try to vote and see what happens.

(Jessica): And with that, let's go ahead and vote on evidence.

Harold Pincus: Just to clarify, we're voting – exactly upon my understanding. What it is exactly I'm voting on?

Male: HBIPS-5.

Harold Pincus: Yes. But I understand it's HBIPS-5, but am I voting on with the assumption that this information that's contained in the numerator is expected to be and – it's expected to be transmitted in the continuing care plan or not. That would make a big difference on how I vote.

Male: Harold, it sounds like – it sounds like you've tried to asked that question of the Joint Commission twice.

Harold Pincus: I know. And it seems to me it's a simple yes, no but I don't understand the answer.

Ann Watt: This is Ann Watt at the Joint Commission. The data element that we're looking at here in H55 says that the data element definition which we could read to you again says that the titration needs to be included in the next – in the continuing care document in the medical record. That's what this measure says.

Harold Pincus: It sounds like…

Caroline Carney-Doebbeling: I think Harold – this is Caroline. I think the next measure though, and if I'm understanding Harold's concern, is that H56 does not require that the justification in titration be included in the continuing care plan which is as an indication (inaudible) which is not the same thing.

Female: Yes, OK. Now I get it.

Ann Watt: This is Ann, and I don't know if this helps. But a case cannot pass H55 unless the titration is in the continuing care plan.

Female: But we're asking about H56. ...…

Do you say the continuing care – the justification that is in the continuing care plan under H55 is what must be in H56 which is the creation of the continuing care plan

Peter Briss: But, you know – this is Peter. It sounds like what you're asking for is that the same piece of information gets included. So, in order to pass five, what they've just told you is that the titration has to be included in the continuing care plan with their – so the – it doesn't appear to me to be – if necessarily be all that useful to require that piece information in both five and six.

Caroline Carney-Doebbeling: OK.

Peter Briss: In order to pass five it has to be in the continuing care plan based on what they just said. So I think, Carol, that the answer – the simple answer to your question based on what they just read to us is yes.

Male: You might have to modify six a little bit.

Female: A little bit.

Male: Yes.

Female: I would offer that the fact that there is so much confusion even among the committee members. My (inaudible) underline the fact that (inaudible) and clarified better.

Male: Yes. I can (simply) agree.

Male: And, the wording that's six needs the maximum wording in five so that we're sure that five is getting into six, is that right?

Female: Correct.

Lisa Shea: Well, this is Lisa. But six, you know, includes a lot more…

Female: Yes. All right. Yes.

(Crosstalk)

Male: One element. At least ..…

Male: Right.

(Crosstalk).

Male: We (inaudible) coordination among the description.

Peter Briss: Yes. So I actually think that we probably circled around this issue. I think that the issue is actually fairly clear at this point. Let's try to continue with the voting.

(Jessica): OK, going back to the voting. The response for evidence was 13 yes, six no, one insufficient.

So we'll continue on to performance gap (1b). We have four high, 12 moderate, four low.

High priority. And if you haven't cast your vote yet, please go ahead and do so. We have nine high, eight moderate, three low.

Continuing on reliability. We have one high, 13 moderate, five low, one insufficient

Validity. 13 moderate, six low, one insufficient.

Usability. We have three high, nine moderate, eight low.

Feasibility. Two high, 12 moderate, five low, one insufficient.

Overall suitability for endorsement. 12 yes, eight no, measure 560 is recommended for endorsement by the steering committee.

We'll move to measure 557-H56.

Male: Yes, (inaudible) Joint Commission liked that. And we've already done a little bit of teeing up of this measure but, yes, additional stuff from the Joint Commission, please.

Celeste Milton: Hi, Celeste, Joint Commission. H56 is going to be looking at the creation of a continuing care plan. And of this, what we'd be looking for at a minimum in the continuing care plan that would contain the reason for hospitalization, the discharge diagnoses, all the medications which include the dosages and the indications for use, and then recommendation for any specific things that need to be continued to the next level of care provider, for example, like a attending AE meetings, social work follow up, follow up with probation officer, various things like that. And the goal is to have a higher rate so that all of these elements would be present in the continuing care plan which is a part of a medical record.

Female: And they all need to be included.

Celeste Milton: All need to be included. And hospital does have the opportunity to understand if they're failing the measure that the individual elements or for our staffs that they could receive a report that show them where they may not be documenting one of the elements that, perhaps, are causing them to fail.

Male: ....

Celeste Milton: This a paired measure with H57 which is looking at transmission of the continuing care plans. They're not meant to be looked alone, they're meant to be looked at as a pair of measures just like H54 and 5.

Male: And I think that, you know, that the committee member who is a primary reviewer for this was Nancy Hanrahan.

Nancy Hanrahan: Yes, yes. The group generally recognized that these measures meet national priority of continuity of care which is a very important area to address around the quality of care. Also, it has the potential for standardizing a discharge process, and that the measure has excellent evidence that the measure can be created some of the electronic health record and paper record. And it stands with – and a lot of what has been said previously, as a standalone, it may not be as an important of measure as it is if it is – there is documentation or follow through which would really be – that connected with providing evidence about continuity of care at least closer to it.

The weakness is that it's not stratified for any disparity. And, there are – in general, the group – workgroup agreed that moderate evidence is presented to support the measure and agreed that developers establishes the structure process outcome link, that is a continuing care plan. It's critical for best outcomes.

The group agreed that the scientific – that the measure was scientifically acceptable, that reliability and validity testing is quite expensive. However, in other measures it's been already discussed. There is a selection bias in some regard to what our hospitals are volunteering to use the measure.

