NATIONAL QUALITY FORUM

Moderator: Lauralei Dorian
June 6, 2013
12:24 p.m. ET

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 everyone and welcome to the second day of the Behavioral Health Steering Committee Web Meeting. We appreciate you calling in again and we appreciate your perseverance yesterday. We think that there were really robust discussions throughout the day and we're hoping to be able to get through the rest of the measures today as well as embark upon a harmonization discussion later in the afternoon.

Just to recap what happened yesterday. These are the – you should see in front of you on your Webinar - the measures that we're recommended for endorsements. And then there was one…

Peter Briss: Apology but it's very difficult to hear you, if you could speak closer to the phone.

Lauralei Dorian: Let me—maybe another microphone. What about now? Is it still very soft?

Female: It's much better.

Peter Briss: There's an echo now. As you read you're backstage you're not quite as echoing as you were yesterday but you're back to a lot of that same echo.

Lauralei Dorian: OK, we're working on it. Can you hear what I'm saying?

Peter Briss: Yes. You're OK, thank you.

Lauralei Dorian: OK so Peter and Harold, I just want to turn it over to you to comment on to the recap what happened yesterday before we get started today.

(Harold Daman): OK, so we managed to make it through. I think with that, given the circumstances I thought very well we had positive discussion. Fewer technical glitches along the way but actually I think I congratulate the staff as well as the committee members for really hanging in there and really doing a great job.

Peter Briss: Yes and this is Peter Briss. I was very pleased with the level of engaged discussion that we were able to manage in a nationwide Webinar and I hope that we can be successful today. Thanks very much for everybody that's engaged and run in persevering.

Lauralei Dorian: Great, thank you. Before we get started I'm just going to run quickly through the roster just to confirm who we have on the phone. Caroline are you on the phone?

Caroline Carney-Doebbeling: I am, good morning.

Lauralei Dorian: Good morning. Maybe I think…

David Einzig: It's David Einzig here up.

Lauralei Dorian: Great, David. David Einzig?

David Einzig: Yes, I'm here.

Lauralei Dorian: Nancy Hanrahan? Emma Hoo? (Jody)?

Jody Hundley: I'm here.

Lauralei Dorian: Michael Lardiere? Madeline?

Madeline Naegle: Yes, I'm here. Good morning.

Lauralei Dorian: Good morning. Tami?

Tami Mark: I'm here, good morning.

Lauralei Dorian: Good morning. Bernadette?

Bernadette Melynk: Hi, I'm here.

Lauralei Dorian: Great. David Pating?

David Pating: Here, yes.

Lauralei Dorian: Karlene Phillips?

Karlene Phillips: Yes, I'm here. Good morning.

Lauralei Dorian: Good morning. Harold, I know you're here. Vanita?

Vanita Pindolia: I'm here.

Lauralei Dorian: Jeffrey Samet?

Jeffrey Samet: Here.

Lauralei Dorian: Lisa?

Lisa Shea: Here, good morning.

Lauralei Dorian: Good morning. Jeffrey Susman?

Jeffrey Susman: Good morning.

Lauralei Dorian: Good morning. Mark Wolraich?

Mark Wolraich: Yes, good morning.

Lauralei Dorian: Great, good morning. Bonnie Zima?

Bonnie Zima: I'm here.

Lauralei Dorian: And Les. OK, great so I suppose we are ready to get started. Can I just remind you to please keep your phones on mute when you're not speaking and the call is being recorded? So, the first measure we have – so you want to tee that up?

Leslie Zun: Sure so…

Harold Pincus: Could you again get a little closer to the phone when you're talking? I'm sorry.

Leslie Zun: You're talking about me, Harold?

Lauralei Dorian: Yes.

Harold Pincus: No, not you Harold. You're fine. OK so, we're starting off with 0103 major depressive disorder diagnostic evaluation and can we here from the measure developers?

Lauralei Dorian: Dr. (Holden) will be right with you.

Male: OK. There are technical issue? Setting it up?

Lauralei Dorian: No, it's not a technical issue. We're just waiting for the PCPI …

Male: ... I'm sorry to interrupt.

Lauralei Dorian: (Inaudible) thank you.

Male: So, tell me and where…

Male: So, (John) we've asked each of the measure developers to sort of tee up and give a description of the measure and it's personnel.

Male: Hi, Harold how are you?

Harold Pincus: OK.

Male: Good, OK. And the two that I have to say a word about are 0103 on measure depressive disorder diagnosis and then 0104 on suicide risk assessment. So…

Harold Pincus: Right now assuming 0103.

Male: OK fine so, let me just say a word about that. This is a measure that really is fairly simple one which is to establish a DSM we should probably changed it now to, say, DSM-5 diagnosis of major depressive disorder. So, that that's a base line that's been established with clarity for future work with patients and this would be for, generally used in specialty services but also in primary care. I know this has been discussed previously but I would just say a couple of other things about it. One is, there are other measures that are out there. We think that this is one that's really important so that the standard is the same in increasingly throughout medicine and the standard being the specialty to write evidence based diagnostic system which is the DSM-5 for those who aren't familiar with that the DSM-5 has just been released this, just a few weeks ago to which the most recent addition. One of these reasons I think this is important is that in many ways setting the diagnosis by these criteria has importance in guiding treatment selection. And indications for treatment are particularly important to be correlated with level of severity.

So, this particular measure establishes a DSM-5 diagnosis and then establishes a level of severity. And the reason that's important is that there are differences in terms of treatment recommendations depending upon level of severity. DSM-5 it self provides a guideline for determining level of severity and it's fairly simple and straight forward really reflecting the first, the number of criteria, the number of criteria required or five out of nine. And the levels of severity are mild to moderate or severe and the that level is fairly easy to establish and in many ways it's very similar to establishing level of severity for all kinds of medical conditions such as heart disease or pulmonary disease and it's just in extremity. If you have severe level of impairment based on major depressive disorder it would be critical to have antidepressant medication as a recommended evidence based treatment. If you have mild or

moderate you could have either medication or cognitive behavior therapy or other forms of evidence based psychotherapy. All of which have been studied and found to be useful and effective treatments for a major depressive disorder.

But the differentiation, that's important is establishing that if it's sever you definitely have medication and not just therapy because that would not be the recommendation from the practice guideline. And these correlates with the evidence based practice guidelines from each of depressive disorder that the APA has already developed and there's a new edition, relatively new edition of that that was published in 2010.

So, that's a quick over view. Harold, you want more comments or is that-–

Harold Pincus: No, not now let's hear from the-–I don't know who's who is the person, who in the sub work group discussion is, as to lead.

(Mark Morris): It was me, (Mark Morris). In our discussion group was pretty well split or I mean I think there was agreement that this is an important issue to assess but there were concerns about how well it's, about particularly relating to severity, how that's operational or both from the standpoint of the condition and then how well it can be easily recorded from the records as part of it and I think that affected the considerations about feasibility and usability as well. So, in terms of suitability for endorsement again, the group really split down the middle on this measure.

Male: OK. Harold, can I add one thing and that is again, I think that the level of severity and determination is fairly straightforward and it's very clear. So, you just need to have substantially more than the minimum requirement of five criteria in order to judge the severity, again, the severe category. The other thing I would say is that on…

Harold Pincus: Has that thing tested for reliability?

Male: I don't know. I don't know the answer to that. I would say one other thing and that is the another instrument that's been thought about a lot is whether the Patient Health Questionnaire PHQ-9 would be an alternative. Well, the PHQ-

9 is literally an identical replica of the nine criteria turned into sort of shorthand for patient self-report form. But the problem is that they determine the presence of major depressive disorder at a much lower threshold than that which is required in DSM-5. And so, what you might then be doing is pulling people into a diagnostic threshold who would not be necessarily diagnosed that way by DSM-5. And that's the area of criticism I have to air all over in terms of inappropriately medicating people who have mild depression but not really major depressive disorder. And those…

Harold Pincus: Isn't the severity supposed to or to a great extent measure function and not just the presentation of symptoms?

Male: Well, the criteria or nine criteria that include symptoms that reflect function but the severity determination by DSM-5 is really a criteria account. But what I'm saying is that they also, the DSM-5 requires that all but one of these nine criteria are present nearly everyday for two weeks sustained. The PHQ-9 has a whole column that says, this could all be there just more than half of the days during a two-week period. So, the bar of threshold is that much lower and that's going to sweep in people with…

Harold Pincus: Oh, but no but it's PHQ-9 is not a diagnostic tool, it is a way of assessing severity and treatment response but it's not a diagnostic tool.

Male: Yes, that's right. But what I'm saying is that the nine items are actually the nine criteria for the diagnostic…

Harold Pincus: Right. Right, but it's not intended to establish a diagnosis.

Male: I know but some people have viewed this inappropriately that something that could be use for that purpose.

Harold Pincus: Other comments?

Female: Hi, this is – go ahead.

Female: This is Bernadette Melynk. I just want to add that there is very good essence in terms of the algorithm to treat severity of depression. And right now we've

got a lot of people being treated for mild to moderate depression only with SSRIs who are not getting good standard evidence-based treatment with cognitive behavioral therapy or individual therapy. So, I'm really in favor of this particular measure. The second thing and maybe we can talk about this after this initial conversation is over. We endorsed screening yesterday for 12 to 18 year olds as well and this has to deal with adult patient to 18 and older.

Male: Other comments?

Tami Mark: Hi, this is Tami Mark. I'm trying to think through that this is a process measure. So, the question is how does this lead to an improvement in population health? So, I'd like to hear more about how it's anticipated that this should be used and reported and what the anticipated impact would be on population health. So, it's a thought that people are with mild to moderate depression are getting inappropriately prescribed antidepressants and that this would lead to a reduction in that, or is it an issue of underidentification. What is the call pathway that people are anticipating? This would improve or act upon?

Male: I would say a couple things about that. One is I think there is clear epidemiological data from population studies that these patients are – that there's a high prevalence of this condition and it's not – it is under identify. And so, there's an important need to identify this people carefully and systematically. It also had something that does make difference in terms of treatment. And I think it's probably fair to say that in the primary care and family practice there's a pretty severe rush and pressed for time and the modal treatment would likely be medication rather than the recommendation for psychotherapy. And psychotherapy is an extremely important option reflective…

Male: How does this influence the choice of psychotherapy, it's not unclear to me because the level of severity would (inaudible) hide you and you could recommend clearly if it's not severe depression. Psychotherapy alone as an option that patients might prefer and that they could benefit from, but if you don't do the severity level.

Male: How does that – I'm not sure how that changes behavior.

Male: Well, what I mean is that if you don't do a severity level and if you have termination that's not precise that this patient has depression that you haven't determined severity, in many parts (inaudible) practice in medicine, the patient will be giving anti-depressant medication.

Jeffrey Samet: So this is Jeffrey Samet. I'm just trying to follow this one as well. I understand the rational but I was struck in the review that the committee had talked on the phone about. They were pretending about the lack of data that showed that this rationale which, you know, makes sense on it's phase is supported.

Peter Briss: Yes, this is Peter also. I had that concern in the reading they did at this person. Ideally, you would have (inaudible) I'm not an expert in depression treatment but in the conceptual rationale that you presented today makes-–it has a lot of phase validity but essentially there is nothing in the importance to measure and report that would allow me to actually see the empirical evidence on the quality and consistency of the studies that supports the proposed logic. And so (inaudible) at least as a communication thing in the submission, that might be something to think about.

Male: In fact, this is just (inaudible) it seems to me that equally important is measurements based therapy that you actually strike a baseline and can determine whether you're actually being effective. Does this measure like a lot of the measures we considered yesterday is fairly far off screen. And if alone, if I'm going to change the quality of care to it because it's really contingent upon, one either choosing treatment differently based on the initial measurement or following up in measuring again (inaudible) to determine that the treatment is actually effective.

So you know, it is what it is. It's a very upstream measure and you needed to buy that as an important component to lingering more effective to question care or not. But there is a use (inaudible) and it is highly distal to the outcomes.

Male: ... I think there are certainly data that would be important to study and further evaluate. In the process guideline, there are a number of residences in terms of treatment guidance based on severity. When we originally put this together a PCPI and that was many years ago, we have a multi-visit chart on a one pager so that you would have a way to record how the patient was doing sequentially over about 6 different visits. And on that, we would be clearly documenting what the patients have improved, what's the saying or what's worse.

And so the level of severity was tracked. So it can be used-–because you do have a usual level severity back in (inaudible) as a major change.

Male: Mrs. (Harold) let me (inaudible) in the Chairman's role, and I guess I was one of the more vocal critics on in the workgroup. And here is my concern, is that (inaudible) sort of three levels. One is that this is a chart review measure that requires a fair amount of effort to gather this information and requires a significant amount of documentation that is often not available. And now one could say that people would respond to this measure by enhancing the documentation. So unclear and there's no evidence that they would necessarily enhance the actual assessments. But it's a lot of effort to gather this information and the question is whether it's worth it in terms of the outcome.

Number 2 is that the available information at least from my reading at the DSM-V field trials is that actually there was not great reliability for in the field trials for major depression. And I don't think that the severity component has been studied with regard to tis reliability.

And then number 3 is that, you know, we will be considering sort of other measures that actually look more as (Jeff) was saying instead of longitudinally over you know, establishing a baseline and then serial assessments with you know, well with the PHQ9 which you know, gives you a kind of way of measuring in a quantifiable way whether people are getting better or not and it's embedded within this longitudinal kind of perspective that you know, that (John) you said was kind of an aspiration from the initial PCPI.

Male: Right.

Female: Right.

Male: This is David ....

Male: Just do it (Chris).

Male: Go ahead.

Male: Yes, just a couple of comments also from a clinical perspective. My concern is with labels and, my concern would be either over treatment or under treatment potentially. In other words if you have a person with mild depression, that might be what the evaluation shows at that point in time, but symptoms fluctuate overtime also. And might that prevent treatment, and potentially prevent suicide as they do get treated if you have more of a longitudinal no history but not the label.

And then in converse of that is the major depression, you know, what if they're bipolar and because he got the label, we had started treatments inadvertently making we care back. Second comment is, if you look at the criteria for major depression in my clinic it's really rare to see a person who has just one diagnosis of depression, they also have BBHD and anxiety and other things.

And then might be other reasons for insomnia or weight gain or weight loss. And so it's – I'm concerned about labels.

Male: I was just going to add to (Gerald's) comments that documentation it seems to me that it's relatively simple to do a PHQ-9 if you buy that that's the adequate severity assessment. Moreover, with EHRs, you know, this issue is becoming less and less concerning, because there are certainly modules available to document severity assessments symptom counts and the like, based on PHQ or otherwise.

But I think again (Harold) laid out the problems with this measure and I think the end we're going to have to just vote to our conscience of whether there's enough of the causal pathway that makes this worth approving.

Kendra Hanley: And this is Kendra Hanley from the PCPI. I did want to just to remind the committee that we did prepare and submit electronic classifications and did conduct testing in the electronic environment for this measure.

Jeffrey Samet: This is Jeffrey Samet just one more account it just the last sense at our criteria should be whether we thing there's a causal pathway. I think we really should be working on the basis of is there evidence that shows that our hypothesize causal pathway, really is if the intervention on what we think might be the cause of pathway is benefits, benefits folk that it shouldn't be on our impression it should be on what the data is telling us. Thanks.

(John): This is John I'd say there's a fairly extensive amount of data in the evidence based practice guideline which is based on the diagnosis that that's the separate publication.

Harold Pincus: Other comments or questions? I think we're ready to vote.

Lauralei Dorian: All right, please go ahead and vote for evidence.

Lisa Shea: Excuse me. This is Lisa. I'm not seeing anything on my screen yet.

Lauralei Dorian: OK. (Sean), would you be able to work with Lisa?

Operator: Absolutely. We'll have your line pulled right now, Lisa.

Lisa Shea: Thank you.

Female: Is everyone else ....

Male: Yes.

Male: It looks good.

Male: 18 of us have voted already, so a lot of people seemed to be able to do it.

Lauralei Dorian: Yes. OK, and if you have not voted yet, please go ahead and vote now. We have 2 yes, 9 no, 7 insufficient. Measure 103 will not move forward, not been recommended by the committee.

We'll move on to measure 104.

Samantha Tierney: Excuse me. This is Sam Tierney with the AMA PCPI. I just wanted to ask if it might be possible for the measure to be considered for an exception to the evidence to be considered. I know an NQF guidance related to evidence. There's the opportunity for that recognizing that not all areas of medicine are subject to strong evidence or randomized controlled trials during with that type of evidence and the causal pathway could be identified. So, I just wondered if that would be a possibility now I know and others joined committees, we've participated and they've taken a vote as to whether or not they'd like to consider that.

And also if I could ask, is the general path of question and other committees it seems like the criteria on importance are voted according to ABC. So, starting with the impact and then the opportunity for improvement, and then, finally, the evidence. And I just wondered if there's a change in process just so that we have an understanding for the future. Thanks.

Karen Pace: Hi, this is Karen Pace and I'll answer the last question first. We changed towards the end of last year the order that we're looking at the important sub-criteria because – and this is the new order for the criteria in the latest posting of the criteria. So, we did start this some time towards the end of last year looking at evidence first then performance gap, and finally priority.

In regards to the exception to the evidence, again, that's not a routine thing but it's certainly something that the committee can consider if they wish to. So, it's not, you know, kind of a routine thing that we do with every measure because it goes down on the evidence, it is supposed to be an exception not kind of a standard practice, but we'll post that question at this hearing committee and see if there's any interest in exploring this as an exception to the evidence. And if so, we can do a vote on that.

So I'll turn it back to Harold to talk with the committee about that.

Harold Pincus: So does anyone in the committee want to move to add that as a consideration?

(Jeff Satin): I would not say (relive). This is (Jeff Satin).

(Maggie): This is (Maggie), I would not favor that.

(Peter): Yes, this is (Peter). It sounds to me like – it sounds to me like this isn't just an issue of the evidence. It's also an – it's also an issue that we've been talking about that sort of, I mean it's not clear that – to the committee, as I've heard the discussion, whether the upside of this measure is – has been demonstrated to, if you keep it downsized in terms of reporting burden and other things. And so – so, I don't think I would favor as you were.

Bonnie Zima: This is Bonnie Zima it's not going to change things.

Harold Pincus: Does anybody want to make a motion?

Nancy Hanrahan: Well, could I just throw in a contrasting view? This Nancy Hanrahan. The measure itself – home healthcare is where that, this is getting measured. And the measure itself is already embedded, I think, in most of the…

Harold Pincus: No, this is not for home healthcare.

Nancy Hanrahan: It's not?

Harold Pincus: No.

Nancy Hanrahan: I'm sorry.

Harold Pincus: It's 0103.

Nancy Hanrahan: OK. Well, thank you. That helps.

Harold Pincus: Does anybody on the committee want to make a motion?

Karelene Phillips: This is Karelene. I'll make a motion.

Harold Pincus: Is there a second?

...

Harold Pincus: I didn't hear the motion.

Male: Yes. So presumably, the motion is that we don't want to make an exception, is that the motion?

Female: That's the motion.

Madeline Naegle: And I will second that it's Madeline.

Harold Pincus: So this is that we don't want to make an exception.

Female: Correct.

Male: Yes.

Harold Pincus: OK. I'm not sure we need to vote on that.

Female: I don't think we need to vote since no one is moving.

Harold Pincus: Only if somebody wants to make a motion that we make an exception. And then we need to vote. Because, otherwise, things stand the way they are.

Anybody want to make a motion that we make an exception to the evidence rule?

So hearing none, let's move on to 0104.

(John), do you want to layout the thinking for that one?

(John): Yes, sure. This is a measure that would indicate making sure that you ask about potential suicide risk when you have a new diagnosis or a current episode of major depressive disorder, identifies that suicide risk as not to be as completed during that visit, when a new diagnosis was either identified or the new episode identified. This is a measure that really, again, a front door measure but one that we feel at least and the idea is extremely important, and the AMA felt so as well.

On this side, this is an extremely important aspect of a potentially lethal illness called major depressive disorder. And one type of discussion that is not one that's comfortable or easy for many practitioners and a guidance to really encourage people to proactively bring this up and ask about it when depression is a question, I feel it's extremely important.

I did read a number of the comments from the discussion that we've had about it, and again so I'm a little puzzled by some of them because it seems to me that the guidance should not be whether primary care or family care or practitioners are comfortable whether they're not. In fact, if it's discomfort that prevent somebody from bringing it up, that's why this proposal is made to help people get more familiar with it comfortable asking the question. I don't think that…

Male: (John), I think that actually was at least in – during the worker. But I think that was actually put forward as a reason in favor of the measure.

(John): Well, OK. And in fact that's good. I couldn't tell from the way that comments were worded that it meant that. So, if that's the case, that's great.

The other comment that was made that simply asking about something like suicide as though distilled to the desired outcome. Again, that's a process and a metrics question. But it seems to me, the way I would respond to that at least is you have to ask and you have to get the information and know whether that's at a level of risk to be of concern. And it's one that – the problem is that people are hesitant to ask because of the fear that they wouldn't be clear or it might be complex or challenging to know what to do if the answer is yes. But it's really – I guess just the analogy I would just make very quickly is the APA was – and I'm quite vigorous today in Florida when there was a piece of legislation passed that made it a criminal offense for physicians to ask a patient if there were guns in the home because they're worried about potential either self injury or homicide. That then changed now. But this is an example where you really need to be able to ask the question as a way to protect the safety of the patient.

So, those are the main comments I would say. I just think it's a critical question that's one that we need to help people get comfortable talking about and actually have then a fear – we have a research project here at the medical clinic looking at suicide that's based on work by David Jobes in Washington called Collaborative Assessment in Management of Suicidality kind of urges the proactive exploration of this area as a much more effective way to deal with it and help patients devise alternative solutions where they've been that ultimately lethal plan of action.

So those would be my general comments about it.

Harold Pincus: Thanks, (John). And the lead from the workgroup?

Female: No, (inaudible). The workgroup also thought as an important measure, but we are rather split on the evidence because there was not a lot of evidence that this would help. Also split on usability. It is, again, going to take a lot of work to find the answers because most of the assessment will be in a dictated or written document. And I guess that's about it you can see what else we send. You kind of already went through, questions are concurring well.

(John): This is (John). I would of course just add, even though it was just for two of these I guess, but the negative of the problem within the military and within the veteran's populations is so huge at this part, and that's also a big population that people as they're needing care.

(Crosstalk)

Female: That wasn't the argument. We do agree that this is an important thing to look at. We're just not sure that the way that it is set up is a way that will make it easily done.

Bernadette Melynk: I have a question. This is Bernadette again. Why was then it could forward to, also, to this in 12 to 18 year-olds?

Samantha Tierney: This is Sam Tierney with the PCPI. Just related to that comment, if I may, we do have a measure that as NQF endorse for children and adolescents with

MDD, and it does cover that patient population. And it's identical essentially to this measure.

Harold Pincus: Was that submitted under this project?

Samantha Tierney: It was in endorsed recent – more recently. And I think it's – as a result but I don't believe it was subject to review as part of this process. But NQF (inaudible) might be able to comment.

Female: Thanks, Sam. That's correct. It was endorsed in the child project.

Female: OK thanks.

Harold Pincus: Other comments and questions by the committee?

(Madi): This is (Madi). So, again, this measure is a one-time not longitudinal measure, right? It's not done over and over and over again.

Male: No, this is at the first visit, when the measure depressive episode is identified or the recurrent episode.

(Madi): OK, thanks for the clarification.

Madeline Naegle: Excuse me. Hi, it's Madeline. The guidelines, however, APA guidelines do specify that the inquiry we've made on every visit for the individual who was diagnosed with major depressive disorder so that assessing for suicidality is part of best clinical practice, and that's well documented in the literature.

(John): Yes, and that's important to note. That's not written into this particular measure, but the guideline does recommend that. Actually, when we first developed this measure in that early phase when we had a sequence of six or so sequential visits, one of the members of the workgroup was a pediatrician who acknowledged he himself had a depressive disorder and he said that he really wouldn't want to be asked about it in every visit when he was doing well. We would actually change the wording. They asked about it at every visit until remission. But you have to certainly not just do it once.

Male: So, the reality is having looked at probably thousands of primary care doctor's charts is that this isn't being done. At least it isn't being documented and I have to believe from my observation to the actual practice that this isn't being done but even doing it once is an improvement, although may not be sufficient to our goal.

Male: Right.

Male: All right this is data pitting, but the evidence submitted shows there really wasn't much of a gap. And in my system, this is an adverse consequence in suicide wasn't addressed even if it was – during the course of detection of depression, that's – that's a significant event. It goes right to the quality committee.

So I think there's other bodies that are looking at this, and then I guess the gap that I was – you can't even distinguish someone through 25th from the 20th that's in file. I don't know whether that you get from 25th to the test that if it's a 100 percent at the 90th, 100 percent of the 75th, 100 percent of the 50th and the 25th. And when you get these outliers at 94.4 in the 10 percent file, which is I don't know whether it's tested with the national measure, although, I mean, I feel really bad about this because I'm on many suicide prevention board and we I say that this is really important. But talked through the data showing a gap.

