NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
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02:00 am CT

Woman: And we'd like to remind you to please make sure that you're logged into CenturyLink so that you can actually access the platform visually and logged in on your phone so that you can participate in the conversation as well as for our committee members we just want to remind you to log into the poll everywhere so that you're able to vote.

All right. Thank you.

(Chicana Gom): All right. Good afternoon everyone. Thank you for joining our Behavioral Health & Substance Use Evaluation Fall 2018 Cycle of Measures.

I am (Chicana Gom) and I am seated at the table with my colleague Michael Abrams who is the Senior Director, Nicolette Niehaus who is the director and me again (Chicana Gom) I am the Senior Project Manager for this project and (Mary Quiones) who is the Project Analyst. We are also joined by at (Alisa Montali) who is our Senior Vice President of the Quality Measurement Department.

Today, we will have introductions and disclosures of interests. We'll do a quick overview of the evaluation process as we did not have orientation meeting for this standing committee because you all are veterans at the at the process but we will do our overview just as a reminder.

Today we will review candidate measures 3451 and 2152. We will have NQF member and public comment next steps and then we will adjourn for the day.

So with that I will hand it over to Alisa so that she can complete disclosures of interest.

(Alisa Montali): Thank you (Chicana) and welcome everyone and thank you for being on the committee. Today we will combine our introductions with disclosures of interest. And when you were named to this committee, you received a pretty lengthy form in which we asked you a number of questions across such an activities as they're related to the Behavioral House Committee.

So what we're asking today is for you to orally disclose any information that you gave us on the form. Nothing lengthy only as it's related to the work in front of you. This includes grants, research any consulting you may have done that's relevant to the Behavioral Health Committee.

Just a couple of reminders you sit on this group as an individual. You do not represent the interests of your employer or anyone who may have nominated you for this committee. We're interested not just in unpaid activities as they relate to the work but also those of paid and unpaid actually

And this is the most important reminder. Just because you disclose is something you have a conflict of interest. We go through this process in the

interest of openness and transparency. And so I will start with, you know, co-chairs I understand Harold is out. I will ask everyone to introduce yourself.

Let us know who you're with and let us know if you have a disclosure of interests. And once we go through your coach's disclosures, we'll go through everyone in alphabetical order. I'll call your name out on. We have this projected on the screen. And so we'll start with Peter.

Peter Briss: Good afternoon everybody. I am still Peter Briss and I'm still with CDC. And I work on a - or I consulted on a CDC that evaluated measure 2152 and I'll be recused for that measure otherwise nothing to disclose.

And I should just note here that that Harold can't be heard today. He's getting on and off planes and so Jeff Sussman will co-chair, it will - it has accepted a battlefield promotion to co-chair today's session. And he'll run the discussion of 2152. Thank you.

(Alisa Montali): Thank you so much Peter. Jeff, are you on?

Jeff Sussman: Yes I am. Yes, so I have nothing to disclose. I'm still Jeff Sussman and I'm still (unintelligible) and VPHA. And I've had nothing to do with the cold weather.

(Alisa Montali): Oh, thank you so much for letting us know. (Meidy), are you on?

(Meidy Trump): Yes I'm on. I am also still (Meidy Trump). I am on the mathematics a technical expert panel. I have been so for measure 3453 tomorrow I will have to recuse myself. And otherwise I have nothing to disclose.

(Alisa Montali): Thank you so much. David anything?

(David Ian Sack): Hey (David Ian Sack), here. I'm really cold in Minnesota. Otherwise nothing to disclose.

(Alisa Montali): Thank you, David. (Julie Goldstein)?

(Julie Goldstein): Hi, I'm on as well. And I have nothing to disclose. Thanks.

(Alisa Montali): Thanks Julie. Constance, Akoni?

Akoni: Yes, hello. I'm still at Brandeis at the Institute for Behavioral Health. My disclosures relate to the fact that I am on the Behavioral Health Advisory Panel for NCQA. And NCQA is a steward on a few of the measures. Brandeis also is a subcontractor to Mathematical on the development of the substance use measures and in particular one that will be reviewed tomorrow the continuity of care. The 3453 I was actively involved in.

(Alisa Montali): Thank you so much for that information. Raquel Jeffers?

Raquel Jeffers: Hi, this is Raquel Jeffers. I am working at the Nicholson Foundation and I have nothing to disclose.

(Alisa Montali): Thanks Raquel. (Lisa Johnson)?

Lisa Jansen: Hi, this is Lisa Jansen. I work for Veterans Health Administration and I have nothing to disclose.

(Alisa Montali): Thanks Lisa. (Dolores Kelleher)?

(Jodi Kelleher): Hello, it's (Jodi Kelleher) to my friends and I'm an Independent Consultant working with employers and Startup behavioral health company focused on helping them design and deploy their programs on the commercial side. And I have no comfort, no disclosures other than that.

(Alisa Montali): Thank you. Kraig Knudsen?

Kraig Knudsen: Hi, I am Kraig Knudsen, and I work for the Ohio Department of Mental Health and Addiction Services and I have nothing to disclose.

(Alisa Montali): Thanks, Kraig. (Charles Gross)? Michael?

Michael Lardieri: Oh yes, hi. It's Michael Lardieri, and I work for Advanced Health Network Behavioral Health IPA in New York and I have nothing to disclose.

(Alisa Montali): Thank you. Tami?

Tami Mark: Hi I'm Tami Mark. I'm an employee of RTI International and I have nothing to disclose.

(Alisa Montali): Thank you Tami. (Bernadette Norman)? Okay, we'll come back to you. Laurence Miller?

Laurence Miller: Hello, this is (Laurie) Miller who is working in Arkansas. I'm a clinical professor at the University of Arkansas for Medical Sciences. And I have nothing to disclose except that I'm in bed with a flu.

(Alisa Montali): Oh, sorry about that. Hope you feel better.

Laurence Miller: Thank you.

(Alisa Montali): (Brooke) are you on the phone?

(Brooke Parish): I am. Hi. My name is (Brooke Parish) and I work for HDFC. I also am a Surveyor for Joint Commission and have been trained as a surveyor for NCQA but have never worked on any measures. I really don't have anything to disclose.

(Alisa Montali): Thank you very much. And I understand that (David Padding) is not joining us today. (Venita)?

(Venita): Hi, this is (Venita) with Henry Ford Health System. And I have nothing to disclose.

(Alisa Montali): Thank you (Venita). Lisa Shea?

Lisa Shea: Yes. Hi, I'm Lisa Shea. I'm a psychiatrist at Lifespan in Providence, Rhode Island. And I have served on tap for the Health Services Advisory Group which the appointment has ended but it's not really pertinent to any the measures reviewing this route.

(Alisa Montali): Okay. Thank you so much Lisa. (Andrew Sperling)?

Andrew Sperling: Good afternoon Andrew Sperling with National Alliance on Mental Illness and I have nothing to disclose.

(Alisa Montali): Thank you so much Andrew. And I understand (Michael Prengler) will not be with us either. Bobby…

(Michael Prengler): No, I am here. No.

(Alisa Montali): Oh, you are here. Okay. Great. Oh, it's that, I think…

(Michael Prengler): This is (Michael Prengler).

(Alisa Montali): Okay. Hi, Michael sorry about that please go ahead. Let us know if you have anything to disclose.

(Michael Prengler): I have been involved in several entities. None of which are coming up today or in tomorrow's discussion. But there Minnesota Community Measurement likely said Health Services Advisory Group and then quality insight but no conflicts for any measures coming up today or tomorrow.

(Alisa Montali): Okay. Thank you so much. Bonnie?

Bonnie Zimmer: Yes. This is Bonnie Zimmer, Professor in Residence UCLA Center for Health Services and I've nothing to disclose.

(Alisa Montali): Thank you Bonnie. And Les, Leslie?

Leslie Zun: Yes, I wear a couple of hats professor and chair of Emergency Medicine and Chicago Medical School. And I am the Medical Director for the Lake County Illinois Health Department. And I have nothing to disclose.

(Alisa Montali): Thank you very much. Thank you everyone for participating in the disclosure of interest process. We just wanted to remind you at any time if you remember that you have a conflict, we want you to speak up.

You can do so in real time or you can send a message to any one of us on the NQF staff or to Peter or to Jeff who is acting chair today. Likewise, if you

believe that any one of your colleagues is acting in a biased manner, we want you to speak up.

So thank you very much and I'll hand it over to Chicana.

(Harold): Actually this is this is Harold.