And, the usability of the measure is (edited), usable, and it's actually being adopted by CMS for final rule for Inpatients Psychiatric Hospital Quality Reporting.

The measure was decided by the group that it was feasible and the data generated by and used by healthcare personnel during the (inaudible) of care – and that it was the – it has a mechanism now through the Joint Commission that has been in effect in 2008 of the (ORC's) measurement system.

So, I think that's pretty much what the workgroup said about it. There was general agreement that this was a measure that they would see as important, however, it's interesting, there was a split between – the group is split, yes, this measure is important to report and there were three that said yes, three that said no.

Peter Briss: So with that – well; actually, overall – I'm sorry. I think that that is – This is Peter, I was also on the workgroup and I'm just checking. Oh, and some of the issues that are important to measure and report was a bit similar to our discussions about (inaudible) important about this measure related more to the independent value of the measure given by – given that the next measure is going to be easier that transition of a care plan to the next level of care.

So, with that, yes, the floor is open for additional questions, comments, or concern.

Vanita Pindolia: Hi, this is Vanita. I think this is an excellent measure for transition of care – we need this. But this question is more for NQF. As we're trying to harmonize the measures and make sure we're not duplicating, is there something like this already developed for just general discharge planning? Or there's – this is a first type of this kind developed? Specifically for inpatient psych only, right?

Female: ....

Helen Burstin: Hi, Vanita. It's Helen Burstin. I don't have it in front of me but I believe there are two companion measures on a transition record from PCPI that look at discharge from hospital and discharge from ED. Is that correct ...?

Vanita Pindolia: Correct.

Helen Burstin: OK. I think there are actually just from memory from the care coordination project. I think there are three of the transistors the ED, the hospital, and then there's one that's transmitted to the next provider, but I can get that information for you.

Vanita Pindolia: Because from the elements that I see listed on this from what I recall and I just don't have access and I don't recall exactly what's already been approved by (JACO) for (inaudible) discharge. Many of these elements were the same that I believe that we're trying to implement already in the hospital for general. So, I'm assuming it's – unless that there's something very unique, it sounds like this is already part of a process.

But, I'd had to have someone confirm if every element they list here is listed in the other one, and is there a way that we can just combine and in that way it's just generalized because we really need this for all patients' transition of care?

Helen Burstin: Well, we actually at NQF, we are really upping our game in terms of harmonization and we did, at the beginning of this project, identify all related measures. Those measures were not identified as related because they had different setting, and were specified so differently. But, certainly, we would

want the specifications like age changes and stuff like that to be as similar as possible.

But, maybe we could ask PCPI after this meeting to respond to have similar specifications are ...…

Peter Briss: I wonder if – this is Peter. I wonder if for today, trying to get to the work that's before us we could ask staffs to explore or we could take this measure on it's own as it's currently specified and ask the staff to work to the developers about whether additional reconciliation – to have smaller numbers of broader measures would be possible. Is that something that staffs could do?

Helen Burstin: Certainly. Yes.

Male: ...

Male: Go ahead. I'm sorry.

Peter Briss: I was going to ask if that was a – that was an acceptable resolution, is that (inaudible) question.

Vanita Pindolia: Oh, yes. That's fine. I'm definitely not saying not to pass or do vote, anything. I just want to make sure we're not having like six here and then three there, and four there, that's all.

Peter Briss: OK. Thank you. And now, (inaudible), you're going to go next?

Male: Yes. I had a question. I noted that in the measure, there's nothing about medical problems or medical follow up. Now, if 50 percent of psychiatric patients chronically mentally ill have a medical problem, why would that not be included in a discharge referral or information?

Male: So, would the Joint Commission like to take a round at that, please?

Celeste Milton: Hi. Yes, this is Celeste at Joint Commission. And that exactly is one of the things that would be in recommendation to the next level of care provider, is that the patient would be seeing maybe their PCP for diabetes management or

cardiac conditions. It's an expectation that those recommendations would be relayed to the next level of care provider. Absolutely.

Male: But, it's not a specific criteria on discharge that's going to be a (lot) of it?

Celeste Milton: Right.

Male: OK.

Celeste Milton: It's actually listed in the data element. It's a part of what – some of the recommendations for the next level of care providers should indeed be, and that's one of the elements, one of the inclusions.

Peter Briss: Additional questions, comments, concerns?

Michael Lardiere: This is Mike Lardiere. Are we good with the language from the previous one? It's the going to match up with this one so all those elements on – that's five or that's six (inaudible) – we just had that little discussion, and I just want to make sure that the same language follows all the way through so that same information goes through this and then into seven as well, I guess, because that's the one we actually transmitted. So, I just want to make sure that it all flows through.

Peter Briss: Could we use (inaudible), is that something that we can recommend to the developer off line?

Female: Yes. We can recommend that to the developer to be sure they align.

Male: ....

Female: I wonder also, is this somewhat referenced by someone talking about the physical health problems. But I think it would be (inaudible) to think about or the Joint Commission to think about approaching this with the assumption that there are – there is a high incidence of physical problems and that we want to push toward an integrated care model so that the discharge plan should reflect in integrated care process.

And, one of the reasons why I understand that the physical aspects of care are not necessarily noted on discharge plan., it's because of the liability that psychiatrists may experience by identifying medical problems that then is not – that they either did not follow through while inpatient – while the patient was inpatient or that it places some degree of liability on their part to have made that diagnosis and the patient have it – having to get treatment.

So, there's a whole (legislative) component to this that I wonder – I just want to make a note of. I don't think it should stop putting – asking people to identify an integrated care planning or continuing the care plan.

Peter Briss: Thank you. Anybody else have questions or comments or concern? So, hearing none, I wonder if we could try voting, please.

