COMM PARTNERS

Moderator: n\a
April 18, 2017
11:15 a.m. ET

Operator: This is conference # kate

Operator: Your conference is being recorded. Press star, six. To un-mute, press pound, six. Your conference is being recorded.

Female: OK. So, we are going to get started. I just wanted to check if everyone has the discussions guide. I sent them most of (to date one) last night. There are almost no changes to it, but I just wanted to make sure for the discussion guide that we were all setup. And then if anyone had any questions about how to use it, or?

Male: So, you just sent it last night?

Female: Yes. And it's been – I sent the – I sent it at …

Male: 5:42.

Female: Yes. And so, it's almost identical to the one that we sent last week.

Male: Yes, great.

Female: But it just has – it will allow us to follow and get some of the measure (spec).

Male: OK.

Female: So if you – so, for example, if you click on under the 4 p.m. measure concept (waited for) discussion, that's in the …

(Off-Mic)

Female: … and you can get full measure specification.

Female: Yes. Yes. Perfect. Got it.

(Off-Mic)

Female: (David), could you send …

(Off-Mic)

(David): (Why)?

Female: OK, got it. Thank you. Good. So, there may be some questions that we have that you'll be able to very well answer very well answer when it (deals with a) (Washington) measure.

(David): Oh, sure.

Female: So, just turn the air con on, so just get a little more …

Female: Yes.

Female: … oxygen moving. So right, I think we are all ready. And -- do we want to move slides, actually looking …

Female: All right, excellent. So, good morning everybody. It's almost afternoon. We've got a lot of measures to get through, so we're going to need to try to be as efficient as possible in our review of them. And really, follow this flow chart so that when we hit a low, we (jettison) that one. And maybe after the first – after we get through maybe the first one or two, we might want to stop and say, OK, how this process is working because it's going to take a little time I think for us to sort of get into our rhythm on it. Any questions anybody has before we get started?

All right, awesome. So, why don't we go ahead then and start with the first one. Everybody should be at …

Female: Is it OK if I go through some (parts)?

Female: Oh, by all means, yes.

Female: So yes. So, (Shelby), would you mind going to slide number four?

So, this is just a review of how we got here, which measures we'll be doing. The top box represents measures that had the average measure score of all measure and measure concepts identified, that way, they're (at) or above. And see that bottom blue box represents measures that did not (exceed) the mean but that – and here, you have an example of a member who chose to retain one, and that will also go through decision logic. So, that's just re-explaining how we got here.

And then we go to the next slide. So, I just to take a little bit of a look at which measures were identified within the Physical and Mental Health Integration measure landscape. And so here, we have a breakdown of all measures and measure concepts identified. And so these are all and not just the ones ready for discussion.

So, as you can see, almost over half of all our measures are access measures. Almost a third of the measures are related to clinical care. Ten percent were safety measures. And three percent were access in patient caregiver experience measures. So, I know that (Karen) mentioned and it was discussed during the main session that not all of the domains are going to be hit. We didn't have anything that that was the population health domain. And you can see, we have kind of a (dirk) of some of the other domains.

And so, if we go on to the next slide. So here's the breakdown of the 63 measures and measure concepts identified. Of the 63, 40 were qualified as measures, 23 were qualified as measure concepts. And you can see that we looked at the overall means, so not just the mean for the measures or the measure concepts, but overall. And you can see that 36 of the 40 measures

met or exceeded the measure threshold, where only one of the measure concepts did.

One of the things that I'd like to point out is that seven measures and measure concepts were retained by TEP numbers. So the three of which are measures and four of which are measure concepts, which then if we go to the next slide, gets us to our total of 44 measures and measure concepts being reviewed.

And as we mentioned, we have notes of who retained measures. And so that when we go through the decision logic, if that person could kind of ask of the lead discussant, then maybe additional information that they have that were unable to capture. So that will really inform the process.

And then I wanted to check to see if there were any questions on the decision logic that we reviewed earlier?

Male: We have a question and maybe they mentioned it upstairs but I forgot. But is there a desire to have measures from each of the domains you identified? Or is that like a (weighted factor)?

Female: So that is actually a really good question. And so what it is, is for the TEP process, it's just finding the best in class. But Coordinating Committee will really look to see the holistic measures recommended by the TEP and weigh the balance of the different domains.

Male: Great. Thanks.

Female: When you say best in class, it is possible though that you could have two measures that might be in the same domain and maybe within the same family, but they might happen to certain other various issues that might make it – make sense to have both?

Female: Yes, right.

Female: OK.

