BEHAVIORAL HEALTH WEBINAR 2

Moderator: Benita Kornegay Henry
June 19, 2019
1:00 pm CT

Woman 1: Good afternoon everyone. Thank you for logging back on for our second June 19 web meeting.

We finished up the measures 0560, 0640 and 0641 in our first web meeting. And we will be beginning at Measure 1922 with performance gaps for this meeting.

But before we get started and I hand it over to the Co-Chairs, I just want to take a moment to see if there were any other Committee members who were not on the first call to see if we have them logged on so you can introduce yourselves and present any disclosures you may have.

Okay. With that, I will hand it over to (Harold) and (Peter). I know that we promised to give you some time back. So we're hoping to wrap things up around 3:30 and we will send the survey link and the recording immediately following this meeting.

Sow with that, I'll hand it over to (Harold) and (Peter).

(Peter): So with that, we were on the performance gaps on Measure 1922. And so if (Vivian) maybe would like to walk us through that that would be great.

(Vivian): Okay. So performance gap, there were performance data directly submitted to the Joint Commission between 2009 and 2018. The number of hospitals reporting ranged from 300 to 1082 per year.

The mean performance in 2009, the first year of the data was 87%. And in 2018, the last year we have the performance data for was 92.7%. Twenty Eighteen, the 20th percentile was 92.38% and the 70th percentile was 99.85%.

So in other words, the data shows there's a fairly narrow performance gap with high performance rates across the hospitals but with some variation. There doesn't seem to be anything mentioned according to the developers in the literature around disparities. And there doesn't anything - to be any significant strong evidence of disparities for the measure.

(Peter): (Maby) anything to add? She may not be back. Anybody else have anything to add?

(Harold): I guess, this is (Harold). The only question I have is, are there - when people talk about performance gaps for other measures for NQF, something - how does something in the sort of high 80s, mid 90s sort of flow out in terms of documenting a performance gap?

(Michael): So (Harold), (Michael) here at NQF. So we do see stuff that, you know, when it gets up pretty high obviously you're thinking about things topping out. But sometimes that can be eased if there's variability on other, you know, parameters.

And nothing like that is demonstrated here. So for example, there's no, you know, disparities between Medicaid and Medicare providers and Medicaid providers something like that.

So it's really at this - for this measure the judgment of you all, if you think, you know, those - that that 13% gap let's say or what we were talking about more recently is about 8% gap for the average hospital is something that should be followed forward and try to close.

Or it at least suggests that there are other hospitals and other that aren't at the average that need to be and continued to monitor and encourage. That's the sort of the judgment call about it.

(Harold): Okay thank you.

(Peter): This is (Peter). I would have been tempted; I would have been a little tempted to call this a topped out measure on its face. So overall performance is high. There's not much of distribution between providers. There's not much of a distribution between populations.

Does anybody want to make an argument that there's still enough of a - that we're either far enough from 100% or that there's enough distribution by population or provider that this one shouldn't be called topped out?

(Jeff Sessman): This is (Jeff Sessman). I'm not going to make the argument. But just briefly, I think that NQF should get some methodologists and some other folks who are familiar with the process together to look at this issue of topping out.

There really isn't a conceptual framework that we operate under consistently. And this is a great example.

(Peter): It's a threshold question (Jeff), for example, perhaps. But, yes so noted.

(Jess Sessman): It's more than that. It's more than a threshold question because it's complicated. It may be that only a select group of hospitals or organizations are participating in the measure.

It may be that while this part of the causal pathway has been solved. The actual outcome measure that we want to look at, a patient-oriented outcome isn't affected.

It may be that actually there are significant exceptions. Like maybe seclusion is appropriate in x percentage of patients.

So I think there's some common threads that we talked about when topping out. But we never really get to, I think, a clear explanation. My sense on this one is that, yes, we're probably pretty much topped out.

(Harold): (Jeff) I would agree with you because I think it also depends upon the nature of the measure. Something like this which is, which is in response to a question about what's the kind of logic train that goes along with this.

And this seemingly sort of an easy documentation measure doesn't mean that we've solved the problem of violent substance use and psychological trauma among these populations. And it suggests that there may be another way to go at this.

(Jeff Sessman): Yes, no I agree.

(Peter): That's right. Does the developer have comments on this issue about whether this measure might - may or may not be topped out?

(Elvira Ryan): Hi this is (Elvira Ryan). While you were talking we were having some discussion here. And in our experience, what we're seeing is that we do see some variability between facilities. And that the rates are not necessarily the same for a free standing facility versus a facility within an acute hospital unit or military - government facilities.

And because there is still the gap and the rates do not demonstrate being close to 100% and we know that the facilities that are accredited by the Joint Commission are still using this measure, we still feel that it's a viable measure.

(Peter): Thank you. And anybody else have comments or concerns about performance gap?

(Jodie): Yes before we move on -- this is (Jodie) -- so I have the same sort of pull and tug with the evidence and importance to measure. These are longstanding clinical screening questions that should in theory be 100% right unless the person is just totally unable to answer, refuses. So as long as I've been in the field which is over 30 years at this point.

So I'm sort of torn, you know, in terms of what would define enough. I'm certainly not a fan of needing perfect. But, you know, if there's any room for -- reasonable room -- for improvement than I think this is a great import to measure.

(Peter): Thank you. And anybody else have comments? Let's move to reliability please.

(Vivian): Reliability, the reliability testing was a sample of 191 patient records. And there was very high level of agreement along each of the data elements in the numerator and denominator of greater than essentially 98%. So that's the reliability testing.

Somewhat more related to the validity, again, we have a slight positive correlation between this measure and five multiple antipsychotic medications at discharge for what it's worth.

(Peter): So these are essentially similar to what we've seen on the last couple of measures. (Maby) do you have anything to add?

(Maby): No.

(Peter): Anybody else? Anybody else have comments, questions or concerns?

(Harold): Yes. I mean I really don't consider that validity because it's really you're really just validating the extent to which hospitals are documenting stuff. And not necessarily the validity of the, you know, of the measure itself.

Man: Yes, I want to agree with (Harold) about this. There are a number of JCHAL measures that are checkmark measures. And you're measuring the checkmark, you're not measuring the measure itself.

(Jodie): Right so this is (Jodie). Yes, I agree. I think whether these get reapproved again or not that really there needs to be an immediate and strong discussion about sort of asks to developers in general around more outcome measures.

So this one, in theory could be tied to whether in fact there is correlation with the treatment plan or something. Even if we can't have stronger outcome data.

(Maby): And let me add one comment to that, this is in-treatment outcomes. You're not looking for outcomes after the person got better ostensibly or improved or whatever after the hospitalization. This is during a hospitalization.

So the ability to find out whether a treatment plan addressed anything in the screening ought not to be - ought to be as difficult as anything else to collecting during treatment.