(Jessica): Let's go ahead and vote on evidence.

And if you haven't voted, please – we have them. ....

(1b) performance gap. And, if you haven't voted yet – we have four high, 14 moderate, two low.

High priority. 16 high, four moderate.

Reliability. Two high, 19 moderate.

Validity. And if you haven't voted, please do so now. One high, 18 moderate, two low.

Usability. Five high, 16 moderate.

Feasibility. And if you haven't voted, please do so now. Four high, 17 moderate.

Overall suitability for endorsement. And if you haven't voted, please do so now. We have 20 yes, one no.

Measure 557 has been recommended for endorsement by the steering committee. We'll move on to measure 558-H57.

Peter Briss: So, does the Joint Commission have anything to add for this measure?

Female: Hi, Peter. Just briefly at the left here. This is again the second of the period of measures. And now that the plan has been created, the next goal is to get this information transmitted to the next level of care provider within five days after discharge from the hospital. So, that's what this measure is evaluating that all of those elements that were in the care plan were all transmitted then to the next level of care provider.

Peter Briss: And so, this is (Peter). This one – it was I'll be brief to it, essentially the center of gravity of the workers was – is that it's important to measure and report that the evidence is – makes sense, that we were unanimous on – that measure was scientifically acceptable with somewhat higher scores on reliability than validity that we can really thought it was – on the (inaudible) usefulness and higher moderate feasibility. And essentially, and much of the specific rationale have already been discussed on the previous measure.

So, I will leave it there (inaudible) and open it up for the floor.

And maybe since we have a bit of radio silence, and we've sort of hash every (inaudible) of these issues with the last measurement, here we can move straight to voting.

Nancy Hanrahan: I just like to comment. This is Nancy Hanrahan. This measure is – to actually carry out this measure is really a tough one. With some of the populations or some of the people with serious mental illness that are hospitalized, given that many of them are very difficult to follow up with. They move frequently. The use – they may have a phone that is a pay phone and then they change another number. You know, the – if the phone – connecting with somebody may – and some people put in their – the admission data of relative or a friend phone number. And then, you have the issues around disclosure when you call them and leaving messages or – it's just a very tough thing to have happen, and so there's going to be a high level of data that's not going to actually be collected with this one.

I'd like the idea that we – that it gets established as a criteria or a measure and then people will start to build into systems ways to do this. But it's a – I just think it's really questionable whether or not what kind of data is going to get collected from this. And we are still in such siloed operations here that we want to see continuity of care happening. And this will help, but I don't know. Maybe (inaudible) that we'll see growth.

Male: But (inaudible) data going to the provider, it's not going to the family or the patient, you're not to track down the patient, you just have to track down the provider and get it to them.

Male: Yes. This is a different measure than follow up with the patient.

Male: Right.

Peter Briss: Right. Yes. This one's – they're just transmitting the continuing care plan to the provider.

Lisa Shea: Right. And, this is Lisa. And I think one small challenge that can happen is when the patient – if they're in a, for example, a free standing facility and they get emergently transferred to a medical facility making sure that all of that information is available instantaneously because they are going to an ER setting. That's been one challenge that we've had. But overall, I think that this measure's been very helpful for us in making sure we focus very high priority on transitions of care.

Male: You might not have all of it.

Peter Briss: Are there…

Caroline Carney-Doebbeling: This is Caroline. I have a question about the measure. It's Caroline. What types of transmission are allowed is it telephonic, e-mail, letters? What is allowed?

Celeste Milton: Hi, it's Celeste, Joint Commission. Now, telephone conversation is not appropriate. It has to be documented. So, any of those methods such as method e-mail, by letter, by fax, if there's documentation that the next level of

care provider has access to the EMR, well, they're all sufficient method of documenting transmission. Or as the information is actually handed off to like an ambulance dependent one that would be transporting the patient. Those are all considered appropriate methods. But it has to be actually documented in writing, what the continuing care plan elements are.

Michael Lardiere: If it went up to a – this is Mike Lardiere. If they went up to a health information exchange and then the other provider pulled it from the health information exchange, would that be allowed?

Celeste Milton: As long as there is documentation that the next level of care provider has access to this information electronically, then that meets the intent of the measure.

Michael Lardiere: OK. Thank you.

Celeste Milton: You're welcome.

Male: So ...…

Female: How do you know it was actually transmitted to the next level of care even if it's a fax or a letter?

Female: Sorry.

Celeste Milton: There needs to be documentation in the medical records stating that they have done the transmission on what the method was. So we're going to take that at safe value. They've documented that they faxed this document and the date the data (inaudible) faxed it, so they faxed it too. Many times, we'll put the fax cover sheet as part of the medical record as evidence that this transmission occurred. So they're all acceptable.

Female: So repeat of that information isn't being measured, it's just whether or not the discharging group shows that they tried to convey the information?

Celeste Milton: Absolutely. You don't have to open the e-mail.

Male: This is (inaudible). I have a couple of questions as well. So the next level of care, help me understand, if we're sending the patient to multiple people and, you know, multiple providers, is that next level of care? Is it psychiatric as a mental health resource? Is that next level of care? Is it an internal medicine? Is that family medicine? Is it a multispecialty clinic? So, what – I just want to make sure that this is explicit enough that everybody understands it.

Celeste Milton: Hi, Celeste, Joint Commission. We specifically specify that the next level of care provider in cases will be the clinician or the entity that the clinic, for example, or another hospital that will be primarily responsible for managing the patient's medication plans. And in the absence of medications, and it should be that person or that entity that's been designated is going to be providing primary treatment. That's not to say that the others that are involved in the patient's next level of care shouldn't receive this information but we – they should be identifying who the primary person is in making sure that they get that information at the time of discharge.

