NATIONAL QUALITY FORUM

Moderator: Sheila Crawford
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4:45 pm CT

(Chicana Goam): Okay, now I think I can start.

Good afternoon. This is (Chicana Goam). And I want to welcome everyone to the Behavioral Health & Substance Use Standing Committee Meeting. This is Day 2 of our evaluation meeting for our candidate measures. I am the Senior Project Manager staffing this project. I'm in the room joined by Michael Abrams, who is our Senior Director staffing the project; (Nicolette Mejas), who is the Director on the project; and (Desmira King), who is the Project Analyst.

We are going to move on and just recap Day 1 and I'll hand it over to Michael for that.

Michael Abrams: So welcome back, everybody. Michael Abrams here, Senior Director on the project, and welcome back to this odd thing that we refer to in human discourse as the Webinar. We appreciate all of your indulgence and hard work yesterday. Things went well. We're on track to finish the four measures that we have under consideration for the Behavioral Health and Substance Use Committee. So I think everything is going fine.

Yesterday, just to remind you, we took a look at a measure about mental health services (unintelligible). We decided to send that back for revision to the developer and hopefully we'll see resubmission from them responding to our comments in the next cycle. So we got done with that.

We were halfway through then as well with Measure 2152 which is looking at unhealthy, I'll call, use screening and brief counseling related to that. We're on the feasibility section of that. I want to just remind you all that - and you all have noticed pretty well, I think, but just to remind you all that we have this idiosyncratic voting and discussion process that we go through. We go through each criterion with (interlead) discussion on each criterion and then we vote on each. And although that may seem a bit cumbersome, it's designed to help keep us all staff as well as you all reliable and valid and efficient. So, we appreciate you conforming to that.

And in general, I just want to thank you all for your involvement. And one final thing, all of us should try -- and especially the chairs -- and staff here will try to keep us on course to finish up the other two measures today or 2-1/2 measures that we have left. So we probably want to take about 15 minutes to finish up the first measure we're on and then about 40 minutes at most on each of the other two measures, just to give you some idea.

And so with that, I'll hand it off, I think, to Pete - to (Chicana)…

(Chicana Goam): Yes.

Michael Abrams: …to move us forward.

(Chicana Goam): I'll do a quick roll call. I have a few members notified us that they will be a little late to the call. So I'll go through the names and then repeat in hopes that some of our members have joined.

So I'll start off with our co-chairs, Peter Briss?

Peter Briss: I'm here. Welcome.

(Chicana Goam): Hi, Peter. Harold?

Harold Pincus: Hi, I'm on.

(Chicana Goam): Perfect. And then, of course, Jeff Susman is going to act as chair for our first measure discussion and, Jeff, you are on, correct?

Jeffery Susman: Yes, I'm putting the stunt double for Harold.

Man: Good.

(Chicana Goam): All right. Mady Chalk?

Mady Chalk: I'm here.

(Chicana Goam): David Einzig? I know I said the name wrong.

David Einzig: Close enough, Einzig. Good morning.

(Chicana Goam): Einzig, good morning. Julie Grumet?

Julie Grumet: Hi, I'm here. Good morning.

(Chicana Goam): Good morning. (Charles Growth)?

Okay. Constance Horgan?

Constance Horgan: Hello, everyone. I'm here.

(Chicana Goam): Lisa Jensen?

Lisa Jensen: I'm here.

(Chicana Goam): Dodi Kelleher?

Dodi Kelleher: Here.

(Chicana Goam): Kraig Knudsen?

Kraig Knudsen: Here.

(Chicana Goam): Michael Lardieri?

Michael Lardieri: Yes, hi, morning. I'm here.

(Chicana Goam): Tami Mark?

Tami Mark: Hi, I'm here.

(Chicana Goam): Raquel Jeffers?

Laurence Miller?

Laurence Miller: I'm here.

(Chicana Goam): Brooke Parish?

Brooke Parish: I'm here.

(Chicana Goam): David Pating?

Vanita?

Vanita Pindolia: I'm here.

(Chicana Goam): All right. Lisa Shea?

Lisa Shea: Yes. Hi.

(Chicana Goam): Andrew?

Michael Trangle?

Michael Trangle: Present.

(Chicana Goam): Bonnie Zima?

Bonnie Zima: Here.

(Chicana Goam): Leslie Zun?

Okay. All right. I'll just go back and check and see if Raquel has joined us.

Andrew Sperling?

All right. All right. So we'll move on. As Michael said, we are going to start our day off with discussing 2152. We'll start at feasibility. Then we'll move to Measure 3453. And then we'll go through all four if we have time. We'll have a harmonization discussion as well as a gap discussion open for member and public comment and talk about next steps. And then (unintelligible) will adjourn us.

And I will hand it over to Peter to review some ground rules.

Peter Briss: So everybody has seen this before. So be prepared to follow the guidelines. Please remain engaged. You guys did great with that yesterday with insights and focus. We do have - as has already been said today, we have a lot to - three today. So conciseness and sort of saying things at once is probably - would be really helpful to us. Announce your name when you're speaking and avoid dominating. Everything you need to know you learn in kindergarten again.

(Chicana Goam): All right. We will start our (unintelligible).

All right. We will go back to 2152 and start with our feasibility discussion. We started the discussion yesterday but just as a reminder, we want to go ahead and start that discussion again. So I will turn it over to Jeff.

Jeffery Susman: Hi, everybody. Thank you for your attendance today. I'll try to get through this fairly swiftly. We did have a nice, robust discussion about feasibility and, you know, at the end of the day, this is about the burden of generating the data and that the measures really aren't too high. I'll entertain any further thoughts

about feasibility but we did talk with the developer and among ourselves concerning this yesterday.

Raquel Jeffers: And hi. I just wanted to mention this is Raquel. I just joined.

Jeffery Susman: Okay, Raquel. Do you have any comments additionally about feasibility?

Raquel Jeffers: Not at this time.

Jeffery Susman: Okay. Thank you.

So I think, unless there's objection, we're ready to vote. And currently, my screen has the scientific accessibility up. And I'll just remind people that I can't see your hands raised. So if you do have a question, comment, just try them up and we'll take them in order.

(Chicana Goam): And, Jeff, we're working now to pull up the screen for feasibility so that the vote can start.

Jeffery Susman: Okay. Great.

Dodi Kelleher: So while we're waiting, and this shouldn't hold up the vote, this is Dodi Kelleher, I think - I don't know if it was (Les) or someone brought up yesterday the need to discuss not particular just to this measure the whole issue of including telehealth. And I think this is a very important side discussion to have at some point because telehealth is now sort of well-established in the commercial side and I believe also in the public side. So I think it needs to be addressed to the general developer community because coming up on its heels in the startup world anyway is digital.

Jeffery Susman: I think that's a great comment and certainly Peter, Harold, myself who have roles outside, whether on the board or CSEC, can also use that as forum to discuss not only telehealth but I also heard a lot of comments about theme-based care and how we account for that with these measures.

((Crosstalk))

Jeffery Susman: Trying to do a little tap dance here waiting for the poll.

Man: Yes.

Michael Abrams: So this is Michael, Michael Abrams at NQF. What I'm going to suggest about both telehealth and theme-based care is that you should all note that we will note that in the report as a concern. This is really a validity and evidence kind of discourse. It did come up there. We will note it in the report. But otherwise, I would suggest in the interest of time and given that the measure is otherwise - has otherwise made it through those - that level of discourse, we won't - probably won't have time to discuss these two issues in any more detail for this particular measure.

So I just want to let you know that that's likely the way that we will proceed, unless we free up some extra time which I don't anticipate, okay? So we will note it in the report but, otherwise, proceed with the focus of - that remains on this measure and then proceed with other measures, okay?

Jeffery Susman: Yes, thank you. I think we're just trying to fill in some blank space and we do have feasibility up for voting now. A is high; B, moderate; C, low; and D is insufficient. I might suggest we start voting.

(Desmira King): Perfect. Thank you.

Jeffery Susman: You've taught me well.

(Desmira King): Okay. We are going to get ready to vote on the feasibility of Measure 2152. I'm going to unlock your vote. So we have Option A of high; Option B, moderate; Option C, low; and Option D, insufficient. The feasibility of Measure 2152, Option 1, high; Option B, moderate; Option C, low; and Option D, insufficient.

Okay, we're at 13 votes. Waiting for a few more.

We need 15 votes today to be able to be at quorum, to reach our quorum.

Man: Remember that some of us are recused.

(Desmira King): Yes. Thank you. And we have it. We are at 16 votes. I will lock the vote now. We have three individuals that voted "High," 12 individuals that voted "Moderate," one individual that voted "Low" and zero individuals that voted for "Insufficient." Okay. So this pass is feasibility criteria. For percentages, it was 19% high, 75% moderate, 6% low and 0% for insufficient.