(Peter): Anybody else have comments on reliability or validity?

(Michael): This is (Michael) at NQF, two quick comments. And actually a question for the developer. The exclusion of being unable, unwilling to be tested for this, did you guys test that data element in any way for its reproducibility? Can you just comment about that for the developers?

(Elvira Ryan): The inability of the screening to take place is captured in the allowable values for each of the specific five criteria.

(Michael): Okay.

(Elvira Ryan): So that's the way that we look to see, you know, we can analyze how often that allowable value was abstracted for that…

(Michael): Okay so that's 100% agreement across 191. You tested that like the other data elements.

(Elvira Ryan): Right because it's built into the other data elements.

(Michael): Okay that's good. And then one follow-up comment to I think the comment that (Maby) just made. So while it's true that this isn't in a treatment assessment, nothing stops a validity presentation where they would take this measure and whether or not the screening happened. And looking downstream for a subset of individuals or with other outside data to see whether or not it correlated with a better outcome.

I just want to, you know, that certainly is allowed. I get that it's more complicated. But it certainly is allowed as a validity test that could be presented to you all. So…

(Harold): Or even yesterday we attended to that issue.

(Michael): That's fair enough too. That's right. That's a more proximal measure, agreed.

(Peter): So before we get too far downstream on that, the, you know, it's processing the staff to include context in the report about, you know, a lot of the discussion today has suggested that validity assessments can be improved.

And then having said that, when we're evaluating measures today, we have to evaluate the measures that are in front of us and not the measures that we wish we had. So I'd rather not get us too far astray about future or where we'd like to be in the future.

(Nicolette): This is (Nicolette) from NQF. Agree with that and just out of fairness to the developer and kind of what we require currently for our validity standards, we do allow, you know, this type of correlation testing to be provided as evidence of validity.

And it's up to the Committee to decide if you, you know, feel as those results are appropriate. But the test itself is something that we allow as an appropriate test for validity currently.

(Peter): So given all that, given all that, are there other comments on reliability or validity that haven't been surfaced? Hearing none, could we go to feasibility please?

(Vivian): Feasibility, the data elements are generated during the care process for the most part. For this measure it's via manual review of the paper medical record.

So there are some, evidently, some elements that are defined in electronic sources. And they're freely in use and they're generally understood.

(Peter): And they've been in play for a long time and they're consistent with the other measures we test.

(Vivian): Absolutely, yes.

(Peter): Anything else (Maby)?

(Maby): Nope.

(Peter): Anything else from anybody else? All right, hearing none, Usability and use.

(Vivian): Usability, this is a publicly reported measure, performance measure and used in the Joint Commission of Hospital Accreditation Program.

(Peter): And again, largely consistent with the other measures we did this morning. And (Maby) any other comments?

(Maby): No.

(Peter): Anybody else, other comments? Hearing none and any comments on related or competing?

(Maby): Just that the developer says that this is the only measure of its kind for hospitals or facilities.

(Peter): Okay thank you (Maby). Anything else?

(Maby): No.

(Peter): Anybody else, anything else?

(Michael): So just one comment from (Michael) here at NQF related to use and usability. They did demonstrate, you know, with a regression model, random effects model that adjusts for healthcare organizations, an increase of 18% in the overall measure from the period, the ten-year period beginning in 2009 and completing in 2018.

So the direction of that effect was as expected, things got better.

(Peter): Thank you. Any final closing comments on this one? All right hearing none, I will hand the baton to (Harold). Thank you.

(Harold): Okay so we're not doing a final vote on these things correct?

(Debbie): Correct.

(Peter): Yes, that's right -- (Peter) to (Harold) -- we're not going to vote. All the vote is going to be offline with those survey monkeys that will be sent out tomorrow right?

(Debbie): No they'll be sent out today.

(Peter): Okay survey monkey will be sent out today. And links to the…

(Debbie): Recordings.

(Peter): Recordings as well to facilitate and transcripts sent out tomorrow if you prefer that mode to review comments.

(Harold): And what is the deadline for those so far?

(Debbie): It will be Friday. So the deadline is there. Voting results are due 48 hours after the meeting. And so it will be Friday COB, close of business on Friday.

(Harold): And so this will also be a test of our memory.

(Debbie): Yes, slightly.

(Constance): This is (Constance). This is a question. In the usual format, the Chairs usually have summarized the discussion on each measure at the end and then we vote. And I don't think we've been doing any summaries of the measure.

Will we be doing a summary of each of the measures that we'll be voting on towards the end of today's meeting?

(Michael): So the survey monkey will be, you know, explicitly worded for each criteria you vote on and have bubbles to pick. So that will help your memory.

And then, of course, you have the documents themselves that summarize, you know, that have brief summaries at the top and the more detailed summaries as well. And you will have the transcripts and the recordings as well.

So...

(Constance): My question was…

(Michael): The delay is in time. We're you looking for something else?

(Constance): No I wasn't. I wasn't asking about actually from the perspective of memory. Usually there's a summary. And if there are - it's just saying is this reflecting accurately what was said.

So it's useful to have a sort of a closing on each measure before we vote. So anyway that's all I'm.

(Michael): I see. Okay.

(Constance): I mean maybe the Chairs would like to address that because that's something that they've been doing in the past. It's fine if you don't do it. But I was just wondering if we would be doing it.

(Michael): Yes. (Peter), (Harold)?

(Peter): Yes, so my take on this is that without the voting to help us do that it's a very hard thing to fairly summarize complicated conversations without unduly influencing them.

So I actually think that that's unlikely to be possible here. And it may not be desirable. And none of us could have done anything about this but the process is going to be harder this time.

I'm not sure that us trying to do a summary at the end would actually help us with that much is my take.

(Harold): I would agree with (Peter). That, you know, it would be really hard to take our own perspectives out of that summary. You know, we can try but I don't think it would be completely, you know, an objective summary of the discussion. And so I think that's part of the problem.

You know, and I think it's harder for the ones that we've just been discussing because it gets really harder when they're kind of far from perfect and there's a lot more complexities

In some ways it's almost easier when, you know, when there's, you know, when there's that, you know, there's very either very, very strong information or there's either positively or negatively. Or there's some, you know, a couple of key controversies that could be highlighted.

(Peter): The other thing -- this is (Peter) again -- the other thing that strikes me as hard about this having been around now a lot of these tables on this Committee and others is I often find…

I have often found that the voting is on a lot of measures or a lot of criteria for measures that the voting actually surprises me sometimes about being more positive about a measure than the discussion led me to believe a priori that it might.

And so another thing that worries me a little about us trying to summarize is that we might come out a little more negative than the Committee intended. And so I think what I would suggest is that (Harold) and I not try to summarize at the end.