Female: And one of the questions that we had at the main session was talking about (duplicative) measures. We're not – the TEP isn't really going to work too

much up to (duplicative) measures. We want good measures even if they are related each other. And then the Coordinating Committee will really look to see what the whole step looks like.

We will say though, if you feel that (threatens or conflictive) or you have concerns, please say them aloud, that way, we could have it captured. That will be really important for the Coordinating Committee. All of the feedback and rationale goes straight to them and it will really inform that process.

Female: Thank you.

Female: Are there any other questions? OK. So with that, you could start with (the next slide).

Female: All right. So the next slide then? Oh, no, OK. No, so there is really is no next slide that focuses on the measure. We just really go into the discussion guide and hit access and start with the access one which is the first one being mental health service penetration, correct?

Female: Yes.

Female: OK. So, I'm looking at the first question there within our algorithm. To what extent does this measure address critical quality objective of the CMS quality measurement domain and/or identified program area key concepts? Comments about that? So anyone who thinks that it does not? OK. Would people give this a moderate or a high, medium or high?

(That's great, everybody feels that way?)

Male: Yes.

Female: All right. Yes?

Female: So we will need to take a formal hand vote.

Female: We have – need a formal hand vote on that. OK. So how many people believe that this is a higher, medium concept? Raise your hand if you have that.

Female: High or medium?

(Crosstalk)

Male: You want us to vote for high or medium?

Female: So, let's do high first and then medium.

Female: OK. So we need to go high, medium, and then like there's nobody, if it's low than it's zero. OK, so high? OK. So, we got around five. Medium? (One out of five).

OK. Low, I think there's no one, right? OK. So why don't we go onto the next one. To what extent will this measure address an opportunity for improvement and or significant variation in care? Evidence like quality challenges for each program area? Any comments both on that?

Female: And …

Male: So, can you tell me a little bit about how?

Female: We also asked – so we only have – unfortunately, only have one speaker. So, just for our transcription purposes to speak as loudly as we can. OK. So yes?

Male: There's some people telling me to be quiet. So, as we go over each one, is there – do you all have any thoughts about how each one of these might or might not apply to the specific indicator?

I mean, for example, talked about evidence like quality challenges for each program area. So, how does this measure penetration applies to (THPH) in general?

Female: So I'm sorry. I'm not sure I quite understand. But …

Male: I guess I wasn't very clear. So, the measure is, you know, we're counting how many people get a mental health service? So, I feel it's an important indicator and – but I don't know that it directly applies to (THPH) per se. So, it seems

to me it's an important indicator for behavioral health services more broadly, but doesn't necessarily really have lots of – necessarily all that much, so specific applications, this area as opposed to another one or as opposed to program …

Male: So this is a (Washington) state …

(Off-Mic)

Male: … it's pulling as we're implementing integrated physical and behavioral managed care plans, in anticipation, that we'll see a greater (rate) for that, thus, with plans that have an integrated benefit physical health care and mental health (substitute) disorder.

There's also a signal related to the denominator for this measure, I think it's -- one of the values of this measure is the denominator provides population stratification because it's -- it's used in mental health services among those identified (in need).

So it's -- the denominator itself is why we deploy for a disparity from differences across different groups. And also, the denominator concept has been used in (clause) experimental evaluation. And (new ARG) for that matter, to look at whether there's any signal between access that's defined by this major and utilization of mental health and physical health care.

And there are a couple of studies published on our website, I'm not sure really, but using peer-reviewed journal quality methods that show there were (careful) relationship between the essence of this measure and utilization and other outcomes, even social (indeterminates) like that

So as we do use it in Washington state it does -- it is a very foundational major that connects to how we're majoring the effectiveness of this behavioral integration from a payer perspective and also relates to a broad range of outcomes of interest in general disparities reporting, taking the denominator from this measure to compare diabetes. And (that's you're results) if you want.

Female: So …

Male: Yes.

Female: … to being able to better assess the …

Male: I guess that …

(Crosstalk)

Female: How do you define needs?

Male: The denominator criteria defines need based on combination of diagnosis, service utilization, so the procedure codes for example that are indicative of receiving as a therapy event of treatment. It also includes effect of medications. So diagnosis effect of medication received. Essentially five large therapy classes, anti-psychotic, anti-(emetic), anti-depressant, anti-anxiety and ADHD medication. Plus received services which are generally numerator qualifying services but also getting …

Female: Right.

Male: … to the denominator as well.