Jeffery Susman: Okay. Let's move on to use and usability. Raquel, do you have some summary comments there?

Raquel Jeffers: I think most people summary, if I recall from my notes, everybody found that mostly useful. The only issue was raised, which we have already discussed, is that the screening might not be captured in the claims data but - because it might be part of the regular visit. So - but I think we had a fairly robust discussion about it.

Jeffery Susman: Yes. And this is a maintenance measure. It's currently in MIPS. So there's certainly a fairly broad utilization that supports that. Indeed, maybe with a little bit of jiggering, it does get used and is usable.

Questions or comments from the group?

If not, I'll move us on to voting for usability and use.

(Desmira King): Okay, we are now voting on the usability and use of Measure 2152. Option A is pass; Option B, no pass. For the use actually of Measure 2152, it's Option A, pass; Option B, no pass. So we're voting on the use first and our next vote will be for usability. Okay.

All right. The voting is now closed. Looks like 15 individuals voted for "Pass," two individuals voted for "No pass." And percentage-wise, that is 88% voted for "Pass" and 12% voted for "No pass."

So our next poll question is for usability. Jeff, would you like to have a discussion about usability or are you ready to vote?

Jeffery Susman: I think we pretty much covered it. Does anybody have any objections to voting?

Hearing none, why don't we go ahead and vote?

(Desmira King): Okay. We are voting for the usability of Measure 2152. Option A, high; Option B, moderate; Option C, low; and Option D, insufficient information. This is for the usability of Measure 2152. Option A, high; Option B, moderate; Option C, low; and Option D, insufficient information.

Five more seconds.

Okay. Voting is now closed. Three individuals voted "High." Fifteen individuals voted "Moderate." One individual voted "Low." And zero individuals voted for "Insufficient Information." The percentages for that are 16% voted "High," 79% voted "Moderately" and 5% voted for "Low, 0% voted "Insufficient Information."

So this pass is for usability. And the next question is for overall suitability for endorsement of Measure 2152. And I'll pause here for questions, Jeff.

Jeffery Susman: Thank you. I think we've had a robust discussion. Is there anything further anyone wants to raise prior to our taking our final vote here?

Raquel Jeffers: This is Raquel. I would just put a pin in the fact that it seems like this measure can be harmonized with others but I know that we have some harmonization discussions later.

Jeffery Susman: Yes, that's right.

((Crosstalk))

Jeffery Susman: Yes. We will try to get that in today or attend to that at our next meeting. Appreciate that and at the time we'll consider it. And I think now we're probably ready to vote.

(Desmira King): Okay. We're voting now for the overall suitability for endorsement of Measure 2152. Option A, yes; Option B, no. And this is for the overall suitability for endorsement of Measure 2152. Option A, yes; Option B, no.

Five more seconds.

Okay. Voting is now closed for the overall suitability for endorsement of Measure 2152. Sixteen individuals voted "Yes" and two individuals voted "No." So percentages are 89% voted "Yes" and 11% voted "No." This measure (unintelligible) pass is for the overall suitability for endorsement of Measure 2152.

Jeffery Susman: Okay. Well, thank you, everybody. I think that's the robust discussion. A couple of parking lot items related to the use of the care team and EHR and consideration of competing in related measures to come later on. Thank you.

(Desmira King): Thanks, Jeff.

Woman: Thank you, Jeff. Harold, our co-chair, our next measure is 3453, continuity of care after inpatient (unintelligible).

Michael Lardieri: Can I just interject for a minute - it's Mike Lardieri.

Woman: Yes?

Michael Lardieri: I'm just having a problem and it's all around the telehealth stuff. Many of the measures, I mean, might work. But if you're not including the telehealth, I don't - I just don't think it's suitable, feasible, valid to any of it because there's so much activity that's going to be happening with telehealth. I'm trying to implement programs now that would be using telehealth and all those patients would be excluded in that last measure. So it sounds like the only recourse we have right now is vote no for the different, you know, aspects of the measure but, you know, I just wanted to point that out because, you know, otherwise, I might approve the measure and I'm not sure why they can't do

something around just accepting that Medicare already identified that a telehealth visit is a visit and why we made the separation in the measures is sort of confusing to me.

((Crosstalk))

Tami Mark: This is Tami. It's Tami. The good news, just to highlight, is that in the next measure, there is a - telehealth codes are included, if you look at the value set.

Man: That's great.

Michael Abrams: Yes. And I can comment. This is Michael Abrams at NQF. So what you're talking about, Mike, is sensitivity of the measure to a key numerator event. And as it stands right now and as it's testified right now, the measure did receive the committee's endorsement but your concern, as well as others who have mentioned the concern about telehealth, will absolutely be noted in the report and conveyed not just in that form to CMS and to others who read that documentation but also back to the developer as well. So presumably, there will be some individuals - key individuals involved who could respond to that sensitivity issue that you brought up. So it certainly goes recognized.

Peter Briss: In addition…

((Crosstalk))

Peter Briss: In addition, this is Peter. In addition, this is Peter, another - this is how we usually use this section of the report but we might be able to include that as a generally speaking measure gap which we'll talk about later in the process. So there are probably a couple of places to address this issue.

Man: Yes. I'll take them.

Man: Yes. The other thing is there may be certain measures where that issue is more important and more relevant than in other measures. And so we should - in the discussion, we should identify that issue.

Man: Okay, thank you.

Man: So we're going to take on Measure 3453?

(Desmira King): Yes.

Man: And I believe, Tami, are you taking the lead on that or Lisa?

Tami Mark: Sure.

Man: Do we want to let the developer tee it up for us first?

Tami Mark: Sure.

Deborah Garnick: Thank you. This is Deborah Garnick and I'm from the Institute for Behavioral Health at Brandeis University where I am joined by a colleague from our team at Brandeis and at Mathematica. So we're happy to queue up this measure for you.

The measure under consideration was developed by Mathematica Policy Research in Brandeis University under a contract from CMS. And this measure is intended for voluntary use in state Medicaid quality improvement efforts related to the delivery of care to adults with substance use disorders.

Continuity after inpatient or residential treatment for substance use disorder is defined as the percentage of discharges from inpatient or residential treatment for an SUD for Medicaid beneficiaries who are 18 to 64 which is followed by a treatment service for SUD. These treatment services include treatment with an outpatient visit, an intensive outpatient encounter or partial hospitalization. Happy to tell you telehealth encounter where filling a prescription or being administered or ordered a medication for SUD.

Also, because moving from inpatient, general inpatient hospital, to specialty residential care is considered good care, residential treatment after an inpatient discharge also counts as continuity of care. States will report two rates for this measure, a 7-day rate and a 14-day rate, after discharge.

Generally, continuity of care after inpatient or residential treatment is low across a range of populations, Medicaid as well as commercial insurer in the VA, although there are variations across states in our testing. However, there is evidence that continuity within a short time after discharge is associated with better outcomes. While the definition of continuity varies across different studies, there is agreement that continuity is related to reduced substance use, readmissions, criminal justice and mortality, as well as improved employment status.

We found a moderate level of validity and high levels of reliability and feasibility for this measure through testing with administrative Medicaid data from 2014 with 14 states and stakeholder interviews. The consensus was that the benefits of implementing this measure outweigh any risk.

We also conducted a systematic phased validity and assessment with members of the technical expert panel. And among the 11 respondents on that panel, all

agreed -- or strongly agreed -- in the measure's phased validity, although, too, noted that their strong agreement applied only to seven days.

Also, we found moderate convergence validity with NQF 3312, continuity after detoxification for both 7- and 14-day rates.

So the proposed measure is related to five NQF endorsed measures: NQF 0004, initiation engagement, which you'll be discussing next, as well as other measures of follow-up after hospitalization for mental illness, hospitalization for schizophrenia, emergency department visit follow-up or detoxification.

It is harmonized to the extent possible among multiple dimensions with those measures and we considered timing of the continuity of care, inclusion of primary or secondary SUD diagnoses in the continuity surface, and which services are included as continuity. We would, of course, be happy to offer details about harmonization with specific of these measures.

In conclusion, this measure of continuity of care after inpatient or residential treatment could provide more contexts for understanding the quality of care that beneficiaries with SUD receive. It's conceptually related to other measures that are all focused on continuity or follow-up in behavioral healthcare.

As developers, of course, we thank you for your consideration and we look forward to hearing your review.

Man: Thank you, Deborah. So before we discuss - re-discuss this as we speak, are there any major questions and clarifications that committee members would have for Deborah?

Lisa Jensen: This is Lisa Jensen and I just have a couple of questions. One is I couldn't find a list of the medications that you would consider for substance abuse treatment. And I know this came up yesterday with one of the measures but I think it's also a concern with this. For example, if someone were being prescribed gabapentin for alcohol use disorder, is it going to pop up here? What if they're taking gabapentin for seizures or some other disorder? So I was just wondering about that.