Let's all take the survey like we're supposed to. And if we have to discuss some of the results on the follow-up call I think that that might be a preferable thing for us to make sure that we're comfortable with the results as opposed to having us try to summarize now.

And, you know, we're sort of, I think, we're kind of unavoidably here stuck with ironing out what for us is a new process. So that's what I think I would suggest as of today.

(Harold): Yes. And I guess going forward with the rush to discuss ideas for people to, you know, take notes, you know, as reminders to them so.

(Constance): Okay, thank you.

(Harold): So we're going to move ahead to Measure 3488. Am I correct?

(Debbie): Yes, you're correct.

(Harold): And, you know, I have a conflict with the NCQA measures in that I'm on the National - NCQA Behavioral Health Measurement Advisory panel. So I will not be making sort of comments about the measure.

But I will call on sort of (Michael) and (Jeff) to, you know, be the primary reviewers.

(Peter): Before you do that, you may want to have the developer tee it up.

(Harold): Oh yes, forgot about that. Yes. So who's on for NCQA?

(Chin-Ching Lydia): Hi this is (Chin-Ching Lydia) in NCQA. Could you hear me?

(Harold): There's a little bit of a blip when you were talking.

(Chin-Ching Lydia): How is it now?

(Harold): I think it's okay, go ahead.

(Chin-Ching Lydia): Okay. Give me one second. So I'll introduce both measures together because they are similar measures. The intent of the measures is to ensure patients discharged from the emergency department for substance abuse or mental illness receive timely follow-up care for their substance abuse or mental illness respectively.

That's a tool, follow-up, NCQA measures that we will review. And so the clinical published guidelines and literature reported ongoing treatment of patients with substance abuse or mental illness including follow-up care after an acute episode of the illness such as an ED visit.

Conceptually, people receiving follow-up care will have a better disease management and fewer at-risk events. Actually the evidence has shown us individuals who do not receive follow-up care after an ED visit for the earlier health conditions are six times more likely to be admitted again to the ED.

Similar measures address a significant gaps in care as a measure performance rate indicated that about 80% of individuals with substance abuse and 40% of individuals with mental illness, across product lines, do not receive follow-up care within 30 days of the ED visit for their behavioral health conditions.

The measures demonstrate a high reliability and good validity. The measures are used in multiple national reporting programs such as the Medicaid Core Concepts as stand-in for demonstration programs to certify a community's behavioral clinics and HEDIS reporting by all product lines to NCQA.

The performance of the measures suggests there's a gap in care and room for improvement. Continued endorsement of the measures provides our healthcare organizations with a way to monitor quality of care for these vulnerable populations.

We look forward to answering any questions you may have about the measures. Thank you.

(Harold): Okay thank you. (Michael), (Jeff), do you want to proceed?

(Jeff Sessman): Sure, (Michael) do you want to go ahead.

(Michael): Yes, yes I'll start; thanks (Jeff). Hi everybody.

So this measure is actually broken apart from previous measures where they had mental health and substance use. So now this measure is focusing just on substance use and the percentage of the people that had a visit within seven days and 30 days after the ED for substance use treatment.

There is the result that did identify the rationale. People who are discharged from the emergency department too many risks which are disengaging from treatment and readmission to the emergency department so that was pretty clear.

I think this is an important measure to report on, carry over from the previous measures that were combined. So it still seems to be a very important measure to continue to report on.

When we get to and this is, I guess, we're talking this is a - it's a maintenance measure correct? Because it follows from the previous ones who were connected with mental health?

(Harold): Yes, NQF speaking, that's how we're treating it. Because in fact it came from two original measures. Which means that they do have to demonstrate that it's being used like in the scorecard and so forth so.

(Jeff Sessman): Great, okay. So there was good evidence that the measure is important. There was a systematic review of the measure. There was consistency in quality and quantity of the measure and the measure was graded.

In terms of evaluation of reliability and validity, they did validity testing at a score level and it indicated a strong positive correlation within the measure rate. So that was good.

And there was some difference, a variation of 5% to 15% within the 25th and 75th percentiles. And the measure is not risk adjusted. But it is stratified by age group.

So in terms then of scientific acceptability, it's a process measure. It's based on claims so it should be able to be reported on easily. And the comment from the Committee is that there's significant evidence to support the measure so that's the comment.

In terms of performance gap, the performance gap was provided and it does seem that there's like a 30%, only about 30% of patients receive a follow-up appointment after a substance use treatment in the ED. And there's lower levels whether you're in Medicaid or Medicare but across all plans it's less than 30%. So there's certainly a gap there.

(Michael): Yes, (Michael) here. It's (Michael) from NQF with some specific numbers.

(Jeff Sessman): Okay.

(Michael): Average 30-day follow-up performance across all ages, 12% for Medicare plans, 18% for Medicaid plans and 14% for commercial plans so well below 20% across all ages. Just specific numbers for you there.

(Jeff Sessman): Great. And then there are some disparities that were identified. And white patients are more likely to access treatment than other racial and ethnic groups.

Individuals that are ages 25 to 29 are more likely to enter treatment which is somewhat surprising to me. I thought that group would probably be less

likely but that's just me. Patients with depression and substance use disorder, women are more likely to actually receive treatment.

And a major augment to this is if the patient is diagnosed with mental health problems and they have a high number of ED visits and they also have substance use they were much less likely to follow up with treatment and are more likely to die within two years. So that's an important patient population.

And previously the Committee talked about problems with making linkages to outpatient services in rural settings. So I'm not sure how much rural plays in some of the analysis versus urban situations.

In terms of reliability, it is reliable. It is replicated. There are some exclusions. Individuals who have substance use disorder that have been transferred to a subacute residential treatment setting are excluded from the numerator.

You do have to have a primary diagnosis of substance use disorder. And the follow-up timeframe is seven days and 30 days, we talked about that. The measure was updated to include tele health. So I'd like to put my plug into M2-3 and say thank you for that. That's great. I'm glad you did that.

There was some reliability testing. And they have rates for reliability broken down by commercial and Medicaid. And then there's some Medicare as well.

So for the age groups, so on the commercial it's .83 for 30 days, ages 15 to 17. And on Medicaid it's .85. And then for 18 plus for the 30 day, it's .92 and .98. And then on the other 30 day follow-up, the total is .92, .98 and .86. I've done the seven-day follow-up the numbers are all around the same numbers for seven day as well. So that was pretty consistent.

(Michael): So (Michael), it's (Michael) here at NQF. You've given us a lot of information here mostly favorable it seems. But I just want to pause and ask the following question for discussion.

So you've reviewed I think pretty well evidence, performance gap and reliability. And you touched on other things too. But for those three things, evidence, performance gap, reliability, are there, I just want to ask the question are there any concerns that the Committee has or specific questions that the Committee has for any of those three.