Female: Right. Can I just – just to that I'm trying to understand that briefly. So, and then primary care, I get a (PHT) score of 15, I get diagnosed with depression, I get put on antidepressants not necessarily needing a mental health referral, right? Where does that – so that's actually kind of where I'm trying to fir that in.

Male: So this measure, the numerator qualifying services would include certainly that visit where you're doing all of that, so …

Female: So that primary care visit …

Male: Exactly.

Female: … would actually be the behavioral health …

Male: Exactly.

(Crosstalk)

Female: OK. That was my clarifying question. OK.

Male: Yes. So there is a component that it's working to get at primary care management and mental health …

Female: So if depression was the chief guide, there's primary diagnosis essentially.

Male: Yes, in an outpatient office.

Female: OK. Thank you. Sorry. So, didn't mean to go into the weeds.

(Crosstalk)

Female: Yes. So, we've established that behavioral healthcare that can be provided by a non-behavioral health clinician is included in this. We've also established that it has the potential for linking that to additional information or data about a physical condition, physical health condition.

One of the things that came to my mind is if you don't have access to behavioral health, then it is more challenging to integrate physical with behavioral health. Because I was originally thinking about this – (Jim) or (James)?

(James): (James).

Female: (James)?

(James): Yes.

Female: In the same way you were which is, is this really an integration measure?

(James): Right.

Female: But the more I thought about it, I thought, well, there is …

(James): Yes, it could be.

Female: Yes.

(James): But there are lots of things that could impact in addition to the integration.

Male: True. Yes.

Female: They do have …

Male: But I think …

Female: Oh, go ahead.

(James): So, I think it's a great measure. I think that depending on the setting, (the higher) might not be robust around measuring integration per se.

Female: OK. Yes. So (Angela), anything you would add at this point?

(Angela): It seems like a very basic measure. I think the utility of it depends on how you actually run your system. Because I've seen a lot of data like this and it helps you nothing unless you have the key to kind of dive in.

(James): Yes. Well, I thought – I'm speaking partly from our experience in Pennsylvania. So from implementation of managed care model in Medicaid, the penetration doubled over a period of about 10 years. So like 12 percent to 25. So there were a lot more people getting services. So, which, you know …

(Angela): Right.

Male: … based on (to me), it seems like a good thing.

(Angela): So …

Male: I agree it's basic, I might spin that as foundational.

(Angela): Yes. I think that's an appropriate …

(Maureen): So, do we feel ready at this point to look at this from a perspective of raising hands, looking at it from high would be that it addresses multiple quality challenges and opportunities for improvement, medium being more of the measure has the potential to address for variation, and low being it does not address quality challenges or opportunities within a program area. Do people feel ready to – OK.

So, how many people here say high? One, two. OK. How many people say medium? Three. OK. And so there are no lows then. OK. So, we move on to the next level with it. Thank you.

To what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement, etcetera, and/or contribute to the alignment of measures across program, health plans and/or states?

Comments about that? Anybody wants to discuss it or shall we vote at this point?

Male: So this claim and encounter based though it would be dependent in -- in the context of a mental health carve-out or behavioral carve-out on having integrated physical and behavioral health claim or encounter data. So you could argue that that's both the, essentially, resource challenge for some states, but also promoting alignment as being a measure that's dependent on having both the physical and behavioral health perspective.

Male: And then …

(Crosstalk)

Female: Essentially it's helping to promote integration.

Male: Right, and the state (would help).

Female: Yes.

Male: Yes, in general, (as long as they require it).

Male: Yes.

(Maureen): All right, other comments about this one? OK. So, do we feel ready to raise our hands?

All right, so to what degree would you vote high? And that measure demonstrates efficient use of measurement resources addresses a broad population is not (duplicative) of existing measures and contributes to alignment across states, programs and health plans. Medium, full stop for a moment. High? So, medium? That would be me. OK, so four to one, great.

So, let's go on to the next one which is to what extent is this measure ready for immediate view? Any thoughts about that?

Male: So we do have value sets then are available. And actually, they've been deployed for commercial plan use and centralized reporting (forum in launch). So, to show as an example, that's been beyond just in Washington Medicaid program is being they're fully initiated (that way) with commercial plans in Washington.

(Off-Mic)

Male: … like text (as far as) implementation logic.

Female: How easily accessible would this be for other states to use? I know that Missouri has one similar but it's not the same.

Male: I think that pretty straightforward, we do have a website that publishes the (value sets) …

Female: OK.

Male: … that will be available regularly …

Female: It would be publicly available. And how often is this – I'm seeing here the – your organization – your (state) is the steward. So how often do you refresh it?

Male: At least annually in terms of the (specs).