Male: OK. And then, the next thing that I see is for exclusions. If a patient has no coverage and under the ACO, they're undocumented alien, we may have difficulty finding the next level of care for that patient because they will not, under Obama Care, have any resource, whatsoever.

Male: Well that's not necessarily true. We have to send them to the federally qualified health center in their area and they take everybody and they have to by law so you get back to the default that you would have.

Male: OK.

Male: Yes, it's an issue that some people be undocumented and not have coverage but you still have to try to find the provider for them before you can discharge them.

Male: OK.

Jeffrey Samet: This is Jeffrey Samet. So, this next level of care is strictly within the Mental Health System and not linking to a General Medicine System or – I'm trying to sort that out ....

Celeste Milton: Hi, it's Celeste again. It may be a primary care physician that's going to be responsible for that patient's medications. In some parts of the country, that's appropriate for them to follow up on a patient. So it's really, you know, at the time of discharge, they should be identifying who that primary next level of care provider will be, and that's who should be, at a minimum, receiving this information. Once again, that's not to say that not – the rest of them shouldn't receive it but for the purposes of this measure, we want to make sure that the primary next level of care provider is the one that receives this information.

Jeffrey Samet: So it could be one or the other but they won't be out for ...?

Celeste Milton: That's correct, because they – as what's pointed out, they could be transferred to an acute care facility because they've a got a medical problem.

Jeffrey Samet: Yes.

Celeste Milton: So it wouldn't be that a mental health provider would necessarily need that information if they're having chest pain and it looks like they're having an MI and you would want to make sure that that information gets to that hospital that's going to be treating them, the acute care hospital. So it's going to vary on the circumstances of the discharge for the patient.

Jeffrey Samet: Thanks.

Vanita Pindolia: Hello.

Peter Briss: Hello. Are there other questions or comments or concerns?

Vanita Pindolia: This is Vanita. Sorry, I think I mute and unmute, and didn't know what I was doing. So I just had a question on the actual feasibility. So all these items are very useful, I can see how this will very much help with the transition of care. But working with different EMRs and trying to have each one provide different pieces of data is very difficult to get the process changed, has that been addressed by (JACO)? Is this available in every EMR to be printed out and spit out with the discharge note? Or is this something especially created?

Ann Watt: This is Ann at the Joint Commission. It's – the short answer is no, they're – we haven't made arrangement with every EHR vendor to include this data elements. But one thing that we have learned is or as you know, I'm sure the degree of implementation of electronic health record nationally varies a great deal. But what we have seen as we've gone out and on reliability studies and so forth on these measures is that most hospitals within EHR have to have developed a recording template for the – for these data elements.

Just of interest maybe, is that, you know, we're also working to specify these measures so that the data can be pulled directly from the electronic health record. We're not there yet because again, the state of implementation of the EHR varies so much.

Michael Lardiere: And this is Mike Lardiere. The CCD which is what actually transports the data from the EHR, some of these elements are already structured data. The ones that are not structured data that can be allowed within the template in text form. The organization just has to, you know, set it up that way and it can be included in text so it's – there's no blockage of it. It's just not structured data.

Vanita Pindolia: And the reason I'm asking, we're just converting from one EMR system to the Epic which was now, I think, 30 percent of the nation is on, and it's interesting as a field for having the diagnosis is not an element for the discharge drugs. And so that blows my mind with the brand new EMR system that that would not be required and so that just made wonder how many of these other elements would not already be in there that people would have to make modifications to whatever they bought already.

Michael Lardiere: Yes, they just seem to require that it gets imported in it – in at this side. Which text field in the CCD it goes to? And then make sure (inaudible) programs at that way, it's not a problem, they just haven't done that for a number of elements. They're not – they haven't been identified as structured data yet.

Vanita Pindolia: OK, so then (JACO), question for you. Your analysis for the hospitals, what percentage of hospitals were able to have all these fields already available?

Ann Watt: This is Ann. I don't – I honestly don't know any answer to that question.

Vanita Pindolia: OK.

Michael Lardiere: And I'm on a committee, the group that's looking at the transitions of care record. And so from the behavioral health side, we have requested that a number of these elements be added as structured data. So in the next version, we'll see that and on the CCD, we'll be able to carry on the structured data and we won't have a problem because we notice those gaps in what was being identified so far as the data element. So there are gaps but we're already working towards having them filled to include this behavioral health information.

Vanita Pindolia: OK. Thank you.

Peter Briss: So does anybody else have new things that we need to discuss before we can move on to voting? Hearing none, why don't we try to vote?

(Jessica): At this time, please vote on evidence. And Emma, would you like to cast your vote?

Emma Hoo: Yes, ...

(Jessica): Yes, no or insufficient. Sorry, go ahead.

Emma Hoo: Oh, it's yes.

(Jessica): 20 yes.

1B performance gap, high, moderate, low, insufficient? Emma?

Emma Hoo: Moderate:

(Jessica): Six high, 14 moderate.

High priority, high, moderate, low, or insufficient? Emma? Emma?

Emma Hoo: Moderate. Sorry, I'm in mute.

(Jessica): Sure. 14 high, six moderate.

Reliability, high, moderate, low, or insufficient? Emma?

Emma Hoo: Moderate.

(Jessica): One high, 16 moderate, three low.

Validity, high, moderate, low, or insufficient? Emma?

Emma Hoo: High.

(Jessica): One high, 18 moderate, one low.

Usability, high, moderate, low, or insufficient? Emma?

Emma Hoo: High.