Along the same lines, I'm always concerned just because somebody gets a prescription billed doesn't mean that they're going to take the prescription. So, you know, compliance.

And then my one other question and this probably is just kind of a stupid question but, you know, if you're looking at your rates, 7 days and 14 days, follow up within 7, within 14, if somebody comes in, in seven days, wouldn't they automatically then hit the 14-day measure also? Does that make sense?

Deborah Garnick: So thank you for those questions, for the first set of questions. I'm going to ask our colleague on the team, Cindy Thomas, who's an expert in this area, to respond.

Cindy Thomas: In our testing, we included FDA-approved medications for SUD treatment. And I'm not sure whether we had gabapentin was not one of the medications tested. And you're correct. In using claims data, we can tell who is dispensed the medication but don't know whether they have taken it. So we test dispense, not specifically prescribe, just dispense. So there's that limitation with the data.

Lisa Jensen: Okay. Thank you.

Cindy Thomas: And an answer to your other clarifying question, yes, if you meet the seven-day criteria, you automatically also meet the 14-day criteria.

Lisa Jensen: So just I could list it like twice or you just get listed once?

Cindy Thomas: So it would be something like within the state, the rate for 7 days is 32 and the rate for 14 days is 37, something like that. The 14 days have the additional marginal people that came in between 8 and 14 days.

Lisa Jensen: Okay. Thank you.

Vanita Pindolia: This is Vanita.

((Crosstalk))

Man: So other questions that people have for the developer?

((Crosstalk))

Man: Oops, I'm sorry.

Vanita Pindolia: I'm sorry. I can't find - I can raise my hand. Let me do that. Go ahead while I raise my hand.

Man: Oh. Yes, my question was, does this include the same day of discharge with that count?

Deborah Garnick: That's a good question and we are - the answer to that vary by which of the services you're talking about. We thought this through very - we thought about this a lot. So if it is an outpatient visit, an intensive outpatient encounter

or partial hospitalization with primary, it is on the day after discharge through 7 or 14. Same thing for telehealth, that's the day after discharge. Pharmacotherapy is the day of discharge and inpatient - for inpatient only, it's residential admissions on Day 3 through 7.

Man: Is it identifying the reasoning for why outpatient visit the same day and discharge would not - I mean, we're doing so much of that in the field now, getting the person on the same day, walking them through the clinic to make sure that they get a connection and it's hard to understand why that wouldn't be counted.

Deborah Garnick: So this, to me, is reminiscent of a discussion that we - that the committee had within itself and with us about the detox measure where we had the same concern. And we thought that there are - that you can't tell whether something that is outpatient is really considered part of the same encounter, et cetera, and we also, in the test, thought about this as well. We had some discussions that had to do with that - something on the same day is, in the sense, part of the inpatient and its planning and that it should be something on the Days 14 through - 7 or 14.

Man: So just a corollary to that, just to clarify, is there alignment in terms of blood counts with regard to day of discharge in terms of how much we did in this measure versus - there's other followup measures that you discussed?

Deborah Garnick: Consistent with the detox measure, it's consistent with, I believe, some updates from the initiation and engagement measure as well.

Man: What about from the 7 and 14 - 7- and 30-day hospitalization measure?

Deborah Garnick: I apologize that I don't know that answer, the day of versus not day of answer on that particular one.

((Crosstalk))

Man: …they would be - I think consistently it would be really important in this case.

Man: Yes. Actually on the 7- and 30-day, this came up in one of our other discussions and actually there's two out there. There's an NQF measure. The current NQF measure includes the day of discharge. But what NCQA has out there under NCQA doesn't because they changed that midstream. So, the current NQF measure does include the same day but the NCQA measure doesn't.

Michael Trangle: This is Michael Trangle. Can I comment in that and ask a couple of questions? I know that…

Man: Sure, Mike.

Michael Trangle: …for the 7- and 30-day readmission rate, at least in our neck of the woods, there were sort of a number of places that basically had patients being discharged from inpatient psych units. They would meet with a hospital employee very briefly who enter a checklist then count it as a visit initially or they might get a phone call from a health plan person. Neither of those providers though were people that were going to continue to work with them. They were just sort of doing a "How are you doing?" kind of thing and it was sort of felt like they were gaining the system to get credit in a way that wasn't really talking about continuity of care, you know. And there were some

pushbacks about that which could play out in this venue with this measure as well.

Deborah Garnick: That's exactly what we…

Man: I had…

((Crosstalk))

Michael Trangle: In some sense, in our area, there was this pseudoconsensus that it'll be better to do the day after. And ideally, what you're really shooting for from clinical perspective is you want to really have them start working with whoever they're going to work with versus a onetime sort of brief discussion that - where they have no continuity, per se. It's not…

Woman: Yes.

((Crosstalk))

Michael Lardieri: Yes. And I would - this is Mike Lardieri again. I would agree with that but, you know, we're at the opposite spectrum. We're bringing outpatient providers in, meeting with the person as they're discharged, bringing them over to the clinic, so it's not, you know, the hospital system, which I could see that…

Man: Right.

Michael Lardieri: …gaining in. But then those…

Man: Yes.

Michael Lardieri: …providers who are doing all that hard work -- and it's hard work to do that -- you don't get credit for it. So it's - I'm not sure…

((Crosstalk))

Man: …whether it's practical.

((Crosstalk))

Man: One at a time.

Man: Anyway, Mike…

((Crosstalk))

Raquel Jeffers: This is Raquel. Wouldn't the patient also - if they went to an outpatient visit on the day of discharge, wouldn't they also be due for a second outpatient visit within seven at - at least within 14 days? So, it might be captured as having met the measure because I would imagine that outpatient services are, at a minimum, once a week.

Man: You know, you might be able to configure it where instead of just one visit or phone call counting, if you actually had a series, a couple of them over the next 30 days, it might imply that you're really in business with them versus a onetime kind of half sham thing.

Man: Right.

Man: That will be a different measure thing. And it hasn't been kept, you know, stacked out or researched.

Man: Let me just step out of the chair and talk for a second my comments. You know, it seems to me that what we're contemplating are two different types of measures and what is a transitions in care measure versus a follow-up measure. And I think we should think about how we can distinguish those two that, you know, optimal transitions in care people would want to expect there to be some sort of contact, some sort of initial engagement during the transition period of, you know, while the person still is in the process of leaving the hospital. Follow-up teach me a somewhat different concept. It means that once the person has left the hospital, there is follow-up.

Man: Good point.

Michael Trangle: This is - can I connect my second point? This is Michael Trangle. In our state, we're just - we've just recently started an initiative where MA will be paying for basically care coordinators, case managers doing some sort of follow-up with people post CD treatment. And my sense is that that'll be a billable service here. The people that are going to be qualified to do that will not necessarily be the type of people that would be billable people for commercial health science versus our state defined MA and wanting to have continuity. I have no idea how that might play out with this measure. Any thoughts from the developer?

Deborah Garnick: I apologize that we missed the track of your conversation because we were just - we got the follow-up after mental illness hospitalization and what we…

Michael Trangle: Yes. I was…

Deborah Garnick: …same day is not counted there.

Michael Trangle: Right. What I'm talking about is a new initiative for people that are being discharged from CD treatment, residential or inpatient. And a new thing for our state is people that would not necessarily be billable people for commercial health plans can bill MA to do care navigation, care coordination, case management on the road kind of mobiley to meet with these folks and keep them engaged. Do you have any clue how that might play out for this measure?

Deborah Garnick: Well, it would show up in claims because - if it is billable. And we would have to go back and review the specific services that we included. I'm recalling that we erred on the side of yes including case management kind of visits if they were - if they included the client. So if they didn't include the client, it was just their family or something. We did not include that. But if we - if it included the client that we thought to include that, we would have to check to make sure that that's a - the great details to make sure that that's an accurate answer to you.

Michael Abrams: All right. So, everybody, this is Michael Abrams here at NQF. So, we've noted discussions about same-day billing, as well as about transition to care and care navigation services being included as well. So, what I want to encourage at this point is moving on to specific review of each criteria. And at that point, indeed, if something comes up or the developer needs to respond to that, that's fine. But I want to move on to actually brief discourse about evidence, et cetera, and then a voting interlead with each of those discussions there. So can you pivot us to that, please, Harold?

((Crosstalk))

Vanita Pindolia: I'm sorry, this is Vanita. I had my hand raised and I've been waiting for a question. And so I do want to understand for the discharge diagnosis for inpatient. Is that a primary discharge diagnosis or is it at any point listed? I'm trying to understand where nicotine, as an example, where would that be? Where would you pull that from? And I couldn't find that in the specs to understand. It'll just help me better understand what is that opportunity.