(Alisa Montali): Hi Harold, how are you?

(Harold): Hi. So as I was supposed to not be able to do on the calls but my flight has gotten delayed for hours so in the waiting area in LaGuardia. So I could, you know, listen in but I have conflict and I really won't be able to share. I just want to let you know that.

(Alisa Montali): Thank you so much for joining us on this thing and we hope you get on your flight soon. So I will turn it over to Chicana.

(Chicana Gom): All right Peter. Well, as we move through our slide deck we are now moving to Slide 6 and Peter will introduce the next couple of slides.

Peter Briss: So, thank you this is Peter again. So we've been through this drill a number of times now. So, we suggests a review where we're evaluating possible measures against evaluation criteria. We're making recommendations for endorsement or not. And we're overseeing the overall portfolio. Slide please.

And I gave, all of my family members are teachers in every direction. So this is my - I call this fondly the kindergarten slide. So each attendance is most of the work. Raise your hand if you'd like to speak, announce your name or sort of remain engage and active, keep focus. Slide please.

And then this is the rest of the drills. So if you recall that for each measure the measure developer will tee it up for us. The lead discussion discussed hence rather we'll get us started on kicking off the information with the developers will be around to respond to questions if we have some. And then, there'll be a full committee discussion and we'll vote on each private material one at a time.

(Chicana Gom): All right. Thank you Peter. So as we start to look at voting. We have a new voting platform as you all know. You will see a couple of e-mails just how to log onto the platform and so forth. And thus now we'll go over voting when we move a little closer to the evaluation. But this is a reminder, vote will be taken after the discussion of each criterion.

Important to measure and report is must pass. The vote for evidence is a must pass. Scientific acceptability of measure properties reliability and validity those votes must passed.

Feasibility, we'll be voting on as well as youth which is also a must pass for maintenance measures usability. And just as a reminder, if a measure does not pass a must pass criteria and discussion and subsequent voting or remaining criteria will stop.

We can move to the next slide. And so this is also a reminder of just some of the process for the maintenance measures have changed not since our last evaluation. So just as a reminder, today we will discuss one new measure and one maintenance measure, the same for tomorrow.

There has been a decreased emphasis on evidence for maintenance measures. If the developer assessed that no changes in evidence have occurred since the

measure was last evaluated the committee can agree not to repeat the discussion in vote.

Same thing applies in instances where evidence has been updated but the committee agrees that the evidence basis for the measure has not changed. The committee can agree not to repeat discussion and vote from the last review stand. However, there has been an increased emphasis on gap or opportunity for improvement and queue up required to develop or to present data on current performance gap and care for all maintenance measures.

Next slide. No different for new/old maintenance measures. All measures require updated specification. When we look at reliability and validity, there is a decreased emphasis for maintenance measures unless there has been a change in data source low of analysis or setting or if testing was limited to space for lending.

On the previous evaluation of the measure. Now empirical validity testing is expected at the time of maintenance review. If prior testing was adequate meaning empirical validity testing was presented to in prior evaluation the committee can agree not to repeat the discussion and vote.

For feasibility requirements for both new and maintenance measures are the same usability and use. So use is a must pass as I mentioned earlier for maintenance for measures being evaluated - weighted for maintenance of endorsement. Those maintenance measures have to show the developers must show performance results are used in at least one accountability application within three years after initial endorsement and publicly reported within six years after initial endorsement.

NQF asked the developer to include feedback on the measure about those being measure for others. For usability that is not a must pass, developers must show benefits and improvement.

Next slide. Any question. Okay.

(Daisy): All right, we're seeing no question. This is Daisy of American Unit. I'm going to go over the voting overview briefly. And this will be a good opportunity for us to test out the functionality of our platform. So before I get started I'm going to share the screen so that you can see what we are going to see in the room as the votes are tallying.

But I do want to make sure that everyone is logged into the poll everywhere platform so that the committee members will actually be able to vote. So, with that being said I'm going to activate the poll. When I activate the poll, the poll will show up on the vote that we're voting on will show up on your end. I will read each vote out aloud and tell you what the options are. I will unlock the vote so that you can enter your voting results.

And so we are looking for, what is our number today in, Chicana?

(Chicana Gom): Well, it varies. Remember that for consensus, for quorum we have to have 66% of the committee. And for our very first measure that we will review 3451 we have no refusals for that measure. And therefore our quorum will be 16. However, for the 2152 which is our maintenance measure we have two refusals that is Peter and Harold so that drop that quorum to 14.

(Daisy): Okay. Thank you. So at this time I'm going to read the vote and unlock it so that you can enter your testing result, your voting result and we will see that everyone is actually logged on properly.

So this vote is for the behavioral health and substance use committee and it's a test vote. Are you logged into the poll everywhere. Option A is yes and option B is no. You may enter your results. I see the results coming in. Option A is yes and option B is no. Looking for a few more votes. We're at 13 now.

(Michael Traigler): This is really confusing.

(Tami Mark): It looks like it says I'm logged in because it says National Quality 661 presentation but I'm not seeing your most recent poll.

(Daisy): Who was that that I'm speaking to?

(Man): Tami.

(Tami Mark): (Tami Mark).

(Daisy): Okay, Tami. I'll send you a new link right away.

(Tami Mark): Thank you.

(Daisy): Is there anyone else who's having issues?

(Michael Traigler): I am having issue ((Crosstalk))

(Daisy): Who is that?

(Michael Traigler): This is (Michael Traigler). I'm just making sure that it's in my vote comes through. It took me a while to find it.

(Daisy): As long as you see it. And you'll be able to see that your result. If you can see the poll then your vote is gone through. Is there anyone who's not seeing the test question?

(Man): I see the test question but I don't know if I am able to…

((Crosstalk))

(Daisy): Okay. So this is what we'll do it. Looks like we're up to 16 votes, which would be enough for quorum right now. I will have those who are having issues to send me a message in the chat box. And I will troubleshoot with you individually. Okay.

(Jodi): Yes. So this is Jodi. I would have been able to see and respond and says it's recorded. But there another response history part which isn't showing anything. Is that okay Miss?

(Daisy): Yes that's fine.

(Jodi): Okay, thank you.

(Daisy): And we're actually up to 17 votes now. So it looks like some of you are getting the hang of it. So if you're still having issues, send us a message to the chat box and we'll be able to go ahead and rectify that for you.

When the vote is finished, I will lock the votes so that no one else can vote so that we will remain - the vote total will remain the same after we move on to the next vote. Just wanted to mention that.

Okay, I'll turn it back over to you.

(Chicana Gom): All right, Peter you are facilitating our first measure 3451 non-acute mental health services utilization for dual eligible beneficiaries.

Peter Briss: Thank you. So, is the developer on the line and would you like to see this up for us?

John Schurrer: Yes. This is John Schurrer from Mathematica Policy Research. Can you hear me okay?

Peter Briss: Yes.

John Schurrer: Okay. And my colleague Mary Burton from NCQA is joining me today. Mary, are you on the line wondering if your folks can hear you.

Mary Burton: I'm on the line. Can you hear me John?

John Schurrer: Yes I can. Thanks.

Marry Burton: Terrific.

John Schurrer: Okay. The measure under consideration non-acute mental health service utilization for dual eligible beneficiaries was developed and tested under a contract with CMS. This measure provides a means for monitoring the use of mental health services for beneficiaries with a mental health service needs were eligible for both Medicare and Medicaid. These beneficiaries are also known as dual eligible beneficiaries.

Specifically, this measure reports the percentage of dual eligible beneficiaries age is 21 and older with an identified mental health service need who received a non-acute mental health service during the measurement year. We stratified the measure by age into two groups. Twenty one to 64 and 65 and older for two reasons.

Number 1, to account for the differences in the population enrolled in Medicare-Medicaid Plans or MMPs across the states. And Number 2, to assist MMPs in targeting improvements in access to mental health services toward the elderly population where the performance gap is greatest.

Mental health conditions are common among dual eligible beneficiaries. The CBO report found that about 30% of dual eligible beneficiaries have been diagnosed with a mental illness. SAMS study found that the average yearly health care expenditures for dual eligible beneficiaries with behavioral health conditions were twice as high as that of non-dual eligible beneficiaries.

This higher cost of care could reflect the use of costly inpatient and emergency department care to treat conditions, it could be managed in a non-acute setting.

Now this measure does not assess the appropriateness, adequacy or intensity of care. But rather it measures whether beneficiaries with mental health needs have accessed to non-acute mental health services. In our testing which included over 77,000 beneficiaries and 40 MMPs show low performance indicating a gap in access and a clear opportunity for improvement.