(Jessica): Five high, 11 moderate, four low.

Feasibility, high, moderate, low, or insufficient? Emma?

Emma Hoo: Moderate.

(Jessica): Two high, 10 moderate, five low, two insufficient.

Overall suitability from endorsement. Yes or no? Emma?

Emma Hoo: Yes.

(Jessica): 18 yes, two no.

Measure 558 has been recommended by the steering committee for endorsement.

We'll move on to measure 0418.

Peter Briss: And Harold, I think that…

...

Peter Briss: And Harold, I think that (inaudible) passes back to you.

Harold Pincus: Yes. Give you a rest, Peter.

So this measure is on the depression screening and followup plan, and is the measure steward available, CMS.

Female: Yes. Hi. Can you hear us?

Harold Pincus: Yes.

Female: OK…

...

Female: My name is.

Harold Pincus: …summary and introduce this?

Female: Sure, sure. My name is (inaudible), I am the RN Coordinator here at Quality Insights of Pennsylvania. Quality Insights is the measures steward representing CMS for the screening measure. The measure NQF 0418 was initially developed in 2007 by Quality Insights in CMS with the intensive use of the screening measure to be reported by Claim State and registry based reporting for the division quality reporting system, PQRS. Moving forward, this measure will continue to be part of the PQRS program and will also be included in the 64 outpatient measures utilized for meaningful use starting in January of 2014. The measure received initial endorsement by NQF in July 2008 and in September 2011 went from time limited endorsement to full endorsement status.

To be maintained in the PQRS program, this measure undergoes a comprehensive annual update process including an environmental scan of the latest evidence literature completed by our subcontractors at Thomas Jefferson School of Population Health. It also undergoes a review of measures code test. A review by a technical expert panel composed of subject matter specialists such as psychologists, physicians, social workers, occupational therapists, and audiologists.

Reliability testing was also performed for random sample of providers who reported this measure through claims for the first quarter of 2012. So measure 0418 is a process measure which focuses on encounters for patient aged 12 years and older. The measure's intent is to screen all eligible patients annually which is once for the 12-month reporting period for PQRS. They are screened for clinical depression using an age-appropriate standardized tool and documenting a followup plan if indicated.

The clinical guidelines such as the Institute for Clinical Systems Improvement, the US Preventative Service Task Forces, recommend screening adult and adolescents for depression when systems are in place to assure accurate diagnosis, effective treatment, and followup. So the evidence reveals a high impact of the depression on the population and how crucial it is to identify and treat depression in it's early stages to prevent the negative outcomes associated with depression. Negative outcomes of depression include, but are not limited to, suffering…

Harold Pincus: Could you –excuse me. Could you like maybe summarize some of the different elements, specifically with regard to the particular elements that we're going to be evaluating it on?

Female: Sure. Sure. We're just finishing up here. So, you know, the highlights that – are addressed in the important section as far as the high impact of depression on the population in regards to the quality of life. The high cost, you know, that was all included within the submission form, so.

Harold Pincus: Could you say something about your experience having implemented a measure? What's been learned in terms of it's use? Because this is coming – this is a coming up for re-endorsement part of maintenance. So is there anything that's going to learn that would sort of change the way of thinking that was considered originally which regard to the measure?

Female: This is (inaudible) and I'm the Director of the Mid Program at Quality Insights of Pennsylvania and we did after testing this measure, we did find that some of the providers felt that they misunderstood some of our HCPCS code that are attached to the actual measure specification.

So when we were doing our testing, we actually have providers contact us to say that they realized when we requested their records that they had inappropriately recorded their activities.

So they tell that was a very valuable measure that they screened the patient. They did determine that a lot of the patients were actually negative. Unfortunately, they've reported the wrong HCPCS thinking that the pass code was a screen and they were negative where there's two HCPCS code that are pass code if you will. There's, if they screen them and the result was positive and they documented the followup plan or they also have a pass code if you will, if they screened them, and it was negative. So we did learn that we needed to educate providers much more on the differentiation between the two pass codes and also, we also learned that they did a screening but didn't always identify the tool that they utilized. Then we updated the measure for 2014, we really increased the language within the specification to identify these elements.

We did find it interesting when we were making these measures suitable for meaningful use that we could go through and actually look for those data elements with either SNOMED Code or LOINC Code and we updated the logic to be very specific for those elements that the providers were having trouble with in the claims and registry format.

Harold Pincus: So this has been retooled for electronic transmission.

Female: Yes, it has. In fact we just add, it's going to be published – it was supposed to be published the first of June, they've delayed it to the 15th but the new specification has been updated and it's – we actually applied for new LOINC code for this. So, it will be much more specific for the data elements we're looking for.

Harold Pincus: OK. Who from the steering committee is presenting this?

(Jody Kellar): This is (Jody Kellar). I'm presenting it.

Male: OK.

(Jody Kellar): Are you ready?

Male: Yes.

(Jody Kellar). All right. The workgroup on this summary – I'm going to give this summary, and then I would ask the specific workgroup members if they so choose who had specific issues, or questions, and concerns to elaborate on my summary.

There was a general agreement of the importance to measures, especially in light of expanding the age range for this measure to 12 years and older, and the inclusion of pediatricians into the provider mix even though Quality Insights noted that there was some reluctance today on the part of the pediatricians to submit our patient records due to the patient age. And so, therefore, most of the testing was primarily done on adult.