Samantha Tierney: This is Sam Tierney with the PCPI. Could I comment on the PQRS data? I think it might need some clarification.

Harold Pincus: Could somebody please kind of off that – the line with the music.

Operator: We're having that line pulled, thank you.

Samantha Tierney: This is Sam Tierney with the PCPI. Again, if I could just comment on the PQRS data just to put it into some context. So, just to clarify, so the PQRS is a – currently, a voluntary reporting program. And the data that we shared was from 2010. And at that point, only about 24 percent of eligible professionals were participating using any reporting options. So, we actually are very cautious about looking at that data as nationally representative in any way.

Additionally, I guess I would add that if you look at the information included in above that information in the submission form, data from the medical literature actually indicates there's quite a gap in this area ranging from about 25 percent of folks actually doing this to about 40 – to about 29 percent. So I would actually refer more to the medical literature data given the nature of the PQRS program.

(Crosstalk)

Peter Briss: This is Peter. I was going to say much of the same thing. We had this issue – we had this issue once yesterday too about – it's being a little caught perhaps being a little cautious about a lack of gap data when the data come from highly motivated volunteers who likely are doing well which is why they're – which is why they volunteer.

Harold Pincus: Right. I think we need to think differently about, you know, comparing – looking at the program versus looking at the measure. I think the way the program is set up is that it, you know, people choose which ones they think are going to do well on. And so it's a different kind of issue than looking at the measure per say in a more broadly representative population.

Other comments? Questions?

Let me step out of the chair, well – and just say that I feel a little – I feel conservatively differently about this one than I did about the other one. And that, it's not n ideal measure, but it is a, I think, a very important one because there is often a failure document. Just when we were sort of running a national depression program and actually trying to get people to implement the PHQ-9. One of the things we found that there were a number of different places that would only PHQ-8 because they were concerned about asking about suicide.

And so, you know, we, you know, we felt it was king of crazy because, you know, if you're really worried about getting sued, if I was an attorney and says, "You chose to eliminate the suicide question, that would sort of make you much more liable." But the – but nonetheless, there is a kind of

reluctance for people to delve into this, and I think that there's value in having a measure like this.

I think it will be much better – be a much better measure if there was a more systematic measurement tool that was used, and whether it'd be the PHQ-9 or the, you know, recently there's been a well validated one, the Columbia Suicide Assessment Tool. Or – and also, if it was built into some longitudinal framework, it would be much better. But I think, given the importance and given what I believe to be fairly good evidence about a gap nationally, I think there's value in this measure.

(John): Harold, this is (John). I just wanted to comment about that. When we originally talked about this, we deliberately decided not to endorse a particular assessment method because we felt that that was lock people in a way that have potential forensic implications and that was actually was one of the reasons why a suicide risk assessment that had been thought for DSM-5 was ultimately not included, so that's periodic complications to go with that. I understand the point.

Male: Other comments and questions?

Jeffrey Samet: Yes, this is Jeffrey Samet. So, I'm just trying to clear the, the piece that has me a little a stuck here, is just this feasibility stuff and people had talked about it. But and I see when the committee discussed it, they were pretty split too. So, you can use any way you want to do it. It's the sense that it's feasible - I'm kind of confused why people think it's so hard to be feasible. It's more feasible how they assess if it's actually done. Is that the understanding and then I need thoughts on that.

(John): Hello. This is (John). I would just say that our thought was that this would be feasible because it's a expectation to document that this was discussed and asked about, but wasn't dictating a specific method to do it.

Male: And so as capturing, is that part of feasibility?

Male: ... maybe, maybe the PCPI out here could say, what are the specific elements that have to be identified you know in the chart?

Samantha Tierney: Hello. This is Sam Tierney at the PCPI. We're happy to explain that. I guess it seems like the discussion related to feasibility should probably take place during the review of the feasibility criterion, and I thought that the beginning of the review of the feasibility criteria…

...

Male: Oh my God.

Male: They were in an airport somewhere.

Female: Sorry about that.

Male: Well, let me just explain if you're still on the line that we had a discussion yesterday about how we would run the discussion, and the idea was we put all the discussion upfront and then run through the voting afterwards right on having individual discussion about each of the criteria.

Female: Yes, that's fair. I just wanted - it was…

...

Male: So, we're just explaining that, just to tell you so that this is your opportunity to discuss…

Female: OK.

Male: … to drive the feasibility.

Female: OK, great. Thank you. It's following a slightly different process than we're used to, so I just wanted to get a clarification on that. I appreciate it. So…

Male: Yes, there's a lot of difference when you do it on the Webinar.

Female: Yes, that's understandable. So, the suicide risk assessment in the measure to find as including questions about the following one suicidal ideation to patient's intent of initiating a suicide attempt and then if either is present, the

patient (three) the patients plans for a suicide attempt that for whether the patient has means for completing suicide.

David Pating: So, this is David Pating. If you did PHQ-9 or systems that are implementing PHQ-9, would that satisfy this measure? Have you done that? I mean it doesn't go doesn't have those additional on this …

Female: Hello.

Male: … You have to, it sounds like you have to roll out.

Female: Speaking.

Male: Hello. This is…

Male: You do not like…

(John): This is (John). I don't think…

Female: OK.

Male: … that the PHQ-9 would address this adequately because the item on PHQ-9 has thoughts that you would be better off dead or of hurting yourself and thinking you'd be better off dead is a very different word.

Female: No…

Male: All right, but I think that - I think it would because that was suicide ideation. I think it would capture the first, the first element. But wouldn't capture the additional elements if somebody was positive to one or two.

Male: Right, which would be the higher risk elements.

Male: Yes.

Male: Other comments or questions? OK, I think we're ready to proceed with the voting.

Lauralei Dorian: Please go ahead and vote on evidence, and we should have 20 votes total.

And if you haven't voted yet, please go ahead and vote now. And we have 15 yes, two no, three insufficient. Performance gap?

We have eight high, seven moderate, one low, four insufficient. High priority?

16 high, four moderate. Reliability?

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

Female: OK. Sure.

Lauralei Dorian: We have 12 moderate, three low, four insufficient.

Female: OK.

Lauralei Dorian: Validity.

Female: Fine. No problem. That's fine.

Male: Somebody may need to mute their phone.

Lauralei Dorian: And we have 14 moderate, one low, six insufficient. Usability?

Female: OK, great. Thank you.

Lauralei Dorian: And we have two high, 14 moderate, four insufficient. Feasibility?

And we have 13 moderate, six low, one insufficient. Overall suitability for endorsement. And we have 15 yes, five no, measure at 104 has been recommended by the Steering Committee for endorsement. And we'll move on to measure 1884.

Male: OK, I'm signing off, (John Ovum) here. Thanks very much for letting me join.

Female: Thanks, John.

Male: Yes.

Female: Thank you.

Male: OK.

Female: Thank you.

Male: So, can we hear from the measure developer from the Minnesota Community Measurement?

Collette Pitzen: Eric, good morning. This is Collette Pitzen from Minnesota Community Measurement. Can you hear me OK?

Male: Yes.

Collette Pitzen: Great. The first measure that we're bringing forward for endorsement is major depression response at six months progress towards remission. This is a longitudinal patient reported outcome measure that's looking at adults age 18 and older with the diagnosis of major depression, dysphemia and an initial PHQ-9 score of greater than nine. The numerator for this population is then at six months through minus 30 days for allowing a grace window around that six months time frame. We're looking for a PHQ-9 for that if reduced by 50 percent or greater at initial PHQ-9.

I just also wanted to share that this is a companion measure. We consider this to be an intermediate outcome to our gold standard measures that's related to the depression remission at sixth month which you're looking at PHQ-9 score of less than five. These measures were developed in concert with the Institute for Clinical Systems Improvement back in 2008. We're bringing this measure forward now. Initially, we had used this measure for quality improvement purposes and we've had request from the providers in our community that this is not an easy measure to achieve great outcome results and part of that is due to patients who are lost to follow up. But they wanted to have an additional measure for public reporting that would demonstrate this intermediate progress.

Following the work script discussion, there were the request for additional information from us, additional analysis and this is provided. And part of that question was for the patients that do achieve a follow up contact for this letter there is (inaudible) and actually they are quite high at 42.3 percent for a most recently submitted data.

However, I do want to stress that one of the major incomes of this measure is really to encourage follow up and continue all contact with the patients to meet those – than outcome goal and to initiate stepwise treatment if those goals are not being obtained.

Male: Can I ask a quick question?

Collette Pitzen: Sure.

Male: When you say 42 percent, what's the denominator in that? Does that include – does the denominator include individuals for whom there is a failure to get a follow up PHQ-9?

Collette Pitzen: Oh no, thank you for the clarification. Actually, in the denominator of the measure as specified, our current rate is 11.4 percent and those include – the denominator includes patients that were not connected with in followup. So the additional analysis of that, please look at those patients that do that are contacted and that's where of course the rates are much higher.

Male: OK, thank you, that's helpful.

Collette Pitzen: Sure.

Male: So, continue.

Collette Pitzen: Let's see, a few more things about the measure. There are some exclusions to the measure. We exclude patients who die, patients who are in hospice or permanent nursing home resident. There is no upper age found for this measure. We also have exclusions for bipolar disorder and personality disorder and I talk a little bit about that in the initial stages of the pilot testing

and development of this measure. We thought it was simply enough to specify major depression and dysthymia.

And particularly in the behavioral health settings, there are difficulties, let's just say best clinical practice for coding is not always followed and sometimes patients initially are thought to have major depression and then to the course of treatments, additional visits, they're discovered to have bipolar disease. Even though there's lots of ICD-9 Codings for coding the different phases of bipolar, providers continue to use major depression code with bipolar patients and a little bit similar with some of the personality disorders. So that's like those measures are – or why those conditions are excluded from the measure.

I think that's about it. I know that there was a lot of discussion at the subgroup about a concern about the number of patients that are lost to follow up. We are making some incremental progress over time. The tool is widely adopted, the PHQ-9 in Minnesota and keep making those efforts, case management efforts, healthcare home efforts for continually reaching out to those patients to maintain contact.

Male: Thank you. Can we hear from the – can we first hear on the workgroup?

Caroline Carney-Doebbeling: Sure. This is Caroline. Tami, you also reviewed this, would you like to go? I'm happy to…

Tami Mark: Sure, why don't you go ahead Caroline.

Carolyn: OK.

Tami Mark: I can – I can follow up.

Caroline Carney-Doebbeling: Chime in, please. The workgroup evaluated this measure and was somewhat split. Even initially on the importance of the measure, in part we understood that depression is common and costly and we know that many folks are lost to follow up in this but there were significant concerns about the measure regarding missing data at six months and how much of those missing data were due to failure by clinicians to assess depression at six months versus patients who truly are lost to follow up. The numbers that we're provided with

regard to the measure itself working show that in the initial denominator, there were 86,000 patients roughly.

By the time that there were – there was a six-month assessment done, only 23,000 of those members or patients remain. There were concerns about this scientific acceptability of the measure properties itself because of the range of the score and a wide variance of the score from 0 to 40 percent depending on the clinic. There was also concern that regression to the mean would affect the use of this measure going forward.

Additionally, there were concerns about patients who had dysthymia or minor depression being able to be measured with a 50 percent reduction or complete remission of their scores were low to begin with and how they would be dealt with in the denominator and their inclusion in the numerator. There were concerns about using this measure because of the effort involved in bringing folks back for six months especially in the primary care setting.

These efforts were described as being directed at implementing care management systems in the primary care practices which was brought up would add another cause and burden to primary care providers. And that the measure would be difficult to routinely get and to measure without widespread chart review without EMR widely available in all systems.

So overall, the group was split on many of the elements that we assess going into the measure and at the final endorsement we were split three to two on adopting the measure.

Male: So most of the comments you made were sort of criticism of the measure but it's still pass three or two. What were people saying in favor of it?

Caroline Carney-Doebbeling: None of the favorable comments really were recorded except to say that it's an important counteractive study. We need to know what outcomes of depression are at six months and whether people who have been diagnosed are improving. But really, very few positive comments were included in the right of this you'll see in your handouts today.

Male: Right, and beyond the write up, what is the write up? What about the discussion?

Caroline Carney-Doebbeling: I think the write up very clearly reflects the discussion. I would ask (Tammy) to jump in if she remembers other more positive comments about the measure. I think one of the only other real positive comment about this that I do recall is that in Minnesota, the groups that have adopted it have improved markedly in the screening of depression at six months. That is – that has been a positive outcome of implementing the measure in Minnesota today.

Jody Hundley: This is Jody. I was on this workgroup and I was the one that was much more favorably impressed by it. Number one, I'm thrilled to see an outcome measure and one with a companion, a 12-months follow up. In fact if, you know, I wondered why, maybe we can talk about this, if we have time why there wasn't a three-month, six-month and a 12-month follow up using a standardized tool using something that would be – with 2014 come in meaningful use and the EMR finally able to, you know, be useful in this kind of endeavor that this was, you know, I had thought that the work that they did was barely impressive given that this is an outcome measure and it sort of has a validated tool and longitudinal components to it.

So and I do believe that, you know, again I get this, it's understanding improvement overtime and that 1 or 2 or 3 percent improvement year over year and there's sort of an effort is not a bad thing, so.

(Crosstalk)

Caroline Carney-Doebbeling: I pulled my – I pulled my note, this is Caroline again and one thing that I did note from the actual conversation that day is that there was some discussion about this potentially being in and of itself a two-part measure. One is the task being done and separating that from whether or not a 50 percent reduction or a remission score was brought up. So that's was going to be discussion about the measure as well.

Jody Hundley: Right. I mean just to leverage on that – to leverage on that Caroline, I mean, I do – I was also thrilled to see this measure and I think this is absolutely terrific

to get providers looking at outcomes and also to encourage follow up. I – my main issue was that they are lumping these two very distinct outcomes and it would make it hard for providers to know where the issue was when they were lumping, you know, basically if you didn't follow up, it was recorded as not being in remission.

As you can see the data that they submitted, you get very different impressions when you separate out those two outcomes as when you lump them. So little difference then maybe on what, you know, my take on, for me.

Collete Pitzen: This is Collete from Minnesota Measurement, may I make a comment? I just like to additionally share that – the companion measures for this have been E specified. They were in the CMS HHS project. Two of the measures were selected for meaningful use. We also have an additional measure that is simply the use of the PHQ-9 for patients that have a diagnosis of major depression or dysthymia.

So that process measure is considered to be a companion to these as well, but in terms of, you know, as things are going forward, the PHQ-9 tool itself is linked coded so ready for EHR use in the extraction over time and eMeasure modification to the kinds of applications for this measure, this companion measure would be a simple numerator change. And additionally, we do provide information about what the group's follow ups rates are with their patients and are planning to go publically reporting that process measure as well.

Female: Thank you.

Michael Lardiere: This is Mike. I have a question – I have a question with the measure, does the patient have to go in the office or can this be submitted through patient generated data into the EHR to the provider?

Caroline Carney-Doebbeling: Great question. One of the keystones of the denominator is you do need to have the diagnosis of depression or dysthymia and an elevated PHQ-9 together so basically that happens in the office, but all the follow up content with the patient is completely acceptable by mail, by phone calls, completely acceptable for inclusion.

Michael Lardiere: OK, fine thank you.

Caroline Carney-Doebbeling: Yes.

Male: Other comments or questions?

Male: ... So they're coming at there are three months follow up visits and they got divorced or their dog dies that's significantly influences what they write up in their PHQ-9. So my concern is using that 50 percent decrease in score as the strong measure of responds.

Bonnie Zima: This is Bonnie Zima, member of the workgroup. I think this discussion has been very good because it points to areas where this measure could be refined and again, the big issue for me was an 80 percent missing data rated six months.

Jeffrey Susman: This Jeffrey Susman. It seems to me though that we're trying to look at a progressive positive path in the treatment of depressions with this sort of measure. I'd like to see there are a lot of tools, lots of refinements that would need refinement, there is added burden and added challenges into collecting the data which is already is challenging enough. So overall, I think this was the type of measure we should be looking at and recognizing there's always trade offs.

Jeffrey Samet: Jeffrey Samet here. So, being in primary care and – working in primary care myself, depression is incredibly common so this has potential to, you know, added substantial burden to the workload which is fine if it – if it benefits the patients who have this common diagnosis and EMR is coming so I'm less concerned – a little less concerned about the issues than to a feasibility but what I was looking for which I'm not sure I heard was that in doing this data, does this data exist that this follow up assessment has made a difference and outcomes had people reported that specifically?

Karen Pace: This is Karen Pace. This is the outcome, the – you mean the final outcome in terms of the actual remission.

(Crosstalk)

Male: Maybe I can respond that. I think, you know, that there are actually, I think well over a dozen sort of clinical trials of interventions that have a bit of systems interventions, that has as a key component serial assessments of PHQ-9 as part of that, you know, broader sort of care, you know, care management strategy and they've all shown significant improvements.

Let me step out of the chair's position for a minute and just say that, you know, I was just thinking that some of the critics, if we were to put in place instead of saying PHQ-9 and say blood pressure, they would be the exactly the same critic that, you know, they worry about progression the mean, they worry that, you know, the person was, you know, having some issues that they – that raise their blood pressure, concerns about the burden of making an assessment of blood pressure but I don't think we had questions about that. And also the lack of follow up.

I – you know and I think, just going to Bonnie Zima's point. I think, you know, I'm split on the notion of, you know, in some ways, the failure to get a follow up is a failure of response. It doesn't give you information about your overall response rate but from the point of view of quality, that something that I think, you know, suggest that that you have a quality problem if you are not being able to follow up people. Also if you're not able to get people better, there's a potential quality problem.

So that I think that including that in the denominator – including people who did not have a follow up in the denominator is important. There's an overall measure of quality but I also think that having the information on both denominators would also be helpful.

Female: Yes, I think that would require just a little bit of revision on the numerator. I mean if we wanted to use it as an indicator of continuity.

Male: Yes, but I think, I think that is already – if I'm not mistaken, I think the issue of the continuity that is of getting a PHQ-9 measure is already an NQF-Endorsed measure.

Female: That's correct.

Female: That's fair enough.

Male: Other comments or questions?

Tami Mark: So, it's – there's a process question. This is Tami Mark, if we didn't want to encourage the reporting because this is actually on a consumer Web site. It's been recorded for, you can correct me, I think like two or three years we did want to recommend that. There'd be several reporting of remission rates among those who are to follow up as well as the percentage that followed up, is that – how does that occur? You just take a note that we recommended that?

Male: Karen ....

Karen Pace: This is Karen Pace. Well, first of all, you know, NQF would be endorsing the performance measure and then, you know, you can make some suggestions in terms of reported but you also have to realize that if you start reporting these two things separately that's really two measures and we've only been looking at the specifications, the testing for the measure as it before you.

So, you know, certainly having that data is for the providers, for performance improvement is helpful and obviously they will have that data based on, you know, having to have the data for the measure as it specified so it's something that you can suggest to the developer to look at but you're really going to be voting on the measure as it is and…

Male: But isn't there are already a measure that's been endorsed that actually captures follow up PHQ-9?

Karen Pace: I'll let Collette mentioned that we do have a measure about using the PHQ-9, that Collete can you answer specifically, I don't have that in front of me in terms of what that's measuring and what point in time?

Collette Pitzen: I'd be happy to do that. Thanks Karen. The current endorsed measure that we have is actually paired with the remission measures. It is a – it is a process

measure that simply looking at all patients with major depression or dysthymia regardless of what they're PHQ-9 score is looking at all patients during a four months timeframe where a visit occurred was that patient assessed with the PHQ-9 tool. And that was to promote and support frequent follow up with patients and to, you know, help with the implementation of the tool itself. We do have measures for follow up rate with PHQ-9 at six and 12 months. We have not put that probable process measures forward for endorsement.

...

Male: … I guess in answer to your question is that there is an endorsed measure that captures something like what you are suggesting but it's not precisely what you're suggesting and that we'd be voting on this measure as it is but making a recommendation that they sort of consider submitting a future measure that would capture exactly what you're suggesting.

Female: This is – OK.

Collette Pitzen: And I just want to ask for clarification. We can certainly provide this feedback to our measure development workgroup. One of the reasons why we constructed the current response and remission measures for all patients that meets the denominator criteria versus those that we contact. We believe that we would not be changing care and would not be impacting those lost to follow up rate from us. We highlighted that and included it as part of the measure.

So part of me says there's a little bit of hesitancy about publically reporting only those that you're connecting with in terms of we won't be moving the intent of the measure forward but I can certainly bring that feedback to the work group and it's another consideration is our data portal calculates lots of measures. This one is currently not in the calculation but it could be a value add for providers to let them know how they're doing. Thank you.

Female: Thank you for that. I would just not to believe at this point but, you know, these are all for intended to be used and are being used by consumers so just pecking as a consumer if I want to look at which provider I want to go to and I

felt pretty certain that I would follow up with my treatment. I might want to know how good the provider did in terms of achieving remission separately from the issue of a follow up.

So not just from a – taking not just from a provider perspective, but from a consumer perspective that information would be very useful I think for consumer so I just…

...

Male: Yes, I mean I also worry about gaining, this that, you know, if an organization put their resources for following up on the people that they felt would do better.

Collette Pitzen: There was some concern about that also with regard to risk adjustment and the risk, the measure currently as reported out was risk adjusted by baseline depression score across the bands of moderate and high and so on but was not risk adjusted by any of the kind of demographic or socioeconomic factors attending – patients attending certain clinics which may also vary what the consumer is able to understand when they pick up on the score of remission.

Male: Yes. So I think we're ready to vote.

Vanita Pindolia: Can I say one more time. This is Vanita. I was on the committee. I listened to everything and I agree what everyone says. I'm really happy to see a measure that's actually going right for the outcome, but because of the low rate, we – I was really hoping to have the two elements separated more because once it's approved and then if it's an ACL with a health plan or if it's in employer group going to a health plan, it would really be helpful to understand and give data on the reason the depression scores aren't improving is they're not showing up so there's a cope phase to, I mean just trying to figure out what we can do to improve the process, improve the scores, not by gaining but understanding what might be causing the problem versus just saying it's – people aren't getting to gold.

So that was my – that was my intention of saying that why, you know, if we could have the two separated at the same time, it would be very helpful to

figure out the cause and – the root cause in trying to help make a solution in partnership with the physicians.

...

Male: Oh (Helen)?

(Helen): Yes.

Male: Is that you?

(Helen): Yes, so I was…

...

(Helen): … if I could, we're likely be doing another round of behavioral health in the coming year so we will have an opportunity to potentially bring in those process measure, that is submitted to the committe measurement to do so. In addition, it's important to note we have already endorsed the companion measures that refer to up front about actual remission at six and 12 months so this was actually intended. I think to be more of an intermediate outcome toward the full blown remission measure which is already endorsed and I believe most likely be reviewed in the next phase of work as well. So just to put that in context a bit.

Male: Thank you (Helen). Once again I would have is that something that NQF may want to think about in general for, you know, for that chronic disease measures is the issue of thinking about – when you're looking at outcomes, how you deal with the denominators with regard to follow up? I think that that something that cuts across all of these, like I said before, this is blood pressure versus PHQ-9 versus hemoglobin A1Cs. You know, that they have some consistently of thinking about those would be helpful.

Karen Pace: Carol, this is Karen Pace again and that's a good point and I think the point you made earlier is kind of how it's been viewed is that follow up is an important element of care and, you know, you all have some discussions yesterday about not separating out the assessment from the process and this is

a little bit on the same order but I think, you know, there's certainly different ways to view this but I think, you know, your points that you made earlier are right on.

Male: OK, we're good. So why don't we move to vote?

Female: 1C evidence.

And if you haven't voted, please go ahead and vote now. 19 yes, performance gap.

And if you haven't voted, please go ahead and vote now. We have 9 high, 11 moderate. High priority. 13 high, 5 moderate, 2 insufficient.

Reliability. And if you haven't voted, please go ahead and vote now. 1 high, 15 moderate, 5 low. Validity. 4 high, 9 moderate, 7 low. Usability.

Three high, 10 moderate, eight low. Feasibility.

Two high, 13 moderate, five low. Overall feasibilities endorsement.

17 yes, three no, measure at 1884 has been recommended for endorsement by the Steering Committee. We'll move on to measure 1885.

Male: So, this measure is basically the same measure we just discussed except of the different time frame. All right, is anybody feel that we need to have further discussion of this measure?

(Jeffrey Simon): This is (Jeffrey Simon). The only issue is that the burden issue that two measures looking at this overtime would cause in what's the basis for supporting both of those.

Male: Measure developer have a comment.

Female: Yes, thank you very much. I do. In terms of burden, when we are pulling and submitting and reporting this data, is it the same (competition) invitations the same processes? So, it's almost like a byproduct of pulling for the first measure, you are continually pulling in those PHQ-9s and it's almost like

giving a second chance. If you didn't re-measure them in the first six months, let's hope that we have more people heading their mission at 12 months. Again, with the caveat of - you know it is difficult to maintain contact with patients overtime.