For those 21 to 64 years of age the average performance score was 50%. For those 65 and older, it was 22%.

Access to these services is a crucial first step in providing the evidence-based ambulatory mental health services such as psychosocial interventions and pharmaceutical therapy treatment. They can improve the quality of life and reduce the risk of unintended and unwanted consequences of non-treatments such as hospitalization homelessness or incarceration.

The measure demonstrated high reliability using signal-to-noise reliability estimation with estimates that over 0.90 for both straight up. And in a systematic face validity assessment with our tap all members who responded either agreed or strongly agreed that the denominator and numerator were appropriate. That a higher score would indicate that a plan was providing greater access to services and that the measure could distinguish between good and poor performing MMPs.

This measure is planned for implementation in CMS's financial alignment initiative for MMPs, which seeks to provide dual eligible beneficiaries with better care and to better align the financial incentives of the programs. We believe this measure will be useful to plans to identify beneficiaries who may need ambulatory mental health services. And that it serves it as a tool to facilitate access to these services, starting point improving the lives of beneficiaries with mental health needs.

We thank you for your consideration. We look forward to your review and are happy to answer any questions that the committee may have about the measure.

Peter Briss: Thank you so much. And so I have the lead discussions on this measure as (Andrew Sperling and Bonnie Zimmer). So could one of you walk us through the evidence criterion, please.

Bonnie Zimmer: Andrew, did you want to lead this or…

(Andrew Sperling): Can we ask clarifying questions before we move into the discussion?

Peter Briss: Sure. Tami was that you?

(Tami Mark): Yes.

Peter Briss: Go ahead.

(Tami Mark): I was just going to ask developer if they could define need.

(Meidy Trump): So that was also my question. This is Meidy.

John Schurrer: Sure. So we took a broad definition to defining need in this measure. And specifically for our denominator we're looking for folks who have a diagnosis of a mental illness. Then there's a variety of values that's to identify that who received a psychotropic medications or had any claim with a mental health service procedure code.

In addition, stays in inpatient psychiatric facilities or community psychiatric hospitals are also used to identify the denominator population.

(Tami Mark): Thanks.

Peter Briss: Anybody else want to open with general questions for the developer? Okay, with that ((Crosstalk))

Mike Lardieri: Yes, I guess, Mike Lardieri here, I was trying to raise my hand at this.

Peter Briss: I'm sorry.

Mike Lardieri: Oh yes, Mike Lardieri, I just had question around the - I didn't see that this included telehealth visits and I just want to clarify whether it does or doesn't.

John Schurrer: Yes. We noticed that in the feedback too. So, Telehealth is permitted in either setting and in primary care or in the mental health setting. The measure does not exclude Telehealth in mental health settings. It permits the use of the Telehealth modifiers, which can be added to specific CPT codes for guidance provided by the AMA.

And the CPT codes are not specific to care settings and therefore Telehealth would satisfy the numerator in both the primary care and mental health care settings as long as the CPT is with the Telehealth modifiers.

Mike Lardieri: Okay, got you. Okay. And then maybe just make that clear some place in the write up when it goes out, that would be helpful. Thank you.

John Schurrer: Sure. Thank you.

Peter Briss: Anybody else?

(Anita): This is Anita. I just want to clarify I know you've answered just for Tami but I just want to make sure I understood clearly. The denominator is if they have any diagnosis code or if they filled any psychotropic medication or is it the combination?

John Schurrer: It's an or statement.

(Anita): So, just an anti-anxiety drug alone would qualify?

John Schurrer: That would qualify someone for the denominator, correct.

(Anita): Okay. Thanks.

Peter Briss: Anybody else? And I'm discovering that I don't seem to be able to see if people are raising their hands and so the staff may need to help me identify folks that are raising hands.

(Chicana Gom): Yes, we can do that for you. Peter.

Peter Briss: Thank you.

Michael Abrams: So this is Michael Abrams at NQF. I just wanted to clarify the inclusion of two dementia codes F03.9 and 0.91. Was that intended to be included in the denominator?

John Schurrer: Yes, those are included in the denominator.

Michael Abrams: That is problematic.

John Schurrer: So we did examine this in testing. Please go ahead.

Peter Briss No, no, after you.

John Schurrer: So, we did examine the dementia in our testing. And we did this in two ways, first we subset our analysis to dual eligible beneficiaries with dementia who entered the denominator solely through a prescription for an anti-psychotic medication. And what we found there is that very few dual eligible

beneficiaries with dementia who entered the denominator that way. They were very few 1800 out of about 77,000.

And excluding them had a negligible impact on the average performance for 0.1% points. And we also looked at dual eligible beneficiaries with the comorbid diagnosis of dementia regardless of whether or not they receive a psychotropic medication. We found that excluding these dual eligible beneficiaries a modestly increase the average performance score across both age strata from 32% to 34.8%.

However, excluding or stratifying the measure based on these criteria does reduce the number of MMPs with sufficient denominator sizes to report the measure. And we presented these findings to the tap and the recommendation was to move forward with them included in that.

Peter Briss: So, anybody else? Anybody else have clarifying questions. We'll have additional opportunities to drill down into details as we go criterion-by-criterion. And so I want to make sure that we all have the opportunity to understand the nuts and bolts of the measure well enough that we can start the discussion. This introductory discussion won't be our last time to drill down into details.

So it sounds to me like I can probably take silence as an end and I wonder if, so we'll start on important to measure and report. And we'll start with evidence and if Andrew or Bonnie could take us through that criterion I'd appreciate it. Thank you.

(Andrew Sperling): Are you ready?

Bonnie Zimmer: Yes, I can do it unless you want to Andrew.

(Andrew Sperling): Please go ahead.

Bonnie Zimmer: Okay. So, the bottom line with these measures as we can always see it that it's a broad indicator of access to care. And the breadth of this quality measure I think raises a lot of questions for our discussion today. There is a performance gap that's fairly well documented. The team used data from 40 Medicare-Medicaid Plans among eight states.

And what's important here is when you look at the eight states 42% of the beneficiaries were contributed by Ohio. Another 21% were contributed by Illinois. California is excluded because of poor data quality and Rhode Island is excluded because of low enrollment. The other states are excluded because they did not have at least 30 beneficiaries for the denominator.

The overall mean performance on this measure is only about a third 32.4% when the team, like, John was mentioning stratified by two major age groups adults versus seniors. We see of almost 49.6% pass rate for adults, only at 21.9% pass rate for our seniors. There was also a gender difference such that only women pass 38.8% compared to men at almost half at 48.4%.

When they looked at the adult sample they did, they were able to detect variation by race/ethnicity between whites, Asians blacks and Hispanics. When they did this stratification by race/ethnicity for a seniors there was less disparities found such that they can only find a significant difference between black versus an aggregate variable that combined white Asian Hispanic.

So I will pause there before reliability.

Peter Briss: Yes, please. So if they were. At this point, we're trying to look at the evidence that this measure is connected to better patient outcomes. And we'll turn next into the gap in performance and then we'll walk through one criterion at a time. So at this moment we're trying to have a specific conversation about evidence.

Bonnie Zimmer: Okay. I think you can make an argument that improves access to care is a Public Health importance. I think the relationship of adherence to this measure outcomes would probably far more under validity.

Peter Briss: Thank you. And Andrew, anything you'd like to add to that discussion?

(Andrew Sperling) The importance of this is due to non-elderly disabled or we see additional, absolutely miserable outcomes and these are very high-cost beneficiaries sort of for high reliability of services and poor outcomes.

Peter Briss: Thank you. And then with that the floor is open for the whole committee for any comments on evidence criterion.

(Alisa Montali): Peter, I'm sorry. I can't find my link to be able to raise my hand. Can I ask a question?

Peter Briss: Please do. And I can't see when people raise hands either. It looks to me like if you hover over the lower left hand corner of your screen you can find where to click to raise a hand. But unfortunately when you do that I can't see you. So, Alisa it please go ahead.

(Alisa Montali): Okay. So my question is I just want to try to understand the evidence that might have been shared just one prescription pill, like, an anti-anxiety drugs

such as valium which has good or bad, right or wrong, many patients using her low back pain.

Is there evidence to show that there might have been patients, you know, what percent were inappropriately classified as having behavioral health psychotropic issues that needed to have that level of service?

Peter Briss: Could we ask that developer to comment on that question please? And it might help you with that with answering that question, if you have specific data about how many people were included in the measure just based on anti-anxiety drugs that might help in part answer that question.