Deborah Garnick: So we had a lot of discussion about whether or not we should include the principal diagnosis from the mission or secondary diagnosis and in the end based on the recommendations of the test and thinking it through, we included only hospitalizations or residential treatments that had a primary SUD or principal SUD diagnosis. We also did not include nicotine in the SUD diagnosis that we looked at.

Vanita Pindolia: Perfect. Thank you so much for that clarification.

Deborah Garnick: You're welcome.

Raquel Jeffers: And hi, this is Raquel…

Harold Pincus: So why don't we move on to - oh, yes?

Raquel Jeffers: I'm sorry, I had my hand raised also for a while. I just had a different…

Harold Pincus: Yes. We can't tell who's got hand raised.

Raquel Jeffers: Yes. That's okay. I just wanted to clarify that the setting of the followup visit includes primary care settings as well as specialty care settings for each count.

Deborah Garnick: So in the interest of brevity, I'll answer your question very succinctly. Yes.

Raquel Jeffers: Great.

Harold Pincus: Okay.

(Chicana Goam): So, Harold, before we move on - Harold, this is (Chicana). Before we move on to evidence, this is the reminder. If you check your chat box, I'm chatting you all of the members who have their hands raised. So just check your chat box and you'll see…

Harold Pincus: Oh, okay.

(Chicana Goam): All right.

Harold Pincus: Oh, okay. Now I see. Yes. I didn't have that open. Okay.

Okay. So, Tami, you want to sort of kick off the discussion about the evidence?

Tami Mark: Sure. And then I guess we can tag team, Lisa. We probably talked about that before.

Harold Pincus: Yes.

Tami Mark: So…

Harold Pincus: Maybe you could alternate. Tami then Lisa.

Tami Mark: Yes.

Harold Pincus: You know, Tami, do evidence. Lisa, start off with performance gaps. Okay.

Tami Mark: So in terms of evidence, as Deb went through and the documents highlight, there's been a number of studies that have looked at the - looked at this measure and what they find is that if you track continuity of care, patients who have better continuity within a short period of time after inpatient or residential has reduced substance use, reduced readmissions, reduced criminal justice involvement, improved employment and, kind of most dramatically from my perspective, they find actually significantly reduced death rates post - two years post discharge. So, I think there's a lot of strong evidence that these measures are measuring important aspects for quality of care.

((Crosstalk))

Tami Mark: No, I don't have anything else to add on the evidence.

Harold Pincus: Okay. Shall we ask go next to performance gap?

Tami Mark: Yes. And I can talk about performance gaps.

((Crosstalk))

(Chicana Goam): Excuse me. Sorry. Before we move on, if that's all of the discussion around evidence, we would encourage the committee to take a vote on evidence as evidence and performance gaps are voted upon separately, so…

Harold Pincus: Okay. So we set up for that.

Woman: Yes. Is everyone able to view the polls? This is important to measure and report. Evidence?

(Nicolette Mejas): And just - and this is (Nicolette Mejas) again from NQF and just wanted to add that the highest possible vote on this one is "moderate" because grading of the evidence was not provided.

(Desmira King): Okay, perfect. If committee members would go to their Poll Everywhere link, we are now voting on the importance of measure report for evidence for Measure 3453. And we'd like to enter your vote now. The vote is unlocked. Option A, moderate; Option B, low; and Option C, insufficient.

Woman: I still haven't unlocked.

Woman: Mine is locked.

((Crosstalk))

(Desmira King): Sorry.

((Crosstalk))

Woman: Thank you.

Man: You might have to refresh your screen. That worked for me at least.

(Desmira King): Thank you. So we're voting on Measure 3453, the continuity of care after inpatient or residential treatment for SUD. Option A is moderate; Option B, low; and Option C for insufficient, the evidence of Measure 3453. Waiting for a couple of more votes.

Two seconds. And the vote is now locked. Thank you. For the importance to measure and report with the evidence of Measure 3453, 16 individuals voted "Moderate," two individuals voted "Low" and zero individuals voted "Insufficient." So percentages for those, for the evidence, 89% of individuals voted "Moderate," 11% of individuals of voted "Low" and 0% for "Insufficient."

((Crosstalk))

Harold Pincus: Okay. Lisa, you want to take us on performance gaps?

Lisa Jensen: Yes. On performance gap for the 2014 Medicaid data, the average for seven days was 18.4% with a range of 8.9% to 41%. The 14-day rate was 24.2%. That range was 13.2% to 51.1%. They're the higher rate for females, from white, from the category of all other race groups and also a higher rate from rural areas which kind of counterintuitive. I'm not sure what that is about but, anyway, there's performance gaps there as nearly as I can tell. So, anyone care to comment on that?

Michael Trangle: This is Michael Trangle. I have a question. I noticed the two people on the technical expert panel sort of specifically commented on the decreased significant reliability of the 14 versus the 7-day. I'm just wondering if the developer could comment on that.

Harold Pincus: I think that's going to come up when we talk about reliability.

Man: Yes, well done, Harold. That's right. Let's save that for reliability specifically, please.

(Les): Hi. This is (Les). I'm sorry I've been trying to ask a question for a while. Can you hear me okay?

Woman: Yes, we hear you.

Man: Okay. I know this is a little out of sequence but what if the patient gets discharged from one of the programs and just wants to do AA, for instance. How would that be captured?

Deborah Garnick: This is Deborah. Should we be responding to this?

Harold Pincus: Sure, go ahead.

Deborah Garnick: So because Medicaid data is not capturing AA, that would not be captured, although - so the technical expert panel and the literature seems to indicate that in addition to AA, there should be at least one followup kind of visit after discharge. And so that's the thinking here.

Harold Pincus: Thank you. Let's go back to the performance gap discussion. Anybody had any comments on performance gaps specifically?

So I think we're ready to vote.

(Desmira King): Okay. The poll is activated for the performance gap of Measure 3453. Option A, high; Option B, moderate; Option C, low; and Option D, insufficient. We're voting on the performance gap of Measure 3453. Option A is high; Option B, moderate; Option C, low; and Option D, insufficient.

Okay. Two more seconds. Voting is now closed. And for the performance gap of Measure 3453, ten individuals voted "High," seven individuals voted

"Moderate," zero individuals voted for "Low" and zero individuals voted for "Insufficient." For the percentages, 59% voted "High" and 41% voted "Moderate," 0% for "Low" and 0% for "Insufficient." So for Measure 3453, it passes the performance gap. So we can start the discussion for reliability.

Harold Pincus: Okay. Tami?

Tami Mark: Reliability was measured using the Medicaid claims data and a signal-to-noise ratio which is standard for these claims measures at the state level. They found our values better than 0.9 for both 7 and 14 days measures, suggesting that the measure is reliable and can distinguish among high- and low-performing states.

Harold Pincus: Lisa, anything further?

Lisa Jensen: No, I don't have anything.

Harold Pincus: Okay. Comments on reliability? There was one that came up just before.

Michael Trangle: Maybe the developer could just comment on why two people kind of specifically made that comment.

Deborah Garnick: I think they were - that was really having to do, I believe, more with phase validity and their view was that we don't - they didn't really believe in the 14-day measure as much because they thought every person that was discharged should be seen within 14 days - within 7 days rather.

Harold Pincus: Thanks. Any other comments about reliability?

So hearing none, why don't we set up the vote?

(Desmira King): Okay. We're all ready to vote on the reliability of Measure 3453. Option is A, high; Option B is moderate; Option C, low; and Option D, insufficient. For the reliability of Measure 3453, Option A, high; Option B, moderate; Option C, low; and Option D, insufficient.

Give it two more seconds.

Okay, voting is now locked. For the reliability of Measure 3453, three individuals voted "High," 14 individuals voted "Moderate," zero individuals voted "Low" and zero individuals voted "Insufficient." The percentages are 18% voted "High" and 82% voted "Moderate," 0% for "Low" and 0% for "Insufficient." So this passes the reliability for Measure 3453. And we can go and move forward to validity.

Harold Pincus: Okay.

((Crosstalk))

Lisa Jensen: Yes. Validity, base validity was established for the 12-member technical expert panel which I think we've already kind of touched on. That 12 out of the 12 respondents agreed or strongly agreed that the performance for - can be used to distinguish good from poor quality. And as was already mentioned, too, their very strong assessment only applies to the 7-day, not the 14-day continuity rates. The empirical validity testing, convergence validity was not significant. The (experiment) rate correlation was 0.4 for the seven-day and 0.46 for the 14-day.

Harold Pincus: Okay. Tami, anything further?

Tami Mark: No.

Harold Pincus: Okay. Other comments on validity?

Michael Abrams: This is Michael Abrams at NQF. Just wanted to point out a couple of things that came up and comments from you all that might be relevant to this validity discussion. One is - actually there's just a singular point I wanted to touch on. The exclusion of those who relapsed early to inpatient. And this is a question for the developer, if you could clarify for the committee, please, how you deal with people who relapsed to inpatient. Are they retained in a denominator, I think, is the key question here.