Female: OK.

Male: Yes.

Female: All right.

Female: Yes.

Male: Yes.

Female: Go ahead.

Male: All those in the Pennsylvania report, it's available readily.

(Maureen): OK, good. OK, great. Any other discussions that anybody wants to have on that one?

OK. So how many people would like to vote high towards this being ready for immediate use? OK. So that's unanimous. Let's go on. Great.

To what extent do you think this measure is important to State Medicaid Agencies and other key stakeholders such as consumers, families, Medicaid managed care organizations and providers? Thoughts about that?

Male: I think it's important, right? People aren't getting access to care, the quality of the care is probably not quite as (good) – not getting any.

Female: Right. Yes.

Female: At this point, we agree.

Female: Yes. I mean, I think a lot of people identify, you know, with their clinical home and if they're able to get care or where they identified their clinical home …

Female: Yes.

(Maureen): So, I'll just comment that the (counter EMEA) is -- it appears that you would only know all individuals who get at least one mental health service. So, that's a very low bar? So, when I look at like initiation and engagement for substance use disorders, I get a much clearer picture of access because I'm seeing how, what percentage of individuals actually got an assessment or an initial intake within 30 days or request, and then with the engagement, you know, up to two visits within 30 days.

That to me is a much more robust measure of access. So, I was disappointed that I didn't ever find anything on the initiation engagement from mental health disorders and that's what I would like to say. I don't have the expertise in this field …

Female: Yes.

Female: … you know.

Female: I mean, yes.

Female: Yes.

Female: So (the fact is) is that information about use of access either from a consumer perspective or from a time perspective in terms of time of perhaps or whole or outreach getting to …

Male: Yes.

(Crosstalk)

Female: Absolutely. Absolutely. And by the way, I would like to expand on that because NIMH is research on early psychosis shows that the duration untreated psychosis is directly correlated with outcomes. So if we can't narrow that gap between symptoms, access to treatment, engagement in treatment, we can't address outcomes. So to me, this is a very low bar. That said, but …

(Crosstalk)

Male: I those are great points and they're great. It doesn't parallel, initiate the (IAT), biggest (IAT) major. It's really designed to be more parallel to (AAP)—(the elusive) acronyms and it (develop access) to (preventive care) -- which is also the very like threshold at least one we encounter. In Washington State, this rate where it goes to about 42 percent, low bar with 42 percent.

Male: Those are?

Male: For Medicaid adults, for this penetration rate major.

Male: OK.

Male: If we do the – we do just carve-out services, it's 25 percent. So I agree with the low bar, but it points to the – you know, are we to equity?

Female: Yes. Yes.

Male: Are we (discovering)?

Male: Right.

Male: And it – so I agree …

Female: OK.

Male: … that this would be the (department). But other majors can get a richer measurement of clinical experience.

Male: And NCQA actually was using the HEDIS initiation and engagement measure for depression …

(Off-Mic)

Male: … So, it kind of reinforces your point, right.

Female: Yes. No, I think that's right. So it sounds like we're really getting close to getting a vote unless (Verna) had anything she wanted to add. And that where we lay this is regardless of the outcome of this vote, we would like to make

sure that comments are noted, which regard to what (Angela) is saying about there's some clear gaps here in terms of looking at consumer experience, their experience in terms of (weight) or access to care and possible (weight).

Also, looking at actual (sample) measurements in terms of time from inquiry or request for service, actually receiving service. Anything else from that perspective?

(Angela): And that engagement piece, the number of actual encounters in (healthcare), that's the key.

Female: OK. So I think that's the engagement probably because you could measure just like a (90791) as an initial visit. But then, if they don't get passed that.

Female: Right.

Female: You know, good point. Yes. So I'm thinking, have those noted. And regardless of what we vote on, if we could make sure that gets noted. That'd be great.

So how many people recommend this measure for inclusion from a high perspective at this point in time? One, two, three, four, and we'll make that unanimous. OK.

(Off-Mic)

Female : Yes, by all means.

Female: OK. So, the TEP have voted to include measure which is -- mental health service concentration in the recommendation to the Coordinating Committee. Thank you.

Female: OK. So, let's go on to the next measure then, mental health …

Male: I think that was the question now.

Female: Yes.

Male: But I – that we do not plan ahead technology wise. Is there any opportunity to have a paper copy of some of …

Female: We – so we actually – I have a spare laptop that we can get right now. Yes. So, is it OK if we take just a five minute break?

Male: Yes, OK.

Female: Or, how long are we breaking because I can share in the meantime.

Male: Sure.