John Schurrer: So I do not have the data on the inclusion of what fraction of beneficiaries entered the denominator solely through the anti-anxiety medication. That's something that we could take up but I do not have that right now.

(Alisa Montali): I was just using anti-anxiety as an example but there could be others and still have off-label use and normally for from TQA and when we're trying to develop any drug-related qualifiers. You know, it's usually at least two-filled just to confirm.

But in this case just because of what we're asking for follow-up that was like I initially wanted to have clarification if there was a linkage of the drug and the diagnosis together at all.

(Meidy Trump): This is Meidy, that also applies to a one visit and it's not clear to me what the visit is even for. So, you know, I have some concerns about that not just about the anti-anxiety med.

John Schurrer: Right. I understand the concerns. Again, the measure is not intended to assess the appropriateness for the adequacy or intensity of the services or treatment. It sets this bar for access given that we know that there's a gap in this basic bar of access to the services. That's why we have this bar for the one visit established there.

And when we're testing we did test the measure and required at least two qualifying visits for a numerator. And we found that rates of 43% in the 21 to 64 age group and that's compared to about 50% in the one visit version of the measure. And it was 16% compared to 22% on the 65 and older group. So we did test a version of that measure.

Again we presented those results to the tap and they had given the intent of the measure as a measure of access to these services that it was more appropriate to have the one visit criterion In regards to the medications and how to enter the denominator again intended to provide the tool.

You know, one of the intentions is for the plan to have a tool to identify beneficiaries who may be able to benefit from these services. And so that's the framing in which we're probably thinking about that.

Peter Briss: So I understand that Tami's Hand is right. Tami, would you like to go next?

Tami Mark: Yes, thanks Peter. I mean if we're voting on whether access in general among this population there's a gap in access and I think that's issue. But I'm struggling with voting at whether there's a gap in access has conceptualized by this measure which I have finding a very odd definition.

So for example if denominator is, if you received any mental health medication, like, an anti-anxiety medication, you're going to fight it with

someone who has need but not necessarily med need. If you received any mental health service in the news - you're identified as someone who has a need or not necessarily met need.

So you're in the denominator. Your only as a numerator is having met need. If you have a primary diagnosis associate with some of your visits and/or you have a pretty close procedure code identified. And given that we know that many, many people are getting psychiatric medications appropriately from primary care physicians and other providers without any diagnosis on the client.

And I think it's very confusing and probably inaccurate to say those people are having unmet need. So I guess just in terms of procedure, I'm not sure how to vote on the gap because clearly we all probably agree it was a gap in access. But if we're going on whether there's a gap in access as conceptualize by this measure, I'll probably say no.

Man: That's another main thing, yes.

Peter Briss: So, was the developer like to comment on that issue?

John Schurrer: Yes, I understand the concern and again what we're trying, you know, one of the intent of the measure is to provide the plans with the tool and the opportunity to identify the beneficiaries and to find those folk who could identify with or who could benefit from appropriate follow up care.

And so again, therefore, that's the approach and the framework we're thinking of with regard to the constructions of this measure.

Man: Thank you. And I understand that (David Ian Sack's) hand is up.

(David Ian Sack): Yes, thanks. So my comments has to do with the vagueness of this. If we're just looking at the chart, looking at a diagnosis for medication which we describe is not - it doesn't seems like it's looking at the individual in terms of severity of symptoms, impact on global functioning.

And just because they have a label, going along with say my inch of doesn't necessarily equate that they need or would be appropriate to follow up with the behavioral test list if they're functioning finding to be followed by their primary care doc.

So if we're just looking at a label or if a medication was prescribed I'm having trouble tying this to improving outcome, if we're just looking at a number without looking at the specific patient's needs.

Man: So, can mathematic can help us with that, is that a correct characterization of this measure that having a service from a behavioral health specialists would be the only indicator of a med need and that for example a visit with the primary care physician would not?

(David Ian Sack): No, beneficiary can enter the numerator through any claim from a primary care provider with the primary diagnosis for the mental health condition. And then there's a set of procedure codes office-based and Telehealth as well. So, beneficiaries can enter that way as well.

And one other thing I'll note is that I think if a beneficiaries prescribed a medication and these relates to the primary care setting in a previous year, you know, it would be appropriate to have some type of follow-up or have a touching base with the physician and care provider. And the primary care

setting were instrument in the mental health setting if that's appropriate to follow up, to make sure that they are functioning.

And we do allow for that flexibility infos types of care settings in the (unintelligible)

Peter Briss: Thank you.

Jeff Sussman: This is Jeff Sussman.

Peter Briss: Jeff, let me - I have a couple of other people in line before you...

Jeff Sussman: Okay.

Peter Briss: So, I'm going to go Laurence Miller and then Venita and Jeff. So, Laurence would you go next please.

Laurence Miller: Yes, this is Larry. I want to go back to the medication question for a second because the intent of the measure is to inform health care plans about the needs of access for care for mental health services. But again if the medication is prescribed for a non-mental health issue, it may be informing the plans of something different.

And I think including the medications like that probably gives them a false message.

Peter Briss: Thank you and Venita.

(Venita): So, the reason I have that concern is from having to work with dual eligibility and analysis before the demonstration and the amount of effort and care

coordination with the care court. You know, care manager for every patients then having the pharmacies involved with the weekly home with the member and kind of going through it almost like a decent type patient and knowing that these measures that end up going and being applied to withhold.

And then it becomes financial. I just want to make sure before we add any more measures on that population. We really are doing the due diligence of identifying the appropriate ones that need to have that kind of level of service or have the ability to be able to remove somebody.

If there was a conference and discussed and found that this patient truly is using a drug for a different purpose because that part never gets included into the measure and then the withhold start. So that's why I'm being a little bit stronger about that concern.

Peter Briss: Thank you Venita and that goes off to you, Jeff.

Jeff Sussman: Okay. Am I to understand John that the specification for primary care has to be in the primary diagnosis field to enter the memory?

(David Ian Sack): That's correct.

Jeff Sussman: Well, I have problems with that because there's a primary care doctor, we're often confronted particularly in this population with patients with 10 diagnoses literally. And the fact that one gets listed before or after is often a quirk.

And in fact in mental health conditions, there's often deliberate miscoding. So that one doesn't see that in the primary care diagnosis which might be less likely to be reimbursed depending on the specifics of the insurer. And I'm

worried about that as a threat primarily I guess the validity, not to necessarily the importance of this measure. Thank you.

Peter Briss: And so, we say that we've had a lot of discussion about some variant of - some sort of vagueness in the way this measure is specified about what gets you into either the numerator or the denominator. Are there other issues that folks would like to raise?

(Michael Frankel): I have my hand raised but I don't think it's showing, this is Michael Frankel.

Peter Briss: Hi Michael, go ahead.

(Michael Frankel): I'd like to ask the developer what evidence exists to show that if you do have the visit that's been talked about, it actually is correlated at all with any outcomes of improvement, whether it's functional improvement or just any kind of outcomes with the patient getting better versus just following up.

Laurence Miller: Sure. So, again, with the intent of the measure is not to asses that that adequacies of the treatment or the appropriateness. Given that there is the gap in access to the care and that first step. That's one of the reasons why we chose to focus on this on a more general measure of access to the care kind of that initial step in the trajectory of patient's health.

So again we're not trying to directly link a single visit with an adequacy argument or appropriateness but simply saying that for these beneficiaries would with for whom that the plans identified a need was there this and this follow up this baseline kind of access issue that was that they met.

But there, you know, there is strong evidence that outpatient care is necessary to prevent poor outcomes in general settings. There is that that linkage but within the construct of the measure what we're measuring is the access to that care, the utilization of the non-acute service.

(Michael Frankel): Okay. So, I think I'd like to let me know if somebody has issues that that they believe haven't been discussed as they'd like that they'd still like to discuss.

I think we've heard this be keyed up fairly well. So, I think on the one hand, we've heard a lot of discussion that's sort of about. There's some concerns about vagueness in both the kinds of people who might land in the denominator of this measure and/or whether appropriate follow up has actually been captured in the numerator.

I suppose you could also make the argument that that is a performance on the kind of performance level that that are being discussed in this measure are so low that the fuss in the numerator or the denominator any reasonable level of fuss suggests that there's low access to care in this population in any case. And we're reasonably certain that follow up for people that needed is a good thing.