Deborah Garnick: You know, the people who come back, relapsed to inpatient are indeed excluded because how could you measure your having follow-ups. So - and that is entirely consistent with the various other mental health followup measures as well. We took the lead from them in that. And it's done separately for 14 days and separately for the seven days. So for example, if you went back to inpatient care within Day 12 or 13, you would be included in the seven-day measure but not in the 14-day measure.

Julie Grumet: This is Julie. Can I just make one quick comment? Because I was the person who wrote that. It makes sense to me and it makes sense that that's consistent with what a lot of other measures but that doesn't make them excellent measures because one of the things that I'm cognizant of is that it may not be - this puts the burden really on the patient that it was, in some way, a failure in some regards to be compliant at the failure of the patient in their recovery. I guess I'm looking at it as maybe it's the failure of the healthcare system because they didn't adequately prepare the patient post discharge. For their transition, they weren't engaged enough. They weren't educated enough,

motivated enough for their continuity of care. So can you comment on that or your thoughts on that?

Deborah Garnick: Well, to repeat, if you - if the patient or if the client, the beneficiary comes back into inpatient or residential that they're excluded from the measure and testing was found that this was not a huge high number. I don't have the attrition off hands to report on that. So in a sense, they're not included in the measure. Is it a failure if the reason for their readmission it could be either readmission is generally thought to be some kind of an issue that happened in one of three kinds of places. The quality of care is the initial say. The quality or the amount of follow-up that then support that is offered or things that are just outside of the control of the healthcare system that are perhaps social determinants kinds of things. So I think I'm rambling because we don't have a concrete answer to what you're suggesting.

Tami Mark: Hi, this is Tami. I just wanted to make another comment about validity. You know, I think if we look at the literature again, there's a lot of evidence that this measure is a valid measure of quality of care or this concept, maybe not this particular - I'm not sure this particular specification was tested but the measure developer could comment down that, you know, but a close enough relation to it has been tested and sounded like it's related to mortality with a fairly dramatic way. So I think the evidence was pretty strong that this is valid.

My other comment is that there seems to be a standard and data applications that people test validity by looking at the correlation between the existing measure and some other NQF measure and, in general, I find that very unsatisfactory - and, I don't know, because it's expedient or, you know, the resources aren't there. You know, for this measure, I think it's important to

look beyond that validity test to what's really been shown in the literature about these measures.

Deborah Garnick: Thank you, Tami. And this is Deborah. And we agree that we feel that some of the correlation it has with other NQF measures had to do with the fact that this measure, while seemingly similar to some, is not - should not necessarily be as tightly correlated as one might think.

I also want to mention sort of pull out two studies in support of what you're saying. One was the Harris et al. study of 2015. In that study, they tested 14 days with a - that was the one that has lower two-year mortality rates and the specification was practically identical to what we're talking about.

And the other one was the article that our colleague at Brandeis led, Sharon Reif, and that had to do with readmissions. And that use of survival analysis say that continuity within 14 days had an impact on hospital readmission. Some kinds of continuity did. Some didn't. But it - that generally showed that same effect.

So we appreciate your comment, Tami, very much about the validity of the concept, the testing of the correlation not being necessarily the strongest but what we were able to do in the fast time that we were working on this and also the strength of the literature.

Harold Pincus: Other comments on validity?

Michael Abrams: One final comment from NQF staff here, Michael Abrams here. And this came up early or somebody brought this up but I just wanted to make sure it got addressed. The rural rates, could the developer discuss these somewhat ironic findings with regard to that, please, briefly? We'd appreciate that.

Deborah Garnick: We do not have any across the board understanding of the rural rates being higher. But it may be - and this is conjecture that comes from work that my colleagues did under our Brandeis/Harvard NIDA Center funding of a project in Washington State where we found that many people who live in rural areas, their inpatient or their residential treatment happen very far from their homes from travel distance and it was not close to where their residential - residence was.

So it may be that in cases where someone has their inpatient or residential treatment far from home that there is a greater effort to have followup care coordinated. That's really conjecture on our part.

((Crosstalk))

Harold Pincus: …between rural and the urban in terms of the pattern or distribution of the types of numerator values at numerator categories in terms of the types of visits that people have?

Deborah Garnick: We did not - we didn't look at patterns of the - of what's the different types of follow-ups were. We did not cross that, so to speak, by rural or urban to be able to know that difference.

Harold Pincus: Yes. It might be worthwhile looking at that.

Deborah Garnick: That's a very good suggestion. Thank you.

Harold Pincus: Other comments for that issue? For validity in general.

So hearing none, let's move to vote on validity.

(Desmira King): Okay. The poll is active. And we are now voting on the validity of Measure 3453. Option A is high; Option B, moderate; Option C, low; and Option D, insufficient.

Voting is now open for the validity of Measure 3453. Option A, high; Option B, moderate; Option C, low; and Option D, insufficient.

Okay. Voting is now closed. For "High," five individuals voted "High," 11 individuals voted "Moderate," one individual voted "Low" and zero individuals voted for "Insufficient." For percentages for the validity of Measure 3453, 29% voted "High," 65% voted "Moderate" and 6% voted "Low," 0%voted "Insufficient." We'd pass the validity criteria and we can begin the discussion for feasibility.

Harold Pincus: Feasibility, Tami?

Tami Mark: This is a claims-based measure. So it should be relatively easy to adopt. I think the developers made the point though that actually improving this measure may require some investments. So it's…

((Crosstalk))

Tami Mark: So basically, you know, if you're going to improve discharge follow-up, you're going to have to make more connections with outpatient providers. You're going to have to do a better job with your referrals and all of that could be costly, at least initially.

Harold Pincus: Yes. But I just want to see that feasibility in terms of the feasibility of collecting the data.

Tami Mark: Yes. Yes, you're right. So that's really off point. So in terms of collecting the data, simply put, this is a claims-based measure. It should be easy and feasible. There are many other measures like this already out there.

Harold Pincus: Lisa, any other comments about feasibility?

Lisa Jensen: No. I agree with what Tami said. She covered the basis.

Harold Pincus: I mean, one issue with sounds like they came up a discussion earlier with regards to feasibility is that there are some types of encounter that may not be captured in claims and, you know, some of the things that Mike was talking about. Do you think that's an issue?

Tami Mark: I think - I thought what Mike was saying was that private insurance doesn't pay necessarily for case management, the things that Medicaid pays for and ideally, if they start to see that their post-discharge follow-up rate is lower than Medicaid, they'll start to cover some of those things. I don't think that's a measure issue. I think it's more of a system issue.

Peter Briss: Yes, this is Peter. I would consider that lack of feasibility issue and more of a reliability and validity issue in terms of it's not always perfect when measuring all of the things that might be appropriate follow-up and then having said that it is, in my view, is that it is capturing enough of the things that are appropriate follow-ups.

Michael Abrams: NQF staff agrees with, you know, this is a bit more of a validity issue than a feasibility issue. The claims are pretty straightforward to use. So, we agree.

Harold Pincus: Okay. Any more discussion about feasibility?

(Unintelligible) to vote on that.

(Desmira King): Okay. Voting is now open for the feasibility of Measure 3453. Option A, high; Option B, moderate; Option C, low; and Option D, insufficient. For the feasibility of Measure 3453, Option A is high; Option B, moderate; Option C, low; and Option D, insufficient.

Looking for a few more votes. I'll wait two more seconds.

Thank you. Voting is now closed for the feasibility of Measure 3453. Ten individuals voted "High." Eight individuals voted "Moderate." Zero individuals voted "Low" and zero individuals voted for "Insufficient." The percentages are 56% voted "High," 44% voted "Moderate," 0% for "Low" and 0% for "Insufficient." So this passes the feasibility for Measure 3453 and we can move forward to use and usability.

Harold Pincus: Okay. So use and usability, Lisa, you want to kick it off?

Lisa Jensen: Yes. So use certainly we have low rates from the testing data, so there's room for improvement. We would hope that this could be used by states to improve care for Medicaid recipients.

In terms of unintended consequences, it's possible that there could be a tendency to find any sort of placement very quickly to get somebody in for follow-up and it may not be the best placement for an individual client. There's a possibility that organizations may not want to work with difficult clients or hard-to-place clients because it'll bring down their numbers. And states could hold the treatment facility accountable with another comment of possible unintended consequence.

Harold Pincus: Okay. Tami, any further comments?

Tami Mark: No.

Harold Pincus: Okay. Comments on use and usability?

Okay. Hearing none, I think we're going to vote.

(Desmira King): Okay. Voting is now open for the use of Measure 3453. Option A is pass; Option B is no pass. We are now voting on the use of Measure 3453. Option A, pass; Option B, no pass.