(David Datin): Hi, this is (David Datin). Based on that (melodic) model, I would prefer like a three and six months interval better than a six and 12 months because all that rate at 12 months is just going to be enormous. And I actually would have preferred more tension including you know the outcomes at three months, then if you do have a significant you know reductions sometimes by that time. So, probably had been my preference and it's having a hard time finding anybody at a year and particularly in primary care. It might be hard to get in that there's somebody - I know I think I would present it at people exchange plan if they're in quite a plan that every three to four years, people change plans. They just find it valuable here when you start going out of year that makes this problematic for me that wasn't problematic at six months. So, it's with that, I would prefer and three and six rather than six to 12.

Jody Hundley: This is Jody. I actually like three, six in it and 12 recognizing that at 12 months, you're going to have more lost to follow up that it seems to me in terms of - you know it maybe a stretch call, but quality treatment, assessment treatment, you would want an annual anyway. And again, it allows us to look overtime at the response and remission rate as in perfect the same maybe at 12 months because of the follow up issues.

(Jeffrey Simon): So, this is Jeffrey again. I won't talk anymore on fees matters after this comment, but I think what we're missing in the overall discussion which bothers me I was putting on a table and leave it alone is there are burden with this. It would be great to do it everyday you know at three, six, 12, six with that but so if some way to descend to the world the rest to implement this, why is the step in intervals and maybe all at it is, is that it just makes sense and if or we should do it. But that's - if that's what it say, OK, but it seems like we're asking for there to be more evidence that such follow up makes a difference, so…

(Marty): Hi, this (Marty). I just want to interject with that Jeffrey. You know usually what we end up doing in integrated cash settings is I ask the first two questions, you don't have to do the whole PHQ-9. That's the not the two questions in the suicide question. The votes are negative and you don't have to vote through all the rest of them. So the burden is really - you don't have to sit down and spend five minutes with everyone to go through that or if the patient does it themselves. They just cross is, so I'm not sure that it is such a burden to collect it at the (vermin).

Female: Right, and more and more of the - it's being proactive, it can't be self-reported collective like you fill out the form at the beginning as you're sitting in the waiting room in a primary care office. But then if you are positive, it seems to me a minimum requirement to attempt to follow up and measure the impact of treatment whether it's medication therapy or both at these intervals, if you have someone who truly has a score that indicates someone that of depression.

Caroline Carney-Doebbeling: This is Caroline. I am sitting on the sense with these measures quite a bit because I as a psychiatrist who has practiced fully understand the importance of the follow up assessments and the drive toward remission, but working as just them, it has in that primary care setting as well. There are two things that are occurring, one is the addition of burden of whether it's blood pressure and BMI and depression and you know all of the other things that are being measured in that setting. I do believe that the burden issue is somewhat real whether or not it applies to this as another story, but I think as a collective group, we need to keep that in mind. Secondly, these measures don't measure whether people actually were treated or how they were treated or whether they were adherent to treatment. It's only at six and 12 months with their score reduced. So, I don't think we can draw a straight line back to whether treatment was initiated and adherent to.

Harold Pincus: This is Harold. Let me just say that for a clinical and a logic point of view that the - you know the average length of the depression episode is six months. But as average and it cuts the cost and it - and number two is the period after the episode is a period of significant risk for relapse. So that the timing makes a lot of sense from a sort of clinical, well in a logic point of view.

Female: I agree with that and I think that supports the comments about the three months window as well being included. If the whole set is being included that it would makes sense to add three months.

Male: But we're going to voting on this measure and we can make recommendations for additional things. Other comments, any further comments on this measure.

Emma Hoo: This is Emma Hoo. I would add that in some pilot set you know I did in ARP have conducted through disease management program, the interval that we've been using for measurement has actually been nine to 12 months. Because in practice, it's difficult to hone in on that specific period and we didn't have a three month measure partly because there was a lot of change in treatment happening in accord more than in population so that as treatment was being refined. It made more sense to collect data at six months.

Male: Other comments?

Collete Pitzen: Hi, this is Collette from Minnesota Community Measurement. I just want to ask a question of the Encore Staff and the Steering Committee for clarification. Would you be open? And this is kind of a big thing because we are provider burden as well and issues around that. But if our community was opened to additional measures at three months, would the Steering Committee and Encore staff be favorable to having again companion or parallel measures at different time frames? Because they would be a separate measure, thank you.

Male: You know it seems to me the issue of burden is somewhat off the cable in the sense that organizations and clinicians are going to scribe which of these measures to implement and while some of them will be uptake for national efforts to good quality. In reality is most organizations are choosing measures or individual practitioners are choosing measures. So well, yes, there is a burden if you have to report on every measure in NQFs endorsed. The reality is it seems to me we should be sticking more to the scientific evidence or whether the usability potentially for motivated, clinicians and organization. The addition of a three-month interval measurement to me is, yes, it's great,

you know. I don't think it should really get in the way of our approving this measure. Thank you.

Harold Pincus: My view is that a three month interval for assessment makes sense. But, you know, there's a lot of sort of early moving around in terms of the treatment decision making and changing strategies in terms of the response that people have. And so, it may be premature to expect that you're going to find sort of a fairly smooth glide path for people to get – all be getting better in three months. I think six months and 12 months make sense.

But, you know, on the other hand, I think having an assessment of three months makes sense.

Female: I agree. We have to assess in order to meet requirements for med adherence and whether meds need to continue or to change.

I would like to make one final comment about the burden. I look at the group of federally qualified health centers across my state and those health centers, if they're implementing EMRs are under meaningful use guidelines to meet, that specific measures that they may be under the CHIP for guidelines for the Medicaid members in their care. They're also under the first guidelines for reporting which include many of these measures.

So, while a single organization perhaps in a private setting may choose the measures that many of the types of facilities, community mental health centers, FQHC, rural health centers, those sorts of things that are dependent upon lines of federal funding are under a tremendous burden of reporting because each of the agencies that they are, they're holding to have their own measure set. Then there is not a lot of harmonization between those agencies at this point.

So, I do think burden is important to consider as it relates to the feasibility and usability of the measures.

Harold Pincus: Any other comments before we move to voting?

David Einzig: Just a quick comment. David Einzig again. I think it makes sense to use this as a tool to measure for response at every visit. I think it's a quick and easy tool to have patients fill out while they're waiting to see the doc. The question of, does it have to be within three months, six months, plus or minus 30 days, I don't know if it's as important to have that strict criteria for that specific with timeline other than to say I think it's important to use this as a screening tool as a tracking tool at every visit.

Harold Pincus: OK. Are we ready to vote?

Lauralei Dorian: We'd go ahead and vote on evidence.

...

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

19 yes.

Performance gap?

11 high, nine moderate. High priority.

Male: Which vote fell out? Votes fell out. It didn't wash anything. I clicked them on and I have to reload everything.

Lauralei Dorian: Let me please remind everybody to keep their phones on mute, you know, if you can. Thank you.

13 high, six moderate, one low.

Reliability.

four high, 13 moderate, three low.

Validity.

Two high, 12 moderate, five low.

Usability.

Four high, 12 moderate, four low.

Feasibility.

Two high, 14 moderate, four low.

Overall, suitability for endorsement.

16 yes, four no.

Measure 1815, 15 recommended for endorsement by the steering committee.

We'll move on to measure 518.

Harold Pincus: OK. Can we hear from the measure developer?

Deborah Deitz: Hi. This is Deborah Deitz from Abt Associates and I'm going to be presenting initially on this measure. This 0518, depression assessment conducted, it's a CMS measure and it's maintained under a contract with Acumen with support from Abt Associates, the University of Colorado and Case Western Reserve. It reports on the percent of home-bound adult patients that are receiving skilled home health services who were screened for depression using a standardized screening tool. It was first endorsed by NQF in 2009. It's been publicly reported on the Home Health Compare Medicare Web sites since 2010. During that time, we've updated our literature review, we've conducted additional testing as part of our measure maintenance activities, and we've seen that the average agency performance went from 88 percent in 2010 to 95 percent in 2012. And the 10th percent title agency went from 65 percent to 89 percent.

So, we've seen a lot of improvement particularly among agencies who found the measure challenging with, also had questions from agencies on acceptable screening tools and in response with that, guidance on definitions of standardized tools and the use of screening tools for different patient populations. We have some concern that if we seize to publicly report measure, rates of screening may climb.

I know there's a harmonization discussion scheduled for later, but for now, I do want to say that the development team has had discussions with the developer of 0418, the screening for clinical depression and follow-up plan. And we looked at the possibilities for harmonization. We do think it would be appropriate to incorporate the requirement for follow-up plan into the homework depression assessment measure if NQF is in favor of that. And we already have the data infrastructure in place to do that resulting additional burden to agencies. So, if NQF is in support of that, we may want to consider the measure with that change.

Is there a question?

Harold Pincus: Can you say why you didn't do that anyway?

Deborah Deitz: We reviewed during the workgroup call, that we had initially put before and to have three different measures that included a follow-up plan measure. And it was rejected because N2F feedback was that the feeling was that it was too burdensome on agencies and unrealistic to expect that they could actually have a follow-up plan in place, because that required action from the primary care doc versus action that they could take. So, based on that feedback, we have not gone forward with it. However, when we started this process, the spring, it was clear that N2F had sort of shifted it's – you know the feelings had sort of shifted and we also think that it would be reasonable. As I said, we did originally want to measure and report that. So, that's why.

Male: Comments from the Steering Committee – from the workgroup?

Bonnie Zima: Yes, this is Bonnie Zima. This is the measure I was to lead on. Just a point of clarification from NQF, this was a time-limited endorsement in 2009.

Female: That's correct.

Female: I believe it was time limited and then it was approved finally in 2011.

Bonnie Zima: OK. OK, and then following sort of the order 1C evidence, in reviewing the evidence the – for the most part our workgroup voted yes on it and there was one no. There were comments about data not presented supporting the

process-outcome relationship. Also the USPSTF recommendations that was rec – were commented on also were contingent on the presence of a staff assisted depression care support and it's not clear that this puts also a requirement of home health agencies. And the developer appropriately reports that there were no guidelines specific to depression screening for home health care agencies.

As far as opportunity of improvement as discussed for the developer, there has been a big shift so that when reviewing this measure, the performance gap presented on the application was really quite small with an average of 96 percent in the 50th percentile of 99 percent, so this did raise some questions of maturation. And I think it's the challenge sort of asking to kind of speculate whether the shift that's occurred with this group would be anticipated if this went nationally.

As far as evidence of high impact, the group was also split, the rationale for high-impact discourse prevalence rates, the depression quite high and negative consequences of depression. So the group there was like yes three, no two. Unscientific acceptability, even though there were some concerns like the liability based solely on beta-binomial method.

The level of analysis with hospital referral regions of validity was also based solely on face validity based on a technical expert panel similar to many of the other measures. So (inaudible) were concerns that was based only on face validity. It did pass five yes, zero no. On usability, it was split between two high, moderate two and then feasibility to report high three, moderate two split and consistent with an endorsement split of yes three, no two.

Male: Other comments from the committee?

Lauralei Dorian: This is Benita. I was on the committee as well and I'm in the group, sorry. My question or my comment or concern was just I think and again addressed here by CMS is just looking at if we already have this mandatory through oasis, and that's part of their payment, and we're achieving the 96 or 95 or whatever percent we're achieving, is there a way to move this to something else that home health care agencies would have to do next, whether it's just

even reporting this out to the physicians if it's too burdensome for them to create a plan because it's true. It's not going to be them. It's going to be up to the physician. But just capturing the data, but then that relaying it to anywhere else, it just seems like it's just not a quality measure at this point.

Male: Other comments.

Deborah Deitz: This is Deborah Deitz again. I just want to clarify if possible that these care processes are measured as part of the oasis that is required the oasis is required to be completed. But the care processes are not mandated and agencies aren't impacted financially or otherwise based on the response of whether they implemented the process you turned on. So, I just want to clarify that.

Bonnie Zima: Yes, this is Bonnie. That's a very important point because that did that was clarified in our workgroup as well, and just to be very clear, the home health agencies are mandated to report using the oasis data but not mandated to come to comply with depression screening. Is it correct?

Female: That's correct. And they're not impacted by their response, other than it being publicly reported.

Female: Right, right. And all of that discussion came out of really trying to figure out, well, you know you had a 50th percentile, 99 percent and again the very small performance gap presented. But also again with the discussion showing that there was a shift at improvement with this measure.

Male: Other comments?

(Maggie): This is (Maggie). I have a question. In order for this measure to be considered lighter as part of harmonization, does it need to be endorsed?

Female: Yes, maybe. It's (Helen) it does.

(Maggie): OK.

Male: So, actually, (Helen), could you explain a little bit more about that process? So, if we in – I mean, clearly you had discussions earlier about the need to go

beyond screening by itself and wanting to have some indication of subsequent action that – and we could sort of not endorse this and then it would go away, but on the other hand, that would leave out an important component of the health care system in terms of home health. And so, we might endorse, if we endorse it and then it goes to the discussion on later on, how – and then it's decided by the measures toward not to make any changes, what happens?

(Helen): Yes, that's a good question. I will point out we've already gotten a pretty extensive note this morning from (inaudible) which they've already gone fairly far down the list of thinking through the harmonization piece. If you guys indicate strongly that you know this measure needs to be further harmonized with the other measure as part of the harmonization discussion, we would hope to have some response back to that before the measures go out for comment. And so hopefully you either will get that as part of the common trade, and if you feel like post-comment that the measure doesn't adequately reflect what you are hoping. Again, you always have an opportunity to reconsider the measure at that time.

Male: OK, so that we can essentially make a recommendation at both. We endorse it contingent upon these time changes.

Male: OK.

Female: Yes.

Female: Oh, that's great. Thanks.

Male: Are there comments, questions?

Male: OK, so let's proceed with the voting.

Female: Please go ahead and vote on evidence. And if you have not voted, please go ahead and vote now. We have 18 yes, one no. Performance gap. Two high, 12 moderate, six low. High priority. Twelve high. Thirteen high, six moderate, one low. Reliability. Two high, 18 moderate. Validity. And if you haven't voted, please go ahead and vote now. One high, 16 moderate, two low. Usability. One high, 19 moderate. Feasibility. And if you haven't

voted, please go ahead and vote now. Three high, 16 moderate, 17 moderate. Overall suitability for endorsement. And if you haven't voted, 17 yes. Measure 518 has been recommended for endorsement by the steering committee.

Male: And I think with the assumption that there will be efforts of harmonization which brought to the follow-up.

Female: And we'll have that, yes. We'll move on to measure 1651, tobacco use screening.

Peter Briss: So, this is Peter, I'll take back the Chair hat and that tobacco – 1651 is the first of a set of four related measures on tobacco use screening and treatment and follow-up. And so I wonder if the Joint Commission would like to kick us off on the set of measures as well as any specifications with 1651.

Female: Peter, we're just checking to make sure and (inaudible) joint commissioner are on the phone.

Peter Briss: OK, thank you.

Female: We're running a little bit ahead of schedule.

Female: And Peter, I think you had some instructions for the committee when we start to discuss the measures about the important vote.

Peter Briss: Yes, so – so this set of measures that the committee will recall that we had – we had started through this and assessment of these measures on the – on the first round of behavioral health issues and not shockingly I would say that, you know, we did not have much disagreements in last year's committee discussion or this year's workgroup discussion on the public health, the public health importance of tobacco or on the importance of screening and effective treatments in both pharmacologic treatments and counseling treatments. And so in general, unless there are members who would like to rehash these issues, we can move – we expect that we should be able to move straight to the rest of the criteria.

And are there – are there any other – or are there any other issues that – are there any other issues of staff we'd like to tee up as we're starting?

Female: We can finally make sure that the folks in the Joint Commission are online. We just sent them a quick note because it's really actually remarkably about 15 minutes ahead of schedule. But yes, I think as you pointed out, Peter, we're not going to revisit importance. The votes you've already taken will stand on those. They've already met that threshold and we'll move right into the discussion of a lively validity and the rest of the criteria where they had done additional testing.

Peter Briss: Right.

Female: So operator, are you able to check whether to see whether (Anne Waters) or (Celeste Nelson) are yet on the phone?

Operator: They haven't joined at this time.

Female: We'll give them – maybe we'll give them a minute because we did just e-mail them. Or perhaps does anybody feel like taking a five minute stretch break?

Peter Briss: Yes, or perhaps – yes, perhaps the committee would like a five-minute stretch break while we try to connect with the Joint Commission.

Male: Yes, but don't hang up or cut off your Web connection.

Peter Briss: OK, so I have 11:00, essentially 11:05, let's take exactly 5 minutes and reconvene at 11:10.

Female: Sounds good.

Peter Briss: And don't disconnect anything, we'll be right back.

Samantha Tierney: This is Sam Tierney with the PCPI. I have a question for (inaudible) staff about the agenda if I may?

Female: Sure.

Samantha Tierney: I'm was just wondering, I know you said you're just ahead by about 15 minutes but the agenda we have says that tobacco measures aren't going to start until 1:00 Eastern. So I'm just wondering, is there an updated agenda available or…

...

Female: So it should be agenda was updated in the following meeting last night because we weren't able to get to one meeting. We have sent it out but could you (inaudible). You should have received it around 7:30 last night but we can resend it to you just so you can see.

Samantha Tierney: OK, well let me see. So did that come from (Lorelei)?

Female: That came from (Jessica Webber).

Female: OK.

Anne Celeste: Hello, this is Anne Celeste from the Joint Commission. I just wanted you to know that we are here.

Female: That's great.

Female: Welcome, we didn't want to start without you so we gave them a five-minute stretch break.

Anne Celeste: Well, you're running ahead then, great.

Female: Yes, we are. And we also already clarified with them that we're, you know, leaping right over importance and moving on to the other criteria.

Anne Celeste: Thank you.

Female: You're welcome.

Peter Briss: This is Peter. I hope that – I hope that after that long break, everybody is refreshed and renewed and has been able to fire off an e-mail or two what –

over the next minute or so, let's – let's – let's get reconvened and we'll try to start.

Helen: Great, Peter, and our Joint Commission colleagues are with us.

Peter: I heard, Helen, thank you very much.

Female: So, (Anne Celeste), would you like to go ahead and introduce the tobacco ...

Male: OK. Before we do that, can we just – can we just hear at some voices on the phones to confirm that people are back?

Female: Yes, I'm back.

Caroline Carney-Doebbeling: Yes, Caroline is back.

Male: Yes, I'm back.

(Crosstalk)

Peter Briss: I consider that a voice for a vote quorum. So, Leslie, are you ready (inaudible) the set of – the overview of the set of the tobacco measures as well as any particular issues on 1551?

Leslie Zun: Yes. Good morning, Peter, this is allotted to my commission. This morning, we'll be discussing the first two in the series of four of the tobacco treatment measures. And just to give you a little bit of background this started back in 2008 when the Joint Commission received funding from the Partnership for Prevention, and the Department of Health and Human Services, specifically from SAMHSA to develop, specify and test standardized measures related tobacco – to tobacco screening, cessation and counseling, and also alcohol screening and brief intervention. At that time, it was known as the tobacco and alcohol measures which have since then split into two measure steps. So we'll be talking about tobacco treatment first.

The word came about from recommendations of our technical advisory panel that convened in 2009. And at that time, they suggested a total of eight

performance measures that were put forward for pilot testing. We also had public comments period on the measures prior to pilot testing. And then following our reliability testing brought our panel back together, and at that time, they decided to split – they mentioned split the measures into two different sets.

We had a total of 24 hospitals across 19 states that did volunteer on the six-month pilot test. And the first measure that we'll be discussing this morning is the tobacco screening measure which is taking a look at tobacco use that is being screened on all patients that are 18 years of age or older that are hospitalized inpatients.

So that will be our first measure that we're queuing up this morning.

Peter Briss: Thank you. And in addition to (inaudible), it's along now, I think I'm on the hook to introduce what measure four, the workgroup as well as sharing thoughts. I am in for the moment taking off my chair hat and introducing the measure. So as we've noted, we want to talk about importance to measure and report the scientific acceptability of measure property plug an issue that the committee had last year. Since last year, the Joint Commission has done additional work on reliability and validity in general even workgroup thought that things were improved. We had 5 yeses and 1 no on that issue.

In general, a good bit of work has been done on phase validity testing on inter-reviewer reliability on the measure agreement once you reviewers do with it approaching 90 percent. Agreement on tobacco use status is still only fair, but with 75, and that could be – it could be acceptable. Generally public comments and the testing hospital thought that the measure was reasonable on that or – there in terms of usability, the workers agree if measure can use them and we agree that it's usable. And we expect that it should be relatively understandable for public and providers. It's currently, again, reported on the quality check Web sites.

And we generally agreed that because of all of that, it was also feasible. There were – there's a – if there's a – there are ways that workgroup – yes, I mean part of the workgroup thought that the measure should be extend – it's

currently petrified for 18 and over and at least some of us thought that the measure should be extended to 13 and over and maybe before further into the discussion of this measure value that the age range issue is going to – it's likely to come up for – in the whole set of measures. And so, I wonder if (Steph) could give us some guidelines – guides on what our working range of options or degrees of freedom are they in terms of handling the potential for asking to have the age range extended.

Female: We would have to review the measure in front of us and we can make a recommendation that goes along with whatever this steering committee decides today for, OK, for expansion of that denominator and also Joint Commission to respond?

Female: Can barely hear you.

Ann Watt: This is Ann at the Joint Commission and I believe that Dr. (Fiore) is with – is on the line. Not true.

Dr. (Fiore) who is our technical advisory panel chair and who was of course an expert in this is planning on calling in but I think because of the timing thing we might have caught him unaware, so perhaps we can discuss that at the tail end and hopefully he would have been able to have joined us by then.

Peter Briss: OK. So, I will – this is Peter again and we'll now, yes, I will now put my chair hat back on and open the floor to discussion.

Harold Pincus: This is Harold. I have a question. So exactly what additional testing was done because I remember there was for a number of this I can't remember which ones where the biggest problem, the different number of these left hand view were very poor kappa that and so – what their – and there was going to be some retooling of chart instruction and then there was going to be retesting and so could somebody provide a short summary of that.

Male: So Ann or Collette can you answer that part please?

Ann Watt: Yes. Hello again, this is Ann from the Joint Commission and just to refresh everybody's memory. When we brought these measures forward to this Joint

Committee the last time, we had shared with you that the – we shared the testing results from the pilot test and we also shared with you that as the result of the pilot test which is our standard operating procedure we made adjustments and clarifications to the specifications in order for them to be more clearly understandable to the measure users and the data that we presented to you were the data from the original testing and as we had in the data this time.

Generally, speaking it's been our experience that, you know, we make the adjustment to the specifications and the reliability improve, but this – during committee asked for additional testing in order to demonstrate that to be the case. So we went out and did additional reliability testing in the – well I guess, it's close to a year ago now in the summer of 2012 and what you see here in the submission is the results of that – of that testing.

Male: So for example on this – for example on this measure here or the inter-reviewer agreements on the measure was approaching 90 percent.

Male: So, is it just – what were the kind of things you did to tweak specification just curious.

Ann Watt: You know, to be perfectly honest with you that's been a few years ago now and I'm not – I don't have that detail and the last was not our clinical lead for that set at that time but they were things like clarifying definitions of word in terms whether or not we – go ahead Collette.

Collete Pitzen: Descriptions in one we're taking a look primarily what you're looking at is tobacco, your status with this measure so we wanted to make sure that it was clear, you know, what they were – what type of tobacco they were using, the level of use, that sort of things, so things like than were clarified so it was – and then notes to the instructors as they're reviewing the records, what they should be looking for in order to make the appropriate selection for an allowable value.

Female: OK.

Peter Briss: So – and so thank you for that. Any additional comments or questions from the committee please.

Female: What tool is used for the assessment? Is it just a question and just ask them and document them in the chart. I'm sure you're applying that in the specs.

Female: This is our data collection tool of actually the hospital's use so it's standardized according to the data element which is tobacco use status which contains all of the appropriate allowable value. The hospital uses that as they review the medical record to make the appropriate selections.

Harold Pincus: And just one of the question is last time you presented kappa values, this time you're presenting percent agreement. Is there reason for the change?

Peter Briss: Well, we had problems with the kappa, just conceptual problems with the kappa and that it's very dependent on the margin.

Ann Watt: Excuse, just – sorry for interrupting just a minute. This is Ann at the Joint Committee. I'd like to introduce Stephen Schmaltz he is our biostatistician.

Peter Briss: Oh, sorry.

Stephen Schmaltz: OK. So, the percent agreement it's kind of like an overall global but then we looked at sensitivity and specificity of the numerators and denominators to really get more specific and actually more information about how well the measure is doing with reliability and actually because we have an adjudication at the end, it's almost more a measure as I understand from NQF, a validity rather than reliability although it's really a combination of those two because we used the adjudication process.

Peter Briss: And Harold, what – as a general rule, what kappa does is correct for chance agreement on when – when, you know, in this kind of things where the – based on agreement is 90 percent, you get it – you got low, you tend to get low kappa just because of the high baseline.