And then I think you can proceed with wrapping up the other criteria. So evidence, performance gap, reliability, any concerns, questions that the Committee specifically has across those points or within any of them individually?

Man 1: Yes, I had one and I was just waiting for other people to jump in if somebody was.

Man 2: Oh please go ahead.

Man 1: I…

Man 2: Yes, I'm sorry; go ahead.

Man 1: So my question was and I believe I read it that the way the measure would work, if a patient was in the ED multiple times during the month, they only count the first one. And so, you know, for a patient who goes in five times, those other four times they're not included in the analysis.

So it would seem to me that you're going to miss your most difficult patients. And you're going to look better when you do because you're only counting the first one.

Man 2: Right. And maybe requesting this, the first one and don't just count it again.

Man 1: Right. So I just had a concern about that issue.

(Jeff Sessman): Well but presumably if it's within that period of time, they, you know, would probably not be followed up. If it's within in the…

Man 1: Yes but what if they missed - what if they were in the ED the first time. They had follow-up so that gets counted. Now they're in the ED ten days later. And they don't make the seven-day appointment. Then that one doesn't get counted.

Well I think it should be counted because it's another instance. I mean that's the way thinking is going.

Man 2: Yes, and mine.

(Harold): That's a good question. (Unintelligible) and I could see, you know, an argument both ways.

(Jeff Sessman): Yes, I can see it. This is (Jeff Sessman). I certainly see your point. I don't see that this is really a critical flaw. So I have minor comments about the first three criterion. I honestly don't find anything that's major wrong with this.

Man 1: Okay.

(Jeff Sessman): As every measure, yes, it could be tweaked. We could argue about a few points. But I think compared to the other measures we've talked about today; this is much more solid.

Man 1: Good.

(Lisa Shea): This is (Lisa Shea). I just had a question about whether contact with a primary care provider would count if in the codes there were a behavioral health diagnosis or something like that? Just in terms of many areas there's such shortages of mental health professionals.

(Harold): I've read it as any practitioner. Is that correct developer?

(Chin-Ching Lydia): Yes that's correct. Any practitioner counts as far as the primary substance use or the dependence diagnosis.

Man 1: And it was the other issue that came up. So and if I read it correctly and the developer can correct me if I didn't.

But the way I read it was that doing an online assessment would count as a visit and serve the count as criteria. And I don't see where online assessment is really treatment. It's not like you're doing tele health.

It's doing an assessment. You might identify where the patient would go. But I'm not sure that you would want to include an online assessment as saying the patient was engaged in treatment or made it to another treatment provider. Could you clarify that?

(Chin-Ching Lydia): Hi, this is the Team Leader at NCQA again. Yes, I'm happy to clarify that. So there are two online assessment codes in the measure. Let me start

with process codes and then I can tell you a little bit about context, about our process.

We evaluate evidence for any commonality for inclusion in measures. So the two codes are about inquiry that is initiated by the patient and responded to by the clinician.

So we are specific that those are two-way communications between a patient and the clinician and it's initiated by the patient. So those are the codes in the measure.

So the process for which we had a cost cutting contract to evaluate common health modalities based on recent evidence to assess the suitability of inclusion of any specific common health modalities in the needed measures.

So all the behavioral health measures were assessed together. And we also consulted a behavioral health measurement advisory panel as well as a total health expert group. So based on the research evidence and the expert panels input, these are the modalities that are recommended by the group and that's included in the measures.

Man 1: Okay. So you're talking about a regular tele health visit assessment not an electronic form that somebody does an assessment. They don't have a synchronous connection with a provider, correct?

Man: (Unintelligible).

Man 1: Yes if it's a regular tele health visit assessment with a provider then I'm fine with that. We're I'm struggling if it's a just a, you know, go into the website.

You do your assessment, you get out. I just wanted to clarify what we're actually talking about.

(Michael Frankelite): Yes, this is (Michael Frankelite). I think there's a way to ratify…

(Mary Burton): Can I speak for just a second on behalf of the development team? Hello?

(Harold): Yes, yes go ahead.

(Mary Burton): Oh thank you; thank you so much. So I think that what (Chin-Ching) was describing is that it has to be a two-way communication. So I would think of it more like email.

The patient initiates a conversation with me, the provider, I respond. And that is the kind of interaction. It is asynchronous because I don't have to respond at the same time as they send me the message. But it does require two-way communication.

Is that right (Chin-Ching), did I get it right?

(Chin-Ching Lydia): Yes.

((Crosstalk))

Man 1: All right so there's back and forth with the provider. Then I'm fine with that. I thought it was going in, you do your electronic assessment, you get out. And there's no communication back and forth with the provider.

(Jeff Sessman): But even in that case, it's possible to have brief, kind of limited or complex interaction. And there's some criteria at least if you're billing things that could fit this.

Man 1: Okay. Okay, yes, that back and forth is what I was missing. And I didn't pick that up from what I'm read. So I'm fine with that now.

(Peter): This is (Peter). The only other question that I had about both of these measures actually is or this is probably a forward-looking comment and not so much about now in the moment.

But I wondered about the requirement for a primary mental health diagnosis in the ER visit. I wondered about how many of these people might have - might show up in an ER for both a mental health and physical health issue that still needs this sort of follow up, a connection to follow-up.

And so I wondered about have you thought about also including secondary diagnosis?

(Harold): That's a great question.

(Jeff Sessman): Yes, on the other hand, it would add tremendously for folks who just had incidental issue of substance abuse disorder or alcohol abuse dependency. So I mean there's the pros and cons. Sensitivity, specificity sort of tradeoff.

(Michael): So can the developer -- (Michael) at NQF -- can a developer comment. Did you consider including in both measures the instance of a co-occurring, adding the small code or, it could be fairly large, co-occurring population that might add to both the numerators? And consider the magnitude of that.

Have you done that empirically? Or any comment about why you decided not to do that and folks on primary. Can you just quickly comment about that?

(Chin-Ching Lydia): Sure. The question was whether we considered allowing secondary mental illness or substance abuse disorders in their measure?

(Michael): Sorry, I'm being a little more prescriptive than that. So it would be that there - there would have to be a co-occurrence. So it would be primary for substance use but you could also include individuals who had a secondary, if they had a mental health diagnosis in the substance use disorder, okay, denominator. Does that make sense?

I'm adding a little bit more…

(Jeff Sessman): I'm not sure I understand your question.

(Harold): (Michael) can you say a little bit more about the rationale for that?

(Peter): So this is (Peter) again. I think the question that I was trying to ask is, it strikes me that it's possible that people with a meaningful behavioral or mental health disorder that show up in an emergency room might also have a co-existing physical or health issue that wound up being the primary disorder - primary diagnosis rather.

And so the question I was trying to ask is did you consider the pros and cons about of including mental or behavioral health diagnoses either primary or secondary?