Female: Yes, why don't we do that?

Female: OK. And then …

Male: Maybe after lunch …

(Off-Mic)

Female: Yes.

Female: Appreciate it. We need to be on a roll here because I'm vetting this took us even more than seven to eight minutes …

Female: OK.

Male: … what they're saying.

Male: Is that what we're scheduled for?

Female: Well …

Male: And that's what we're budgeted for?

Female: … if we could get some more – yes, you got it.

Female: That's what we're budgeted for. OK.

Female: OK.

Female: So let's go on to the mental health utilization one please. Number and percentage of measures – of members receiving the (falling) mental health services during the measurement year, any service, in-patients, intensive out-patient, partial hospitalization, out-patient or emergency department. I believe this is the HEDIS 2017 measure.

So before we – are there any questions about this measure? One that I think people are generally familiar with, my question would be, (David), if you could help us to understand what you see is the difference between this measure and the measure that we just voted on, please.

(David): So, this is going to get at utilization rates as opposed to (proportion) of the population (who need) to make a (threshold) of (access).

Female: OK.

(David): … with parallel …

Female: Yes, but with more penetration …

(David): Right, yes.

Female: … utilization, OK. Starts to look – get a little bit at what you're talking about but not entirely. OK.

(David): So …

Female: Right.

Female: Yes.

Male: Could you tell, (David), your thoughts about how this is a quality metric? They just – I know, for example, NCQA used to have a utilization measure and they dropped it because the way they framed it was last (use) is better (of these things). But that's not always the case, so they just dropped it.

Female: Right. Right.

(David): So, I'm personally not the biggest fan of this type of measure in this context. I think, for example, it would be – so I believe in the ED utilization, for example, reflect to be compartmentalization of ED use around visits that are primary behavioral health and mental risk factors.

And I'd much prefer utilization to be measured more globally with the ability to stratify across the Medicaid population, to looking those with mental health needs, those with (sudden) risk, those who maybe co-occurring, and so with global EDs. Because much of (the disparity in EDs) between persons with mental health needs and the general population is in EDs but this measure doesn't capture.

So this is not in the list here because I'm recommending it. I do think some value is having utilization metrics similar to clients to be compared across states. There would probably need some variation under the hood on how states would actually implement this, if it needs some (land lines) in comparison.

But, you know, if we were to prioritize a modest number of majors, I probably wouldn't go there for (this one).

Male: OK, I think it's an important effort. I'm just not exactly hearing how you framed the results in terms of whether it's good or bad from the quality perspective.

Male: Right, right, because …

Male: And this is quite a long measure.

Male: Yes, because higher rates sort of us – it means that some of these areas would probably reflect better access.

Male: But reflects, yes, I mean like inpatient is going to be higher than (other) areas …

Male: Right.

Male: … but doesn't necessarily mean that (they're there), right.

Female: Right.

Male: Right.

Female: Outpatient, more outpatient.

(Crosstalk)

Male: So that's going to probably correlate pretty closely with penetration.

Female: Yes. I said inclined, yes.

Female: Yes.

Female: And it will (cut), yes, with penetration, right.

Female: This includes E.D.?

Female: Correct.

Female: So …

Male: But I think that only is the – a small (slice) of E.D.

Female: It's the behavioral health E.D., right, the behavior health.

Male: Behavioral primary diagnosis, mental health primary diagnose. So, that's majority of EDs which I think …

Male: They're not going to be many. There'll be a lot of substance use but not …

Female: Yes.

Female: I think where I see that it's got some value is because it is commercial Medicaid in the Medicare product line, you can then compare utilization across the product lines. I also see value from the perspective that this is going to be a quality measure that Medicaid plans that are HEDIS – that are

NCQA accredited will definitely be reporting on. So I see some value from a utility perspective in terms of a lot of entities report on it.

Female: (Rona), your thoughts as it counts.

(Rona): Yes, I don't know if I'm – so I mean I'm just thinking of all of the nuances that come in here that it doesn't feel valid to me. I mean I guess that's where I'm struggling with it. I'm not articulating that probably very well, but.

Female: Can you give an example on the ones that you're …

(Rona): I mean I think certainly the E.D. utilization, you know, is probably one. I also think, you know, when we think about a lot of the stabilization where you're getting, you know, a good one visit and what does that look like, I mean we want to encourage that to some where it's appropriate, you know. And I think, you know, I'm just not – yes.