Harold Pincus: But there's also – there's also a methodology to adjust for prevalence in kappa as well. I just say, I just want to know why was the – the change but also you

said there was an adjudication process or the tool reviewers are not making an independent judgment?

Stephen Schmaltz: The tool reviewer is making independent judgment yet the original reviewer but on the re-obstruction, if the re-obstruction disagrees with the original reviewer, there's an adjudication process to figure out which one is correct.

Harold Pincus: OK, but for the – but for making – but for looking at measure agreement, you're looking just at the initial – considerably in practice, there wouldn't be this adjudication process. There going to be one reviewer right?

Stephen Schmaltz: Correct.

Karen Pace: Harold, this is Karen Pace and I had this discussion with Joint Commission. What they're actually comparing is that initial reviewer to this adjudicated agreed what would be considered truth are the really correct information and that's why conceptually it seems more validity is – did the obstructor actually get the correct answer? It's saying they just compared the two independent obstructors which is what we initially thought they had been doing than you would kind of leave that more as a reliability as a data input.

Harold Pincus: It's all reliability data, I mean, is there something that's looking just at the two initial assessment.

Peter Briss: But as – this is Peter, as a conceptual thing it can't be valid if it's not reliable and so you can't – you can't get sort of 90 percent agreement the truth without having reasonable reliability of the practical manner.

Male: I agree with that.

Ann Watt: Excuse me, this is Ann, you know, one thing I want to clarify that maybe isn't clear. When we do the adjudication, it has been the situation first from the original obstruction disagrees with the re-obstruction which is done by Joint Commission's staff. This is – the – this is not a negotiation process. There are just times when our staff is not so familiar with the client's medical record that we can find something. Let's say, "We didn't see this, where is it?" And they show it to us and we go, "Oh, you're right, we were wrong." That's – that

happens and that's the type of adjudication that happens not that we are negotiating with them. You're right, we're right, it's they're clarifying for us. We – the Joint Commission…

Harold Pincus: That wasn't my question. My question was that, you know, from – at least from my point of view, in terms of the importance of reliability is that in fact, you know, if you have obstructors going about, sort of obstructing information, how likely is it that they're, you know, coming out with the same results that they would have looked – that everybody else is coming up with. That's really the question you're – we're just trying to – I would post. So the question is that if you have two independent raters, you know, what's the likelihood that they're going to agree beyond chance especially when it's a binary kind of thing?

Stephen Schmaltz:: Although conceptually they're different.

Harold Pincus: And so – so my question is, is there a data that you're presenting on that issue?

Stephen Schmaltz: Well, I mean we do have the data, we did not present the data specifically but I can say that the likelihood that when there was a disagreement that the original reviewer was correct, was very, very rare so for practical purposes they're the same thing.

Harold Pincus: I'm not sure if I understand that.

Karen Pace: Harold, this is Karen Pace again. From the standpoint of the guidance and the NQF Measure Testing Task Force report, if they do data element validity which by doing the sensitivity and specificity and the comparison of the obstructor to, you know, what was determined to be the right information, we would consider that a test of the validity of the data and our task force said, because of that data element level of those are so close to rely and don't set that with supplies for both the data element validity and reliability.

Stephen Schmaltz: As a general rule, Harold the epidemiologic kind of truism about this is what I gave you before which you can't have valid data without reliable data.

Harold Pincus: Right, but that's the – no, but you can't have – you can't have – I guess my concern is that, you know, having been involved with a lot of reliability testing around psychiatric diagnosis that people can be unreliable for different reasons so that if you have a single sort of abstract or being compared to a gold standard that's not the same as assessing reliability out in practice. You really want to compare, you know, people out in practice about the essential which they – which agreement and then they compare that to gold standard, but – so what was presented to as last time? Was it the same thing or was it the?

Peter Briss: Harold, I think they answered that question before. What they presented to us last time was they said the data pilot, they got relatively low agreement, a measured agreement. They expect the – they said they saw, that they fixed the abstract and guidance to fix the problem that they had found and they expected that in practice, the reliability would be better and what they since done is show that reliability actually did get up here to get better.

Harold Pincus: But my question was, are they showing me as the same kind of thing, the comparison, the last time that they show is comparison with a rater to a gold standard that you (inaudible) or as they are presenting this time or was that a different methodology last time?

Male: We used the same methodology. We just didn't identify it with as such the first time.

Harold Pincus: OK, thank you.

Male: So anybody else questions or comments or concerns?

Then maybe let's try to move to voting.

Female: Please go ahead and vote for reliability.

And if you haven't voted, please go ahead and vote now. 5 high, 13 moderate, 1 insufficient.

Validity. And if you haven't voted, please go ahead and vote now. 4 high, 12 moderate, 2 low, 2 insufficient.

Usability. 7 high, 13 moderate.

Feasibility, 4 high, 14 moderate, 2 low, 1 insufficient.

Overall feasibility for endorsement, and if you haven't voted, please go ahead and vote now, 18 yes.

Measures 1651 has been recommended for endorsement. We have 19 yes. We'll move forward with – to measures 1654.

Male: And if, (Lester) you're in would like to key this up for us please?

(Lester): Sure, hi it's (Lester) at Joint Commission. The second measure is looking at the tobacco treatment on intervention being done both of patients that have been identified as tobacco users so there's two components to this. There's a brief counseling and then there's also tobacco cessation medication. Patients that are pregnant however are excluded from tobacco cessation medication and patients that are considered the lighter smokers are also not considered for tobacco cessation medication so both interventions would apply to someone that's a – the heavy or moderate user of tobacco products and whereas if they're pregnant patient or a light smoker than we'd only been looking at the counseling to occur and this would be doing the hospitalization period.

Male: Thank you and the committee member for this measure, I think is Michael Lardiere.

Michael Lardiere: Yes, that's me and we had discussion about this and the group on the discussion will, you know, it's – a very important measure in terms of the reliability, we were treated one that was reliable. I also felt that the usability and was very useful on the feasibility we had 1 high and 3 moderate in the feasibility of it. We did have the issue the same as you identified earlier that we would want to see this harmonize. Some of us would want to see this harmonized with being at age 13 and not age 18 and really got harmonized with meaningful use across the board and that was really the only major issue

that was – we really discussed. It seemed that we did want to approve this measure moving forward but with that modification.

Male: Excellent regard, the floor is open for general committee discussion (play)

Jeffrey Samet: Jeffrey Samet here. Just one question, the whole screening, brief intervention for substances seem to be, let's say dependent in terms of a lot of the outcome data and just may ignorance here should have the – the story on tobacco, the data – there's a lot of data that screen and interventions for tobacco are effective. Those exist as well for in hospital setting where this is intended.

Michael Lardiere: With the Joint Commission, or in my theory, it seems on the phone like a comment on that please.

Lisa Shea: Hi, it's Lisa at the Joint Commission and yes this is based on the evidence layout. Patients will benefit form practical counseling. You have an opportunity while they're in the hospital, you have I guess you could say a captive patient so at this point in time, you know, that you can draw their attention that especially so they're with problems related to their tobacco use, their medical problems that it had them hospitalized in the first place. So that they're – there have been studies that show that this is an excellent time that you can have this intervention with them. And what the Practical Counseling is doing is basically getting them to recognize dangerous situation, develop coping skills, and then just provide them with basic information about quitting while they're in the hospital. And then, once again, if they've been identified through the tobacco use screening, which is the first measure, at someone that is a heavy or moderate user of tobacco products, then they're offered tobacco cessation medication at that time.

Male: Right, so that…

...

Peter Briss: So lots have been – so lots have been evidentiary thing? As an evidentiary thing, as I recall, the – you presented systematic reviews on the effectiveness of these interventions and I thought that those were in hospitalized patients, is that correct?

Lisa Shea: Yes, that is correct.

Male: Thank you.

Male: So, anybody else, questions or comments or concern?

Male: Have we got an announcer yet about the meaningful use reconciliation? Is there a process around that, just for information?

Peter Briss: What – what are – maybe – I would do – why don't we, at this period, why don't we – since the issue about age 18 or 13, is likely to flow through modes or all of these measured. Why don't we work on the measures that are currently in front of us at the moment and then maybe talk about what the committee would like to recommend at that age range of going forward about the whole set. Would that be a reasonable way to approach in the question?

Male: Yes. But, it would also apply to the one that we just went through and approved, right?

Male: Yes, right. Is that acceptable to the committee members?

Male: Yes.

Female: Yes.

Male: Yes.

Female: Yes.

Male: Go for it.

Michael Lardiere: OK. So let's work to the set as they're currently transcribing and it will be good with at the age range at the end.

So on this second measure, are there any other questions or comments or concerns that anybody would like to raise?

Female: I just had a question. So I was trying to read the specs, I understand the need for the screening and then if they do, they're obviously there in the bed, and you can do education. Is there any data to show that was there any follow up, like did we actually see a quick rate of any sort with that functionality being done in the hospital?

Ann Watt: This is Ann from the Joint Commission. That is not something that we specifically look at through this measure, but if we'll talk about in a few minutes or some time, tobacco for that actually does look for – it's actually a follow up in whether or not the patient, you know, has continued to have abstained from tobacco.

Female: OK. And the reason I'm asking, being so involved with all of the transition of care processes, at least within Henry Ford Health System, there is just so many thing that we're expecting of inpatient case managers and the nursing staff to change force. And I just want to make sure that this is going to bring value for the amount of time and resources that'll be needed for that to be done adequately.

Male: Yes. I'm not sure the question was answered though. It's not so much what the additional measure that would find that out but how much of an impact does in-hospital counseling have in terms of the impact on subsequent cessation from the intervention study that we're reviewed?

Celeste Milton: Hi, it's Celeste of Joint Commission. When we went over the important section, we talked about guidelines and the recommendations for Treating Tobacco Use and Dependence clinical guideline, Practice Guideline, the 2008 update that shows that there – where the 2007 (Cochrane) analysis that reviewed intensive intervention, that would be inpatient, plus follow up, which is what the fourth measure will be discussing. What facility associated with this significant higher quit rate compared to controlled conditions?

Male: How much of a higher rate?

Celeste Milton: There were 17 trials that were evaluated. The odd ratio was 1.65, with a confidence interval of 95 percent at 1.44 to 1.90.

Male: OK.

Ann Watt: So, definitely, as long as they're coupled together. But there's no data with just this alone, correct?

Peter Briss: Yes, which is the – as I understand, which is the conceptual rationale for the – that are linking the set of measure?

Female: OK.

Harold Pincus: Yes, although the – what was done in the intervention study isn't exactly the same thing as what's being proposed in the – which is tobacco use four or five.

Female: This is…

Male: So, we'll get into that.

Female: I had a question in terms – I'm just following up on the counseling. Did the specification say what type of individual is qualified to do that counseling in the hospital?

Celeste Milton: We don't specify an individual, but in many of the hospitals, we learned through our pilot testing that the respiratory therapist, in many cases, are the ones that do the intervention. So we'll be – a lot of the materials that they use are from the guidelines, and so this is something that any qualified health care professional should be able to educate the patient about. They're pretty straightforward guidelines.

Male: So, additional questions or comments or concerns?

Harold Pincus: Just the one – there is one reason – the reason I was asking about how much of a difference (inaudible) I think as previously mentioned a pretty significant additional sort of expectation and accountability on hospitals and staff, and we just have to make sure that, again, effort is going to result in something that's meaningful.

Male: And so, so the odd ratio is 1.65, and this is the leading cause of your stat.

Ann Watt: With odd ratio, there's a – those were done with analyzing both inpatient and then outpatient together. So, I guess, as long as we hook them all up and do it.

Harold Pincus: Right. Yes.

Yes, and it also involves more intensive follow up than is necessarily filled into this.

Michael Lardiere: And – this is Mike. Just on that burden of the follow up, I think, you know, if we look two years down the road, or even just right to 2014, you know, we have 80 percent of the hospitals on EHRs already. And as they begin to do health information exchange, they're not going to have to do so much follow up, they'll be able to query the exchange, get the information from the inventory provider, where we have 50 percent of the providers on EHRs now. So, I think, you know, that the burden will get less and less as we move forward.

Peter Briss: And it's generally true that care coordination is, I think, is a big deal that nobody has fully solved. But, you know, but it's – yes, by seeing the workgroup discussion, we talked about this a fair amount, and at least some of them felt that, you know, this is a really important problem that the system needs to be working on, solving. And this kind of high burden known effect to get intervention, the problem is a very good place to start.

David Pating: This is David Pating speaking from (inaudible) level, with most hospitals now being smoke-free environment, this is just a perfect combination. I mean they have to tolerate being smoke-free, and so, it's actually after the intervention that goes along with those other hospital issues.

(Jenny Mark): Just – this is (Jenny Mark), just a question for the developers. The exclusion criteria include people that were cognitively impaired and that would – is that for broadly interpreted to include anyone who is in – who's so typically ill that they couldn't be receptive to the counseling or (pre-set) intervention.

Celeste Milton: Yes – Hi. It's Celeste at Joint Commission. You're absolutely correct. It would be someone that doesn't have the ability to process the information that

you would be trying to present. So, they would be excluded from the measure.

(Madie): This is (Madie). I'm also on the Dual Eligibles Committee and of the (inaudible) and we draft extensively about how to – interventions such as the tobacco intervention with people who are cognitively impaired. And I have some concerns about leaving them out and not making the effort to. So, I don't know what NQF staff has to say about the end of end of play between measures that do a lot allowable for working on, (Inaudible) that we're working on here.

(Audio Gap)

(Helen Borsa): (Baby), his is (Helen Borsa). It's a good question and we do try to make - that to make sure that our different pieces connect with each other. My understanding of the work where the people that's really identifying where those gaps are and where work needs to be done to bring those measures forward. So, I think we would want to try and reconcile some of that as part of you know discussion of gaps with this group as well and perhaps we could even bring in on a post-summit call some of that priority list from the …(inaudible)…and how this group weigh in.

Female: All right, thanks.

Jeffrey Samet: This is Jeffrey Samet. So, I feel like the contrarian today. You know this is all important stuff but the comments made about - this is - this may impact half the people in the hospital. I mean this is a lot of people in the hospitals all over. And it seems like a dimension that we're not capturing, have been getting an odd ratio whatever 1.4 it doesn't really answer the question of - for what effort are we getting what resolved? And we kind of know what the effort is and that's substantial but we don't really know the magnitude of the results. So, it's really a process issue for NQF I think to think about and gets towards perhaps the cost effectiveness or something. But I just - I'll share my concerns.

Harold Pincus: Any other issues with the measure or can we move to voting?

Why don't we try voting?

Lauralei Dorian: Please go ahead and vote on reliability.

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

Three high, 14 moderate, one insufficient. Validity

Two high, 12 moderate, two low, three insufficient. Usability.

Three high, 10 moderate, one low, six insufficient. Feasibility.

Two high, seven moderate, three low, eight insufficient. Overall feasibility for endorsement. And if you haven't voted, please go ahead and vote now.

13 yes, six no, measure is 16, 54…

Male: I'm sorry.

Lauralei Dorian: 13 yes, six no, the measure is 16, 54 has been recommended by the Steering Committee for endorsement. And now that we've concluded voting on that measure, we can either go ahead and move forward to discuss measure 16, 56 or we can go to public comment and an early lunch.

Peter Briss: OK, I think - I might have voted where we're only 10 minutes ahead of schedule and so – we're out where we were supposed to be in the morning and we're only 10 minutes ahead of schedule. So, I'm a little worried about, I'm a little worried about losing people that we needed to have on the time schedule, so I might save or move in straight to public comment and coming back for the afternoon schedule on.

Angela Franklin: And Peter, this is Angela. I just want to check to see if we have Representative Mike Fiore on the line, representative for Joint Commission. I guess his line has been muted or check to see if his line has been muted.

Male: Mike, are you out there?

Lauralei Dorian: Operator, are you able to check to see if Mike's line has been muted?

Operator: Mike's last name please.

Lauralei Dorian: Fiore.

Operator: I don't see him connected. Everyone's line is open.

Lauralei Dorian: OK, thank you. So, why don't we open the line for any public comments now.

OK, well hearing none, why don't we adjourn for lunch and…

Harold Pincus: Given the fact that we're adjourning early, would it be possible to move things up a little bit?

Lauralei Dorian: Sure. So, we come back at 12:30 if that's OK with everybody?

Female: That would be terrific.

Male: Yes.

Female: Yes.

Lauralei Dorian: Great and…

Male: Thank you.

Lauralei Dorian: … please leave your Webinars running rather than shutting it down.

Harold Pincus: OK, so we'll reconvene promptly at 12:30. Thanks everybody for a great morning.

(Laura Lye): Hi everyone. This is (Laura Lye). Welcome back from lunch. I hope you had a good - I'll be at short break. So, we'll pick right back up again. I'll turn it over to Peter who will introduce - actually I think the lead discussing for the next measure with MadelineNaegle for 16,56.

Madeline Naegle: Yes.

Male: So, and those for Madeline. Before Madeline start and stuff may need to mute their line, and so we could – before Madeline start the - would the Joint Commission like to say anything about this measure?

(Elise): Hi it's (Elise) with the Joint Commission. The next measure that you will be considering for endorsement is tobacco treatment of till 3. And just taking a look at tobacco use treatment provided or offered it discharged. It also has a sub-measure which is taking a look at all of those patients that actually received treatment at discharge. So, what we're looking at, are going to be those patients that were identified in the first tobacco measure as a tobacco user. And those old patients then, it would be at the time of discharge, they would be offered outpatient counseling to continue with their tobacco cessation efforts and tobacco cessation medication prescription if they were eligible and once again if they are light-smoker or they're pregnant-smoker, they would not be offered the prescription, just the outpatient continued counseling. So, the first measure we're going to take a look at everyone that was actually offered and refused. The second one, we'll be looking at those that were offered and actually received this outpatient or cessation at discharge.

Harold Pincus: And with that …

Female: Thank you, that's a nice summary. I think - are we ready to go, Peter?

Peter Briss: Yes, Madeline go ahead please.

Madeline Naegle: OK, so you had a very nice summary of what this process measure is about and within our work group, we talked a good bit about some of the questions we had and revisiting the reservations that we had originally had last year. The performance gap in this is high. The science is the science that we have discussed in relation to previous measures, good med analytic support and some questions about groups where the interventions were implemented. But smoking cessation interventions as you have mentioned have been found to be equally effective for groups who have experienced disparities in those prevalence and treatment access.

So, within our group, we grade as we create as we had earlier discussed about the importance of this given the widespread prevalence of smoking worldwide, but also the fact that it affects other people as well in the environment, a serious public health risk. So, use has been validated with some of the errands provided by the Joint Commission and the tobacco orders have been recorded in the EHRs with identification and referral of linking to treatment responses in people engaging in treatment.

Our group felt this time that the science was acceptable. Everybody supported that. Looking at the usability were kind of split on how understandable this would be to the public even though it's clearly useful to providers. Issues of feasibility seem to hang on the issue of harmonizing the measures and we spend a lot of time in our group talking about the fact that this really - it was hard to approve this measure, not expanding the – to start earlier downward to people 12 and over we've pointed out that we really do not have the evidence base that the – there are very few studies out in the effectiveness and the use of interventions with young people 12 to 18 so we couldn't make evidence based recommendations, and that was shared in our call.

Feasibility, we did better with this but moderate generally. And the preliminary assessments for criteria, we were split on. So we are happy to bring it to the committee. We had second – some recommendations about combining it possibly with 1657 and harmonizing it with those measures. So, I would just ask my group members if they had anything to add other than our extensive discussion about age.

Male: And so with that the floor can be open for discussion questions or comment.

(Laura Lye): And I'd like – this is (Laura Lye). Can we just the check to see if Mike Fiore is on the call. Mike are you there or operator can be let us know.

Operator: He hasn't joined.

(Laura Lye): OK. Thank you.

Harold Pincus: This is Harold. I think this measure makes a lot of sense in terms of making sure that there is some plan and that there's, you know, a connection. The

only concern I have is that -– that for people that – there maybe situation where people refused the earlier piece about getting counseling or medication earlier.

Female: Yes.

Harold Pincus: And whether – but at this point they are given a prescription and recommendation for counseling, referral for counseling, but whether there's adequate sort of counseling about the use of the medication and rather just a prescription that's given.

Female: But actually the physician does speak to treatment at this charge including a referral to counseling and a prescription. So, it doesn't spell out the type of counseling around the medication. But it would be, it seemed to me that would be given.

You would feel more comfortable so it was spelled out, Harold?

Harold Pincus: No, I'm just sort of, you know, I'm thinking about sort of a situation where, you know, somebody is, you know, approach is screened initially, they're approaching the hospital and they're sort of negative about the counseling or medication. And then at the point of discharge they are given, you know, they're given a prescription but they haven't really had an opportunity to really investigate the pros and cons and to have some discussion and really understand what it's all about.

...

Male: So with the Joint Commission like to comment on that?

Harold Pincus: I mean how would that work? I can see if they were, you know, given the counseling and discussions sort of early on but somewhere, you know, for the middle indicator. But is there someway to make sure that at the point of discharge are getting some degree of counseling about the use of the medication and so forth.

Male: Discharge ....

Female: This is (Anne) from the Joint Commission, and I'm not entirely certain that I understand the question. Is that – let me say this and then tell me if this answer's your questions and that is, it is a component of this measure of our tobacco three measure that the patient can refuse. So, and that is one of the things that we look at.

And so, if the patient is just resistant to counseling or to any kind of medication or follow up care, they can refuse and that's accounted for in this measure. Is that what you're asking?

Harold Pincus: No.

Male: Yes, I think – I think the question as I understand it Anne, is, I think the question as I understand it is, is to what extent are we sure that people are getting – are getting adequate information about the treatments that are being recommended and they're not just being in handed the script because they're being in a hurry ....

Female: Right.

Harold Pincus: Exactly. So that – as they're leaving the hospital and, they see a prescription and they say like "What this is about?"

Female: So, the prescription would have to be issued by a nurse practitioner or a physician, right?

Female: Yes. But is it being explained to the patient as they're being handed…

Female: Yes.

Female: … the prescription. What it's about? How to think about it the fact of component of the counseling what this were at the point of discharge.

Female: Celeste.

Celeste Milton: Hi, it's Celeste at Joint Commission. First let's address the issue with the prescription. Part of our joint commission standards with patient care at the time of discharge and medication management is that the patient is educated

on the indication for use of the medications that they're being prescribed at the time of discharge. So, they would be educated just because not necessarily is there on miss medication but any medication that they're being discharged on they need to understand why they're on the medicines, what the dosage, the route of administration should be, and what kind of follow up they might need in relationship to that for example they had to have follow up labs or something that's just standard that would be done regardless of what kind of medication the patient is being discharged. So, that's not specifically mentioned in this measure because that's something globally that's done according to Joint Commission standards.

Now obviously if they are receptive to counseling at that time they would be provided with additional information about that. And of course the intervention that they may not have accepted while they were hospitalized is not an extensive intervention. The evidence shows that these minimal interventions that last less than three minutes can increase overall tobacco abstinence raise. So, this could be reiterated again at the time of discharge is if at that point they're accepting out patient counseling then they would be provided with the information about how to get this counseling and be provided with the appropriate referral so that they can continue then with the out patient counseling.

Lisa Shea: Excuse me, this is Lisa. I just had a question about the counseling is it the case that they just – given a referrals for or that they actually have to have an appointment in place set up ahead a time before their discharged for that counseling.

Female: Hi, Lisa.

Female: Are you ready for a response?

Female: Yes, so the patient will be given a referral so it's not necessarily an appointment. For example, tobacco quit lines, many of those offers the cessation counseling at the time of discharge. So, it can either be that it is an appointment which for individual counseling, it can be for group counseling, it can include proactive telephone counseling, it can also be an internet

intervention or E-health. So, we specified all of that out as far was what type of referrals can be made at the time of discharge for the tobacco cessation counseling.

Female: Thank you.

Male: Additional questions or comments, or concerns. Hearing none, why don't we try our votes.

Operator: Just one moment while we queue up this line.

Please go ahead and vote on evidence now. I'm so – yes, evidence with tobacco free.

Performance gap.

And if you have not voted please go ahead and vote now.

Nine high, 10 moderate.

High priority.

16 high, three moderate, two low.

Reliability.

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

Two high, 18 moderate.

Validity.

And if you haven't voted, please go ahead and vote. Eighteen moderate, 1 low, 1 insufficient. Usability. And if you haven't voted, please go ahead and vote now. Two high, 13 moderate, 4 low, 1 insufficient. Feasibility. And if you haven't voted, please go ahead and vote now. One high, 11 moderate, 8 low. Overall suitability for endorsement. And if you haven't voted, please go ahead and vote now. Thirteen yes, 6 no. Measure 1656 has been

recommended by the steering committee for endorsement. We move to measure 1657.

Peter Briss: So Celeste or Ann, would you like to queue this one out for us, please?

Celeste Milton: Yes. Thank you, Peter. This is Celeste, Joint Commission. The next measure that you'll be evaluating is 12.4, part of our tobacco treatment set. This is tobacco use assessing status after discharge.