So I think we could probably get to the place of trying to have a vote on the level of evidence for part of this measure and we're always voting on the measure as it's currently specified. So let me know if anybody wants to make a final argument and if not, let's try to move to a vote.

I don't think I've heard anything so let's try voting please.

(Connie Horgan): Can I just, this (Connie Horgan). It's not about content. I just want to clarify that I believe it's been determined that I'm in conflict on this measure, not that I have worked on it but because Brandeis is involved in the overall subcontractors. We were involved with the main contract. So I just wanted to clarify that I think somebody said that everyone could vote on this.

I have not worked on this measure but I am one of the subcontractors on the overall contract.

Woman: Hi Connie…
((Crosstalk))

Peter Briss: Can the staff answer that?

(Alisa Montali): Yes, hi. This is Alisa from NQF. Thank you for your disclosure. You did indicate on your forum that you're part of that's part of the development team so you're not recused from discussion or voting because you weren't directly involved in developing the measure.

(Connie Horgan): So I can't vote, okay. Thank you for the clarification.

(Alisa Montali): You're welcome.

Woman: Okay Peter, are we ready to move to a vote.

Peter Briss: I think so.

Woman: Okay. I'm going to activate the vote now. Everyone should see the importance to measure and report Evidence for Measure 3451. This is a non-acute mental health services utilization for a dual eligible beneficiaries. So,

I'll unlock the vote now and you may now vote on the Evidence of Measure 3451. Option A is moderate, Option B is low, and Option C is insufficient.

We are now voting on the Evidence of Measure 3451. Option A is moderate, Option B low and Option C insufficient. Please send a chat – message into the chat box and we will work with you individually.

Woman: I've been able to go it all along but right now, it says it's blocked.

Woman: Yes, it is blocked because I haven't read the vote – because we're going to re-vote against. So, I want to make sure all of the responses are cleared out so that everyone has a chance to vote for and again together.

Woman: Click on chat. That raised hand, chat.

Man: Yes. Where is the chat thing on this because I'm not seeing it.

Woman: It should be around there.

Man: Up around the lower left-hand corner of the Century Link thing.

Woman: But it has to be on the Century Link, not the voting things, right?

Man: Yes.

Man: Oh, okay. I got it. Well, I'm sorry. Thank you.

Woman: Sure. So Century Link is for the web platform. Right now I'm sharing the screen, so those who are not committee members can view the vote as it's

happening in real time. And poll everywhere is what committee members should be looking at, so that you can actually cast your vote.

Okay. I am going to read the vote again. We are going to vote on the Evidence of Measure 3451. Option A moderate, option B low and Option C insufficient. We're voting on the Evidence of measures 3451. Option A is moderate, option B low and Option C insufficient.

It looks like we have 11 results right now. So, we are going to give you a couple more – oh, we're at 19, perfect. I'm going to lock the vote and read the reading, read the count. It looks like seven individuals voted moderately, eight individuals voted low, four individuals voted for insufficient. So, the percentages of that 37% for moderate, 42% for low and 21% for insufficient.

Peter Briss But this one – this one is a must pass criteria that doesn't pass, right?

Man: That's correct.

Peter Briss So you said, this is did not pass, did not collect $200 on this measure. We don't – as I understand that we don't – correct me, if this is wrong, but I believe I understand that we don't go any further with this evaluation.

I wonder if – generally speaking, developers appreciates feedback from the committee about what might be adjusted to help. And so, is it okay with the staff if we take five minutes and give them additional feedback?

(Alisha): Yes. Peter, this is (Alisha), I was just going to recommend that officially, it's matter of public record, it didn't pass this must pass criteria. But I think this is a good opportunity for the committee to summarize the concerns of the

measure. And hopefully, that can give more guidance to both Mathematica and NCQA.

Peter Briss And let me try to open because some of the things I think were clear from the initial discussion. So, I heard concerns from the committee about some of the ways that one could get into – that a person could get into the denominator of the measure that might not be appropriate for as a marker for a mental health condition.

So, things like using an anti-anxiety med or using any anti-anxiety med for an indication that's not a mental condition like a low back pain. It was one thing. There were concerns about ways that people could be getting, could have appropriate care or appropriate care that might not be captured in the numerator.

So, things like seeing a primary care provider or for a mental health condition but not having it coded as their primary diagnosis for one example. And so, we can at least summarize those. And please, for the rest of you on the committee, any additional advice to the developer is something that the developers typically appreciates.

Bonnie Zimmer: This is Bonnie Zimmer, if we had gone further, I would have commented on. The validity testing I thought was very limited. I mean, it was basically a brief survey of six TEP members using the SurveyMonkey survey.

You know, a three-week comment period in which we only had about five comments to health plans and feedback from an expert work group, which was an open discussion. And I think we've talked about the risks. There was no evidence of improvement if this measure was implemented.

Man: Thank you. Anybody else?

(Tammy): This is (Tammy). One though is to align this measure with the identification measure that is SUD measure. And it's a (hiatus measure), it's not endorsed. Basically, it just says what percentage of people had a SUD diagnosis. And if you pair that with epidemiologic data, it can give a nice understanding of what percentage of people in need are getting services.

Man: Yes. Thank you. Anybody else?

(Michael): This is (Michael). (Michael) with NQF. I just wanted to clarify one other thing in addition to sensitivity for the numerator and denominator. I heard from you all that there was concern about pairing the treatment to the disease more specifically in determining whether somebody enters the numerator. So, I wanted to put that out for the developer as well.

Man: And for Mathematica, this kind of answer about room for improvement is always hard for developers. This isn't to vote on – I'm sure it isn't a vote based on the discussion about the unquestionable importance of the topic. And I wonder if you have any other additional questions for us.

Man: I don't think we have any additional questions. But thank you very much for your consideration and the feedback. We do greatly appreciate that.

Man: And is there anybody else? Is there anybody else on the committee that has additional comments or suggestions?

Jeff Sussman: This is Jeff Sussman. I would like to hear a little bit about the quality data issues particularly in the California group and what that really meant with was a little bit vague to me, maybe I missed it.

Man: Would you like me to respond that can provide a little bit of context for that?

Man: I think at this stage, it's probably water under the bridge but in preparing for resubmission, if you could provide a bit of more of the color commentary, I think it might be helpful.

Man: Anybody else, closing comments?

Man: Hearing none. Thanks. Thanks again to the developer and thanks to the committee and I will pass the baton to Jeff for the next measure. And I have to refuse on this one, so, I'll be listening with interests but I won't be speaking.

Jeff Sussman: Okay. This is Jeff. I can't see anybody's hand. So, you're going to have to chime in and I'll try to keep track of people and make sure we get to everybody.

Woman: Hi, Jeff. I'll be your NQF. We're going to send you a message in the chat when anyone has their hands up, okay?

Jeff Sussman: Okay. That sounds great. My chat seems to work about 20% of the time. So, if I felt (unintelligible) it isn't because I was supposedly trying to ignore something.

Woman: All right. Thank you.

Jeff Sussman: Okay. So, we're going to turn to the next measure here, which is 2152 preventive care and screening unhealthy alcohol use screening and brief counseling. Is the developer PCPI here, today?

(Carrie): Hi, this is (Carrie) with the PCPI. I'm on.

Jeff Sussman: Great. Maybe you could give us a brief say three or five minutes. This is a measure that is for maintenance. So, we have at least some familiarity before and I'll give it over you.

(Carrie): Great. Thank you so much and thank you all for your time today. A measure we have before you today is a maintenance measure as Jeff explained. Our measure evaluates the percentage of patients aged 18 years and older, who were screened for unhealthy alcohol using a systematic screening method.

And for those who screened positive received free counseling regarding your unhealthy alcohol use. Use of this measure is intended to increase screening rates as well as to assist in ensuring that those who screened positive received the brief counseling that they need.

As such, this measure aligns the United States Preventive Services Task Force guideline recommendation. The focus of the measure is unhealthy alcohol use, which should not be confused with alcohol dependence.

Unhealthy alcohol use is defined as drinking beyond the unacceptable limit as defined as men, no more than four drinks a day or 14 drinks per week. And women, no more than three drinks a day or seven drinks in a week.

It should be noted the three systematic screening methods recommended in the guideline recommendation from the USPSTFs are also the ones required to meet this measure, which means use of audit C or the single question screen.

Additionally, free counseling is defined as one or more counseling sessions, a minimum of 5 to 15 minutes each, which may include feedback on alcohol use and firm identification of high risk situations for drinking and coping strategies to deal with that And increased motivation for watching unhealthy alcohol use and the development of a personal action plan to reduce drinking.