In terms of scientific acceptability, there were several questions from the workgroup on process of gathering the data and there was some lengthy explanation around the part B claims and G codes noted that their sampling for reliability testing was a random sample of providers who submitted a total of 10,000 claims and that equated to 77 providers, so it was close to 300 claims as the random pool. There were – there was some question about whether there was actually a gap similar to earlier discussions we have today in terms of performance gap. So I'm not sure – that or there's more questions about that. And there were also questions raised in the group about the definition of underserved versus non-underserved population and whether there was sort of founding of racial and ethnic designation with defining underserved and non-underserved. The developer clarified that the designations were also based on rural and urban categories and were consistent with other CMS projects.

The committee agreed there was – that the measure was usable and moderately feasible, and in the end of the initial endorsement was a split three to two, a three yes, two no. But that was prior to all discussion.

Harold Pincus: Do people on the committee want to comment further or questions? Comments.

Vanita Pindolia: This is Vanita, I was on the committee and I think it wasn't just me, there's one other individual. If CMS could comment on if we're reaching the 98 percent on this measure, it's 93 to 98 percent, or trying to pull up my – from my memory what it was, but it was pretty high, and it was even by region pretty high. Where is the gap? Where have you identified that gap, is it maybe a subpopulation of that or is there a need to continue this measure?

Female: One moment please.

Caroline Carney-Doebbeling: This is Caroline. Well, they're looking, I thought that part of the discussion surrounding this was that the age range had expanded 12 years from just screening the adult population previously.

Bernadette Melynk: This is Bernadette. I'd really like to put a plug-in for keeping the age range to 12. The United States Preventive Services Task Force recommends screening at all adolescents 12 to 18 years of age for major depressive disorder but the proviso to that recommendation is when systems are in place to ensure accurate diagnosis, psychotherapy, and followup, and, you know, in working with a lot of pediatric primary care providers across the country.

The glitch here is this when systems are in place and that's why a lot of primary care pediatrician and nurse practitioners say, they don't screen because they don't have systems in place to deal with these kids once they have diagnosis. But I still think it is critical to follow US PSTF recommendations and include these teenagers 12 to 18 years of age.

(Mark Fuller): This is (Mark Fuller). I will support that to the academy of pediatrics had an initiative to encourage pediatricians to screen depression. There's a guideline that specifically focuses on that and there is a project improvement module that the American Board of Pediatrics developed for screening teenagers for depression and this would help to push, to promote that occurring.

Female: And this is (inaudible) from the Quality Insights team. One thing that we noted that although the performance is quite high for this measure, the actual

utilization of the measure isn't as high as we would like it. So it appears to us that the professionals that use this measure do report it satisfactory but we have a great number of providers who currently do not report this measure. CMS is very committed to this type of a screening measure and they agree with the other individuals who spoke and thought that it was so important that they wanted to move it into the meaningful use camp and they really feel that this is an important measure to continue.

(Jody Kellar): What I'm hearing – this is (Jody). What I'm hearing and what we heard during the workgroup call is that this is a sort of voluntary use today from the providers and the ones that are more likely to respond to this measure are those who are adequately documenting and are sort of committed to it, and I'm hoping I'm not being naively optimistic to believe that in 2014 with meaningful use, that will see a greater uptake of this and other measures that we've been discussing. Do you agree with that?

...

Harold Pincus: Will it be required for quality measure for meaningful use?

(Jody Kellar): It won't be a – it…

Male: No.

(Jody Kellar): Pardon me. Correct. No it's not. It is not required but it does – the requirements for meaningful use are going up as far as the number of measures that the providers need to report. And so this measure will have more exposure with those providers who are in meaningful use.

Michael Lardiere: Yes, this is Mike Lardiere, I would agree with that because you have to do now three sets of three, I believe it is, measures where before you only had to do three measures and previously, they're only three behavior health measures. Now meaningful use stage two, there are about 15 behavior health measures to choose from. So I think this will get much more uptake.

Harold Pincus: Other comments or questions that people have?

David: Hi. This is David and I have an evidential question regarding the evidence for annual screening, but this is an annual screening measure. I'm looking at this HQR, and then the USPTF. The USPTF specifically says there's no recommended interval and I think HQR still says high index (inaudible), you know, intervention moments. So (inaudible) presenting the comorbidities and you should screen basically when there's an index of suspicion. So this sets up an annual requirement for screening which I'm just not sure substantiated what evidence and given the primary care burdens for many just other kinds of screenings going on, cervical cancers, and what not. I just really want to make sure that we're implementing an evidence based screening, not only that screening is important but that's done at a proper interval, that's an essential part of predicted power of these things of how frequently and when you should do it.

So I don't see any evidence that this should be an annual measure and I basically have question about it.

Madeline Naegle: This is Madeline Naegle. I just want to comment on our use of screening of the collegiate population where it's true that it's episodic where they come to the health service and they're screened with PHQ2. But we found incidences of 11 to 15 percent in our collegiate populations and there were 19 universities involved in the study. So that the annual would seem to be minimal and certainly episodic as indicated when there is reason of suspicion. But I speak in supportive of having this be an annual measure for this group at 12 and over.

Bernadette Melynk: This is Bernadette. I totally agree with that because the reoccurrence rate is so high and if we don't catch it early, we're going to see just a huge prevalence that this continuing to reoccur. So, I think with valid and reliable screening tools that are quick and easy to use that I solely support annual screening.

Jeffrey Samet: This is Jeffrey Samet. So, I think the annual point actually is an equivalent. The questioning in terms of the data, not that is not potentially good idea, but isn't great data support that for actually many behavioral health issues. And I was – what I was wondering was the final sort of vote of the committee that

looked at this was fairly split. I'm trying to get us sense of what was the basis that was at the gap issue or was it this issue that was annual or something else.