For this particular measure, you would be looking at those patients that had been identified as tobacco users. And there would be – of those patients, 18 years or older that were tobacco users, we'd be looking that followup contact was initiated with the patient within – between 14 and 30 days after discharge to evaluate their quit status.

Female: OK. Looking at the science, our group supported the fact that it was scientifically valid. We had all, as mentioned previously about the importance of measure, some question about variations and screening and counseling methods that these questions about usability for our group is towards or measure for accountability.

Feasibility, some question about scores being somewhat low in pilot that had previously been done. Some provider gap issues. But we voted that moderate and high. We only have four people participating in this vote. The group overall voted to endorse 3 to 2 for this measure.

Peter Briss: So with that, the floor is open for discussion.

(Crosstalk)

Female: I'm sorry. I just want to let you know that Mike Fiore has joined us, who is a content expert from the Joint Commission. So if anybody has any questions for him about this one, he's here.

Harold Pincus: So I had a couple of questions about this. One thing is clear that this is – this is a measure of contacting this patient and finding out what they did. It does not require any counseling or advice at the point of the call, correct?

Celeste Milton: That is correct.

Harold Pincus: So is there evidence that calling somebody to find out what they did actually has an impact?

Celeste Milton: This is Celeste, Joint Commission again. As I had spoken to previously in the guidelines statements regarding the effect of this, this intervention for post-hospitalized patients, that there was a Cochrane review that showed that if the patient had the interventions and then had the followup that they had significantly higher…

(Crosstalk)

Harold Pincus: No, no. But this is not a followup. This is just finding out what they did. It's not asking – it's not actually encouraging them to do it.

Celeste Milton: It's addressing their quit status at the time of followup. So then, you are going to determine whether they have indeed – they'll not use tobacco at that point when you do the followup.

Harold Pincus: Right.

Celeste Milton: So the combination of the two has found that people that generally have higher quit rates compared to other controlled groups.

Female: Dr. Fiore, would you like to address that?

Mike Fiore: Hi, this is Mike Fiore. The reason that the 2008 clinical practice guideline panel that the public health service endorsed an essential equivalence of this which is arrange followup for all people who receives smoking cessation intervention is that the data suggested that the mere act of having followup increases the likelihood that the smokers who are engaged or the tobacco users who are engaged followthrough on and took advantage of the treatments, whether at the time they were supposed to or subsequently. So that's the basis by which the United States Public Health Service chose to endorse arranging followup upon which (inaudible) was based.

Harold Pincus: So this is not arranging followup, this is just asking them whether – what they did.

Mike Fiore: And that is what the – arranging followup is to setup a followup visit ideally for the public health service guideline within about two weeks up to four weeks to have an additional contact with the patients.

Harold Pincus: I guess I'm still confused. The previous on the – we just discussed with about arranging followup at discharge, this is just calling the patients to say, "What is your status?" If the patient says, "I haven't followed up," there's no expectation that you do anything to arrange anything. Correct?

Mike Fiore: I guess that's directed at me. I believe that as written (inaudible) is solely to check and not to administer counseling or re-prescribe medication if that was the question. What it does do is ask the patient's status at that visit and there are some data that the mere following up of patients results in them following through on treatment even treatment that might have been given to them four weeks ago.

Harold Pincus: I guess here's my concern. I think – I don't like to know more about what the studies and forces are. But my worries that this is really going outside the expectation of what hospitals are expected to do in terms of actually following people long after, you know, two to three – two weeks to 30 days after the hospitalization and simply asking them what they – whether they followed up. That that – because there's nothing that's being done if they say that they haven't followed up. I could see if it's a follow-up visit with a PCP, that would make sense. I could see if we're applying it to an ACO, that would make sense.

But we're adding a very significant burden on the hospitals to set up a methodology where they'll have the higher people to call patients and I can also see how patients might find this intrusive, why is the hospital calling me up. I guess…

(Crosstalk)

To the point that notion that this is a – this substantial amount of effort is going to have an impact. It sounds like the evidence based doesn't pertain to that particular type of intervention. It pertains through followup in the primary care or other kind of setting where there's a relationship.

Mady Chalk: This is Mady. I want to add something to that, Harold. There is evidence that calling patients and following up talking with them about various issues that may be preventing them from following through on a recommendation has some impact. So there is evidence about that.

My concern here is similar to Harold about are you just asking what did you do versus if the patient said I did nothing, saying nothing else.

Male: This is last, I'm sorry I wasn't able to be more involved earlier. I happen to agree with Harold. This is a significant burden for the hospitals and it be – I'm just not sure the evidence backs it up. It really would be much more appropriate for the primary care physician or the medical home to do those kind of things.

Lisa Shea: This is Lisa and I want to echo that, and I also wanted to clarify. It seemed to me that in the reconfiguration, it allowed that you could mail something out to the patient and I'm not sure that any of the evidence supports mailing a document and getting it back from the patient has an impact. And the other thing is the fact that, you know, who the person is making these calls if they're administrative people or something like that. They're not in any position to be able to do a clinical intervention with the patient.

Mike Lardiere: This is Mike Lardiere and I have a little different view here. I think that it is the hospital's responsibility to call and follow up and do something, as maybe saying. But I would like to see that, you know, you first contact the referral source if they showed up. You don't need to make that call. If they didn't show up, then those are the only ones that you actually need to make the call on but when you do make the call, they didn't – then you know you're prepared already to do an intervention and try to counsel them to get to the followup that you originally suggested.

Male: But how did the hospital know if they even showed up?

Mike Lardiere: By following up to PCP. I mean, whoever they made the referral to, you need to have the – close the loop and make sure the person got to the referral. So that's the first part of it. And then if the person didn't get to the referral, you just call those that didn't make…

(Crosstalk)

Male: Every time a hospital discharges somebody for anything for all the comorbidities they have, the hospital should contact every different provider to see whether there was followup.

Mike Lardiere: I needed to do that. I don't know why other folks didn't – don't do that. I think that's a problem we have in our system, so that kind of thing.

Male: Right, I agree on the system but that's not – but again, you know, I could see if we're talking about an affordable care – accountable care organization, if we're talking about, you know, a medical home.

Mike Lardiere: Yes, I think they need to…

Male: And is currently constituted, that seems to be a huge expectation.

Mike Lardiere: I think we need to think (inaudible) doing this on, you know, chisel and stone and you know, we are – and 80 percent of our hospitals now have electronic health records. We're going to need to start sending that data back and forth into exchanges one way the other or using direct in order to send that. It doesn't have to be a people process anymore. So I'm not seeing it as that much of a burden. I think we have to think past of it being a paper process and use the electronic capabilities we have to do this stuff.

(Crosstalk)

Peter Briss: This is Peter. I'd be a little careful about the last road that Harold was going down. I think making a quick follow – so if it does raise some capability issues, then I'm not just counting those, but making a quick followup call on the – to see how the treatment went that you gave a discharge for the leading

US cause of death isn't the same as the hospital having to follow up for everything. So…

Male: Peter, I respectfully disagree with you. I think that if the highest priority would be the reasons why the person is in the hospital because that's their greatest risk and to make sure that there was followup on that. So that for all the major comorbidities. I'm not saying it's unimportant, but I'm not saying that in the decimal cost of a word we would have a system that would follow up on these kinds of things.

Jeffrey Samet: This is Jeffrey Samet here. So feasibility is not around notification, passing on notification. Feasibility is around this followup call. That's the part that takes time, the other piece is part of it. So – and I don't – it's inconceivable given the prevalence of this problem, which is major that this is not a burden and that it impacts my assessment of it's feasibility.

Tami Mark: This is Tami Mark trying to think through that too. So you have a nurse who calls you after you discharged for some major surgery and says, you know, "How's your smoking going," and you say, "Well, you know, I'm still smoking but on top of that, you know, my blood pressure skyrocket and I have all those pain and I really feel depressed," and the nurse says, "OK, thank you." I mean, I guess I worry about the – I just worry about that phone call.

(Crosstalk)

Male: Do not underestimate the effort in trying to locate people because don't forget, the hospital does not necessarily have an ongoing relationship.

Lauralei Dorian: Right. And on that note, the concern I have, I mean, if you look at all the urban hospitals and underserved area, we have so many patients that just don't have a working line, a phone number. One month they have it, the next month they don't. Mailing address, believe it or not is also not feasible in some of these patients. And many of them do not have a PCP alignment and that's like a huge initiative right now we're trying to work on just to make sure they even have a physician that will work with that patient, that they will go see. I just have a lot of concerns of how feasible this will be for every type of hospital setting…

Female: In our health plan, 20 percent of the members annually change their address one or more times in a calendar year. So I'm echoing what Benita is saying about this. It's very difficult to track down folks and find them.

Lisa Shea: And this is Lisa. In terms of patients with primary psychiatric diagnosis, there are stricter privacy rules at times that make it even challenging to even leave a message for someone and not to jump ahead too far in terms of the electronic exchanges with the 42 CFR regulations and substance abuse so I don't think we can just assume that those records can freely be exchanged electronically.

Peter Briss: So clearly, there are lots of feasibility concerns around the virtual table on this. The – do folks have – do folks have additional issue that you'd like to raise that haven't already been raised?

(Madeline Naegle): You know, it's Madeline. I would just reiterate just point. I think that the importance of following up for this particular behavior parallels of the other reasons for hospitalization. But I do support a lot of the questions raised about feasibility.

Nancy Hanrahan: This is Nancy Hanrahan. I'd like to just add to that too that there's just – there is in the background a lot of new communication, ways to communicate with patients after they leave the hospital and I can see something like this working as a text message. Now of course, you've got all the surrounding issues, do they have smartphone, et cetera, et cetera. But you know, even if we make a small dent in this problem, it seems like a good thing.

Peter Briss: Anybody else have other issues that they want to raise that haven't already been raised. Perhaps hearing none, why don't we try to move the voting? I'm sorry, did that work? Perhaps if somebody else has new issues, let's try to move to voting.

Female: OK, let's move to the voting, evidence. And if you haven't yet voted, please do so now.

Male: Is NQ out there?

Female: Yes, we're here, sorry. We just confirmed. So it's 9 yes, 5 no, and 7 insufficient. So this measure will not move forward. We'll go ahead and move to the next measure then which is 1661.

Male: OK, 1661 is – I have David being the primary discusser.

David: First from Joint Commission.

Male: Oh, I'm sorry yes, Joint Commission. Since this is another series of for screening and treatment and followup measures on alcohol but with the Joint Commission, I'd like to key up the set for us please and then anything specific about 1661.

Celeste Milton: Hi, it's Celeste, Joint Commission. The first measure that you will be evaluating, there's a set of four measures in the substance use set. The first one is SUB-1, this is looking alcohol use screening and for this measure, we would be looking at all of hospitalized inpatients that are 18 years of age or older and of those patients, how many were screened for alcohol use using a validated screening questionnaire for unhealthy drinking and that is the goal of this particular measure.

Male: And Celeste, do you want to do – do you want to do a little bit more on the – the whole cascade to get people a little bit of context.

Celeste Milton: This mirrors the tobacco treatment set, it's the same concept.

Male: OK, thank you.

Male: Are there any differences with the tobacco treatment set in terms of the way in which the information is captured? Because as I understand, that means one of them is (inaudible) improved standardized screening tool, are there other types of differences?

Celeste Milton: I'm sorry. You were sort of garbled and we weren't understanding the question. Could you repeat it please?

Male: Why did – could you identify the differences between this set versus the tobacco, because there's at least one difference as I understand it is that it's a standardized screening tool, are there other differences?

Celeste Milton: This requires – This requires the use of a validated tool because there are psychometrically-tested tools to use for alcohol use screening but we don't have psychometric tool for tobacco treatment, that would be the difference.

Male: Any other differences?

Celeste Milton: No.

Female: I will let you know that Eric Goplerud is here who's the technical expert for the Joint Commission if anybody has any questions for him.

Male: Thank you. So David, would you like to (inaudible) from the workers' perspective please.

David Pating: Yes, hi. David Pating. Sorry, (inaudible) was not on the work group but I've reviewed the notes and reviewed the indicator in great depth. This is very simple indicator. I think it does parallel tobacco one in many ways. The numerator is – or the denominator is all patient coming in the hospital that don't have cognitive problems that are over age 18.

In the last time we looked at this, we had questions what is a cognitive disorder and that has been clarified very well in the criteria and in the reliability studies by Joint Commission. It was also in the previous evaluation a concern about (CAPA) or confusion about the (CAPA) score, I think that's been resolved as well and the only question remaining that's really open is can this be extended to less than 13 to be consistent with meaningful use. So in terms of the description of the indicator, again, the denominator is pretty much all admission with a few excluding qualifiers of the cognitive impairment which has been sorted out the criteria. The numerator is those receiving a structured screening tool of which there's a range of tools that are – I don't either recommend it or as if (inaudible) AUDIT, AUDIT-C, AUDIT (inaudible), MAT, GMAT and I believe the (inaudible) drink screening limit, the NIAAA question hospitals allowed. So there's a whole range of tools and

they have different issues with each tool with all community and industry standard tool. The issue of evidence is that was very well substantiated. There were no concerns in the reviews (inaudible) the evidence of screening and the CDC recent report, alcohol screening was number 3, actually 4, above the tobacco – it was right behind tobacco in terms of impact and cost. So very low cost, low side effects and high ....

So with regards to then the evidence, with strong evidence and there was even hospital-based evidence of this intervention that was given and extensive of trauma emergency room evidence that has been given, a lot of that summarizing the work of (Dr. Santiago). Going to then with area of questioning which was the area of reliability. I'm going to actually ask Joint Commission to speak about this. They use a different methodology. The reliability I believe is 96 cases we've looked at and came in around 75 percent which is right at the threshold but it has to do something with the way that the reliability study was performed or the number that part of the reliability, not quite as strong as this might be suspected.

The validity studies were very good with showing the sensitivity in the 85 percent, and then the usability with the hospital across the board that were evaluated gave it usability score 5 being agreed in the – well above the four and a half to five range, so it was found to be very usable. So there was no feasibility issue.

So I think in this second look, the Joint Commission has really answered the questions that we have the first round. I would like to ask them to speak to the reliability measure since that was the major issue from the last review.

Ann Hammersmith: This is Ann at the Joint Commission and I beg your indulgence for a minute. Stephen just went out with a coughing fit, he's sick. But as soon as he gets back in the room, we will ask him to address the question.

Male: Perhaps, this is the rare advantage of not having an in-person meeting.

Jeffrey Samet: This is Jerry Samet (inaudible), I was just throwing a little bit of a contrary to probably not change anything in the big sense but the strength of the evidence supporting effectiveness, well, the screening out is of course on the

effectiveness of doing something about the screening and so we'll be talking about that with the next one. But that evidence for the in-house goal setting is borderline, probably possible and we'll get into more detail but…

Male: Yes, I think the issue was last time, they didn't have evidence for in-hospital setting and this time, they added that over the…

Male: Yes, the evidence was on the border last time. But possibly possible – probably on reanalysis were weaker than that even last time. The evidence got into the feasibility, had I thought that kind of – but anyway, I don't think it will change this one, but we'll be talking more subsequently.

Ann Hammersmith: This is Ann. Thank you, Stephen Schmaltz is back to address the reliability question.

Stephen Schmaltz: The reliability of this was mainly determined by one data element, alcohol use status and the disagreement on that one data element of course – impacted the reliability of the measure itself and the reliability on this particular data element was low the first time as well and improved a little bit the second time. And I think the issue was mainly at one site from the way they use their validated tool. Did you have some more information on that, it's the last thing I remember.

Ann Hammersmith: It basically had to do with asking the screening question, whether screening question is considered valid or non-validated and for patients that ended up not having any kind of drinking whatsoever, and whether to use the first or second reliable value, but since our testing had been corrected.

Stephen Schmaltz: I should also mention that CMS considers a match rate of 75 percent on the measure category assignment that's inaccessible.

Male: And Stephen, since you're – since you have the floor, while you were out of the room a second, it's sort – as a subject matter where question came up about (inaudible) about evidence of (inaudible) treatment center being recommended in the hospital setting. Since this is likely to sort of carry the set of measures, can you comment on that too, please?

Stephen Schmaltz: On the evidence itself for it?

Ann Hammersmith: Perhaps, Dr. Goplerud, who I believe is on the line could address that question?

Eric Goplerud: Certainly. Two things. First is to go back to the point about the reliability on the SUB-1 measure. It was in one hospital, they asked a question, do you drink? And for those people who said no, they did not ask further questions. The reliability then was reduced because asking simply that pre-question was not considered asking a standardized screening instrument. So we have since made the change so that reliability score would be substantially higher agreeing that just a person who says no, they do not drink has met the criteria of being asked. And so – on the pre-screener. So the reliability score would be substantially higher if we – and when we accept that as a reliable pre-screen.

Addressing the second question about the effectiveness of brief intervention, this goes to SUB-2. There is now a Cochrane – one Cochrane collaborative – collaboration meta-analysis on (inaudible) which had reviewed numerous randomized control trials. They found that in general, there was effectiveness in reduction of alcohol use at 3, 6, and 12 months. There was significant reduction in healthcare use and reduction I believe in mortality at one year.

However, the point that the questioner was raising is that brief intervention itself is not a very strong clinical intervention, probably not unreasonable given that many times, these behaviors take a long period of time to develop in one brief counseling session is unlikely in many cases to be sufficiently strong to change one place. It does for some, and randomized control trials including the general (inaudible) study have shown that. But it's very important to point out that a randomized control trial by states of hospitalized inpatients did not find it.

Male: Yes, I'm sorry. Can you – can you restate that last thought, so there was a – to the other question about the evidence in this context is it – can you help us with the applicability of the evidence based on brief intervention to – specifically to the hospitalized setting please?

Eric Goplerud: Yes, yes. The Cochrane collaboration review that I mentioned by (McQueen) is for opportunistically screened and brief interventions provided to general hospital inpatients. So it is specifically on the topic of this performance measures – measure, and (McQueen) found that it was clinically effective.

Male: Thank you. So other questions or comments from the committee please?

Male: I guess I could say I didn't get that the committee (inaudible), the committee supported this one, 4 yes, 0 no on the final recommendation.

Male: I'm sorry, I lost that in a bit of an echo.

Male: Did the final – I'm sorry, the final recommendation of the committee was 5 yes for suitability for endorsement and 0 no.

Male: Thank you. And so, any other questions or comments from the committee before we move to the…

(Madeline Naegle): Hi, it's (Madeline). I just wanted to mention of course the CDC with the screening brief intervention has a very strong initiative in this direction starting out with their FAS group but expanding to a broader base. So that we have a work taking it forward with the American Nurses Association which has endorsed this as a practice to be part of general nursing interventions. And I think that the feasibility in terms of readiness and awareness in the community has improved since we last discussed this.

Eric Goplerud: This is Eric Goplerud. If I could comment one more point is that in – at the end of April, CMS published the interim final rule for the inpatient perspective payment system. And it identified SUB-1 and SUB-4 as measures that they will require inpatient psychiatric hospitals and psych units in general hospitals to report on starting in 2016.

In addition, last year in the IPPS rule, CMS stated probably works a little bit of quotation. There – they said that the – all eight of the measures, the tobacco measures and the four substance use measures were recommended by the (MAP) for inclusion between the hospital IQR program provided they complete the NQF endorsement process prior to inclusion.

So the eight measures have been presented to the (MAP) and so are qualified to be included in the IPPS.

Male: Thanks. Are there other comments or questions from the committee?

Jeffrey Samet: This is Jeffrey Samet. You know, I'll say this now and we won't have to say it when we get to the next one. But I think the committee ought to be aware that the whole issue about the benefits of in-hospital brief intervention is on the edge. And I put it there, and there was a sense another (inaudible) this year which is a pre-leading addiction journal, did a review on intervention through reducing alcohol consumption among general hospital inpatients, a systematic review. So it's one subsequent to the Cochrane which just to quote your line, you know, results from a single session and brief intervention showed no clear benefit on alcohol consumption outcomes with indications of benefit from some studies but not others results to just multiple brief interventions of more than one session could be beneficial in reducing consumption in non-dependent patients. Eighty percent of the people in the hospital are dependent when they're screened positive for alcohol. So we're talking about benefit in a small group with multiple subsequent interventions.

So that's kind of my – that's – that article is my perception of the literature right now. I got to admit, I've seen your author on the (inaudible) paper where we did a nice run and (inaudible) benefits. But, yes, I recognize some studies do, some studies don't. But I just put that out there so it's in that context for which we're – modest benefit for which we're basing these recommendations on.

Male: Thank you.

Eric Goplerud: Jeff, this is Eric again. And Jeff is entirely correct. And of course, as senior author, I wouldn't argue with Jeff anyway. But I do want to point out that this is a four-measure set. And that the third measure is really – the second measure is designed for non-dependent high-risk alcohol use. The third is specifically focused on dependent populations. So it is for those patients who meet the criteria of a substance use disorder. And for those people, the

recommendation is the initiation of treatment or the specific treatment discharge recommendation.

So I think that at – when you think of the four measure set, it well fits where the research evidence is, which is that the brief intervention while a moderately effective intervention for high risk use but it's probably insufficient for dependent use. And the third – SUB-3 focuses on that population, those who have a substance use disorder and for whom it is very likely that more treatment and more intensive treatment is necessary even though we know that more intensive treatment itself is not, you know, formally successful.

Peter Briss: So anybody else have issues to raise that haven't already been raised?

Ann Hammersmith: This is Ann from the Joint Commission. I just want to clarify that we are speaking right now about measure SUB-1 which just looks at screening not intervention?

Male: Yes, I think that that's right, Ann, although people have correctly raised that if you really had questions about the intervention – if you had sufficient questions about the intervention that screening without intervention isn't likely to be useful. So that's why the screening question is getting into some intervention questions as well.

Ann Hammersmith: Thank you.

Lisa Shea: And this is Lisa. I just had a question to given that SUB-3 relates to drug use as well, but it's not included in the screening. I was just wondering what the rationale for that was.

Eric Goplerud: The rationale – this is Eric. The rationale for that was that we stayed within sort of the boundaries at the national (inaudible). The U.S. Preventive Services Task Force reviews which so far have found insufficient evidence that screening and brief intervention is effective with substances other than alcohol. It was the opinion of several members of the technical expert panel that there's no reason for thinking it is not effective, but at the present time, there were insufficient randomized controlled trials that would convince the

U.S. Preventive Services Task Force. Therefore, we stayed very conservatively.

But the same question kind that was raised about the extension of the age for screening which we limited to 18 even though members of the committee thought there was no reason not to extend it to lower – younger ages. But again, the research evidence was not strong enough in place to bring it down to lower ages.

Lisa Shea: Thank you.

Harold Pincus: This is Harold. Even though we're not going to get the SUB-3 in a minute, I just want to get a sense of your thinking because SUB-3 does include drug abuse and other drug – alcohol and other drug abuse. So what was the reason why you're not including the screening of drug abuse because I'm not sure how you're going to be able to link that up when you get – by the time you get to SUB-3?

Celeste Milton: Hi, this is Celeste, Joint Commission. We haven't gotten to SUB-3 yet but those patients that have the substance use disorders other than alcohol would be identified with appropriate ICD-9 codes or documentation by the clinician that they have a substance use – drug use disorder. That's how that would be ascertained at the time of discharge.

Eric Goplerud: So it was not done by a routine screening instrument? At least that was not required by the NQ – by the Joint Commission.

Male: But it would require an additional review of all charts. OK, I guess we'll get to that when we get to SUB-3.

Male: We'll get there.

Male: Yes.

Peter Briss: So, and anybody else have new issues that they want to raise on SUB-1? So hearing none, let's try voting SUB-1, please.

Female: Please go ahead and vote on reliability. Two high, 16 moderate, three low. Validity. Two high, 17 moderate, two low. Usability. Four high, 17 moderate. Feasibility. Four high, 17 moderate. Overall suitability for endorsement. 19 yes, two no. Measure 1661 has been recommended for endorsement by this Joint Committee. We'll move on to measure 1663 SUB-2.

Peter Briss: So with the Joint Commission, I could do this (inaudible) please.

Celeste Milton: Yes, thank you Peter. This is Celeste again at Joint Commission. The next measure that we'll be discussing in this set is SUB-2. We're looking at alcohol use brief intervention provided or offered and there is submeasure that looks at those that actually did accept the alcohol use brief intervention. And we're looking at all those hospitalized in-patients 18 years of age and older who did screen positive for unhealthy alcohol use or an alcohol use disorder. And then are those and we would be looking with the first measure that they actually received or should be intervention and then the second through the sub-measure would be looking at the total number that actually received the brief intervention.

Peter Briss: So this is Peter. I'm taking off my chair (inaudible) for a second and reporting on the work at the workgroup. So on the importance of the measure and reports, this sort of everybody agreed about the importance of alcohol use as a public health problem that there was – we've talked already about the (McQueen) that analysis of – modest to moderate benefits of screening and brief intervention in the last discussion. So everybody agreed about the decision logic for the evidence. The quantity, quality and consistency of the evidence was fairly evenly split between high and moderate. The measures properties were general.