This measure was initially endorsed in 2014 and has been used in federal programs including PQRS and most recently, it has been used in the meds program.

I'd like to introduce (Dr. Catherine Bradley), who is our subject matter expert for this measure. And she's going to talk a little bit about the importance and burdens of unhealthy alcohol use. Dr. Bradley.

(Dr. Catherine Bradley): Thanks, (Carrie). Yes, I just want to make a brief comment on three things related to burden effectiveness and the gap for this measure. The burden of alcohol use is the seventh leading risk factor for both death and disability in the US. And that's based on the Global Burden of Disease work that came out in Lancet in 2018.

As many of you know, probably the US Preventive Services Task Force updated their guideline that came out in December. And again recommended alcohol screening and brief counseling.

I want to highlight for you as well that the national commission on prevention priorities, which has ranged the US Preventive Services Task Force recommendations based on the clinical burden of disease and the clinical effectiveness of the interventions has ranked alcohol screening and brief counseling second sequel to cervical cancer screening, colon cancer screening and aspirin for cardiovascular risk.

And then finally, the gap. I wanted to just point out that there was a study from a couple of years ago 2016 that was a nice national study on the proportion of patients who were reported being screened and then being advised about unhealthy alcohol use and the prevalence of advice from those who screened positive for unhealthy alcohol use with 4.4%.

Women are less likely to get advice than men. So, I just wanted to highlight those important things about burden effectiveness and then the clinical gap we're addressing.

Jeff Sussman: Thank you very much. That was a distinct and useful summary. Unless there are question, we could turn to our lead discussion to (Rachael).

(Rachael): Hi, this is (Rachael). So, I just had one question before we launch into the question on evidence from the NQF staff. It seems like this measure might qualify that for not repeating the evidence discussion based on the fact so that there is not new evidence or new evidence concurs with the old evidence about?

Nicolette Niehaus: Hi. this is Nicolette from NQF. Yes, that is correct. There was no additional evidence that was provided. And the committee did pass this measure on evidence previously. The vote was 18 yes and zero no for some background.

So, the committee can't choose that they do not need to discuss and vote on this measure and can instead accept the previous evidence rating although if you would like to bring anything forward for discussion, that's welcome as well.

Jeff Sussman: (Unintelligible) Do you think we need to relook at evidence or not?

(Rachael): Hi everyone, this is Rachael. I would recommend that we stand on the previous acceptance of that evidence in support of the necessity for the measure.

Jeff Sussman: (Unintelligible) passing on evidence based on the previous evaluation.

Man: Jeff, you want to – can you adjust your microphone for us a little bit please? It's a little muffled.

Jeff Sussman: Okay. Is that better?

Man: Thank you. Try again?

Jeff Sussman: So, (unintelligible) basis. If not, (unintelligible)?

Woman: You don't have to officially vote. But I guess, you know, if anyone seconds your motion or put the motion out there and get it back in.

Jeff Sussman: I think I've heard a motion from Rachael. Would you like to receive that?

Woman: Sure. Hi am…

Jeff Sussman: This is maybe (unintelligible). Okay, so, we'll count that as a motion and a seconds from a lady. Any objections to discussions? All those in favor, say aye.

All: Aye.

Jeff Sussman: Any objections? Hearing none. We'll move on to performance gap.

(Rachael): Hi, so this is (Rachael). I guess I just wanted to open the floor for a discussion on performance gap. And I'll just kick it off by saying there seems to be still a gap – significant enough gap in the number of primary care providers that are screening for unhealthy alcohol use and conducting a brief intervention based on the data that was provided.

So, I am open to hearing if there are other issues that people want to discuss about this but it seems that the performance gap is still present.

Jeff Sussman: So, from the rest of the committee, are there questions or other issues with performance gap?

(Anita): This is (Anita), I'm sorry. I had my hand raised. I don't think you can see it.

Jeff Sussman: No, I can't. I'm so sorry.

(Anita): No, but – and it's not a question I guess on the performance gap, but it was more of a clarity that I wanted to know. Is there a specific tool that's required to be used? I'm sorry I didn't read the whole documents since I briefed through and I might have missed up.

Jeff Sussman: I think our developer outlined does. But could you please repeat the tools or methods that are considered sufficient here?

(Anita): Sure, absolutely. It aligns with the tools that are used in referenced USPSTF guideline recommendations. So, that as it currently stands as audit, audits C or the single question screen.

Woman: Got it. Thank you.

Jeff Sussman: Any other questions? Again, bearing in mind, I can't see you raised hands. If not? Are we ready to vote on performance gap?

Woman: Sounds good, we can vote.

Jeff Sussman: Okay. So we'll get our wizard to the NQF to get this poll up.

Woman: Okay. Give me one second. I'll pull up the vote for you.

Jeff Sussman: All right. In the meantime, we'll huddle by our fireplace and…

Woman: Probably inappropriate on this measure to say huddled by the fireplace and have a glass of brandy.

Jeff Sussman: Only if we screen you and follow-up.

Woman: I didn't know. I'm in California, it's a little early.

Jeff Sussman: How is the weather in California (unintelligible)?

Woman: It's 70 degrees.

Woman: (unintelligible) about 60 and going to rain. So, no complain.

Man: Yes. Okay. (unintelligible) there we go, all right.

Woman: Okay. We are now ready to vote on the performance gap of measures 2152. This is the preventative care and screening unhealthy alcohol use screening and brief counseling measure. And I will – you may enter your vote now. It's

unlocked. Option A is high, option B is moderate, option C is low and option D is insufficient.

So, the performance gap of measure 2152. Option A high, option B moderate, option C low and option D insufficient which is looking for a few more…

(Mattie): This was (Mattie). For whatever reason, all I'm getting is the results. There is no place for me to vote.

Woman: Okay. (Mattie) refresh your screen for me. Were you in the general earlier?

(Mattie): Yes, I was.

Woman: Refresh your screen for me?

(Mattie): Huh?

Woman: Refresh your screen for me, please. We're are at 17 votes now.

(Mattie): And you are on the pool. Everywhere, screen?

Woman: Yes. Remember, if you are viewing Century Link, then you are viewing the results. But you have to physically be on the link for poll everywhere in order to add your links up.

(Mattie): I was but now I have to go out of this whole thing and do it again. (Unintelligible).

Woman: Okay. Also get me your vote, yes.

Woman: Okay, you can cast your vote, maybe.

(Mattie): Okay, I got it, I got it.

Woman: Awesome.

(Mattie): All right.

Woman: All right. We're lacking the vote in for performance gap. We have nine individual who voted high and nine individuals who voted moderate, zero individuals voted low and zero individual voted insufficient. The percentages of that are 50% voted high and 50% voted moderate. We can move forward to reliability.

Jeff Sussman: Okay. (Rachael) talks about reliability.

(Rachael): Yes. Hi, from the comments, it seems like the – one of the major sets of questions around reliability and validity had to do with whether or not there was a specific tool identified for a screening, which we just clarified the audit C in a single question. And then, the specificity around the brief counseling, which is not effect obviously as a tool but it's still clear that, you know, 5 to 10 minutes and it may include one of those components.

So, I guess I should open the conversation for people who have other questions or concerns or comments about the reliability testing. But in terms of the comments that were entered prior to the call, I think we can at least eliminate that there is specificity around the screening instrument itself.

Jeff Sussman: And (Benita) did you have your hand raise now or was it prior?

(Benita): It was prior. I thought I would put it down. I'm trying it again one minute.

Jeff Sussman: No. I mean, yes. Okay, then other questions about reliability? You might as well shut them out.

Julie Goldstein: This is Julie Goldstein. So, I appreciate that there's standardized screening tools that you've identified and I think that's great. I just want to hear if the developers might be able to describe a bit on the guidance. They would give physicians regarding brief counseling because some physicians might feel much more comfortable than others.

And so, even something like motivational interviewing techniques or something might be employed. But I'm wondering if there's any guidance?

(Carrie): Hi, this is (Carrie). Actually yes, within the specifications, we do provide some guidance and definition about what free counseling constitutes. And that actually does also come from the USPSTF recommendations. So, I included it in the overview. It is also in the classification section as guidance as to what brief counseling is.

We can't be as prescriptive only because of the nature of what it is but interest guys could scroll down to where that is in the classification. You could take a look at it verbatim.

Julie Goldstein: Okay. Thank you.

(Carrie): Sure.