Male: I think one (final initiative on another side) -- IMD exclusion or the inpatient side to lead to systematic exclusion of folks that break in Medicaid visits, not there for commercial plan that break in Medicaid coverage for folks who are the 21 to procure whatever (age range) in IMD could lead to them (even falling out) and (making them together). And that utilization, so not on (medication), so not being counted. Probably some signification variation across states (and the country) who use IMD.

Female: Yes.

Female: I think one of the concerns I have is that I do think we need the measures of access. I don't think that necessarily all (states) are going to adapt or use the one that we just looked at previously. And this one does get a little bit at what you were talking about in terms of having more information about utilization from at least of (rate), the thousand kind of perspective.

Female: Any other comments or do people feel ready to vote at this point?

Male: I think my only question is that we were going to – and I see what you're saying, but I wonder if then you'd want to focus on the outpatient. It's really probably the measure – the one that most closely correlates to that (style) care.

Female: Yes, that feels a little stronger to me.

Male: The inpatient is so very (variable). It feels like based on the – what's available geographically that it still might – well, I don't know.

Female: Yes.

Male: Yes.

Female: Yes …

Male: Yes, within the state maybe, that's (relevant)

Female: Yes. Well, utilization, as you know, can mean that you got robust, you know -- intensive outpatient emergency department crisis intervention kinds of services or it can mean a denial of access of care.

Female: Yes. Right.

Female: That can mean either.

Female: Yes.

Female: So yes, yes. OK.

Male: Great suggestion. It focuses on the outpatient.

Male: The outpatient.

Female: I don't think that we can take a – I think we can make a comment about it. But yes, I don't think we can take this measure and change it, yes. So I think …

Female: So that would be (exempt) is that …

Female: Yes.

Male: I think that recording will produce utilization rates across (modalities). So the outpatient could fall on a separate …

Female: Yes, but I don't think you can take just a piece of the measure. Yes.

But I think we can say -- we could capture the comment so far that we've made about some of the noise, if you will, for lack of a better term in those measures in terms of what do they really mean.

And with, you know, and with the sense that intensive outpatient partial hospitalization, outpatients in E.D. may be better reflections of access to care, whereas inpatient information could reflection potentially a lack of access in some instances. Or in other cases, could reflect robust use of other alternatives.

Female: You mean like lifeline and other …

Female: Exactly.

Female: … (purchases) which actually are pretty effective.

Female: Yes, and also much less costly in a lot of ways.

Female: Yes.

Female: Yes. So, do people feel ready at this point to vote on this one?

OK. To what extent does this measure address critical quality objectives of the CMS quality measurement domain, in this case, to access and to identify program concepts? Those who think high, raise your hand. Those who think medium, raise their hand. We've got four raising their hand for medium. Those who think low? OK. Thank you.

To what extend – let's go on to the next one then. To what extent will this measure address an opportunity for improvement and/or significant variation

in care evidenced by quality challenges for each program area? What's on that?

(Off-Mic)

Female: Same.

Female: Same issues.

Female: Same issue, yes.

Female: Yes.

Female: I mean, they're like – and basically, if you can, you know, you'll get a sense of whether or not if you think you've created a wonderful crisis intervention program and all this on your utilization is tanking. Or maybe it (tanks) from the start, you know, you've got some issue there. Same with if you've got an underutilization or what appears to be an underutilization of inpatients, that is essentially an alert, inquire are we looking at underutilization for which kinds of factors

Any other discussion about this one or do people feel ready to vote on this one? OK, let's vote. To what extend will this measure address that opportunity for improvement and/or significant variation in care? How many think high? How many think medium? OK. So we have five medium, one who's really more like, you know, on the fence, five, OK. All right …

Female: Outlier.

(Off-Mic)

Female: Yes, yes, all right. So moving – I mean I think you're capturing the flavor of our discussion about this. To what extend does this measure demonstrate efficient use of resource – measurement resources, data collection processes, performance improvement activities and/or contribute to alignment of measures across program health state?

I will comment on again, just the fact that because this is collected by so many NCQA accredited programs, whether you're talking commercial Medicare, Medicaid, you can therefore get a sense from a comparative perspective. I believe it is also claims – yes, it is a claims data I think, right? Yes, right.

So, talk about that a little …

Male: So one criticism I have is …

Female: Yes.

Male: and this reflects really NCQA's siloing of ED use and even …

(Off-Mic)

Male: … with the stratification …

(Off-Mic)

Male: … utilization major and (utilization) measures which are not in here, but other side of the coin, (like these) measures. That what the way NCQA has approached this is really silent, say mental health service (utilization) can be over here -- even E.D. use, same hospital primary diagnosis (inaudible) you don't get counted regular E.D. So I think that approach doesn't really promote alignment. So that …

(Off-Mic)

Male: … I'll agree with you on …

Female: Yes. And I think what I would say is that regardless of what we decide on this measure, I think those are really important points to make sure we have noted in our discussion. And one that certainly I think NCQA has probably considered, and if not, hopefully based (on our notes), they'll be more likely to consider, so yes.