Everybody agreed that there was higher moderate reliability and validity of the measure itself and the committee generally thought that the – that usability and feasibility were higher or moderate. And I think that there is – I don't think that there is much else that the committee raised – that the worker have raised that hasn't come out in the previous discussion. So with that, I'll ask if

anybody else on the worker would like to add to that? And if not, I'll put my chair head back on and I open for further discussion.

Lisa Shea: This is Lisa. I guess I had a similar question as I had in the previous set as who in the hospital generally was the type of professional that deliver this kind of counseling to the patient?

Celeste Milton: Hi, this is Celeste, Joint Commission and we are saying that you have to be a qualified health care professional so they could be a physician, a nurse or a certified additions counselor, a psychologist, a social worker or a health care educator, all who had been trained in brief intervention.

Peter Briss: And for what – in the place where you folks tested it, do you have sense of who the hospitals were actually using?

Harold Pincus: And also, how you were able to determine whether they had training.

Celeste Milton: We didn't actually collect that kind of information.

Harold Pincus: So, how does – collecting (inaudible) this measure? How do you determine whether somebody had training?

Celeste Milton: The Joint Commission has standards that people are educated for the positions that they are assuming. So, this would be part of their competencies that they would be trained in this in order to be able to perform in brief intervention.

Ann Hammersmith: This is Ann, and the hospital identified these people for us at the time of the reliability testing.

Harold Pincus: So that, I'm just trying to think about how does it work, so an abstractor is going through the chart and they see that a nurse indicated that they had provided some counseling? How would the abstractor know that that nurse was trained?

Ann Hammersmith: If the – if it wasn't clear from the documentation in the medical record, we would ask the – this is Ann, I'm sorry. We would ask the people at the hospital if this was the appropriate category of the individual.

Mike Lardiere: Would they go in right – this is Mike Lardiere. Would you then – would they go to their personal records and look at their training profile and see that they were trained on it, that type of thing?

Ann Hammersmith: Generally speaking what we find is that the people who are in charge of abstracting for these measures that they have lists of the people that they refer to.

Harold Pincus: Although 10,000 employees – because I'm trying to think about how we would do something like this for this specific kind of procedure. Is there anything – is there any measure similar that sort of has this kind of requirement?

Celeste Milton: Hi. It's Celeste, Joint Commission. You know we've discussed the hospital-based inpatients psychiatric services measures yesterday, and qualified psychiatric practitioner, we defined those personnel as far as performing admission screening that they would be like a master of social work. It could be a psychologist, a psychiatrist. So, yes, we do that requirement in other…

Harold Pincus: Well no, but this is different. This is different. This is – number one, it doesn't require you got a (inaudible) mental health professional. And number two it requires specific training in alcohol counseling, brief alcohol counseling. And just – I'm trying to think about how this would work.

Ann Hammersmith: So, what we

(Crosstalk)

Ann Hammersmith: Excuse me, for interrupting, doctor. But what we – this is Ann. What we found in the testing was that hospitals generally develop a cadre of trained brief intervention people, you know, it wasn't like anyone of 10,000 employees could be doing it. They train a finite amount and those were the people that were identified as having pre – having done the intervention.

Mady Chalk: This is Mady, Harold. It does – brief interventions are not brief counseling, and no, it does not require extensive training the way it would if you were training to be an alcohol counselor. It's not the same sense.

Harold Pincus: Yes, I'm not really – I'm not so much concerned about the actual training. I'm trying to think about how they would determine…

(Crosstalk)

Harold Pincus: I mean, would they, you know – would it be like everybody would have to go to a fire safety training and then it would be identified. I'm just trying to think – I'm trying to think through how a hospital would do this.

David Pating: Hi, this is David Pating and my system, we just trained about 3,000 medical assistants and we just basically by class with a designated code, medical assistants needed to be able to receive basic – a one-hour basic training on screening parameters. And then it's very – I think this is really easy to do.

Harold Pincus: I do to.

David Pating: Mandate a one-hour or two-training. They get the – a training on how to use a 10-item questionnaire and then how to follow up with just simple interventions afterwards. And I think it can be done in an hour per facility.

Harold Pincus: There are numbers…

(Crosstalk)

Harold Pincus: You'd apply it to all – because it sounds a little bit different, but I'm – that makes more sense to me than figuring – you know, having to go through all process of having a small cadre of people that can do this and then have to make sure that they see the patients in a period of time.

Jeffrey Samet : So, this is Jeffrey Samet. Was this the issue that this measure felt short on the last time we all?

Harold Pincus: No.

Jeffrey Samet: No?

Harold Pincus: Not as far as I know.

Jeffrey Samet: I mean, I thought it wasn't the evidence for it's effectiveness. It was more on the issue of how we want to assess it which is kind of what we're getting at now, you know, how do you got about – and I'm wondering just the progress on that front which gets at this issue actually. This is a – this is just one piece of it. It was a progress on that realm?

Ann Hammersmith: This is Ann from the Joint Commission and I'm sorry I don't understand your question.

Jeffrey Samet: So, what this – this was brought up when the group met in Washington, (inaudible) when we did that last time and it felt short on the – as I recall on the question of how we'd want to go about and assessing whether this was done you know as a – if you wanted to see, were they meeting quality measures?

Harold Pincus: Yes, it was on the issue of reliability…

Jeffrey Samet: Right, and…

Harold Pincus: And I thought…

Jeffrey Samet: Well, I mean, this issue that that's being discussed right now is a piece of that it seems to me, so I'm wondering if in the big picture, did we make progress on improving it?

Male: I think, last meeting, we just did not trust the (CAPA) score. We thought that they were for measure. We didn't understand them and then they came out low. Since then, my understanding, (inaudible) is you've run some other – you expanded your trials and have changed the measures and...

(Crosstalk)

Female: Instructions and the definition of this or clarify them.

Celeste Milton: Hi, this is Celeste at Joint Commission. And so as the brief intervention, this should correspond with the five As which is ask, advice, assess, assist, ...

Male: Yes, I don't think – Celeste, I don't think that's quite the question. I think it's…

(Crosstalk)

Eric Goplerud: I think the – I think the question was back – this is Eric. It was back to the question about reliability and as Dr. Pating suggested, we have extended the trial and recomputed the (CAPA) scores and so have agreement that it is in the – (inaudible) over 80 percent overall measure agreement for SUB-2 then you have 2A2.3 testing results.

Male: And this was much like, this was much like the improvement on the same issues in tobacco (inaudible) measure.

Eric Goplerud: That's exactly right.

Male: Thanks for the clarification.

Peter Briss: So, other issues that committee members would like to raise, please?

Male: So last, I have a question – question kind of a comment is that, is it more valuable to link these patients without patient services that do substance use treatment versus the short-term treatment. Isn't that a better option to measure the amount of referrals that are made to those resources rather than the short test because we know are the shorter interventions, because we know there are some questions about whether they are effective or not. So why go there if there's a better option?

(Madeline Naegle): May I speak to that Peter? It's Madeline.

Peter Briss: Yes, speak (inaudible) please.

(Madeline Naegle): Just to clarify this, did this – we're really looking at a group of people who are at risk for meeting criteria for abuse or dependence that we're not recommending that this be done with people who have a diagnosis of abuse or dependence. And certainly that someone in the hospital should be making a referral for those folks to substance abuse services. Now these are people who

do not have a diagnosed disorder who are only drinking more than is healthy for them and/or which compromises their health, and for some reason.

So the recommendation is to cut down with the idea that they will improve their health. So it's really important to keep in mind that that's the population, it's only about 25 percent of the general population. It will be – there will be more people who are hospitalized who might meet the criteria for abuse or dependence. But the…

Jeffrey Samet: But the – excuse me, Madeline, that's not what this one says in the denominator. It's 18 years older who's going to pass it for unhealthy use or an alcohol use disorder, abuse or dependence.

(Madeline Naegle): Sure (inaudible). I'm sorry, Jeff. Thank you.

Jeffrey Samet: So to answer your question, I mean to answer the question that's posed is better to refer them. Yes, it'd be nice if they got somewhere because 80 percent will be with the disorder. That's what the data show. So I would like to get them connected because, right, a brief intervention will probably work on them particularly. Well, a brief intervention get them connected. That's a bit of an open question. And but that's why we're doing this.

...

Male: Although for the people who need a referral – for people who need a referral (inaudible) does one of the acceptable – one of the acceptable treatments is a referral to treatment.

So, do we – so step three is going to get to the people who have – who have a diagnosable disorder and need to be referred.

Male: But I guess if institutions have limited resources, and we're going to say we're going to have them now do both things. So they're going to do the short intervention and they're going to make the referrals, isn't it better that we choose one that we think is the most valuable and push that as the quality measure, meaning the referral rather than the short intervention.

(Jody): This is (Jody). My understanding is that the brief intervention is not like therapy or brief treatment or brief counseling. It truly is a brief intervention.

...

Jeffrey Samet: So just to elaborate on what you saying, this is Jeffrey. A brief intervention for someone with unhealthy use without disorder is cut down. A brief intervention for someone who has a disorder is we got to connect to the treatment.

Female: Right.

Jeffrey Samet: That's what it is.

Female: Absolutely.

Male: Yes.

Female: Thanks.

(Mike): This is (Mike). You have to do the – you have to the do intervention before you can figure out whether you're doing a referral. So, yes, I don't see separating that way.

Female: I think it increases possibility that the person who's getting, you know, the person getting the brief intervention may increase their willingness to follow up with any recommended referral.

Male: Do we have data on that?

(Mike): Well, we have data that doesn't work that…

Male: Yes.

...

Male: As a practical matter if the brief intervention for somebody with a diagnosable disorder is we – they connect you with – with actual treatment and then you're going to – then you're going attempt to make a connection with the actual

treatment, I don't see how as a practical matter you could actually do the referral without doing something that would count as a brief intervention.

Female: That's my sense.

...

Male: This is basically the design of the brief negotiated interventions which it's one of the models, you know, that (Ed Bernstein) and (inaudible) and others have as part of a brief negotiated intervention with people with a substance use disorder is a big part of that intervention is negotiating, getting engaged in treatment. And there is some reasonable evidence from, you know, (Bernstein's) work suggesting that it does increase the rate of successful referral or successful treatment engagement. Not through all patients and not even for a majority but for more than if you didn't do it.

Male: Just a question, is there any efficiency obtained if SUB-2 and SUB-3 were combined?

(Crosstalk)

Male: Or is that really more of a complication?

Male: Complication.

Female: That has always been my ....

Male: Yes, just one observation, I didn't bring it at the time but the idea that this is a one hour training for an MA, a medical assistant, I would at least stand in the opposing group that it's more complicated than that. But in truth, people get designated – people do get trained to do this, so I don't find the provider issue so disturbing.

Male: Yes, my (inaudible) is more that not so much we're getting trained piece but having the abstractor be able to identify whether or not they were true.

Lisa Shea: This is Lisa and I (inaudible) I'm just saying these hospitals that were (inaudible) hospitals they were able to do this in a little over half of the

patients. These were very motivated sites that – or experts so I'm just thinking whether there is a lot, you know, and I might speak to the need for it but there is a huge hurdle here.

Male: So, are there other – I'd like to relatively quickly if we can move to voting, are there new issues that haven't already been raised that still needs to be discussed on SUB-2?

David Pating: Hi, this is David Pating, so one last thing. So, SUB-2 I think is the natural outcome of SUB-1. So it doesn't make sense to have that screening questions and not follow up with recommendations based on that and I believe that these recommendations or the brief interventions fall directly from how people will screen high, medium, or low risk. So I think one and two go very intimately hand in hand. And the second thing is with due respect to Dr. Samet who I have great respect for, I see the brief intervention field of actually in transition and we're getting better with our brief intervention science. While it is maybe true that one single intervention, we have less impact in certain environments than we thought.

There is evidence perhaps that small (inaudible) intervention of which one of them in the hospital can have greater impact. And so you're looking at a series of interventions and the hospital is a (inaudible) element for receiving brief counseling around smoking if that's a problem.

Jeffrey Samet: Hi, this is Jeffrey. I agree with what you said.

Male: Anybody else? So why don't we try to move to voting on SUB-2, please.

Female: Please go ahead and vote for reliability now. And if you haven't cast your vote yet, please do so now. Two high, 19 moderate. Validity. And if you haven't cast your vote yet, please do so now. Sixteen moderate, 5 low. Usability. Two high, 14 moderate, 5 low. Feasibility. Fourteen moderate, 7, 1. Overall suitability for endorsement. Sixteen yes, five no. Measure 1663 has been recommended by the steering committee for endorsement. Next (inaudible) to measure, 1664 SUB-3.

Male: All right, so we move into SUB-3, and so we move to SUB-3. And further as we move to SUB-4, I suspect that a lot of the issues that need to be raised have likely already been surfaced in the previous two discussions and on – related to SUB-4 may have already been surfaced in the last tobacco measure. So – so I hope that we can fairly efficiently raise new issues if they move fairly rapidly to voting so that we can say on schedule. So with or with that, you know, with the joint commission like they had anything new.

(Celeste): Hi, (Celeste) again of joint commission. The next measure that you'll be evaluating is SUB-3. This occurred in the set of four substance use measures. We're looking at alcohol or other drug use disorder treatment provided or offered at discharge, and then we have a SUB measure that looks at the ones that the patients had actually agreed to either alcohol or drug use disorder treatment at discharge. So in this particular measure, we're going to be looking at the hospitalized inpatients that are 18 years of age or older who are identified with an alcohol or a drug use disorder.

And as I previously mentioned, this would be the ICD-9 Code that identifies either a diagnosis or procedure related to these conditions, or that their – the position documentation that indicated that the patient had alcohol or drug use disorder. Of these patients then, there are two ways to end the numerator. That would be that the patient was given or accepted or given a referral for addictions treatment or a prescription for medication for treatment of alcohol use disorder.

In the primary measure, this would be that it would be offered and they could refuse. In the second measure, then it would be evaluating those patients that either did accept the prescriptions or the referral for addictions treatment.

Male: So, I think the workgroup member was Mady.

Female: Yes. So in general, the workgroup supported the use of this measure. I mean that the biggest issue was that it is slightly different than the previous two measures. So although it's part of a (inaudible) of measures, it now includes drugs and the (inaudible) it doesn't follow specifically on the brief

intervention any longer. It's probably based on looking at coding and making sure that these are people who have a diagnostic indication for something.

There were some changes that were made for this measure based on what happened last time. The last time we reviewed this, we have significant concerns about reliability here. There was a change, the (inaudible) was changed. There was a refinement of data definition and a large – that helped change the reliability and improvement. I don't know what else to say about it. Are you there? Can people hear me?

(Crosstalk)

Female: OK, that's (inaudible). Let me just go down to the end here to summarize. I don't think there were any other significant comments about it.

Male: OK. So, this is how…

Female: Go ahead.

Harold Pincus: This is Harold. I had one-–and I think this is reasonable and it builds upon the other two, but I have one sort of significant concern, which is by adding the other drug use disorders, there's a potential for adding a very significant additional burden. Adding it by code is not a problem, but by adding it that there's a physician statement in the record somewhere …

Female: Yes.

Harold Pincus: …it says that there's a drug abuse problem means that you have to essentially review all charts for that. And, if you think that's a huge) additional burden that would-–that, you know, that is additional beyond capturing the denominator from the previous two charts.

Female: Yes.

Harold Pincus: Or two-–not charts but indicators. That's my one big concern. I'm not sure what the yield would be from that, and the reliability of that component in either case.

Jody: This is Jody, can we hear-–I also wonder why that in there. So, should we have some response from that?

(Anne Celeste): This is (Anne) from the Joint Commission. And, just to-–I'll let Dr. Goplerud talk about the evidence, but just to clarify for the committee what the process is, in reality these conceived measures are intended to apply to all admission, these charts are going to be looked at anyway for SUB-1 and 2. So, it could be there is not really an additional burden but because we realize that there are a lot of patients admitted to hospitals, there is a sampling methodology so that organization can choose a random sample so that they're not looking at, you know, thousands of charts.

And now, Dr. Goplerud, if you wanted to talk about, you know, the inclusion of the drug dependence, perhaps that would help.

Eric Goplerud: OK, I think this was part of our thinking here is to move us mentally away from paper charts and people looking at paper charts and looking at electronic health records. And the hospitals that has implemented these sets of measures have all moved them into their EHRs so that they're searchable through that and primarily searchable through diagnosis.

NIAAA did a physical chart review and sample of patients and found that in about 50 percent of the cases where they found a substance use disorder, primarily alcohol use disorder through interview, I believe actually between 70 and 80 percent of those cases there was a chart notation but in only 50 percent of them was there any indication that anyone could follow (inaudible) on, so this is really trying to address the gap between a diagnosis or chart notation and actually doing something. (Inaudible) study found similarly that there was quite a discrepancy between notation and substance use in the chart and actual intervention or follow-up.

(Mike): (Eric), this is (Mike), and I wonder why couldn't you just get that from diagnosis and why do have you get it from a progress note?

(Eric): Practically, I think this will be primarily done through diagnosis.

(Mike): OK, so you wouldn't necessarily have to-–because as you're saying if you're reviewing electronic health record…

Male: But that's not what this special occasion says.

(Mike): OK.

Male: Harold is – Harold is absolutely correct. The way that the measure was developed was also to include assessment in the chart.

Male: Yes.

Jeffrey: This is Jeffrey. If you take that complication out here, this one makes all the sense. And I think the evidence that the treatments or value and yet there's a gap. It is straightforward.

Mady Chalk: Then is it possible – this is Mady – for us to – if we approve this measure or make a recommendation to the Joint Commission that the chart review components will be (amended).

No?

Male: Would the staff want to comment on that please?

Female: Are you talking about ...…

Female: Of either one. Yes. Sure.

Male: Yes. Actually I was asking NQF staff, I'm sorry.

Karen Pace: OK. This is Karen Pace. So, right now the measure is specified for the medical record obstructions and certainly Joint Commission has moved some of their measures to eMeasure specification. So, I mean I think you can make that recommendation and we can hear from Joint Commission about what their plans are for this in terms of eMeasure specifications.

Female: OK.

Karen Pace: But you would be actually voting on this measure as it is, as a medical record obstruction.

(Eric): This is a – OK, this is (Eric). As a technical expert, I certainly would not have difficulty recommending that to the Joint Commission.

Ann Watt: This is Ann at the Joint Commission, and we are in the process of specifying all of our measures including this one for electronic data collections.

(David Aiding): Hi, this is (David Aiding). I have to (risk of losing) kinds of this one. I'm going to actually play (death's) role and – so I'm going to disagree really – beat me with the logic model. I'm really worried if this measure will meet the inappropriate care. First, I think the diagnostic inclusion of the other drug use or the other alcohol use disorders other than dependence. It's much too broad. The number one diagnosis coming into hospitals is alcohol intoxication. Not even abuse or dependence that's related to somebody drank and they twisted an ankle and broke a leg during someone – someone broke their party.
So, to go from there, they would qualify as an alcohol use disorder to now in receiving one or two interventions, the referral or medication. I'm actually OK with the referral or the assessment but it's actually the medicines that I'm concerned about. Well we do have – again have a medicines for substance abuse. I think the efficacy of them is just not as good as the medicines for tobacco and so the parallel with tobacco is giving medication treatment which is – just for me, it just doesn't quite hold up.

And then, lastly I am worried about, you know, this 31 percent (user) rate and the usability burden of that. But my primary concerns are the diagnostics inclusion in terms of the denominator. It's overly inclusive. I would just like limit it to dependence. And requirement of medication as, you know, one of the recommendations. I just don't know if I would feel comfortable with that starting medications upon discharge from a hospital and then without a presumption, is this is a primary care follow up or anything – any plans for follow up.

To me, it is sort of hangs there. It substantiate the level of sharing. There's not evidence that they've given that medication, that discharge hospital but,

you know, if effective. So – and again those two areas. The over inclusive diagnosis and then the recommendation with this area potentially.

Female: ... ESM 5 now eliminates dependence of the category. So, it maybe complicated to move the way you describe it.

(Jeffrey): This is (Jeffrey). I'll respond brief to that because and I don't share all the concerns although in part because they have a big or a capitalized OR between medications or referral for treatment. And so, you know, 80 percent of the people in the hospital – screened positive in a hospital do have dependence diagnosis. So that's the data. The published data, anyway.

And – and – so I think it's an appropriate group to target and since you'd have one or the other, I'm not playing the contrary influence.

(Lisa): This is Lisa, I just had a question about a result of 3.5 percent and explanation because those really aren't the great results.

Female: Somebody from the Joint Commission who knows that.

Female: Sorry, which results of 3.5 percent? We're not quite sure what you're referring to?

(Lisa): I'm sorry to the – on 2B 5-3. It says on page 20 of the specifications for SUB-3, it said or maybe I misunderstand how an overall rate of 3.5 percent down from a baseline of 9.2 percent. Oh, that was the rate of compliance for the implementations. And I guess I was wondering how did things improve after the – this went into effect.

Female: I'm sorry to be obtuse, what page? What section and is it the submission that you're referring?

(Lisa): Yes. – I'm sorry, the submission labeled page 20.

Female: Oh, I don't have those in front of me.

(Lisa): The 5.3 recall.

Female: It's actually up on the screen and it's right at the 2B 5.3, the result connections.

(Lisa): Maybe I miss...

Female: Oh, oh, oh. That has to do – that was related to compliance with the measure.

Male: (Lisa), the (image) of testing hospital, the baseline rate was very low.

Female: Yes.

Female: Right.

(Lisa): OK and then what was the rate afterwards? That I guess after the – so if that's the baseline and the (inaudible) place, how much did it go up? I might have just missed that, I'm sorry.

Ann Watt: This is Ann. And we don't have those data in terms of what the rate is at this point because the testing period is over.

Male: Well, what was it at the end of the testing?

Female: I got a few.

Male: And it says that I think it did. The baseline was nine percent. If I'm reading the correct baseline, it was nine percent and then it went down actually to four percent.

Female: OK.

Vanita Pindolia: This is Vanita, I just had a question about the drug therapy options. There's really not many available. So, out of the three, one is extremely expensive to the trial and probably there still many restrictions that most patients trying to ....

Female: ... anymore, but go ahead.

Vanita Pindolia: Sorry. Can anyone hear me?

Female: Yes.

Male: Yes.

Vanita Pindolia: Oh OK. My question was for (JHACO), when you were doing this, was there any particular drug or just Naltrexone to be used or Antabuse or are there any – did you look and follow up how many patients how many patients we're actually able to fill their prescriptions or is that – was that an issue or not after discharge, at point of discharge?

Ann Watt: This is Ann. We have a table of drugs in or specifications that are acceptable. It's FDA approved and they are Methadone, Naltrexone, Revia Oral, Suboxone, and Vivitrol injections. And – Celeste is pointing these things to me. And for the drugs Antabuse, Buprenorphine, Campral, Depade, Disulfiram and so forth. So those are – those are the specific drugs that we direct abstractors to look at or for. And I'm sorry, I know there was a second part to that question and I've lost it. We actually feel that whether…

Vanita Pindolia: ... at the hospital and then obviously they have to be continued on as the drugs won't work just...

Female: Right.

Vanita Pindolia: … once. And most hospitals probably will not have to the Vivitrol under formulary their formula or just because the expense of it and lastly…

Mady Chalk: I beg to differ. This is Mady. I beg to defer about the Vivitrol. And about the…

Vanita Pindolia: About the Vivitrol being non-formulary?

Mady Chalk: Yes, being on hospital formulary. But I'm just in the midst to finishing a study on Medicaid and commercial carriers, and their coverage of benefits for medication.

Female: I think I have it on their – on the outpatient. Yes, I agree. And the outpatient setting but they'll have restrictions. But most hospitals don't want to cover a drug that last for one month long and they have to pay the up front cost for

that. That's at least, that's the practice here in the three different hospital system on Detroit area.

It just too expensive for them to do that but you're right. And the Medicaid and Medicare population and Vivitrol has to be offered but there will be – there are still many restriction because of the expense for it when you have this other options.

Female: Thanks for talking (inaudible) please.

Male: OK.

Mady Chalk: So what I was wondering is, these other drugs are being given, is there any follow up like do the patient actually pick up their drugs? Whether they continue, how does that go on with – after discharge?

Ann Watt: This is Ann for the Joint Commission. And the measure does not address patient compliance with filling prescriptions.

Mady Chalk: And the reason is I think – with the tobacco cessation, most of those are generic now or low cost but in this area, a couple of the more higher, more used ones in to this is just doesn't use as much as it used to be with these other options available. They're expensive, that's how. And so out of a pocket cost could really deter a patient from actually filling at it discharges. And that's what we're finding with many other disease states too.

Female: The next measure is designed to find out from patients what their status is and whether they're taking their medication. Is it not?

(Eric): Let me – this is (Eric). I'd like also to kind of circle back to (Jeff's) comment which is that the measure specifies it's – there's a very – there's a capitalized or which is medication provided or offer or offered on discharge. Or addiction treatment initiated in hospital or on discharge.