(Dr. Bradley): This is (Dr. Bradley) And I'll just add to that this had to be submitted before the updated US Preventive Services Task Force. And they came out very

clearly saying this time that there is no consensus on the specific content of brief counseling. Let me put it that a different way.

It appears to be effective with multiple different ways of offering it and the studies of all over the math both in duration and content. And so, I think we can be reassured by that that that is more about the provider bringing up the issue with the patient and then any particular method that has to be used in order to make it effective.

(Carrie): Yes, that is correct. We actually – I was waiting for the USPSTF updated recommendation to come out and we had to submit those to NQF and actually literally, exactly one week later the new recommendation came out. So, we will be – we've taken a look at it. It hasn't changed enough that would change any intent of the measure. And when our tech meets later this year, we will be taking a look at updating it.

Jeff Sussman: Okay. Any other further questions on reliability while we are going down and looking at what constitutes counselling?

(Lass): This is (Lass). And I'm not sure exactly where this fits. But does it matter who provides the brief counseling, meaning that if a counselor comes in or a social worker or a therapist or a nurse or someone like that comes in, then it's not – It may or may not be a build service under that same visit. So is there an issue with reliability in that regard?

Jeff Sussman: Let me ask our developer to respond.

(Carrie): Ideally, it would be the provider provides that physic screening that would be providing the counseling after the positive screen. But it is not specific as to

who actually needs to provide the counseling best. Or Jamie, do you have anything else to add to that?

(Beth): (Carrie), this is (Beth) and I think you've covered it well. Thank you.

(Carrie): Thank you.

(Lass): I'm sorry. This is (Lass) again. So, but the data that you obtained is based on physician billing for that service, is that correct?

(Rachael): So this is (Rachael). It's my understanding that the data is not coming from claims.

Woman: Correct. This is the registry measures.

Jeff Sussman: Right.

(Rachael): Because I agree with you (Lass). This is (Rachael) that I do think there is an issue in terms of capturing the activity of screening and brief interventions from claims data, because it's not depending on what reimbursement system, you're working in, you're not necessarily reimbursed for the screening.

It's just oftentimes considered part of the regular visits. And so, it's not a separate billable in counter.

Jeff Sussman: So, it seems you defined fields in the HR where registry, is that correct? (Carrie), your guesses?

(Beth): Yes. So, this is (Beth) from the PCPI. And in order to be included in the denominator for this measure, that's correct. There would be – the patient

would be greater than or equal to 18 years old and they would have at least two patients in counter, which are found within the denominator details or one preventive visits.

And then ideally, you would have the screening was performed and then if the patient did screen positive, then it would be identified either as G9621 or G9622 which are both G codes within the registry.

Jeff Sussman: That wouldn't necessarily be provider specific, would it?

Woman: So, I think it's – and maybe if you wouldn't mind clarifying the question a bit further, I think if a provider was reporting a specific encounter code, then it would be attributed to that provider. But I should say for numerator, it isn't necessarily in discrete field, some registries need to sub utilize claims data or other means implement EHR or other electronic data source.

Jeff Sussman: So, I think (Lass)' original question was whether a – let's say we had a counsellor on site and they provided a brief intervention or counselling or whether there was a referral to a mental health provider, licensed, social work, whatever. Would that count and would it get picked up? That's what I'm hearing the question is?

Woman: And I would welcome any other comments from my teammates. But I'll stay for this measure, the numerator is really the patient was identified as unhealthy alcohol user when screened. And then received the brief counseling. But the referral or maybe those other types of services that would be included in the referral or other, you know, healthcare team members isn't necessarily included in the measure.

Jeff Sussman: So, that wouldn't be picked up as a matter of course is what you're saying?

Woman: I don't believe so. As long as the G code would be coded. Then the numerator would be matched.

Jeff Sussman: Right, okay.

(Lass): So, this is (Lass) again. So, I'm a little concerned that someone may be doing this while the patient is still in the clinic but may not code it correctly because it's not the physician doing and it's somebody else doing it. So, are we certain that it gets picked up somewhere along the way if somebody else is doing it?

(Jamie): So, this is (Jamie) with the DPTI. With respect to this measure and the implementation in PQS and quite a stream program, it is, you know, sort of under the, I think assumption that most of these measures that are part of the program are intended to be reported on by those types of providers who would be performing the numerator actions.

So in this instance, the screening and then providing brief counseling if they're identified as unhealthy alcohol user. The weight of the specification is written and the way that the quality data codes, the G codes for the numerator are written, doesn't necessarily specify or indicate that it has to be the exact person who performed the screening.

So, if that was the clinician specifically versus another care team member, I think that there is a little bit of fluidity in terms of how this could be implemented. Especially, if we talk about when the measure could be reported utilizing claims data, if the registry utilizes that type of information or it can be pulled from directly from electronic sources.

So again, I do think that there is a little bit more of the ability to allow for the care team to complete the numerator action of this measure, but it is not explicitly stated or specified within this particular measure.

(Lass): So, when you look at – I'm sorry?

Jeff Sussman: Go ahead. Go ahead (Lass).

(Lass): When you look at the description that's currently in front of us, it says level analysis clinician and it says clinician. It doesn't say anything that we're going to use other people's documentation for this measure or I might consider…

Woman: Yes. I think that that is in fact, something that we have gotten questions on before and we do provide responses to those who inquire about it, that the intent is that the person who performs the screening is the same person who performs that intervention. Because it's more of a direct I think relationship happening screen that would indicate that they should be able to provide an intervention.

But again, at the implementation level, we believe that's the way that it is. But we also have heard that there are there are – there may be other care team members who may provide additional services. But so the whole point I think that we definitely understand your – I think concern because it does say individual that is the level at which the measures are submitted and the data that we have received for the testing this measure is obtained.

So that is why we selected individual.

(Mike Flannery): Hello, this is (Mike Flannery).

Jeff Sussman: Hello?

(Mike Flannery): Yes, this is (Mike Flannery). I have some of the same concerns. So – and we're trying to do an integrated care and some integrated care, it's just Colocation. So, in a Colocation scenario and there's a lot of that going on.

The medical provider might end up doing the screen. And then they hand it off to this behavior health provider who – from another organization but in the same facility. But they're going to bill under their own tent, not under the medical practices tent. So, we would lose all of that activity when they're actually doing the right thing.

And then the other question I have is around Telehealth and I guess it falls into that if we review this by Telehealth and do the brief intervention, then the Telehealth would not count. I couldn't – so, I'd like to ask two questions. The Telehealth and the concern that if you're dong Colocation, anything with Colocation is not going to count towards this measure, if I understand your response correctly?

Jeff Sussman: This is Jeff Sussman. It would sound like it's really going to hinge on whether the initially treating provider codes this with the decode or that there's some place in the registry where that box gets checked. And that's probably variable in how people enact that. I don't know what you find in the field. Can you hear the response from PCPI? Yes, go ahead.

Woman: Well, I was just going to reiterate that I think it's very sound clinical practice if you have some kind of team-based workflow for someone to do screening and someone to do the brief intervention particularly, if someone doing the

brief intervention is trained in some of the evidence-based practices like motivational intervention, where it may be a physician might not be.

So, I think there are sound evidence-based clinical models that are team-based that should allow for a service flow, that is seamless from the perspective of the patient but that provides a screening and a brief intervention not necessarily delivered by the physician. So clinically, I think we're on good ground.

I think the question is how it's captured and I think this is a question for the youth discussion which comes a little later but I'm happy that it's surfacing now. And I think that capturing that this occurred is very variable.

Jeff Sussman: Okay. So, we're at reliability and there's been a number of comments talking about, do we capture all the appropriate ways in which counseling might occur, including those Telehealth.

Are there any other concerns about the reliability of whether this is very reliability of more youth or contribution to the validity of the measure is somewhat debatable.

(Mattie): One other thought on this discussion, which comes in forms of liability. I think providers are going to find a way if officially, if it's a performance system, they're going to find a way to allow whoever is doing the BI to get credit for it. You know, like I've seen this in community mental health centers where they've built it into their EHRs.

They click a box where it's done, and they make it pretty easy if anything they're going to ear on the side indicating they're doing it too often. And I'm

less concern that this is going to not – they are not going to get credit if they are doing the right thing and using collaborative care.

Jeff Sussman: Thank you, (Mattie). Any other new concerns or questions about reliability before we vote? Okay. Why don't we tee up the voting on reliability? There are questions that have been raised about the appropriateness or the ability to capture, ping, care, referral to clinicians outside of the principal provider, Telehealth and some (unintelligible) performance type of environment that people definitely find a way to report it.