(Michael): Okay, all right.

(Maby): Although you could have pulled up (ten) station coded and said trauma but was really under the influence.

(Mary Burton): This is (Mary Burton) again. We did discuss this at great lengths. And the decision that we made based on what I think I heard one of the Committee members speak to was sensitivity versus specificity.

And we wanted to focus in, hone-in on the folks who we knew with great confidence were in need of follow up. And once we get 95% on this measure, we'll go on and spread it out. How about that?

(Peter): (Mary) that's a good answer, thank you.

(Harold): Okay. So (Mike) and (Jeff) you want to continue?

(Jeff Sessman): Sure. So in terms of validity, there were many I won't identify any threats to validity and there's only that one exclusion. They did validity testing. And it's a face validity and empirically validated testing of the measure score is how they got that.

Reliability specifications are well identified. And all the data elements are in claims so this should be easy to get. What else? We addressed that one issue.

(Michael): So (Michael) at NQF here. Let me help you with one detail. So the validity testing that they did was they compared this alcohol and other drug abuse follow-up measure to the mental health measure. The other one we were looking at this afternoon.

And they found that across the different provider types that -- it was at the health plan level -- that they saw correlations between those two measures of .42 to .57. So that was the principal validity that they did.

They also presented the correlation between the seven and the 30-day, no surprise there. That was exceedingly high of .94 was the correlation coefficient generally that they saw between the seven and the 30-day follow-up. So those were the two quantitative validity tests they did.

(Jeff Sessman): Great, thank you very much. All right, should I move onto feasibility?

(Harold): Please.

(Jeff Sessman): Sure, okay. So on the feasibility side, there was really no issues there. We addressed the issue about the diagnosis, there was some comment there.

But all the data elements are in claims. So this should be very feasible to do. So really shouldn't have a problem there.

On the usability and use, it's used in a number of different programs. This was stated. And in my state, they use it in Medicaid as well. So that's all right.

I guess on the usability side, a comment that I had is, I know we have this one on substance use from ED for seven days and 30 days. Then there's another one out there, the 0004 which is engagement in treatment 14 days and two visits in 30 days.

And it gets to the question that we talked about earlier about competing measures. You know, they seem to be the same measures it's just different

date ranges. And so as a provider out there, now I'm building three things for multiple measures when I should just be doing things once.

Because I'm going to get Medicaid is going to give me one measure. And NCO is going to give me the other one. And somebody else is giving another one and so on.

It's all over the place as a provider. So that's a concern I have. And it just gets to that harmonization discussion that we continue to have.

((Crosstalk))

(Michael): Just to clarify for a second, but in some cases I mean as a measure it's not exclusively being used, necessarily, at a plan level. It might also be used at a hospital level too.

(Jeff Sessman): Correct, yes.

(Michael): So that would be, and the second measure you mentioned would not be - would not fit with a hospital per se.

(Jeff Sessman): Well in a system it would. I mean we're all involved in systems now.

(Michael): Yes, I'm saying it was system. But I'm saying a hospital, per se…

(Jeff Sessman): Right, yes.

(Michael): It would be a different…

(Jeff Sessman): I don't think engagement - I don't think you're quite right (Michael) because I don't think engagement is the same things as a single, follow-up visit. I don't think that counts as engagement.

(Michael): No it doesn't. But that other measure, 0004, is one visit within 14 days to get your contact. And then the other two visits in 30 days for your engagement.

(Jeff Sessman): Okay. All right, just a concern because it's, you know, and I'm looking at it from the provider side. Now I'm doing three of them for three different people. And from the provider side it drives you crazy.

(Chin-Ching Lydia): Can I help? This is (Chin-Ching). So the two measures have different intents and they're populations are different too. So the ED measure is only the ED event, is the denominator event.

And that initiating engagement measure is a comprehensive measure that it covers all kinds of care settings with the subacute site office, inpatient, outpatient, the application of ED, etcetera. So that is a comprehensive measure.

And also it requires a look back period so that patients who do not have a subacute sort of encounter in the prior 60 days are in that initial engagement measure. So that is focused on patients with a new episode of substance abuse or dependence and lookout to see if they initiate or engage in treatment.

And this ED measure is quite specific. It doesn't require a lookback period. And we hear a lot of stakeholders say they want to monitor the quality of follow-up ED for this population because some patients tend to be high utilizers of ED visits. They want to have a quality indicator that is specific about follow-up after ED.

(Jeff Sessman): Okay, all right. Thank you for that, that's very helpful. Okay. All right so usability we made that. There are some competing measures. They're on the screen and we just talked about a couple of them that are out there.

And the other thing I want to commend NCQA is that they did include a visit with a subsequent provider on the same day as of the ED visit. So that's great. I know we had some issues with that on the further than 30 day psychiatric hospital. But that makes it very workable.

And the other issue I had is, you know, the focus seems to be on where the psychiatric management and all the documentation from the AMA which is great. But I guess the problem is many substance use providers out in the field, they're not tied into the AMA.

And I didn't see a lot focused on ambulatory substance use clinic-type providers. It just had a lot of the documentation from the AMA which was great. But if somebody from those settings read deeper into it, they'd say how come it's so medically focused, I guess would be the issue. Just because I deal with a lot of providers that are in that space and hear that a lot.

(Michael): Yes.

(Jeff Sessman): Okay. And then the other thing is if a patient only has a detox benefit then they're not included. And I don't know how as a provider I even - I'm not going to know that really easily at all. So I'm not sure how they're going to exclude that.

So those are just some of my questions. Other than that, I think we're done and ready to have more discussion.

(Michael): So (Michael) here at NQF. So just to clarify it. So any, from the Committee, any other questions or comments about validity, feasibility, use, usability or related and competing on this measure, 3988? Or if not, then we can move onto 3989, it's a close cousin.

(Jeff Sessman): Yes, this is (Jeff Sessman). I just want to concur with (Michael) about the competing measure issue or competing concepts. I think we have many measures that are looking at some constellation of care coordination, of follow-up, of handoff that are made appropriately.

And I think we need to start thinking at least at a more global level, trying to bring some parsimony and some more sense of purpose to this. Rather than just going that well, we've got one. You know, is there an appropriate handoff and communication to a mental health and primary care?

Do we have follow up? Do we have evidence that they had a med check? And, you know, we just get exhausted at some point over what are really looking at what, I think, could be broadly called continuity of care, coordination of care better termed.

So that's my soapbox. But I agree, I think this measure is fine.

(Harold): Okay perfect? Anybody have any other concerns about the measure? I guess we can go onto discussing the next measure. Great which is basically, you know, the second half of this measure now, measure that was split which was focusing on visits for mental illness in the emergency department.

And (Lisa) and (Peter) are the primary reviewers.