Okay. Voting is now closed for the use of Measure 3453. Eighteen individuals voted "Pass." Zero individuals voted "No pass" which is 100% voted "Pass" and 0% for "No pass."

If there's no more discussion, we can move to vote for usability, Harold.

Harold Pincus: Okay. Why don't we move on that?

(Desmira King): Okay. We are now voting on the usability of Measure 3453. Option A is high; Option B, moderate; Option C, low; and Option D, insufficient information. For the usability of Measure 3453, Option A, high; Option B, moderate; Option C, low; and Option D, insufficient information.

Voting is now closed. Six individuals voted "High." Twelve individuals voted "Moderate." Zero individuals voted "Low." And zero individuals voted "Insufficient Information." So 33% voted "High" and 67% voted "Moderately." So this passes the use and usability criteria and the last vote is

overall suitability for endorsement. I'll (unintelligible) kind of back to Harold for discussion.

Harold Pincus: Is there any comment that people have on the final - with regards to the final sort of overall endorsement?

So I just would make one comment and then this may come up more when we talk about the layer and competing measures in terms of the issue that we talked about at the beginning in terms of sort of alignment with some of the other followup measures and, you know, it's something probably that needs to be done across all of them to get some alignments (unintelligible) definition specifications. But I don't think that necessarily sort of (unintelligible).

Any other comments?

I guess we're ready to vote.

(Desmira King): Okay. Voting is now open for the overall suitability for endorsement of Measure 3453. Option A is yes and Option B is no. For the overall suitability for endorsement of Measure 3453, Option A is yes and Option B is no.

Voting is now closed for the overall suitability for endorsement of Measure 3453. Eighteen individuals voted "Yes." Zero individuals voted "No." So that's 100% voted "Yes" for the overall suitability for endorsement of Measure 3453. This measure passes.

Woman: Thank you, Harold. And just for a matter of public record, the reason why you did not hear Mady talk and Constance Horgan discuss or vote on this measure is because they were recused. And we will turn it over to Peter who will now chair the initiation and engagement of alcohol and other drug abuse

for dependent treatment and Harold is recused from discussion and vote for this measure.

Peter Briss: As it looks like Mady as well, is that right?

Woman: No, Mady actually is not recused from this measure.

Peter Briss: Okay, thank you.

So I will try to live up to Harold's good example and move this quickly through the - this discussion and time that we have. This is the maintenance measure. Would NCQA like to tee up the measure for us?

Lauren Niles: Hi, yes. Can you hear me all right?

Peter Briss: Yes. Go on.

Lauren Niles: Great. Hi, this is Lauren Niles. And I'm joined by some of my colleagues here at NCQA who will introduce themselves as they jump in.

But to give you just a little bit of background on this measure for a moment, really the intent of this measure is to assess the percentage of adolescent and adult members who have a diagnosis of alcohol, opioid or other drug abuse and dependence to initiate an engagement treatment services using both psychosocial treatment and pharmacotherapy.

There are two indicators, as you know, for this measure: Indication treatment and an engagement in treatment indicator. The measure assesses a significant gap in care. We know that about 22 million people in the United States have a substance use disorder. We also know that access to treatment is very low.

There are some clinical guidelines and literature, including systematic reviews in the state, and those pieces of evidence support the use of psychosocial care to treat substance use disorder and the use of psychosocial care in conjunction with medication for the treatment of opioid and alcohol use disorder.

We believe that this measure is valid and reliable. It's widely used in multiple national reporting programs. We've recently re-evaluated this measure. And during that re-evaluation, we added pharmacotherapy as an appropriate treatment modality for those with opioid and alcohol use disorders.

We also included evidence-based telehealth services to deliver psychosocial treatment and we also added diagnosis codification to the measure.

Since this measure continues to adjust, there's a gap in care and room for improvement. So endorsement of this measure will provide healthcare organizations a way to monitor quality of care for this vulnerable population over time.

And so with that, let's turn it over to you. We're happy to answer any questions that you have about this measure. We're looking forward to a good discussion.

Peter Briss: Good. Thank you for the clear and concise opening statement. And does anybody have initial questions for the developer before we dive in?

(Les): This is (Les). Excuse me. I had a question about the diagnosis. Are they using the DSM 5 criteria to make the diagnosis of alcohol or drug abuse/dependence?

Lauren Niles: Great. That's a great question. So yes, the provider was using the DSM criteria to make that diagnosis. For this measure, we used ICD-10 codes which have been matched to those diagnoses. So we're including diagnosis of substance use disorder which translates to abuse and dependence. We're not including substance use alone.

Peter Briss: Anybody else who has general questions or comments for the developer?

Michael Lardieri: Mike Lardieri. I have the same question about the same day. How does that apply to this measure? Having the service on the same day of discharge.

Lauren Niles: That's a great question. So how it works for this measure is you have a inpatient discharge or an emergency department or observation stay that that results in an inpatient stay, you are able to meet initiation criteria using that stay. If you initiate or if you come in to the measure from an outpatient visit or another service that's defined in the denominator, it has to be initiation on the day after. For engage - at least the day after through the 14-day following. And for engagement, you have to occur 34 days after your initiation of (unintelligible) can occur on the same day of initiation.

Michael Lardieri: Okay, thank you.

Peter Briss: Anybody else with general questions for the developer?

(Les): Yes, I - this is (Les). I have another question. So, what if the patient refuses treatment? Is there any allocation for that?

Lauren Niles: That's a great question. Unfortunately, at this time, we don't include any codes for our patient refusal of services. So those members, unfortunately, would not go on to meet numerator criteria.

Peter Briss: Anybody else, questions or comments?

Hearing none and seeing none, no hands raised in the chat, let's go on and discuss evidence. So this is a maintenance measure. So we could decide to have a discussion or we could decide that evidence is as strong as previously…

Michael Abrams: Peter?

Peter Briss: …discussed or - I'm sorry…

Michael Abrams: Peter? This is Michael at NQF. So there is some new evidence that was presented. So you should at least vote on this, the evidence piece. We can't skip that vote, okay?

Peter Briss: Okay. So with that, Kraig and David, our lead discussions on this one, would one of you, gentlemen, like to tee up the evidence?

Kraig Knudsen: Sure. This is Kraig. In terms of the evidence, the developer added three new practice guidelines. Two were from the American Psychiatric Association. One was from ASAM. And then they also updated the VA guideline specifications. If you look at it, the guidelines have literally thousands of studies showing the effectiveness of SUD treatment for various modalities that are included in this indicator.

In terms of the reviewers, they all agree that there was ample evidence. One reviewer discussed the addition of MAT in telehealth and it's maybe impact on the analysis in the end. But it seems like that was more validity and accessibility of the measure itself.

Any other comment?

Peter Briss: And I'm sorry, was that Kraig?

Kraig Knudsen: Yes, it was.

Peter Briss: Okay, thank you. David, do you have anything to add?

Woman: Peter, I don't believe David is on the call.

Peter Briss: Oh, okay. Thank you.

Woman: Sure.

Peter Briss: That'll make it easier for Kraig to not have to share space.

Although there is new evidence presented, nonetheless, I think that we might decide that the evidence is - continues to be reasonable and/or have the strength since the last time we looked. So - and so we might be able to have a relatively truncated discussion about this particular dimension. Does anybody have additional comments that they'd like to make of that evidence?

Going twice. Tee up a vote, please.

(Desmira King): Okay. We are now going to vote on the importance to measure and report. We're voting on evidence of Measure 0004. This is initiation of engagement in alcohol and other drug abuse to intended treatment measures. Option A is high; Option B, moderate; Option C, low; and Option D, insufficient. For the

evidence of Measure 0004, Option A is high; Option B is moderate; Option C is low; and Option D, insufficient.

I'll wait five more seconds.

Okay. Voting is now closed for the evidence of Measure 0004. Seven individuals voted "High." Eleven individuals voted "Moderate." Zero individuals voted "Low." And zero individuals voted "Insufficient." For the percentages, 39% of individuals voted "High" and 61% voted "Moderate,"0% for "Low" and 0% for "Insufficient."

So we'll go forward with this continuation of performance gaps conversation.

Peter Briss: So with that, Kraig, you want to tee up performance gap for us, please?

Kraig Knudsen: Sure, absolutely. So the developer showed performance gaps between the insurance types, so that's Medicare, Medicaid and commercial insurance, but less of a gap but there is still gap within the insurance type. Data shows slight improvement in the measure over time over the years in various types of insurance. Disparities were examined between the insurance types but not on ethnicity and race. They did not do that study. And they gave rationales around that. Developers provided evidence from other studies, however, around this area of engagement and initiation for ethnicity and racial disparities.

In terms of the reviewer comments, reviewers agreed that there was a performance gap warranting a measure. So there was universal agreement.

Peter Briss: And I would just add - this is Peter. I would just add that although there were sort of variations between insurance types, overall performance was fairly - it was what I would consider to be fairly low in all of the…

Kraig Knudsen: Right.