Can someone get that phone? If you can please mute your phones, that would be helpful.

(Automated Voice): The conference has been muted. The conference has been unmated.

Jeff Sussman: We have somebody with a phone that's ring.

Woman: We are trying to locate whose phone that is.

(Automated Voice): The conference has been muted.

Woman: Okay. We're going to mute the conference for one second and we're going to try to unmute our co-chair, but we are going to get ready to move towards a vote. Hopefully, whoever's phone is ringing, we'll figure it out so that we can move forward without the interruption.

(Automated Voice): The conference has been unmuted.

Woman: Okay.

Jeff Sussman: Well, we're back to phone ringing.

Woman: We are back. So what I'm going to do right now is actually go ahead and share so we can (unintelligible) we can get ready. Maybe we should all hang up and dial back again.

Woman: Well, if you can just give us one minute, we'll work and see if the operator can go in and identify the line to disconnect. Just figured out who it was but…

Woman: Do we have our co-chair still there?

Jeff Sussman: Yes, I am.

Woman: Okay.

Woman: I'm going to hang up and find…

Woman: Okay. We'll do that. We'll disconnect the call and call back.

Jeff Sussman: Okay.

Woman: Okay. no problem. Okay, now that we are all back. We will go ahead and…

Jeff Sussman: Hello, this is Jeff Sussman

Woman: Hi, Jeff. Now that we're all back on the line to get ready to vote. I'm going to unlock the vote so everyone can establish connection to pull everywhere. And we're going to be voting on the reliability of measure 2152. And your

option one, option A is high, option B is moderate, option C is low and option D is insufficient.

So, we're going to vote on the reliability of measure 2152. Option A high, option B moderate, option C low and option D insufficient. And we are at 16 votes now. So we're just looking for a few more.

Jeff Sussman: What's the magic number?

Woman: Okay. We're at 17, now it's 18. Here we go. All right. We'll get ready to lock the votes. So, if you're viewing the ballot, you just enter your decision and that's how you know that you have voted. So we're going to lock this vote now.

It looks like we have three individuals who voted high, 12 individuals who voted moderate, three individuals who voted low and no individuals who voted insufficient. So, the percentage totals of that are 17% voted high and 67% voted moderate and 17% voted low and zero voted for insufficient.

So with this measure, we can move forward to validity.

(Michael): This is (Michael) here. You already started the validity discussion. So, feel free to expedite a little bit. We're getting up close against this and we'd like to try to get through this measure if we can or at least through the validity vote before 2:00.

Jeff Sussman: Okay. So let's move it along. (Cath), do you want to…

Woman: I have nothing to add to the validity conversation. I'm comfortable moving to a vote.

Jeff Sussman: Okay. So, any new questions about the validity or concerns. We've talked about Telehealth and there was some comments earlier about disparities?

Man: I'm not sure that the Telehealth was responded. I just like didn't know the answer to that if we could.

(Beth Boston): Sure. And this is (Beth Boston) from the PCPI. And I think in the past, so what I will say is within the registry specification right now, we currently don't allow for some Telehealth encounters within the specification.

In the past, our approach was really in person encounters to meet the denominator requirements but giving the evolving efficacy of Telehealth evidence states, this is something that we're continuing to monitor. And we'll review with our technical expert panel, which should be meeting again and will likely get their input on Telehealth within the next couple of months.

Man: So, it sounds now it doesn't include Telehealth.

(Beth Boston): Yes, if you take a look – yes, if you take a look at the classification of it without those Telehealth monitor for the encounters with the med nominator requirement.

Jeff Sussman: So, no Telehealth. Any other questions or concerns? Okay, hearing none. Let's go on to vote on validity.

Woman: Okay. We're ready to vote on the validity of measure 2152. The vote is now unlocked. Option A is high, option B is moderate, option C low, and option B insufficient. Let's see, that vote is now active. There we go.

Option A high, option B moderate, option C low, and option D insufficient. This is for the validity of measure 2152. Just looking for a few more votes. They are coming in.

Jeff Sussman: We're up to 16, vote early vote often.

(Connie): (Connie), I got bounced off. Should I – I got completely cut off here. I don't know what happened.

Woman: They were at 17 votes. Sometimes if you sit still on the same screen, sometimes it may go stagnant. If you refresh your screen, you should be able to come back in. We're at 17 votes. I know what's going on?

Jeff Sussman: Well alternatively, you could whisper it very softly.

Woman: Yes, you can actually cast your vote. You can submit your vote into the chat.

(Connie): Everything is gone totally. I'm sorry, I got completely kicked off and it's not coming back with being refresh.

Woman: Okay. Well, we have form on this measure. We will lock this measure and if you chat to us and re-log in, we will go ahead and troubleshoot on the backend. At this point for the validity of measure 2152, three individuals voted high, 11 individuals voted moderate, three individuals voted low and zero individuals voted for insufficient.

So, percentage-wise, let's see. Here we go. Okay, 18% voted high, 65% voted moderate and 18% voted low. So this measure can move forward. So, our next question is feasibility.

Jeff Sussman: Okay. (Rachael), feasibility.

(Rachael): Right. So I think this is, I guess for me, it's confusing feasibility use. But anyway, the one additional question that was raised in the section by some of the comments prior to the call were around the exclusion criteria requiring our chart audit. And I wonder if the developer might speak to that.

Woman: One second, I'm going to interject for one moment and turn the table over to Nicolette.

Nicolette Niehaus: Yes. Hi, this is Nicolette Niehaus and we do appreciate it. We're trying to keep track of the time here and we just wanted to make sure that we do give this as much time as we might need to discuss, and we also have to open up the lines for public comment.

So unfortunately, I think we're going to stop here on this measure and save the remaining discussion on feasibility use and usability until our next meeting. If that's okay with everyone and you as well Peter or Jeff, I mean.

Jeff Sussman: Yes, I think that's a good idea.

Nicolette Niehaus: Okay.

Jeff Sussman: I think we have about a minute to do everything so.

Nicolette Niehaus: Yes.

(Michael): So, before we go to public comment, this is (Michael). Could you go to the…

Woman: No, we need the public…

(Michael): We do public comment first?

Woman: Yes.

(Michael): Okay, very good.

Woman: Can we open up for public comment for a moment? We're just going to give anyone who did not have an opportunity to speak in the public will give you that opportunity right now. And then, we'll wrap up with next step. So please feel free to chat in if you have a public comment at this time.

Jeff Sussman: Doesn't sound like any.

Woman: Okay. And I don't see any hands raised in the chat box. So, we'll go through our next step. We're just going to briefly go over just a quick overview of what we're going to do in tomorrow's meeting. So today, we were able to evaluate measure 3451 and we begin the conversation for 2152 and voting.

So, when we have our meeting tomorrow, we will actually follow up and continue the conversation for measures 2152 and continue with the folks starting with feasibility after the conversation. And then, we're going to go forward and review measures 3453 and 0004.

Following that, assuming and hoping that we can finish up in a timely manner, we'll move forward with the harmonization discussion and we'd like for you to kind of think about the discussion as we go over the portfolio and gaps, any gap.

So, we'd like for you to just kind of peruse the slides in advance so that you can take a look at them and come prepare for that conversation. And then, we will wrap up with public and member comment. We will send out another email tomorrow morning with the links and the instructions on how to log into both the voting platform and Century Link.

And at this time, I just want to thank everyone for joining and I'll turn back over to Peter and just to wrap up.

(Mike Claudia): Hi, this (Mike Claudia). I just have one question I need to think. I think we have to have a discussion around the whole aspect of Telehealth. And if we can bring that in tomorrow, it'll be great. Huge concerns about approving measures that don't include Telehealth.

Man: Yes. There's an NQF activity that's going on which hopefully a lot of time to talk about briefly at the end as well. So hope that done (Michael). Thank you.

Jeff Sussman: This is Jeff Sussman. I just want to thank everybody. I know this is sometimes challenging with the technology and appreciates everybody hanging in there and doing a great job.

Peter Briss: And this is Peter. I want to thank everybody too. And the first day, I always take a little bit longer so, I'm quite sure that we can be efficient and catch up tomorrow. So thanks everybody for their attention today and really look forward to tomorrow.

(Anita): This is (Anita). I sent a question to the NQF staff, if somebody could just respond for me for tomorrow. Thank you.

Woman: Sure. We'll do. Thank you everyone and have a great afternoon. Stay warm.

All: Bye, bye.

END