(Lisa): So this is (Lisa). I can go ahead and I don't think we need to have the developer discuss this because they already really presented this measure along with the previous one.

Again, it's very similar. Individuals discharged from emergency department facing the same risks when they come for a metal health issue as for substance abuse that being disengagement from treatment and readmission to the ED.

It's a previously endorsed measure. The evidence, I will just comment it uses guidance statements, guidelines. And guidelines really address treatment programs. And I'm not sure a follow-up visit is necessarily a treatment program.

You know, a follow-up visit could be many different things. But that being said, the gap in care is not as extreme of a gap as what we saw with the last measure. But there is still a gap.

The 30-day follow up varied from 60% with commercial coverage to 47% with Medicare. And the seven day was varied from 45.8% commercial, to 31% Medicare. Again, they did add tele health so that's a good thing. (Peter) did you want to say anything more about evidence?

(Peter): No. I agree with that comment about extrapolating the guidelines. And in addition to that, the measure is a little bit broader than any of the guidelines which are a little bit more specific. But it's pretty clear that you could quibble about the details but it's pretty clear that follow up is an important component of care.

(Lisa): Exactly. I mean I think we'd be preaching to the choir if we expounded on that any further. So I'm just going to move onto reliability.

Reliability testing was conducted. It used Adams R score. The rating for reliability was moderate. Validity testing was done empirically at the measure core level. And that score is also moderate. And I'll pause to see if anybody has any comments, further comments on reliability or validity.

(Michael): Let me just say -- (Michael) at NQF -- let me just give you a specific statistic, a couple of specific statistics again so you have them in mind.

They did Adams R testing which is they looked at, you know, between entities versus within entity variability. And found that that was mostly between entity variability, .91 was the Adams R.

So remember 1.0 means that all the variability you see is between entities and assumed to reflect quality. So that's a fairly strong Adams R presentation for that.

And then with regard to validity, they looked again at the correlation between seven and 30 days we talked about previously, .92 that's not so surprising. And then just to remind you, the correlation was to alcohol and other drug measure was .4 to .457 as well. So those - that same validity test that was presented previously.

(Lisa): All righty, thank you. Feasibility, this is claims-based data. So the feasibility is rated as moderate. Usability, interesting to note that while this is being used, the performance has not improved over the past two years. And in fact has declined slightly with the Medicare group.

So one might wonder is this measure really doing what we would like it to be doing? And I don't know if the developers want to comment on that?

(Chin-Ching Lydia): Sorry, could you repeat your question again?

(Lisa): Well it's a comment really. A comment that the performance has not improved over the past two years and in fact has declined slightly in the Medicare population. And so, you know, one might question, is this measure really doing what we would hope it's going to be doing?

And I guess that's a question. I don't know if you want to comment on that thought.

(Chin-Ching Lydia): Yes. So these are relatively new measures that have been implemented in the past two years. This is not uncommon across HEDIS measures to see the rates fluctuate the first few years.

I think if we want to see if it is driving quality improvement over time, we would expect to see that when we have more years of data. And Medicare although they're lower I think it's that the variation we sometimes see across broad lines. That is not unique with other measures so that's our thoughts on that.

Man 3: Is this a voluntary measure or a required measure?

(Chin-Ching Lydia): Required for signature reporting.

Man 3: Thank you.

(Les): So this is (Les). And I apologize that I was in a meeting before that I couldn't get out of. But my concern about measures like these are that it's important to look at the quality.

And the numbers didn't go up not because there wasn't interest or desire to make things better. But how does this address resources in the community and the availability of emergency departments to make referrals to resources that don't exist on a timely basis?

Or, you know, the same with the substance abuse issue as well. I mean if you don't have resources, you can't refer them. So and if a hospital is a safety net hospital, can they afford to do tele psych which is very expensive?

So I'd like to know how the developers think that and this may have been my comments when this first came up because I remember having this discussion before. But how is this helping?

(Tammy): I mean this is (Tammy) I can give you a specific example. We approved the follow-up after detox measure recently. And in Delaware, for example, they started using that measure. Realized that folks were not getting followed up. And they are doing a lot to try to invest in follow up at the state level.

For example, they're putting peers in the emergency department that walk people over to their appointments. Putting people who can prescribe opioid medications in the emergency department. They created an online referral system.

So these measures really do have the potential to drive change at the system level. If the system is not looking at these measures, they just ignore it.

(Harold): I think one of the - I think (Les) brings up an important point. But I think, you know, with regard to the measure itself, it, you know, it depends on what level it's employed for purposes of accountability.

You know, it sounds like what you're looking at it is from the point of view of the hospital or the ED. You know, that may be a problem in terms of being dependent upon what's out there in the community.

You know, the funds to be deployed at the level of a health plan, or at a system, or at state level. The accountability moves to, you know, other groups that have more system responsibility.

(Les): That's a great point (Harold). I mean if you think about it, it's really a health plan. HEDIS measures tend to be looking at health plans and incrimination of health plans which is the care and coordination.

Sometimes it involves mobile, sometimes telephonic. But to sort of like look in their networks, see where there's availability and try to make sure that happens. It's not necessarily primarily an ED measure, a delivery measure.

((Crosstalk))

(Harold): We can always clarify. And (Michael) you might want to comment on this. Is that when we endorse the measure, we are not necessarily endorsing it for a very specific purpose.

(Michael): No that's correct. Yes, that's correct. It's not necessarily endorsed for a specific purpose. But it is -- just to clarify what we do endorse for -- it's endorsed for the specific specification.

So, for example, at the plan level, then that's where the endorsement is being placed. So that has some specificity to it. But (Harold), in terms of, you

know, whether you use it for a Medicaid scorecard or other programs, that's not the decision that you guys are making.

(Tammy): But this measure that we're looking at now is being endorsed at the health plan and Medicaid plan level. All the testing and everything is done at that level.

(Chin-Ching Lydia): Correct.

(Michael): That's correct.

(Les): Yes these are plan measures.

(Michael): Yes. So that's how we should be - you should be looking at it critically, yes. That's right (Tammy).

(Jeff Sessman): And you would think then -- this is (Jeff) -- at a plan level you can influence the availability follow up. You can enroll further providers in behavioral health to make access available, etcetera.

(Les): In fact it's their responsibility to have adequate access to their network. And to control the network to make sure that happens.

(Jeff Sessman): Agreed.

(Lisa): Well okay so to just to wrap it up. Relating and competing measures 056 follow up after hospitalization for mental health is a very similar measure. I don't have anything more on it. (Peter) do you have anything.

(Peter): Nothing to add. Again, this is almost all the same issues as the last measure we discussed.

(Lisa): Exactly.

(Mike Gladieri): And this is (Mike Gladieri). I just have one question. What happens to Measure 2605 after these are approved? Is there some way that that goes away? Or does that still stay out there?