Female: Well, would we be then looking more for measures of mental health service delivered in a primary care setting?

Male: I think (so we) have the component, so I do see – I do agree that the outpatient side here is working from the value where they're including building out the ability to capture what's happening in the primary care setting outside of the Medicaid environment, the traditional carve out …

Female: Right.

Male: … the community mental health center context. So, I would agree with, you know …

(Crosstalk)

Female: Well, if they have a contractual relationship as opposed to (a NAQC) developing their own, it would be difficult to measure that.

(Multiple Speakers

Female: Yes.

Female: As opposed to the, you know, PhD.

Male: Or people can see them bill as an individual practitioner.

Female: Yes. So one of the advantages of measure – the previous measure we've just reviewed is that it is capturing more of that behavioral health care provided by a non-behavioral health …

Female: Yes.

Female: Yes, The challenge is that not as many states are currently probably using that measure at least at this point, but it'll certainly be on the menu. Whereas this one is more broadly used and it also allows to compare commercial versus Medicaid versus Medicare in terms of behavioral health utilization, knowing that it's a narrow definition of behavioral health utilization. Yes.

So, other comments? Do people feel ready to vote on this?

Yes. OK. To what extent does this measure demonstrate efficient use of measurement resources, data collection processes and so on and/or contribute to alignment of measures across program, health plans and/or states?

High, how many people would say that in terms of high? So, that's a zero. How many would say medium? Three, four, OK, so that's four. OK. So we then move on to the next one then. So, no low?

(Verna): No. I'm going to stick with my low.

Female: OK. So we got – (Verna) is going to be low for that one. OK.

So, to what extent is this measure ready for immediate use, NCQA highly use measure? Any discussion? People feel ready to vote? To what extent is it ready for immediate use? High? One, two, three, four. Medium? OK, one. Thanks. OK. So, there is medium low, we need …

Female: So it's combined?

Female: Thank you. So it's four.

Female: Yes.

Female: So we're good.

Female: Yes, so …

Female: Yes. All right, thank you.

So, the next question is to what extent do you think this measure is important to State Medicaid Agencies and/or other key stakeholders, consumers, families, Medicaid managed care organizations and provider? What's about that?

Particularly interested in the MCO perspective, so that would be you, (James), and particularly interested in the consumer perspective? Of course, everyone else …

(James): I mean it's clearly important. It's important for reasons beyond quality.

Female: Agree.

(James): Yes. I mean they're (caught) in utilization issues …

(Off-Mic)

(James): So to some stakeholders …

Female: One of the ways I sometimes use that measure is, again, to look and see where we're seeing underutilization. Because from my perspective, that's equally if not more so important …

(James): Sure.

Female: … and it may also, underutilization maybe causing overutilization in some other areas. (Angela).

(Angela): Agree. And this is a side comment that I need to like – you can direct here (for the record) or whatever. In Oregon, they published quarterly – I didn't print it out, but they have a quality tool. And so, you know, the universe is only in CMS measures. That they picked what 17 that they attached financing to a withhold of their Medicaid budget. And every Medicaid managed care organization basically has access to that quality tool for those 17 measures. And it amounts to significant dollars. It's now up to five percent of the Medicaid budget, sort of now I think at three percent.

And – but here's the part from a consumer perspective that's so valuable. They do graphics, I think five – quarterly representation of all the data and it's comparative by managed care organization. In addition, and this is only I printed out, is they do a measure stratification for subset of measures like disability, mental health diagnosis, and by severe and persistent mental illness.

So even though the state for example, as a whole, we do emergency department utilization, you look to the stratification for serious and persistent mental illness that's still extraordinarily high. So, I know that's not the purpose of this meeting, but publicly available data that's graphic and

presented in a way that a lay person can understand and interpret, that's comparative not only within states, between states, compared to benchmark and compared to different managed care organizations, allows you …

Male: Sure.

(Angela): … to become educated and informed in a much more active advocate. So regardless of how these measures play out, they're only as good as how actively people actually use them to inform their chare or their packages.

(Off-Mic)

Female: Yes.

Male: If somebody were to develop standards, there's so much more value in that stratification than in any single major that …

Female: Absolutely.