Peter Briss: …insurance types which means that there's a gap remaining to be filled.

Kraig Knudsen: Right.

Peter Briss: Anybody want to make additional comments or have questions about this topic?

Michael Abrams: It was noticed in reviewing your materials -- this is a question for the developer, Michael Abrams at NQF -- that opioid rates on this measure exceeded alcohol. Could you briefly comment regarding that for us? Give us clarity on what that means in terms of performance.

Lauren Niles: Hi. And thanks for pointing that out. We thought that was an interesting finding as well. So this is the first year of data that we have where we stratify the measure by diagnosis. And what we found was for commercial and Medicaid products, initiation and engagement were higher among that opioid use disorder stratification. But in Medicare, it's actually higher in the alcohol use disorder stratification. So we thought that was an interesting finding, too. I don't think we have much in the way of commenting on why that might be but it is certainly an interesting finding.

Peter Briss: Anybody else have questions or comments about performance gap?

Hearing none, why don't we move to a vote, please?

(Desmira King): Okay. We are now voting on the performance gap of Measure 0004. Option A is high; Option B is moderate; Option C, low; and Option D, insufficient. We are now voting on the performance gap of Measure 0004. Option A, high; Option B, moderate; Option C, low; and Option D, insufficient.

Okay. Voting is now closed. For the performance gap of Measure 0004, ten individuals voted "High," eight individuals voted "Moderate," zero individuals voted "Low" and zero individuals voted "Insufficient." For the percentages, 56% voted "High" and 44% voted "Moderate." Zero percent voted "Low" and 0% voted "Insufficient." So Measure 0004 passes the performance gap criteria and we can move forward to discuss reliability.

Peter Briss: So, Kraig, back to you.

Kraig Knudsen: All right. So in terms of reliability specifications, there were some changes made to this measure. This time around, the developer already kind of discussed that but I'll go ahead and say them again.

Pharmacotherapy for treatment of alcohol and opioid abuse and dependence was included. They added telehealth to the denominator and numerators and extended the engagement of AOD treatment time frame from 30 days to 34 days.

Previous comments in previous review was about the inclusion of both abuse and dependence diagnoses in the measure because that was seen very broad.

And in terms of reviewers' comments, they felt that this was an improvement over past versions of the measure, so. And that's it.

Peter Briss: So this is another area where we previously approved this measure the developers have made some additional improvements since the last time we looked. And so this is sort of one of the dimensions that's relatively deemphasized in the maintenance measure. So given all of that, would anybody like to make additional comments on the reliability of this measure, please?

Raquel Jeffers: So this is Raquel. I just have a question. Are you able to capture with this measure if individuals are receiving medication and counseling? Are you able to see - are you able to capture if people are - or they're just getting medication, if they're actually getting both medication and counseling?

Lauren Niles: That's a great question. As specified right now, we're looking for the medication and the psychosocial care for use together. We don't capture any data elements right now that allow us to parse out if someone is using both or just using psychosocial care because the measure was currently specified prior to this year. So at this time, no, we can't capture those separately.

Peter Briss: And that was the concern of the reviewers as well.

Anybody else have a question or comment about reliability of the measure?

Hearing none, why don't we move to a vote?

(Desmira King): Okay. We are now voting on the reliability of Measure 0004. Option A is high; Option B, moderate; Option C, low; and Option D, insufficient. For the reliability of Measure 0004, you may submit your vote. Option A is high; Option B, moderate; Option C, low; and Option D, insufficient.

Okay, voting is now closed. And for the reliability of Measure 0004, two individuals voted "High," 16 individuals voted "Moderate," zero individuals voted "Low" and zero individuals voted "Insufficient." So that's 11% voted "High" and 89% voted "Moderate," 0% for "Low" and 0% for "Insufficient." So for the reliability of Measure 0004, the measure passes this criteria and we can move forward to the discussion for validity.

Peter Briss: Thank you. So this again is a dimension that - on which we pass the measure previously and so we can deemphasize this one, unless folks feel like important things have changed. So again, Kraig, will you walk us through this one, please?

Kraig Knudsen: All right. So examining - in terms of validity testing, the developers examined whether or not the initiation engagement of alcohol and other drug abuse or dependence treatment. The indicator was positively correlated to the follow-up after emergency department visit for alcohol or other drugs, drug abuse or dependence measure.

So they did the correlation analysis. And they found that most of the correlations were acceptable. Reviewers did note that the scores comparing the two measures were not statistically significant for Medicaid plans. One reviewer felt that the validity testing results were weak. In terms of safe validity, that was done by an advisory panel and the findings were that the measure had adequate safe validity. So also one reviewer - the additions of all the modalities together make it hard for analysis for specific modalities which we already touched on.

Peter Briss: And so I think I have hands raised for Raquel and then Bonnie. And so let's start with those two, please.

Raquel Jeffers: I just didn't lower my hand. My hand is not raised. This is Raquel.

Peter Briss: Oh, thank you, Raquel.

Bonnie, is your hand still raised?

Bonnie Zima: Yes, it is. And I just wanted to kind of share a little bit of a nuance. And that is the interpretation or these adherence rates. And, you know, the issue is we need to also think about the context of how the adherence rates are going to be interpreted. And specifically we know that there's fairly good variation in screening rates. So for example, with the VA which does the much higher rate of screening, the VA may be in the position of being penalized a little bit more because when they have higher screening rates, it actually increases their pool for potentially eligible, less motivated patients.

And this gets back to the issue that was raised earlier about what do we do about patients who refuse care. And I think that, you know, one possibility is that - and I don't know exactly what the protocol is, but what I'm wondering if we could also be on record that in interpreting the findings from this measure that it also be taken into account the context. And that, you know, one possibility is to accompany this measure with some type of balancing measure that actually can set the interpretation of this measure in a context of the proportion of persons screened by that major provider.

Peter Briss: Let's stipulate that. Yes, so staff will include the - this issue of relationship between…

Man: Yes. So this is…

((Crosstalk))

Woman: Let's follow a comment on that. I mean, you can note it, but I'd also like to note, in addition to that, that we have some - I've been doing some research with NCQA and we've - it's under review. And we actually looked at the correlation between the identification rate and the initiation and engagement rate because of this exact concern that potentially if you're improving your finding, your case finding, you may be penalized. And we find in fact the opposite that - will have plans to do a better job with identification, with case finding, do a better job with initiation and engagement.

So I don't think it's necessarily a correct argument.

Peter Briss: Well - and it's likely true that screening and treatment rates are - could be related to each other and as Tami said, they could be related and depending on the problem, could be related in either direction. So let's stipulate that this issue was raised and let's continue on validity.

So - and, Tami, I assume that - I see a hand raised. It sounds like you may have already made your comment. Is that right?

Tami Mark: Yes.

Peter Briss: Anybody else want to comment on validity?

Michael Abrams: So this is Michael at NQF. So one, during the review, at least one of the committee members observed, and this is a question for the developer, that certain types of residential treatment levels of care may be excluded. Can the developer briefly comment about the completeness of those types of values in the value set?

Lauren Niles: Yes, of course. So right now, residential treatment in inpatient, outpatient and specialty setting is included in this measure. One of the things that we are looking into more as we kind of work to strengthen this measure over time is thinking about (per diem day) programs for residential treatment. We have not found code for that yet. But that is something that we've heard we should continue to explore, so.

Peter Briss: Thank you for that. Anybody else with comments on validity?

Junqing Liu: Hi. This is Junqing Liu at NCQA. I like to make a comment on validity. Is it a good time to speak now?

Peter Briss: Sure.

Junqing Liu: So I want to speak to you about a patient…

Michael Abrams: Sorry. We're going to - pardon us. We're going to hold off on public comment until later, please. You will have a chance to speak at the close. Okay? So…

Junqing Liu: This is answering one of the question.

Peter Briss: Michael? Michael, give her - so make your comment quickly, please.

Junqing Liu: Yes. So patient refusal, the question raised earlier, I wanted to respond to that. So this is a plan-level measure. We know that for plan-level measures, we see a patient refusal as random event that make affect our plans equally. So this is consistent with all the other plan-level measures that this is not considered exclusion. By the way, understand that for provider-level

measures, when you deal with fewer patients, there may be measures on that exclusion.

Peter Briss: Thank you for that. Thank you for that clarification.

And so anybody else on validity, please?

Hearing none, let's move to a vote please.

(Desmira King): Okay. We are now voting on the validity of Measure 0004. Action A is high; Action B, moderate; Action C, low; and Action D, insufficient. For the validity of Measure 0004, Action A, high; Action B, moderate; Action C, low; and Action D, insufficient.

Voting is now closed.

One individual voted "High" for the validity of Measure 0004. Seventeen individuals voted "Moderate." Zero individuals voted "Low." And zero individuals voted "Insufficient."