(Peter): That presumably would expire. I think it's, I'm not sure if it's due but I think - do folks at NCAQ know when it's due? Because presumably it would just expire. It wouldn't be renewed.

(Mike Gladieri): Okay. All right, thank you.

(Harold): Are there any other comments from the Committee about this measure?

((Crosstalk))

(Les): So this is (Les). I'm just going to say one more thing about this. So in the developer rationale, if there's appropriate follow up after ED visit for mental health is needed to improve patient outcome and treatment adherence. It doesn't say anything about the health plan or Medicaid insuring there's appropriate resources or availability, or monies to provide this service.

I again, I think this measure is misplaced. I think instead of looking at this, we should look at what resources are available to patients that are in the ED that are provided by the health plans and insurances and those kinds of things.

Because the burden is really being put on EDs and I don't think that's very reasonable. I do think it's an important quality issue. But I think it's misplaced.

(Harold): But wouldn't you agree that if the health plan has accountability for the outcomes which is where the level we're measuring that it isn't measuring the quality of the ED. It's measuring the quality provided by the health plan in this arena.

And therefore…

(Jeff Sessman): It also doesn't affect the hospital accreditation. You know, HEDIS affects health plan accreditation. It's the Joint Commission which doesn't have this as a measure that is responsible for hospital and ED accreditation.

(Harold): Right. So I mean the bottom line is that a health plan hopefully would be motivated if they're performing poorly to assure that there were adequate resources within the plan at the plan level to assure timely and appropriate referral and coordination of care.

I mean I understand and I agree that, you know, that there should be more resources. Clearly in many areas there aren't and there are challenges.

(Les): Right. And I think that in the rationale, it should be not the EDs have to do this. It's that the health plans need to do this. If that's the rationale. The rationale is incorrect.

(Harold): Yes, I see what you're saying. And I think the way it's being framed in the rationale perhaps.

(Jeff Sessman): You know as a statesman, there's a role for ED docs to try to make it happen. And there's a role for health plan people to really be responsible and make

sure that it is happening, you know. But somebody has to notify the health plan to get started.

(Jodie): So this is (Jodie). I can only speak to the commercial world on this. But it's longstanding that the health plans or the behavioral health plans are aware of these measures and have long ago instituted, you know, they get the data capture about the visit.

And then they have resources, personnel whose job it is to make sure that that follow up is done. That there is someone, there's an appointment, you know, scheduled. And that the patient actually made it.

If they didn't make it then they make it on the 30 day mark. So there is, I mean, that is the health plans' resources and accountability and it has to do with, imperfect as it is, with getting notification and knowing that they have to follow up on the follow-up.

(Les): Well I'll just tell you from my personal experience working in an ED, especially in distressed communities, there are no resources to send the patients to. And the health plans are not providing those resources.

And as much as we can say - and the ED does have a responsibility, absolutely, if there's resources. If there's no resources I have nowhere to send them to. So we could - I'm concerned about the patient care here.

(Andrew Sperling): So this is (Andrew Sperling). I completely agree. But I also believe we need to measure this. If we're waiting around, if we're going to wait to get a well lease for a public mental health system before we measure this, it's never going to happen. So it's a dilemma.

(Harold): And it's important to work on.

(Les): And I think this really butts against the limitations that, you know, standards like this and requirements like this are useful but don't get at the root cause, so to speak. And I understand limitations.

Man: But without measuring this stuff also you can't show that there's a gap. So you have to have some data otherwise it's all anecdotal.

(Harold): And (Les) some of us from integrated systems of care, we get to be blamed both ways. Because we have health plans as part of our system as well as EDs. And even when we're trying to work together, it doesn't mean the resources magically appear, you know, especially for psychiatry.

(Les): Well I now moved to an integrated health care system as the Medical Director of Light County Health Department. So I'm getting that exposure.

Man: And I can tell you're enjoying every minute of it.

(Les): It is a wonderful job. We're getting off topic, I'm sorry.

(Harold): Go ahead, proceed. That's good discussion though about this attribution question and noted by staff at NQF so thank you for that. Let's proceed.

And that's goes to the sort of the larger question that this is a theory of change for all of these measures in the first place. So are there any other comments about the measure itself, you know, 3489?

So I guess we could begin to close things off. So (Michael) do you want to go over what happens next for all of us?

(Michael): Yes, let's move onto the slide deck. So per your question (Harold) so all the measures, we've talked about all the measures. And, you know, the next step in terms of considering endorsement is you guys will get the materials and the survey monkey email from (Debbie). To then be able to vote on these in the next 48 hours, okay.

But right now what we want to do because we need to is just hit public comment. And then we'll proceed with a little bit of discussion for a very short period of time, more inspiration ideas for us. And then close out the meeting so.

(Harold): Just to be clear, (Michael) is the after 48 hours, it goes away. It's not a functional connection. So it would be good to know the exact time that we have? Does it expire (Debbie)?

(Debbie): Yes, we will have the survey up until Friday, close of business. I will not…

(Harold): And close of business is 5:00 o'clock Eastern Standard time?

(Debbie): We actually usually give you a little more time. We do it Central time to give you a couple more hours. So as long as it's in by about 7:00 o'clock that evening on Friday.

(Harold): Will they not be able to vote then after 7:00 o'clock? Or will they still be able to vote through the weekend if they need to?

(Debbie): I will not disconnect the survey link. However, after the survey results are pulled on Monday morning, that will be it.

(Harold): Okay. So there you go. It will be available through the weekend if you need it but please try to vote by Friday is what I'm seeing on (Debbie's) face looking at her.

(Jodie): And this is (Jodie).

(Harold): You're in her bed.

(Jodie): And (Jessie) if quorum isn't met on the survey monkey what does that mean?

(Jessie): Yes. So if we have any measures where quorum isn't met or any measures that reach consensus is not reached, we will have to bring them up again on our post meeting call. And we'll have to re-discuss that and revisit that then. And we'll be prepared to vote just in case that happens.

(Jodie): Okay.

Woman 1: So I'll pause just for a moment to see if anyone would like to offer a public or member comment at this time?

(Frank Canossi): Yes, hi (Frank Canossi) here from Rutgers University. A public comment about one of the measures earlier this morning. Is this the time to do that?

Woman 1: Yes, absolutely. Hi (Frank).

(Frank Canossi): Hi, how are you? Just a comment from somebody who was around at the time these things were kicked around.

The restraint and seclusion measures, and I respect and heard with great interest the questions on the call about studies that showed empirical

connections between reducing restraint and somehow improving care. And realize that doing a randomized controlled study on that would be very challenging if not unethical.

But also I wanted to just remind the group for some folks who may not have been part of it that the measures, when they were developed and I think even to this point, really are focused on one of the interventions of behavioral healthcare that are most identified by family and by recipients of care, both young adult and older, as one of the most aversive experiences that they have.