Female: I want to clarify that, you know, that though would be for any discussion that was left, you know, that was the individual discussion and we didn't have a pretty needy discussion but I would ask those on – from the group that should goes to did not want to endorse with the time they originally looked at the measure. What their concerns were?

Vanita Pindiola: This is Vanita, I think for me at one just said, we had attained 93 percent but we did all the loading before we had our discussion. And as someone mentioned, it looks like that was when they were just doing 18 and older. Now they include 12 and older, and obviously that group has not been measured. So we don't know if they have the same baseline high rate. So my vote would change based on the discussion we had.

Male: Other comments and questions?

Male: Actually, I just got – one last call regarding the evidence. So, you know, I'd be interested in looking whether there was actual evidence because I think the risk for adolescents screening are probably different. Or the guidelines for the adolescence screening should be different. So basically there's no evidence here. (Inaudible) from manic though for teens and young adults. And, you know, I could see here there could be bifurcating for the recommendation as well as different tools and putting procedures for screening in adolescents and screening in adults over 21 perhaps. So I just want to clean out this evidence.

So, you know, a lot of people, you know, decide about it. I think screening is important but there's some things that need to be done here to make this an actual measure.

(Jody Kellar): Yes. And this is (Jody), I – one of the things I'd like about this measure was that it did not specify a tool. Now that they're including – and I think it's more important now that they're including the pediatric population. They specifically describe it as an age for re-standardized tool. And, and a followup plan that's documented. In that combination, I thought, you know, gave some appropriate clinical latitude especially as it relates to peds versus

adults. And I do think that there is evidence and continuing evidence. I had – don't have it pulled up. Where in, you know, North America, the primary care physician is often the first point of reference for screening, the first entity that has an opportunity to screen. Sometimes the only entity that has an opportunity to screen for depression in any age and that that continues to be problematic in terms of being relatively low percent of outpatients being screened where the prevalence of depression is this higher than the screening rate. So, I still think it's there in the literature.

(Crosstalk)

Male: When they develop the (inaudible) guidelines for screening. They, certainly, the decision was there was enough evidence for screening adolescence for depression.

Female: Right. I mean the US, on that point, the USPSTF guidelines graded at B, you know, which means that there's high certainty that the net benefit is moderate or there's moderate certainty that the net benefit is moderate to substantial and they talk about two tests that have done well in primary care settings in terms of screening teens and that's the PHQA, and the BDIPC. So, you know, I put a lot of weight on the review that the US Preventative Services Task Force did – I mean, they didn't find evidence for screening in 7 to 11 year olds. You know, the other issue that I'm always sort of harping out here is the potential harm, and they do address that in their document pointing out that, you know, there's no harm to screening, there's potential harm in terms of treatment with SSRI, no harm potentially around suicidality and a presence can of course increase the risk of conversion, depression to bipolar but at least of their evaluation the potential benefits of screening outweighed the risks.

Harold Pincus: Are there other comments or questions on this measure? I just have one comment which is I would encourage CMS at going forward to looking to how they might sort of extend this measure. To look at not just whether there's a followup plan, but whether the followup plan has in fact been implemented. And again, something to think about for the future.

So hearing no other comments or questions, let's move to voting.

I don't think you have voting stuff that is on the Web yet.

Female: Hello.

(Crosstalk)

Female: This is NQF.

Female: Hello.

Male: OK.

Male: We're here.

Female: OK. Great. Sorry about that. We lost – we had some kind of power surge. So we lost you right about the time when we were discussing the pros and cons of the age 12 and over. We're ready to…

Harold Pincus: Yes. We've been ready to vote for a while.

Female: Oh, OK. Fine. But let's check and see if we are able to record your votes.

(Jessica): And can the steering committee see the Webinar right now? It's currently on the 1C evidence slide.

Male: Yes.

Male: Yes.

Male: Yes.

Female: Yes.

(Jessica): OK. Then we can go ahead and move forward with the vote.

So 1C evidence, one yes, two no, three insufficient. Please vote now.

Emma Hoo: This is Emma. Yes.

(Jessica): Thanks Emma.

And if you haven't voted yet, please vote now.

We have 18 yes, two no.

1B performance gap, high, moderate, low, or insufficient? Emma, would you like to vote?

Emma Hoo: Medium.

(Jessica): Six high, 15 moderate.

High priority, one high, two moderate, three low, four insufficient. Emma?

Emma Hoo: Medium.

(Jessica): We have 14 high, five moderate, one low. Reliability? High, moderate, low, insufficient. Emma?

Emma Hoo: Moderate.

(Jessica): Four high, 16 moderate, one low. Validity? High, moderate, low, insufficient. Emma?

Emma Hoo: Moderate.

(Jessica): Three high, 16 moderate, two insufficient. Usability? High, moderate, low, insufficient. Emma?

Emma Hoo: High.

(Jessica): Seven high, 14 moderate, one low. Feasibility? High, moderate, low, insufficient. It appears we have an extra vote for usability so we're going to go back after we capture the feasibility. Emma, did you want to vote on feasibility?

Emma Hoo: High. Oh, on usability high.

(Jessica): And feasibility?

Emma Hoo: And – medium.

(Jessica): OK. For feasibility, the vote was seven high, 14 moderate and now we'll go back and read that on usability. One moment while we queue up the voting.

Female: So go ahead now and read that on usability please.

(Jessica): We have five high, 14 moderate, one low. And now, we'll go forward past feasibility and vote on the overall suitability for endorsement. Yes, no. Emma?

Emma Hoo: Yes.

(Jessica): 19 yes, one no. Measure 418 was recommended for endorsement by the steering committee. Next measure we'll review is measure 518.