So, while we recognized that there are medications for some of the drug dependents, it's not for all types of drug dependents and it is not always available to patients. This measure specifies also could be talking therapy.

Female: Right.

Male: So we're getting – we're getting a bit behind schedule. So, I'd like to move as fairly quickly to try and to vote the measure. So are there – are there any – are there any new issue that haven't already been explored? And – that we really need to – or before folks have enough information to try to vote.

Male: Let's vote.

(Mike): I don't have a new issue. I just don't know – how do we – we do we get around the issue of having to look through the progress note versus using the diagnosis…

Female: If we make a recommendation after we vote on it, (Mike).

(Mike): Is that (inaudible) OK.

(Crosstalk)

Male: It seems to me that – it seems to me that if you decided that the chart review was too burdensome to have this measure be plausible, then you should vote against it as a feasibility issue.

Female: Right.

Male: OK.

Female: Right.

Male: Yes, I think so.

Female: Just – this feasibility to just – I guess I'm still trying to understand why the baseline was 9.2 percent, it went down at 3.5 percent given the specifications. I just get that as a potential feasibility issue.

Male: OK.

Male: OK. Why don't we move things ahead.

Male: Yes, let's – let's try to vote in this measure and see what happens.

Female: Let's go ahead and vote for reliability.

And if you have not voted for reliability yet, please go ahead and do so now.

19 moderate.

Validity. And if you have not voted yet please go ahead and do so now. 16 moderate, five low.

Usability. And if you have not voted yet, please go ahead and do so now. Two high, 11 moderate, eight low.

Feasibility. 11 moderate, nine low.

Overall suitability for endorsement. And if you have not cast your vote yet, go ahead and do so now. 11 yes, nine no.

Measure 1664 was recommended for endorsement by the steering committee.

We'll move on to Measure 1665.

(Crosstalk)

Male: Wrong recommendation about making that change that was discussed with the right feasibility.

Female: Yes. Yes.

Male: Yes.

Female: So, noted. Thank you.

Male: So, on SUB-4. I suspect that either maybe, there may be many of the – the committee clearly had a lot of feasibility and other concerns about assessing status on tobacco for – I suspect that this one may have many of the same issues.

Male: And, others in addition.

Male: Hence, perhaps others in addition. And so, so if the committee feel – I would like to tee this up again the – but I'd like very quickly to assess whether this one going to – is essentially going to have the same issues of tobacco for as it's directed it might. So, with that, can the Joint Commission very briefly we tee this up for us please.

Celeste Milton: Certainly. This is Celeste with Joint Commission. The fourth in the – four measures, the SUB-4 and this is looking at alcohol and drug use assessing status after discharge. And it would be taking a look at those patients that were discharged that were 18 years of age and older who screened positive for unhealthy alcohol use, or who received the diagnosis of alcohol or drug use disorder during their hospital stay.

And also send a follow up would be the number of discharged patients who were contacted within seven to 30 days after discharge from the hospital and following up regarding their alcohol or drug use status being collected.

Male: So, maybe any – can you very briefly…

Female: Yes, I mean…

Male: Yes.

Female: … the big issue here, of course had to do with the feasibility questions and the ability to contact sessions. And, the whole question of how much of this could be routinely reported given drug diagnosis. I mean, this is not a simple matter. The day of accessibility and the ease of collection of data from patients given what we know is – and we talked about this on tobacco but I think the committee felt that it was even more difficult with this – with this issue. And, I don't know what else to say about it. I don't think otherwise anything differs much.

Male: Yes. You, too. So, I think that that's – I think that that's right. So, I wonder whether we could have a very quick conversation on the committee. We know we – we know we didn't support tobacco for because of feasibility

issues. This one is likely to have at least a period of feasibility issues. So, perhaps we could open with – does anybody want to make a strong case that they believe that this is going to – that is essential to view or likely to be better on the feasibility scales than the last one?

(Jeffrey): This is (Jeffrey). I'm not going to take your lead just for second because one point that Mady make that was the evidence – the evidence on this was weak, I thought. And not possible to what they explained with tobacco – so, another strike.

Female: Yes. Yes. The quality of the evidence was low. It was mostly indirect and it hasn't or it hasn't been evaluated at all.

(Helen): And just to point out, this (Helen). This measure has not yet gone through the voting for importance. We had deferred on it at the last meeting.

Male: So, would anybody - I'd like to us to move fairly quickly to voting on this one. Are there other issues that folks would like to raise before we do that?

Male: I may try to take that silence as a (send) into this context. Could we try teeing up voting please?

Female: All right. You're ready to vote on evidence, please go ahead.

And we have 8 no, 13 insufficient. This measure will not go forward.

We'll move to measure 2152.

Jody Hundley: Can I - this is (Jody). Please, are we going to comeback around or have we hold the recommendation about the reducing 12 the assessment, 12 and up each.

Male: We'll discuss later.

Jody Hundley: Later?

Male: OK, with the harmonization.

Jody Hundley: All right, thank you.

Male: So (Harold), I will happily turn the chairmanship back to you for the PCPI measure.

Harold Pincus: OK. So this is measure 2152. Preventive care and screening unhealthy alcohol use, screening and brief counseling.

And can we hear first from the measure steward.

Samantha Tierney: Yes, this is Sam Tierney the PCPI. I'm going to ask Dr. (Dan Kevlian) to make a few if he's on the line.

(Dan Kevlian): I am. Could you hear me OK?

Female: Yes.

Male: Yes.

(Dan Kevlian): Yes, thanks. This is a measure that's really population based to try and gather a team that's come up with some earlier discussions regarding the importance of having not just the screening result but some appropriate clinical action to follow up on that screening result.

This is consistent with the USPSTF recommendation that was just renewed at the B level of enthusiasm last month. They focused on the evidence being sufficient for those 18 years and older, and sufficient for those younger than 18. And so that's the reason that it's limited in that age range.

And part of the evidence we have of the importance of combined population focus measure like this is that if you separate this measures, there is a perverse incentive given the lock of standardization of screening approaches to use something that's less sensitive. And that would reduce the impact on the population most likely to benefit from this kind of brief alcohol counseling.

So I think I leave at that and see if there are other questions or clarifications.

Male: OK. And who was the person who led the discussion in the work group?

Female: I think it was Jeffrey Susman.

Male: Jeffrey, are you on?

I guess Jeffrey is not here.

Jeffrey Susman: Hello. This is Jeff, I just got knocked off or something.

Male: OK. So we're discussing 2152? And if you could sort of fill us in on the discussion in the work group.

Jeffrey Susman: Sure. So as noted by the measure developer, this is for a measure looking at precisely teen or older screened for unhealthy alcohol use. It was once during their career of (measurement) periods systemic screening and received brief counseling if identified positively.

The numerator was very generic about assessment per screening including audit measures case simple screening and alternatives. And the brief counseling was defined as one or more counseling sessions, denominator were all 18 or older patients who are seeing at least twice were at one preventive care visits and there were actually very few exclusions. The general voting on this was that this is clearly an important area. As what's noted, there's a recent U.S. Preventive Services Task Force with the court which quite (inaudible) different look at the evidence behind this which is fairly strong and there was relatively consistent support for this ranging generally from moderate to high and a consensus that this should be adopted as a measure.

Male: Comments and discussions from the committee. Let me ask this question to the staff, if – when we get at the harmonization so this is obviously similar in concept to the alcohol use – alcohol screening and brief counseling component that was – we just discussed within hospitals.

When we get to the harmonization discussion, if there are elements of this that we prefer as compared to the being hospital one, is there a way – how actually would that be worked out to get the harmonization?

Female: There would be a recommendation from the steering committee to the measure developers with the recommendation for the specific areas to be harmonized.

David Pating: OK. Hi, this David Pating. This is an outpatient measure, is that correct?

Female: That's correct.

David Pating: Yes. And then I just actually, (along) harmonization, how does this harmonized with the current NCQA HEDIS measure that we approved, you know, 6 months ago, or last year. (inaudible), if you have an alcohol use disorder, if you're screened positive, you get a brief intervention at same visit. HEDIS requires you to have a separate visit so this measure is about, you know, depending on where you follow up. The two measures maybe at (conflict). I like this measure personally, the one that we're looking, I have a concern to that though, harmonization of the HEDIS ... measure.

(Ben Kevan): Yes this is (Ben Kevan)…

(Audio Gap)

(Ben Kevan): … the HEDIS measure that looks at those who receive a diagnosis, and so that would be a subset on those who are screened positive.

Female: Hi this is NQF, we're just looking that up now but I do want to point that the harmonization discussion you'll be having momentarily will only be inclusive of the measures in this project. So I just want to point out that. You can't set other things...

(Crosstalk)

Female: … initiation engagement.

Female: … but official recommendation will just be right ....

Male: At this point, it would be useful to have one – the harmonization discussion that cuts across all these things…

Male: Yes, it would.

Female: Yes.

Male: And this – it used to be an area that it's primed for ....

Female: Yes actually, I'm…

Female: NQF have to change a bit of our process around harmonization. Now it's going to describe it shortly. But one of the changes is that we reconvene the steering committee after all the measures in this current project are approved by the board of directors, and at that point, we have a discussion of all measures across the NQF portfolio.

Female: That's – that would be very helpful, I think.

(Crosstalk)

Male: … or this measure specifically now without regard to harmonization?

Female: No.

Female: Correct. We have to evaluate the measure that's in front of the panel, (inaudible) all merits.

Male: Right.

Male: Any comments on any of the issues, any of the criteria that we are going to be voting for in a minute, voting on in a minute?

Leslie Zun: Yes, this is (Les). I have a couple of questions. So, when I look at the importance to measure and report rationales, it talks about proper care for substance abuse diagnosis in trauma center. But this is being – is this – is the evidence for this based on trauma centers or is this the evidence based on general admitted patients.

Male: Now, the USPSTF recommendation is focused on primary care.

Female: Yes.

Male: Right. But if you look at the rationale 1A impact, rationale.

Samantha Tierney: This is Sam Tierney with the PCPI (inaudible). You know, as we describe the impact and the importance of the measure, we mentioned the national preventive – prevention strategy, and the fact that they identified (expert) as a high priority area for primary care and trauma centers. I'm not sure if that's what you're referring to but this measure is really more focused in the outpatient setting and primary care.

Female: Yes.

Leslie Zun: And I think there's robust evidence here about the impact and the feasibility.

Male: Yes.

Male: Are there comments, questions?

So, hearing none, it sounds like people are pretty positive on this and ...…

Female: Well, it's cut – what happened?

Male: Yes. So are set into voting?

Male: Check them (inaudible) and let it move fast.

Female: You're all set to vote. Go ahead and vote on evidence. And if you haven't voted yet, please do so now. 18 yes.

Performance gap. And if you haven't voted yet, please do so now. Six high, 14 moderate.

High priority. 18 high, two moderate.

Reliability. Two high, 17 moderate – 18 moderate.

Validity. Two high, 17 moderate, one low.

Usability. Six high, 14 moderate.

Feasibility. Four high, 16 moderate.

Overall suitability for endorsement. And if you haven't voted yet, please do so now. 20 yes.

Measure 2152 has been recommended by the steering committee for endorsement. We'll move on towards harmonization discussion for the tobacco measures now.

Female: Great. Well I'm…

Peter Briss: I wonder if that's – this is Peter. I wonder about whether this might be an appropriate time to talk about the age issue that (inaudible), yes, NQF might need to (inaudible). I wonder if now might be an appropriate time to have a – try to have a brief discussion about the age range issue that we do – measure that we (inaudible) completed?

Lauralei Dorian: Yes, I think that I was just going to give a brief introduction as to the process, but then let's definitely move into the age range question such as they know what the next sort of steps with harmonization will be. NQF – sure, sure. So we haven't changed our guidelines around evaluating harmonization but we have changed some things in our process. We heard from – we had heard from developers and even steering committee members that the harmonization and the competing measures discussions were taking place sort of at the last minute and they always felt rushed.

So one thing that we did in this project was sort of piloting these new ideas as we identified all related or competing measures using our criteria very early on and we've reached out a couple of months ago to all measures we had or to all developers (inaudible) who had any measures related to depression or medication adherence, tobacco, any topics in our project and including reaching out to those developers who had measures in those topics (inaudible) in this project. And we let them know that we were expecting at a certain point, a response, a plan to harmonize this measure.

So today, the focus is on the measures in this project that have been recommended for endorsement. We did go to those developers within this project and we asked them to respond with the preliminary statement which we sent to you. So today, the focus will be around discussing those developer responses and determining whether or not you agree with them and putting forth recommendations for moving forward.

Later on, as I mentioned earlier in this process, after all the measures have been endorsed, we will reconvene this committee to discuss all measures related to this topic. And the reason we're not including measure harmonization or competing measure discussions of measures outside of this project within the steering committee meeting anymore, it's because we've heard that committee members felt that it was unfair. You had just spent a lot of time evaluating measures in this project. So, how did you possibly compare the measures that you were sort of just seeing for the first time?

So that will be a separate process. So, of course, you're still welcome to the (step) how all these measures relate.

So we did – we have – do have side by side tables for you as well as the developer responses. We'll start with the tobacco and alcohol. Tobacco actually might be the most straightforward ones because they're all from the Joint Commission, they are all from the same developers so they're relatively harmonized anyway. But we'll start with those and see where we go from there. So I don't know if the Joint Commission wanted to read their response or introduce their response to measure harmonization for their tobacco measures.

Celeste Milton: Hi, Celeste, Joint Commission. And our preliminary statement about harmonization, the only four measures that were identified in this project were the four Joint Commission measures, and they comprise our tobacco treatment core measure set. And they're complementary to each other and are meant to be used as an entire set by the hospital to evaluate four key processes related to tobacco treatment.

TOB-1 is the tobacco use screening which evaluates patient's tobacco use status. If the patient is identified as a current tobacco user, he or she is then eligible to be evaluated in the remaining three measures comprising the step.

TOB-2 which is tobacco treatment provided or offered, evaluates the patient receiving or refusing practical counseling in tobacco cessation medication, if indicated during the hospitalization. The sub measure TOB-2a, tobacco treatment evaluates only the patients receiving practical counseling and tobacco cessation medication if indicated during the hospitalization, such as those patients who refuse are not included in the measure.

TOB-3 is looking at tobacco use treatment provided or offered at discharge, then evaluates the patient receiving or refusing a referral to outpatient counseling, any prescription for tobacco cessation medication if indicated at the time of discharge. The sub measure TOB-3a, tobacco use treatment at discharge evaluate only patients receiving a referral to outpatient counseling, any prescription for tobacco cessation medication if indicated at the time of discharge such as those patients who refuse are not included in the measure.

And then finally, TOB-4 is tobacco use assessing status after discharge, evaluate patients receiving a follow up call to assess tobacco use status, a patient counseling status and tobacco cessation medication status if indicated.

Ann Watt: And this is Ann. And I might add that these all share a common data dictionary and common population and so forth so we believe that they are harmonized to beat the impossible.

Female: Are there any comments on the set of measures or – would now be a good time to discuss the age range issue?

Peter Briss: This is Peter. It's likely that the age range – you might be fairly simple – simply handle that. There was a lot of sentiment in the workgroup that the Joint Commission had to consider lowering the age range, age group to greater than 12 so that we could sweep up adolescents in this important public health intervention. Clearly, there would be some scientific issues to be sorted out that all of the interventions, for example, the pharmacologic interventions probably don't apply to that age group based on what we noted there. But

screening and counseling probably would apply and there would be some testing, but I suspect that there was enough of that sentiment in the workgroup that if the full committee agree, we could just make a strong recommendation that joint commission that they had to consider lowering the age range where ....

(Mike Therrien): Peter. This is (Mike Therrien) and I'm sure that the Joint Commission will consider anything that the committee suggests. I do though want to share with you why the Technical Advisory Group recommended 18. And really, it comes down to – and I know the issue of 13. It comes up for two reasons. One, to make consistent with what meaningful use does but also, as you just mentioned Peter, this was a really critically important population and then everyone, of course, wants to protect from tobacco dependence and help quit if they've already become dependent. The Technical Advisory Panel for the Joint Commission which had a similar concern, shows to limit it to 18 and over solely because of the evidence.

So, for example, virtually all of the evidence for screening and the utility of screening for tobacco use has been tested in individuals 18 and older. Secondly, as you mentioned, the – there is not evidence to endorse any pharmacotherapeutic options for adolescents. And, in fact, the 2008 Public Health Service Clinical Practice Guideline Panel pulled out smokers under the age of 18 as one of only four subpopulation for whom pharmacotherapy is not recommended.

And finally, even the Office of the National Coordinator, while endorsing screening for individuals 13 to 17, did not endorse treatment of individuals under age 18 because of a lack of evidence. So in terms of their clinical quality measures, it applies to individuals 18 and over.

Just to summarize, the Technical Advisory Panel had a similar concern about we should do everything we can to help those under age 18. They felt that it would be imposing upon hospitals a burden of (administering) treatments that are not evidence-based with the exception possibly of counseling. And because of that, chose to keep – harmonize across the four tobacco measures,

and in all four instances, coordinated to apply only to individuals 18 and older.

Peter Briss: Thanks (Mike) that's very helpful. If your other committee members have – want to speak to this issue.

Jody Hundley: This is Jody. I'm wondering if there's a lack of evidence, the medication aside, is the evidence around the steps in brief intervention or counseling because nobody today has (booked) to this age group.

Male: So just to clarify, there is evidence that counseling in some instances and the evidence mix, is mixed but counseling was endorsed for younger smokers under the age of 18. So I just want to make sure that that's clear. Did that answer your question?

Jody Hundley: Yes, I guess I was asking a question but also wondering whether the lack of evidence here in the alcohol suite for this age group, is because it really hasn't been well-studied yet and so we have sort of a thirst of information. And if this isn't one of those times for the committee to, despite the lack of evidence or guidelines, to make a recommendation because of the importance of screening and offering sort of interventions for this age group.

Male: So to try to address that, they – I think you are correct that around the issue of screening, it's probably – it is a lack of evidence rather than evidence saying it's ineffective. To the issue of medication, there's actually a number of studies that is found that it just isn't effective with this population. Of course, more needs to be done and there is much more limited research on adolescents than on adults for medication.

The other issue which maybe is beyond the group, but these were mentioned. What has been shown to be incredibly effective in this population is more population-wide policy changes in driving this population, first, not to start and then even to consider quitting. The normalization, a high level of sensitivity to price and tax increases, smoking in the movies, to just give three examples of that. So there are interventions that are helpful that have strong evidence bases. Their interventions though less focused on the clinical

setting. But I defer to the committee, obviously, if you want to make a recommendation beyond the evidence.

(Audio Gap)

Female: I just wanted to ask, are other approaches like you are saying has been successful like mass media campaigns? Is absolutely that true in the primary care settings that the (inaudible) is less than (convincing), but the USPSTF, they did put up a new draft recommendation again but that goes with screening and more as counseling-based recommendation. And that is a change from the 2003 recommendations to a de-recommendation in 2013.

Michale Lardiere: And this is Mike Lardiere, I would, you know, delve on what Jody was saying, and I think this will be in the area where and I don't hear you saying that there's no evidence, there are some evidence for counseling and certainly the medications probably not now, is not as much compelling evidence, is not as much evidence but it just hasn't been studied that much. And this would be a time to make a recommendation with less evidence than we would in (normal).

Male: The only thing I would disrespectfully differ with that assessment is there have been a number of studies on the medication side that have found it ineffective in this population.

Male: That's not saying that. OK, yes, I agree with that. That's – and I don't – I'm not – I think the council (inaudible) important piece with this population and we can't ignore that right now.

Female: Yes, and I – and perhaps the recommendation then it gets more specific or you can harmonize the measures and change, you know, for this age group now that what you'd be looking for is an intervention that was more around counseling or…

Male: Right.

Male: We put a big or and like the other ones capital or.

Male: Yes, it sounds like, it sounds like that people who have spoken around the table sounded like – sound like you're generally favoring asking the Joint Commission to consider whether what the age range could be if you reduce that least for the screening and counseling part of the suite of recommendations, does anybody – does anybody disagree with that?

Jeff: It sounds good, this is Jeff.

Male: I'm sorry Jeff, what?

Jeff: That sounds good, I'm in favor of that.

Male: So, would anybody object if we made that sort of a recommendation of the Joint Commission?

Female: Can you repeat that recommendation?

Male: Right, I think that – I'm trying to capture what I felt was the consensus around the table it sounds like – it sounds like if the people are speaking would like the Joint Commission to consider reducing the age range from – from 18 and over to more like 13 and over at least for the screening and counseling parts of the suit of recommendation, suite of measures rather. And we have – I think we could – we could recommend that to the Joint Commission unless there are objections around the table.

Nancy Hanrahan: This is Nancy Hanrahan. I just – I'm looking at the report about measure harmonization and the purpose is to harmonize measures that can be applied across setting populations and episodes of care and the examples that we're talking about, about adolescents being included in some of these measures because there are certain types of treatments that are effective or there are some evidence that they're as effective as in that age group as in 18 years and older, I think the opposite can be also true that there are some measures that we don't want to apply across age groups and one of the things that I think is missing from the – from this purpose statement is the accounting for minority status or, you know, differences according to race and culture.

I could think of one example for instance with people that African-Americans are – don't respond to that (inaudible) with for alcoholism. And so, there are differences that exist that we are aware of from the literature that have to do with these measures and I would just like to recommend that the scope of the measure also include the minority status or the race and gender and also culture, if that's appropriate.

Male: Thank you. So, on the age issue, did I capture like in a sense if anybody would like to – would anybody like to make – to suggest additions or modification.

Male: I'd like to move that we accept the way you worded it.

Female: Second.

Male: Thank you. Let's – when we try – do we need a voice staff?

Female: No need.

Male: Has anybody objected that?

Female: I don't at object it. It sounds like a good idea, but I'd also like to suggest we expand that to these other areas that need to be considered when we're doing these measures.

Female: We agree that those areas definitely necessary to consider I think in the context of this conversation, we need to keep it focus on how these specific measures can be harmonized in the sense that their specifications are the same as other measures in the age ranges and the exclusions and things like that.

If we have time at the end of the meeting, we will have a discussion about (inaudible) and measurement and areas that you would like to see focused on so that might be a chance to raise (inaudible) some of those concerns.

Female: Sure.

Female: I think we're ready then to move on to our next set which is the alcohol set which of course also include the Joint Commission suite that you're just

reviewed and also include an AMA PCPI measure – the care and screening measure that you reviewed as well, the last measure you reviewed. We have a response to measure development as well. So, if we have the Joint Commissioner PCPI on the phone if he like to talk to that about areas where he think there could be potential harmonization, that would be great.

Celeste Milton: Hi, it's Celeste, Joint Commission. We did an analysis and we also had a discussion with the AMA about this and we see a couple of areas for potential harmonization, been looking at the substance use measures. Our SUB-1 measure which is our screening measures, determines on unhealthy alcohol use with the validated screening tools and we actually list those out. Also, if a patient has a blood alcohol test indicative of acute intoxication, they're considered to have unhealthy alcohol use.

The PCPI measure 2152 determines unhealthy alcohol use also with validated screening tool. The only difference is that they do list the CAGE tool whereas we don't consider the CAGE tool to be appropriate for screening general populations because it aims to identify only severely dependent patients. So that was the only difference that we noted there. Also with both of the measures, it's going to exclude these patients that have limited life expectancy and both measures.

And then we also are excluding patients that are cognitively impaired and the PCPI measure does take a look at patients that have medical reasons documented which could indeed include cognitive impairment. So, we feel like we are fairly harmonized as far as what some of the exclusions would be when identifying these two measures.

And then our second measure, SUB-2, is looking at that brief intervention with the health care professional in engaging the patient in a joint decision making process regarding their alcohol use and their plans for followup that are discussed and agreed to and that corresponds to the five As, as we discussed previously, the ask, advice, assess, assist, and arrange this is based on the VA/DoD Clinical Practice Guidelines for the Management of Substance Use Disorders, and the PCPI measure talks about brief counseling, but we weren't exactly sure what their brief counseling consisted of.

So, if it's similar to the five As, then we are harmonized also in that area.

Female: Thanks a lot. Do we have anybody from PCPI who would care to comment as well?

Samantha Tierney: Hi. Yes, this is Sam Tierney. So thank you Celeste for taking the lead and speaking first. I think we would agree with much of what you said. I think that in many areas, the measures appeared to be aligned. There probably are a few areas where greater alignment could be possible as Celeste described and we'd be interested in the Steering Committee's thought as I guess related to those.

Male: Did – does anybody from the committee want to comment?

Jeffrey Susman: This is Jeffrey Susman. It seems like there's some real possibility for harmonization in the alcohol screening measures.

Female: If the committee is – can hand with their response from the Joint Commission and PCCI, we can detail that in our commenting report and send it to you to validate. You might want to take a closer look at the side by side table. And if you have any further recommendation after this meeting closes, we'd be welcome to hear them, here in – about them via e-mail or phone.

Male: I mean, the simple inclusion of the CAGE were not – seems like a relatively small consideration to reconcile.