The percentages for that are 6% voted "High," 94% voted "Moderate," 0% for "Low" and 0% for "Insufficient."

So for 0004, this measure passes the validity criteria and we can move forward to the discussion on feasibility.

Peter Briss: So, Kraig, any key issues on feasibility that you'd like to raise, please?

Kraig Knudsen: Not really. All the data elements are defined and available in electronic formats. And in terms of reviewer comments, as you'll see, claims data will

not accurately capture all encounters as what one reviewer indicated. And then another reviewer indicated that incentives - it has incentives that should be included and may be necessary to ensure adequate data for this particular indicator.

Yes, that's it actually.

Peter Briss: Great. And so some of that may actually be - I'm not sure that all of that is actually a feasibility issue. Some of them may be…

Kraig Knudsen: Right.

Peter Briss: …more about reliability and validity.

Kraig Knudsen: Yes.

Peter Briss: This is a claims rate measure, ought to be - and it's a claims rate measure that's already in play, and so it seems likely feasible. Anybody - would anybody like to spend any more time on this dimension?

Hearing none, let's move to a vote, please.

(Desmira King): Okay. We are now voting on the feasibility of Measure 0004. Action A, high; Action B, moderate; Action C, low; and Action D, insufficient. We are now voting for the feasibility of Measure 0004. Action A, high; Action B, moderate; Action C, low; and Action D, insufficient.

Voting is now closed.

For the feasibility of Measure 0004, ten individuals voted "High," seven individuals voted "Moderate," one individual voted "Low" and zero individuals voted "Insufficient."

The percentages, a 56% voted "High," 39% voted "Moderate," 6% voted "Low" and 0% voted for "Insufficient."

So for the feasibility of Measure 0004, this measure passes its criteria and we can move forward with the discussion of use and usability.

Peter Briss: So, Kraig, take us home. This is - and this is a counter-maintenance measure. This is an up-emphasized issue. So both on the upside, is it (BNU)? So are we making progress and on the - and potentially on the downside, are there recognized unintended consequences?

So back to you, Kraig.

Kraig Knudsen: All right. So this is being used in both public and quality improvement reporting. Medicaid uses this. NCQA uses this. There's a number of areas that use this measure at this point.

In terms of what reviewers had to say, one reviewer had a concern about the lack of age groups ratification given the scientific evidence during adolescents. In terms of usability, there was no concerns from the reviewers around harm surrounding this measure itself.

((Crosstalk))

Peter Briss: With that, I'll open the floor for any additional comment.

And hearing none, let's move to a vote please.

(Desmira King): Okay. We are now voting on the use of Measure 0004. Action A is pass; Action B is no pass. For the use of Measure 0004, Action is pass; Action B, no pass.

Looking for a few more votes.

Perfect. Voting is now closed.

For the use of Measure 0004, 18 individuals voted "Pass," zero individuals voted "No Pass." So this passes with 100% for use. And we can move forward to the vote for usability.

So voting is now open for the usability of Measure 0004. Action A, high; Action B, moderate; Action C, low; and Action D, insufficient information. For the usability of Measure 0004, Action A, high; Action B, moderate; Action C, low; and Action D, insufficient information.

Woman: And I am not seeing that. This is…

((Crosstalk))

(Desmira King): All right. Thanks.

Okay. I'll wait a few more seconds so everyone can submit their vote.

Perfect. Voting is now closed.

For the usability of Measure 0004, four individuals voted "High," 13 individuals voted "Moderate," one individual voted "Low" and zero individual voted for "Insufficient Information."

For the percentages, 22% of individuals voted "High," 72% voted "Moderate," 6% voted "Low" and 0% voted for "Insufficient Information."

So for the usability of Measure 0004, this measure passes its criteria and we can move to the final vote for overall suitability for endorsement. So I will wait…

((Crosstalk))

Peter Briss: And before…

(Desmira King): …for this session.

Peter Briss: … - yes. Yes. And before we move to the vote, would anybody like to make a closing argument, particularly on any issue that hasn't already been raised, please?

Seeing none, let's move to a vote, please.

(Desmira King): Okay. Voting is now open for the overall suitability for endorsement of Measure 0004. Action A is yes; Action B is no. This is for the overall suitability for endorsement of Measure 0004. Action A, yes; and Action B, no.

Looks like we have all our votes. So voting is now closed.

For the overall suitability for endorsement of Measure 0004, 18 individuals voted "Yes," zero individuals voted "No." So that passes at 100% for Measure 0004.

Peter Briss: So with that, should we move to public comment?

Man: Yes.

(Desmira King): Yes, please.

Peter Briss: Yes, so let's move to public comment, please.

Woman: If anyone has a public comment, would you please raise your hand or you can chat us in a chat box.

We'll wait a few moments.

Okay, hearing none. Are there any in the chat, (Chicana)?

Okay. We will move forward to next steps. We want to thank you, everyone, for joining. This was a very productive meeting. I just want to give you a few heads up for the remainder of our fall cycle for fall 2018. We just wrapped up our last two - our two measure valuation Web meetings. But our next meeting will be on February the 5th, which is next Tuesday. And that's going to be our post-Web meeting - our post-meeting Web meeting. On May the 3rd, we have a post-comment Web meeting scheduled. And following that, we'll have CSAC review period which will be from May 22 through June the 12. And appeal will end the cycle from June 14 through July the 15.

We included some information for you about the next cycle. This is spring 2019. These are our cycle updates. So the intent to submit deadline is going to be January - it ended on January the 7th. And eight measures were submitted. Six of those were maintenance measures and two of those were new measures. So we have one measure considered complex and it will be reviewed by the Scientific Methods Panel for a scientific acceptability criterion. And so we will - beginning - we'll probably present some information for you during our next call just so that you can review. That will be different from our committee.

Some of the topics for the next cycle measures that we're expecting are multiple antipsychotic use, physical restraint of - excuse me, (unintelligible), screening for violence, substance abuse or trauma history, follow up after emergency department admission, monitoring long-term opioid use and acute care due to overdose.

And so we just wanted to give you a look at what we're going to be doing. We do want to let you know that at our post-meeting call, we will be reviewing related and competing measures and also addressing performance gaps. So, feel free to look ahead in your slide deck and prepare for that meeting. And as always, you can contact us with our Behavioral Health information that's listed on the screen.

And I will turn it over to Harold and Peter to…

Michael Abrams: Can you - let me make one comment.

((Crosstalk))

(Desmira King): Sure, Michael.

Michael Abrams: So go - would you go to Slide 40 for us, please, (Desmira)?

So this is Michael Abrams here at NQF to inspire you, the committee members especially, for the next meeting.

Go to this slide, right here.

(Desmira King): Okay.

Michael Abrams: We're displaying here a Slide Number 41. If you would glance at that, it has a number of gap concepts that you all came up with in previous meetings. And they generally hit the following areas, outcomes as opposed to process measures, criminal juvenile justice issues hit as well, child development issues, integration coordination issues, supply side and facility issues and prevention and recovery.

And to be a little bit provocative or encouraging to you all, for next meeting, you might think about other gap areas to address. Gun violence, for example, housing and employment support measures, anxiety measures.

And then to give you in the domain of addiction and to give you a little Super Bowl preview, you might think of course about alcohol versus opioids, marijuana legalization, and then finally in the Super Bowl domain, gambling issues. And here's one fact for you to inspire you. Perhaps this weekend, the New York Times reported yesterday that last year's Super Bowl saw $150 million in betting out of Nevada alone. Nationally, illegal betting exceeded $4.6 billion and analysts expect many, if not all states in the next few years will legalize sports betting.

So I wanted to just inspire you with that. So have a look at these points and think about those issues for our gaps discussion next time.

And then, (Des), if you'd go to that slide, that's it, there's also a slide on here called NQF Related Initiatives. There are some links for you to have a look at. We'll discuss that briefly to help connect our initiatives to the puzzle that is NQF or the effort that is happening here at NQF.

So with that, I'll hand it off to the chair. Thank you all. This is a very productive meeting. We achieved all of our goals.

Peter Briss: So I'll get out of the way quickly. This is Peter. So thanks to everybody for your active participation today. I think we got through a lot of materials. Thanks for that. Thanks for the developers for having a lot of good information and communicating it efficiently. And thanks, as always, to the staff for sort of setting us up to get through all this material today.

Harold Pincus: This is Harold. Let me just say ditto with regard to the way - it really requires a large complicated set of people attending to this to make this work when you do it over the phone. And it worked out fine today.

(Desmira King): Thank you. Well, with that, we will end our meeting. Thank you all so much for your participation today. Thank you for our developers. And you all have a wonderful day.

Woman: Thank you.

Man: Great.

Woman: Thank you.

Man: Thank you.

Woman: Thank you.

Woman: Thank you. Bye-bye.

END