Harold Pincus: I guess the question is we were to supposed to end at four, is that correct? And we have 11 minutes left. I wonder if there's enough time to review that measure.

Female: We do have until four to re-adjourn. I'll leave it up to the chairs to decide if he wants to carry this over until tomorrow and I'd like to check with the (inaudible) if they're available or whether we want to stay longer.

Harold Pincus: Yes, I will have to leave at four.

Female: Hi, this is…

...

Female: …on the line.

(Keziah Cook): Yes, this is (Keziah Cook). We are on the West Coast so if this does need to be rescheduled for tomorrow, we would prefer a little later in the day.

Female: That sounds reasonable. Comments from the co-chairs?

Harold Pincus: I'm – I mean I'm fine. If you want to continue, I can step out, that's OK. It's just that I, you know, I assume it was going to end at four and I have another meeting that I have to get to.

Female: Yes, this is (inaudible). I can only stay about 10 minutes past and then I have to get on to another call.

Peter Briss: This is Peter. Right, since it sounds like we're going to be losing people, I guess, I would savor holding this one over until tomorrow. I'm hopeful again that the Joint Commission is back on alcohol measures. It might go relatively fast because they're a family.

Female: OK.

Harold Pincus: Yes, I guess one question is whether tomorrow, we might be able to have a shorter lunch break.

Female: We could definitely do that. What do you propose like half…

Harold Pincus: Yes, like a half hour.

Female: Half hour? OK.

Male: Yes.

Female: We could do that to trim out some time and we could fit in this measure a little bit later in the morning.

Harold Pincus: OK.

Female: Where it makes sense.

Harold Pincus: That sounds right, it makes sense.

Male: Yes.

Female: Will half an hour be enough to make up because we're still having two other measures, right? The harmonization that we're supposed to do. Should we start at 9 tomorrow instead?

Female: We can – let's have a vote about availability of committee members at 9 a.m. instead of 9 tomorrow?

Male: I could do 9. Nine is OK.

Female: I do not.

Female: I – if I don't sound quite as coherent, I'll do it. I'm on the West Coast. This is ....

Male: Yes.

Harold Pincus: I could do 9.

Male: I could do 9.

...

Female: I can also.

Male: Me too.

Male: So we do 9 to 12 and then…

Male: I may be a little late.

Female: OK.

Male: OK.

Female: We can – we'll start at 9 and we will – and up to the chairs again, do we want to start with that harmonization discussion at 9 or just move it off, move it off?

Male: Let's move it off. Yes, let's start…

Female: OK.

Male: …let's start at 9…

Female: Let's start at 9.

Male: …so, and then do 12 and then take a half hour break for lunch and start at 12:30.

Female: Very good.

Male: Yes.

...

Male: OK.

Female: Very good. We would – we will do that. So at this point, I'd like to open it up for member and public comment. Comments from the committee. Hearing none, Peter and Harold, I think we'll close if you have some closing comments?

Peter Briss: I just like to thank – I'd like to thank everybody for how engaged they've been on our Webinar today and I look forward to finishing it up tomorrow.

Harold Pincus: I agree. I think it's, you know, it's much more difficult because we were talking while you were out – while we thank you up for that in the room. We were pointing at how it is harder to keep attention to things. Nonetheless, there really has been some very good discussion.

Male: I think this works because we met each other before and we all know each other. I don't know if this, as a new committee, you could do this from scratch.

Female: Yes, I agree with that. I think it made a bigger difference already knowing people.

...

Jeffrey: This is Jeffrey. I think it's still challenging and the degree of kind of – the tough stuff is harder to get my head and arms around.

Female: We agree. We appreciate that.

Nancy Hanrahan: I would concur with Jeffrey. This is Nancy Hanrahan.

Female: And we do have some representatives here in the room that like – would like to speak ....

Male: OK.

(Kim Roach): Hi, this is (Kim Roach). Just wondering if you could give us a ballpark so that our contractors on the West Coast could be teed up and ready to roll tomorrow morning or tomorrow afternoon.

Female: Sure. If you want to go later in the day, Peter and Harold, I'm just looking at the date too and it looks like after we have the discussion of the Minnesota Community Measurement measures, there might be a place in to discuss (inaudible). So 11:30, Eastern?

Female: That sounds good to us.

(Kim Roach): OK. OK, thank you.

Female: All right, so we'll…

Male: Make sense to me.

Female: Very good. We'll put it in there then.

(Kim Roach): Thank you.

Female: With that, I'd like to thank everyone for your participation and engagement today. We really appreciate your patience with this process so far. We will be reconvening tomorrow morning June 6 at 9 a.m. rather than 9:30 and we'll have all the lines open and we'll be sending you an update agenda with the new line up for measure discussion. So…

Harold Pincus: OK and check with Minnesota Measurements about being available earlier.

Female: I would be able to do that. As well, I just like to make a quick note, please use the same…

Female: For the steering committee members that received that special link to log in to the Webinar to vote, please reuse that link again tomorrow. For the public, I believe there's a new link that you will use to access the Webinar which should be on the agenda.

Female: And the call in number is the same with the same…

Female: For the steering committee, the call in number – the call in number is the same with the different confirmation code for day two and that is on your agenda.

Female: OK, thank you.

Bernadette Melynk: So that will be sent on e-mail about the different confirmation code?

Female: Yes, we will. We will be sending a reminder this evening.

Bernadette Melynk: OK.

Male: Bye-bye, thanks.

Male: Bye-bye.

Male: OK, thank you very much…

Female: Thank you everyone. Bye-bye.

Male: Bye.

Operator: Thank you ladies and gentlemen. This concludes today's conference call. You may now disconnect.

END