Female: Sorry, go ahead.

Jeffrey Samet: This is Jeffrey, so I'm included on this right. You know, the CAGE in terms of reconciling this alcohol as many things. The CAGE does something different than the other ones and probably it's going to be less and less uses a screen and more of an assessment tool because it really looks for lifetime history and all these settings that we were talking about especially with quality, it's looking for current drinking levels and then what risk that puts you at. And make it further if you have to be dependent this and that but that's – the CAGE is kind of an outlier so it may make sense just to not have it.

Male: Exactly and I think it's more of a historical (inaudible) if you will.

Jeffrey Samet: Well, it's useful but more from an assessment that once you find out that there is screen and you want another but that's another issue.

Male: Yes, I think it really represents no longer standard of care although we're in transition right now.

Male: Yes.

Samantha Tierney: This is Sam Tierney with the PCCI, I would like to just comment about the questionnaire issue. I think someone to the Joint Commission and I've asked on this and the last to comment on this as well. Our measure is not specific to which type of screening method is used, it just have to be a systematic screening method. So we list a number of examples of which CAGE is one of the examples we list so we'd be happy to remove that as an example but we've – the measure would still be not – it allows for some variability there so that folks could use any of the systematic screening methods that have been proven to be sensitive and specific for detecting alcohol misuse.

Male: Yes. I think what happen is that since 2005, CAGE is no longer being recommended at screenings. We're also – and there is a lot of commission they're using at and they would feel comforted by it I think, as an example at the (previous) meeting. But I like the broad range that you've provided.

Female: OK. Well, I think unless there are any other issues that the committee members wanted to raise regarding these measures we can move to the set of depression measures.

Jody Hundley: This is Jody, I'd like to bring out the age issue for recommendation on the (alcohol) as well.

Female: OK, the same recommendation?

Jody Hundley: Yes.

Female: OK. That makes sense to me.

Ann Watt: Excuse me, this is Ann. I'm curious as to what – with what measure we're looking to harmonize age for the alcohol measures?

Female: We're not harmonizing because it's present. I think we're making a recommendation (inaudible) harmonizing at it. That can consider to your age and down to greater than 12.

Female: I think that's right. I think maybe it can be a recommendation in those four with both of these measures that discuss to something that's in the harmonization topic but since it's been being discussed all day.

Male: Yes. The harmonization at least in the tobacco realm I think it's (hardly) harmonizing issue because it's harmonizing with meaningful use.

Samantha Tierney: This is Sam Tierney, of the PCCI? I understand that about the issue about age has been discussed quite a bit and I know there was a lot of discussion around tobacco. I think it's something we can certainly think back to our committee but we are – our measure was designed and Dr. (Kibbling) had mentioned this although, he had to step back and be in another call. Our measure was designed to be consistent with the USPSTF recommendations and there was just as Dr. (Kibbling) had mentioned an updated recommendation released in May. And they found the evidence insufficient to recommend for universal screening in adolescent. So, it would be difficult from an evidence perspective for us to support that type of change.

Female: Well, and I don't know if you were on for disagree or on for the tobacco discussion in terms of age. It's – from an NQF committee perspective, we can make our recommendation when there has – because of the importance and the public health importance even though there may not have been, you know, enough evidence on today because it hasn't been studied today.

Samantha Tierney: This is Sam again. I guess, I can appreciate that common perspective and I maybe look for some guidance from NQF fact because I think that if someone in conflict with the requirements around the evidence about the quantity, quality, and consistency. So like, you know, of course like I said, we're happy to take it back to our workgroup and follow our process to

consider modifications. But, I just would like to know how NQF staff might view that potential conflict with their evidence requirements and criterion.

Ann Watt: This is Ann from the Joint Commission and I think that Sam very well put the issue and we really are in need of guidance from NQF if we are to be considering recommendations that are contrary to the evidence which is a very important criterion for NQF endorsement.

(Helen): Yes. Hi, this is (Helen). I completely understand what you're saying. I think that this is really I think more than anything else sort of a food for thought really this is. I think you've heard (inaudible) from those with expertise and the theory that adolescence need to be considered. And while I understand, the evidence may not be quite there yet at least maybe be something that are building towards and looking towards as the evidence emerges.

Peter Briss: Do you have a thing – do you have anything you could consider as, you know, that I think that there was – there should have been quite an agreement all day long about the importance of adolescence. I do think it from an evidentiary standpoint I think it's likely that tobacco and alcohol (inaudible) are one more time end up in quite the same place. And so, you said that evidentiary standard – if the evidence – is the current state of the evidence in tobacco for every adolescence I suspect is going to be stronger than for alcohol. And I'm sure you're going to have to wind up weighing the potential public health importance of the alcohol question in adolescence versus the issue about evidence and provider burden and system burden and that kind of stuff in these groups.

Ann Watt: This is Ann and I just want to say speaking for the Joint Commission. Thank you for that feedback and for that clarification and you can be sure that we will discuss this with our technical advisory panel.

(Helen): So Peter, I know Harold's not on anymore, are you comfortable and the committee comfortable with moving on to the depression harmonization method?

Peter Briss: I'm happy to leave the discussion.

(Helen): All right, we'll just bring up on the screen and measure in our current project. So we have 0104 PCPI. Pull it up here. Hold on one more. So the first one we have in discussion (inaudible) screening and diagnosing measures. Then we…

Male: (Helen) you're – (Helen) you're breaking up quite a lot.

(Helen): Sorry, it's more like – is that better?

Can you hear me?

Female: Yes, that's so much better.

(Helen): OK. So, the first ones we're looking at is the depression screening and diagnosis measures. We have CMS quality inside of Pennsylvania and CMS Acumen OASIS. It's a preventative kind of screening. Screening for clinical depression and follow up plan on the depression and that is happening ...

So, I don't know if those developers are on the call.

Deborah Deitz: Yes, Deborah Deitz is here from Abt Associates in the Acumen team.

(Helen): Would you like to give us your thoughts about harmonizing?

Deborah Deitz: Sure, we looked at the 0518 measure and the 0418 measure together and we certainly found differences and, you know, the focus and the target population in the care setting in which they were – they're referencing but we also had discussions with the 0418 developers and we found that – we think that there are definitely opportunities for harmonization. We know that we think that the addition of a requirement for a follow up is feasible since the OASIS data set already collects information on documentation and information – implementation of the follow up plans. And we already calculate – CMS calculates two separate measures based on those data and give those measures to agencies for using their quality improvement efforts now.

So, we think that that's feasible. There are some other differences between the measures around how the denominator is calculated and the exclusions that we think would be more problematic to harmonize. But I guess, we're looking

for feedback from NQF as to how extensions, the harmonization, you know whether it's valuable to at least incorporate that follow up plan or whether we need to continue to kind of (hot) show whether that the other differences are possible to harmonize.

Female: That's actually a perfect topic to be considered by the steering committee, and the clinical in the topic area experts.

Female: You know, I can say about the denominator. I mean, some of the issues are that the way that the frequency with which the measure is collected is much more frequent for home health. It has to do with at the beginning of every home health episode and whereas the measure that's more relevant to the physician primary care office. I think an annual measure that it's collected. Once every reported one office – every office visit or once per office visit per measurement period.

So, that's a difference set that would be hard to reconcile. In terms of exclusions, the 0418 also excludes patients who are not eligible for screening because of patient refusal and we have not included patients. We continue to include patients in the denominator even if they do refuse based on the idea that they're not being screened for depression. So, we don't want to subtract them from the denominator. It's sort of the way that, you know, many of our other measures are calculated like immunizations and that sort of thing.

So, those are areas that would be interested in feedback on.

Female: Does the committee have any feedback on any of those areas, example?

Jody Hundley: So, this is Jody, I don't have feedback as a question because I haven't been involved in harmonization before. And that is – is it acceptable from NQF (inaudible) to have lesser partial harmonization as it being discussed or it make sense and leave those areas where it would be more difficult alone. So, they are not fully harmonized.

Female: Yes, of course. Any step towards harmonizing measures would be profitable we're always looking for measures with the broadest possible application and better comparable across setting. So…

Female: Because it does make some – to have harmonization around the screening and follow up and have that be documented where so many other areas that needed – needs a bit of a stretch to or maybe not getting what we need to get in those two different areas.

Female: Right. So, that's actually exactly why we bring these issues to you and we ask you to identify areas that you think would be feasible example and certainly identify those that you don't want to be.

Female: This is (inaudible) that I think, one other big difference that probably work especially that on Friday 14, you have – you (inaudible) reentry into home healthcare and so there might be else founding with set of severity (inaudible) like other like population.

Female: I'm sorry, you were breaking up quite a bit and I was getting about every other word. I think, you said something about dependent on reentry into home health care, is that correct?

Female: Yes. Yes. Can you hear me now? Is that better?

Female: Yes, actually.

Female: OK. I think, one big difference beside a team is that you – there's a possibility that persons that are more likely to go in and out of home health care for whatever reason with this. I assume it is more other like population who have more exacerbations to chronic medical illness according to increase across the burden of having the screen all the time. And I actually favored 418 a little bit more just because it had more applicability to see in younger side.

Female: Well, I think that – I don't know if this answers your question but just to clarify, there is an OASIS data set. The person maybe coming into home health aid, you know, home healthcare with one home health agency, you know, one month and then three months later with a different home health agency and the OASIS data set requires that they document whether they did or did not conduct a depression assessment at each of those time points. And, you know, this is a – you're talking about a person that's just experiencing a

pretty, you know, a dramatic change and that they are now requiring to their homebound and we think that's an appropriate time to be collecting that information.

We wouldn't want to have it. Say well, you know, somebody may have asked that person that question three months ago but – so, you don't you have to now. We think it's appropriate to ask it at each beginning of a home health episode.

Female: OK. Fair enough.

Female: So, are there any specific recommendations to the committee you would like to make? Is there any measure or request with the developer?

Jody Hundley: This is Jody. I'd like us to consider on recommending the inclusion of a follow up plan or the – something between 0418 and 0518.

Madeline Naegle : So, hi. This – Hi, I'm Madeleine. I want to ask the – what you're thinking about, but what would that look like as a free-standing measure?

Female: It's a free-standing measure as much as with the – my understanding is with the home health measure that the – they are noting that they did the assessment but there's no, you know, no documentation of any referral or any action being taken based on a positive screen for depression. Correct – or am I not understanding?

Female: No, that's correct. The referral or follow up is in a separate measure currently that is not publicly reported. So we were thinking of perhaps the numerator being changed to the patient with screen for depression using an appropriate tool and follow up plan as documented in the physician order plan of care or the – and or the physician was notified of the patient's positive screening for depression.

Female: Right.

Female: I would support that, I think that's really important.

Female: So in some ways you're harmonizing within other one of your measures that currently is not up.

Female: That's why we're incorporating that other measure, so…

Female: Something you're already doing, so it's really just bringing it in to this reported measure.

Female: Do you – I'm interested if anybody has any thoughts about the idea that if a patient – that patients who already have a diagnosis of depression should be excluded from the denominator and that there would not be – it would not ask someone to do the depression screening on those patients.

Female: Why would you do that or (inaudible) doing that? Because with excessive in older population, people who would be homebound for disability reasons, the fluctuations and episodes of depression are not in frequent. So if they have been diagnosed and you take them out at the denominator, what exactly does that do so they – their accessibility of the screener?

(Mike): Yes, I have the same concern. This is Mike. I would – I think that's a situation where you want to continually screen.

Female: OK.

Male: Yes.

Female: We do include those patients in the denominator, and 0418 does not. And we didn't want to take them out. So I just wanted to check with others about this (inaudible) your thoughts on that.

Jody Hundley: Yes, that's one area, you know, that's why I was asking whether it's OK to have some points of harmonization recommended and others not. And that's one where I – this is Jody. I'm not convinced it would be a good thing.

Female: Good afternoon, this is (inaudible) from Quality Insights with 0418. I just wanted to kind of echo with Deb's been saying as well. You know, we did have a discussion about potential harmonization and we're just echoing that, you know, the place that she brought up that, you know, we were agreeing

with that, as well as, you know, the point that were brought up that are kind of difficult to harmonize. But we just wanted to agree with what she was saying based on discussion we had previously.

Female: All right. It sounds like there's agreement from the committee to recommend the inclusion of a follow up plan and measure 0518 and not but we'll move forward from this discussion at this point.

Deborah Deitz: It's Deborah again, could – would it be appropriate at this time for you to share what the process would be for us going forward?

Female: Yes, the processes are little bit different now. It gives you a lot more time than the old process did. We will ask you – once we put out the report for comment and the committee agrees if that's what the recommendation is. We'll send that to you and ask you to send us back a plan for harmonization within two months. And then we don't actually evaluate your changes until the next annual update for those measures.

Female: Thank you.

Female: Sure.

Female: So, hearing no other – well, I ask, are there any other comments on this group of measures?

OK, hearing none, I think I'll take it upon myself to talk that to Minnesota Community Measure – ones which are the depression response ones which you evaluated today. But we identified them because, of course, they are related, that they are harmonized to be exempt possible at this time. So unless Minnesota Community Measurement is on the phone and wanted to say something or there are any other comments, we might move on to the medication management measures.

Collette Pitzen: This is Collette from Minnesota Community Measurement. I am on the line and thank you and thank you very much. Those first four measures are completely harmonized and just to comment a little bit on the 5th measure, 712 depression utilization of the PHQ-9 tool. The only difference – we have

the same – (inaudible) nine codes that we're including in the population and the same exclusions. The only difference in that one is we're trying to promote the use of the PHQ-9 for patients with depression. So they don't have a qualifier of their PHQ-9 needs to be elevated. That's the only difference.

Female: Great, thanks Collette.

Collette Pitzen: Great, thank you

Female: Any comments or discussion from the committee on those measures?

David Pating: This is David. I'm sorry, could you just summarize extremely briefly what we finally have agreed to?

Female: For the measures we've discussed so far?

David Pating: Yes, just you know, if you could kind of – I didn't grasp all of it.

Female: Sure, well for this discussion, screening and diagnosis measure. I think, and I have the recommendation being the inclusion of the follow up plan and measure 0518 for the alcohol and tobacco measure that I have a recommendation for the Joint Commission to go back to their expert groups and discuss the possibility of lowering the age range which is somewhat of a recommendation outside the scope of harmonization. Another requirement such as a recommendation for them to discuss it.

And I think – and then, I think there was one other, I don't have it right here but – sorry. And then we have a note that for measurement number 2152 that TCPI have said that they would remove the CAGE tool from the list of examples that they give within the measure.

Female: And went through receive the transcript and write up all of our notes, we'll send this to you in a very specific format so that you can go through the line, which we make sure it reflects your discussion.

If you're ready, then I think we can move on for our last group which is the medication management measures. Do we have FMQAI, MCQA on the phone?

(Kyle Campbell): This is (Kyle Campbell) from FSQAS.

Female: Great. Hi, (Kyle).

(Kyle Campbell): How are you?

Female: Good, I'm doing well. Thanks. Are you able to just give a brief summary of your feelings around harmonization with measure 0105?

(Kyle Campbell): Yes. We corresponded with MCQA and we did not really identify any areas for harmonization between the two measures. The target populations are very different for our measure 1880. We're looking at bipolar. For their measure, they are looking at patients with major depression. And the underlying concept here and also different, we're looking at chronic adherence and they're looking at persistent treatment of depression in the acute and continuation phase.

So they have very specific algorithms for time frames, I believe, that are specified in the guidelines. What's similar about the measures of the data sources or similar at their administrative claims and the age of the eligible population. We both looked at the adult population 18 and older. So with that, we didn't identify any other potential opportunities for harmonization between these two measures.

Female: Thanks, Kyle.

(Kyle Campbell): Welcome.

Female: Any committee members?

Male: Sounds like (inaudible) assessment.

Tami Mark: I just have a question about that. This is Tami Mark. So they're both using the PDC, Proportion of Days Covered as the (inaudible) measure?

Male: No, they are not both using PDC. That is – that is a difference. Our measure 1880 is harmonized with all the other NQF adherence measures except I

believe one where the PDC is used as the standard adherence methodology. With the NCQA measure and really this would be for them to speak to. They are looking at persistent treatment into phases of the medication management, the acute and continuation phase. And so I believe they're looking for medication possession like at a 180 days and then I can't recall what the other period is. But if they were to change to PDC, that would be a major revamp of their algorithm. That's not something that we discussed with them.

Tami Mark: So, I guess I'm just trying to push on that a little more. And that seems like although there is great evidence for PDC of 80 percent seems to be the standard adherence target. And I don't hear a lot of justification other than it's a lot of work if you try to harmonize the 0105 measure to be at mind of what seems to be more of the industry standard.

(Crosstalk)

Male: Right. And so 01 – I represent CMS and I'm a steward for 1880…

Female: OK.

Male: … and that would be a decision for NCQA which I'm not sure that they're on the line for 0105.

Male: Yes, we are.

(Kyle): OK. OK, go ahead, (Jeremy). I don't want to speak for you.

(Jeremy): Thanks, (Kyle). I'll just say that, you know, we agree with the idea that PDC of 0.8 as the standard calculation for an adherence measure. It works for a measure that looks at different, you know, of a variable time period. And so we measure that. We actually worked with (Kyle) last year looking at anti-psychotics. You know, it's a variable time period depending on when the members started the medication in measurement year. And so 80 percent proportion of days covered is a standard right to use. With our AMM measure 0105, we are looking at two specific periods rather than what could be a variable time period within a measurement year. And how we calculated our rates of 84 days within a 114-day period, and 180 days within a 231-day

period is based on estimated washout periods or treatment gaps within that bigger timeframe.

And so, if we actually look at the percent of days covered within each of those periods, it's very close to 80 percent that's 0.74 and 0.78.

Tami Mark: Yes. All right. So are you saying that the reason to use PDC is because you have variable. I mean I understand you can use the PDC. We have variable start and end dates but also it's typically used with a continuous, you know, 180 day or one year follow-up. So, it doesn't seem like you can use it just because you're using a 180 day follow-up. I mean you basically just – so I guess I'm not understanding the justification for not using it.

(Jeremy): So, I'm sorry if I misunderstood the question. We, you know, I'm unfortunately wasn't around when this measure was developed and I wasn't around with the expert groups that decided on those timeframe. But it wasn't – it was rather than base it on a 0.8 PDC, it was based on what they believed was most feasible for a health plan performance measure and what made sense as far as allowing gaps and treatment because this measure when you begin treatment for (inaudible), we understand that a drug could change and (inaudible) could change the type of drug you receive. And that's how the allowable gap was developed. And based on these two timeframes within the guideline of an acute phase in the first three months and then a continuation of anywhere between four and nine months, and our panel decided on six month at the time that it was developed.

(Bob): Yes and just - this is (Bob) (inaudible) and thank you for your point. You know, we work with for instance the Pharmacy Quality Alliance on lining some other measures that have been NQF endorsed and we're, you know, aware of their work developing. I mean I think they've been a prime mover of getting the PDC as a commonly used approach.

But also, you know, we have other measures. We have a couple of (inaudible) measures that were endorsed last year by NQF and that are used in our (inaudible) program that have different thresholds because of the nature, the condition, and nature of the medication that are not at the 80 percent level.

We don't really use the term percent they have covered but, you know, in many ways I think (Jeremy) was trying to articulate that we're – as it adds up for this measure, we're pretty close to it at 74 and 78 percent, just kind of using your language again not ours.

I think that, you know, what's interesting is where you have a measure developer like ourselves and also as a measure implementer with, you know, literally a thousand health plans using measures out in the real world where they've become – they've invested a lot, let's just put it this way, in developing their programming and also developing the audit standards, because remember all of our measures are audited.

So, changes like you're suggesting are not a whimsical thing. They're really quite profound and they have carried with them substantial burden to the health system that has to incorporate them.

That said, I think we're always mindful of ways we can streamline our approach. This measure as (Jeremy) indicated yesterday was just to be evaluated and approved by our (TPN) and board of directors last year.

So, it's next cycle would probably be – probably about the same time it comes back up for NQF endorsement. And, you know, it could be at the field. It's beginning to change, but again, I do want to be mindful that we do have other measures that do not do the PDC and that for very good reasons were endorsed by NQF at different levels, different thresholds, if you will.

So, I think that we would certainly take your comments and bring those forward in terms of a larger strategic, you know, strategy overall across our – we have a hundred NQF endorsed measures. So over to those that do speak to adherence and ask that – ask the simple question, would it make sense, you know, in X period of time to think about, you know, the value of doing that and then ask for feedback from our stakeholders to see whether or not that burden, you know, the juice is worth the squeeze in a whole different way than we normally refer to it.

Vanita Pindolia: This is Vanita. I think that would be really useful. I know this measure has been around for many, many years way before when there was medication

possession ratio and now PDC is more the term that's being used and the definition, but the 80 percent has been there from (inaudible) a few, at least a (inaudible) four years well established. I understand the whole part of the health plan change and I agree with you that you probably want to correlate that with whenever you review it there.

The reason I think it would be good to align that, even though you have drug change, drug therapy change, the PDC will take account for drug switches that's based on a GPN I believe.

So, whether you go from generic Celexa to generic – to Paxil or whatever, it will still be accounted for. And the titrations will also be accounted for in the PDC. So, I don't think you lose that effect.

The other reason that it would be nice maybe if you calculated what the 80 percent for the 114 days, it actually means you have to have 91 days of therapy. And the whole problem we're having as you probably know for NCQA, after tracking it for so long you have this higher and three months because everyone just gets a 90-day fill I feel. I'm not sure if they actually take it when we do our MTM. Many of them stop. They don't feel like it's working. They never got a titration. And then, you see this huge drop off at the six-month period.

Male: Yes, I think that you make a great point, (Candy). And again, you know, we're obviously open to feedback from not just our stakeholder community in our public comment, but also obviously the NQF advisory panel.

Female: All right, do we have additional comments around these different measures? Recommendation? OK, hearing none. Go ahead.

Lauralei Dorian: Seeing that we're nearly at four, I thought we might open it up for public comment before I quickly go over some next stuff ....

So operator, I think everybody is on the same line anyway but if you could just check and if there are any member – NQF members or members of the public who like to make a comment, use this as a time.

Operator: Everyone has an open line.

Lauralei Dorian: OK. Well, hearing no comments, I just like to go over a few next steps to everybody, you just (inaudible) so I can go over them ....

The following meeting of course we will summarize everything that's – that went on and we'll start compiling our report as well around – in a couple of weeks fill out for public comments and then we will have member voting period. We're hoping to bring this project to feedback in the board in September of this year and hoping to have the endorsement of our – these group of measures by the end of October.

So we'll be in touch with you for a number of reasons. First of all to look at the (inaudible) the report that we put together for your comments and to look at what we compile regarding harmonization. Also, we usually at the end of meetings have time to go over gap areas and areas that you'd like to see for future measure development. We didn't have time to do that today but we will send you out a SurveyMonkey so that you can sort of write different areas and put them forth as recommendation for the next call for measures, which brings me to my next point. We're hoping and for the (inaudible) that we're going to have a third measure for behavioral health.

So we're just – third phase – did I say? Oh, actually. Third phase of behavioral health, we're just in the process of confirming all of that, but as soon as we know, we will let you (inaudible). And I'll take any comments at this time about next upcoming set.

Peter Briss: You might also consider – this is Peter. You might also consider because we're (inaudible) sort of – definitely you brought us with the (inaudible) this meeting. You might ask the committee their further perspective.

Lauralei Dorian: Yes. I'm glad you brought that up. That's going to be another survey that goes out. So, please be honest because we'd like the feedback about this process. And I would like to say, and I know my whole team here at NQF would like to say, thank you so much. Thank you for the time you put in before this, but particularly for this you're trying these past few days for persevering. We apologize for some of the technical difficulties we

encountered. But we've all been talking about how impressed we have been by the rich conversation that's taking place and I think every measure really was vigorously evaluated, and so we would just like to thank you for your hard work.

Male: And (inaudible) Peter and on behalf of Harold, I think it's not (inaudible) still not here and myself, I (inaudible) good to echo that. Thanks everybody for an enormous amount of hard work and we – got through the whole list of complicated measures and here we really appreciate your engagement and your attention. Thank you.

(Crosstalk)

Male: Thank you.

Male: Harold, you did a great job.

Female: Thanks. Yes.

Male: Good job.

Female: Thank you.

David Pating: Hi. David Pating. I just like to make a request again, at some point whether there's a fourth meeting that we reconcile, that we've gone through so many and we've done them piecemeal but at some point we'll need to look at the whole, the whole shebang, and whether that's next meeting or the fourth meeting and just keep it on our radar. This is one that will help not like 50, so.

Female: Yes, definitely.

...

Female: Yes, that's on our radar as well. Thank you.

Female: OK.

Female: OK. Thank you everyone. Thanks for the committee and developers, and Harold and Peter.

Male: Yes.

Female: Have a great night. Thank you.

Male: Thanks. Bye-bye.

Female: Thank you.

Male: Bye.

Male: OK.

Female: Bye.

Male: Bye.

END