That's the idea that someone lays hands on you and retrains you either mechanically or physically against your will is a profound and for many people traumatic experience. And while I know that the spirit of the four measures often look at empirical validity and the ability to be able to show and point to studies about that, I just want to make sure that that didn't get lost in the discussion.

Because that's the wellspring from which that one came. And I have to tell you that it was 15 years ago when those were discussed. But those feelings are just as strong today among families and patients, both young and old who experienced that. So I just wanted to make sure that somebody reminded folks where that original measure came from.

And I think the energy that still drives it is something important to monitor and to ask facilities to be responsible for measuring. And that was the comment.

Woman 1: Thank you (Frank). Is there anyone else who would like to make a public comment? Okay. Well with that I'm just going to wrap things up briefly.

We're going to give you a few next steps of what's going to happen, what to expect. So as (Michael) mentioned, we'll be following up with you today with the survey monkey and the recordings of both led meetings so that you can respond to that and vote accordingly.

As well, within 24 hours as soon as we receive the transcript, we will make sure that we get that out to you. So hopefully that will be a helpful resource tool for you.

So we will plan to meet back for our post meeting call on June 26 which is I believe next Wednesday. And it's going to be another two hour web meeting from 12:00 to 2:00. And then we will actually finish our conversations.

Between that time, the project team will be reaching out to you to let you know the results of voting. So you don't have to wait until the meeting to hear the results. So we'll be reaching out to the Committee members as well as the measure developers to let you know the results of the voting survey after we wrap that up on Tuesday.

So with that, you see the rest of the project activities and I will give this to (Michael) for just a second.

(Michael): Yes, so let me just review some other content that you have in your slide deck which you can - I encourage you to review when you have a moment.

And one is a slide, (Debbie) if you can go back before Slide 40 and just show them what the relating and competing, how we set that up. Why don't you go click on Slide 39?

So you do have at the end of - around Slide 35 to Slide 40, we have setup related and competing tables for you. If you want to quickly peruse each of the measures we reviewed today. And then have a look and see the brief definitions, you know, in nice tabular formats about what were some of the related measures.

We really had competing direct competition. But they were related measures. Encourage you to do that. You know, per the harmonization kinds of points that came up and just for your own information moving forward. So that's one thing.

And then the other thing, if you would go to Slide 42 for a second. There's also on Slide 42, I'm not going to go through this in any detail. But this is a reminder to you about gaps in the portfolio that you identified back in 2016-2017. Have a look at that. A lot of the same themes are coming up.

You know, desire for patient reported outcomes for example. But have a look at that. Because in the future we will be asking you about, you know, where things should be going and for your own - for yourselves as you are acting as NQF ambassadors and encouraging developers to contact us for technical assistance and to develop new measures.

Presumably these are the kinds of ideas that you want them to be thinking about. Then if you go to Slide 43 for me, please, 43. These are gaps that you all identified in our last cycle of meetings.

And I won't review these except for one. To make one point because I think it was (David Einzick) who suggested that burnout, measures that reflect provider burnout might be an important gap area where there aren't many measures.

And then (Debbie), if you can just click on that link that I identified there on that slide or are you able to make it happen? Okay. So there is a link on there which I encourage to just have a look at.

It's actually just a press release from the World Health Organization. It turns out a month or two ago they announced that ICD 11 actually has a new cluster of disease or at least one disease category that involves burnout as a kind of anxiety type disorder if you will. So I wanted to point that out to the Committee per that suggestion as well.

Again, these are just for you to think about moving forward when we have more time to talk about gaps. And then as you're thinking about the purpose and function of this Committee to review measures and to tender measures so.

Man 4: (Michael) a few more points about that, two points for that.

(Michael): Sure.

Man 4: One is that I'd actually like you to know this is part of it, the World Health Assembly approved the ICD 11. And there's a number of other sort of innovations that are built into the ICD 11 including a number that are in the - that come from the Topic Advisory Group on Quality and Patient Safety that I Co-Chaired with (Phil Galley) from Calgary.

And while coming out of ICD 11 doesn't necessarily impact ICD 10CM it is worth pointing out that the National Committee on Vital and Health Statistics will be looking into how they might adopt different components of the ICD 11.

And one other thing was about the burnout. Also the double AMC and the National Academy of Medicine have joined to develop a kind of initiative around provider burnout. And it might be also worth looking at what they're doing because it may actually include some elements that have to do with measurement.

(Michael): Excellent. Are you able to send us anything? If you have a link to the National Committee on Vital Health Stats that you mentioned? That might be - we'll take a look at that. But then…

Man 4: Yes, they're having like a meeting in August to discuss this.

(Michael): Okay.

Man 4: I mean that's specifically the burnout thing. But the broader issues of…

(Michael): Of ICD 11 stuff.

Man 4: Yes.

(Michael): Okay, got it. Noted. Thank you for that.

(Peter): (Michael) this is (Peter). Another thing that we ought to do in the follow-up meeting if there's time is we had to put (Tammy's) questions about the general issue of what - how does the Method Group interact with the Committee and the specific issue about what were the issues with the opioid measure.

And we ought to at least briefly talk about that in the follow-up meeting next Wednesday assuming that there's time.

(Michael): Yes, very good, thanks for that reminder. We'll definitely make sure that happens.

Woman 1: Okay with that (Harold) and (Peter) do you have any last minute last words that you'd like to say before we closeout?

(Harold): Congratulations to everybody for hanging with us through the meeting. We know that the process was a little complicated today. And I think we did great work. Thanks everyone and thanks to the staff as always.

(Peter): Yes, I would agree with that. And I think it's worth it at some point for us to think about and get and provide some feedback to NQF about like sort of the pros and cons, tradeoffs of doing the meeting like this compared to in-person meeting. It's worth sort of brainstorming about that.

(Michael): Yes, we generally don't try to do them on the same day. But yes, if you have strong feelings that you liked it, please let us know. Because I think we generally don't think it's a good idea. But we appreciate you guys hanging in there, absolutely. Thank you for that.

Woman 1: Indeed.

(Peter): And (Michael) I think there was a lot of sentiment today probably that if we can avoid having the discussion and the voting separated in time it would be better to do them both at the same time again than keeping them separated if we can.

(Michael): Good thank you. Thank you for mentioning that too. That's important.

Woman 1: Yes. We'll definitely take that to the leadership. Well thank you all for joining. With that being said, our contact information is on the slide.

You can always contact us at behavioralhealth@qualityforum.org. if you have any questions. And you can look forward to hearing from us shortly. So with that, thank you all for attending today and participating.

Woman: Thank you.

Man: And have a great day.

((Crosstalk))

(Michael): Bye-bye.

(Harold): Bye-bye.

END