Female: So then, what we'll do, we want to make sure as noted is that stratification is very important. So that even when these measures are adopted, we should be doing – that we would recommend mindfulness regarding two things, one, public disclosure regarding the …

(Angela): Yes.

Female: … regarding the measure performance. And number two, looking at it from a perspective of, when possible, also being able to further stratify performance on the measure by various subpopulation.

(Angela): Specifically serious mental illness and SED in children or how are we going to – whatever terminology is in use for children with serious emotional disturbance. And I would say it's also very important to have comparative data like national benchmarks or – otherwise it's in a (vacuum)

(Off-Mic)

Female: OK. So, I'm going to stop it for a moment now and ask for a vote. How many people would, I believe at the very last (here), right, recommend measure for inclusion –yes. To what extent do you think this measure is important to State Medicaid Agencies and other key stakeholders such as consumers, families, Medicaid managed care organizations and providers? High, raise your hand. Medium, raise your hand. OK, that's unanimous.

Female: OK, so just for the transcript. So, the TEP rated mental health utilization, number and percentage of members receiving the following mental health services during the measurement year, any service, inpatient, in terms with outpatient or partial hospitalization, and outpatient (orientee) to all of the criteria, we'll recommend it to the Coordinating Committee.

Female: So, do we have a high recommendation for that?

Female: So, it's …

Female: No, it's just recommend or not.

Female: OK. Do we have – do we have a vote to recommend?

Female: So it actually already is.

Female: OK.

Female: As soon it goes there, OK, so we don't even have to do that.

Female: No.

Female: OK, awesome.

Female: Let's pause.

Female: Yes. Because I would say, we allow after the discussion, is the main opportunity for public comments.

Female: OK.

Female: And so, I – I'm not sure that any members of the public on the line are on right now. So – but we'll just – just in case it's not showing up. So, operator would you mind opening the public line and giving instructions for comments? So, we have no operator. So, if there are any members of the public comment would like to comment, please do so now. You can also type something into the chat box.

Let's go on.

Female: OK. So, thank you.

Female: All right, thank you. So, I'd like to just pause for a moment because I think it's taking us about 20 minutes per measure and that we're really …

Female: Twelve minutes over is what you say.

Female: Yes, exactly. So, I'll pause about how we might want to streamline this.

Male: I think (we'll be here to eight o'clock) …

(Off-Mic)

Female: OK, all right.

Male: All right, a lot of the measure of the other groups that were also very similar from, you know, with the diabetes one, so.

Female: Right.

Female: Yes.

(Maureen): Yes. And a number of these are also NQF accredited – endorsed, and so that may help. OK.

So, we'll just try to keep moving through these with some speed. Yes. Let's move on to the next one, clinical care, the next domain, adherence to antipsychotic medications for individuals with schizophrenia. This is a

HEDIS measure by – not it's CMS, but it's also I believe a HEDIS measure as well.

So, comments about this from the perspective, up to what extent does this measure address critical quality objectives of the CMS party measurement domain and/or identified program area concepts? Is there anyone here who would like to say that they think it is a low?

OK. So, I'm going to probably ask sometimes. Do you think it's low? If everybody says no, just shake their head and we're going to and start voting, OK, to move it along. So, how many people think that this is high, raise your hand please. OK, we are done with that one. Everybody said high, unanimous.

OK. So the next question, as to what extent will this measure address an opportunity for improvement and/or significant variation in care evidenced by quality challenges for each program area? Is there anyone who thinks low for this? So, then are we ready to vote? How many people think high, raise their hand. OK, it's unanimous.

To what extent does this measure demonstrate efficient use of measurement resources, that is, data collection and so on, it is a claims pharmacy, other data that -- anybody say low on this? OK. So, we're ready to vote. How many people say high? I'm going to say medium because of the other which will make it a little more difficult at times.

Let's move on to the next one. To what extent is this measure ready for immediate use? Is there anyone who says low? We have to discuss it from that perspective. How many people say high then? Unanimous, OK, thanks.

To what extent do you think this measure is important to State Medicaid Agencies and other key stakeholders such as consumers, families, Medicaid managed care organizations and providers? Is there anyone who would say low to this? OK. So, with that in mind, how many people would vote for high? OK, so we've got that one as unanimous. We're done.

Female: So, just for our record, if you won't mind, just – because I know this measure, very quickly, which having a sense, so let's do a rationale as to why we think it's important. Is there something we really like about it? Just to have it for the record as the officiated

(James): (Something) like adhering to antipsychotic medications (appear highly) correlated with thinking stability.

(Maureen): OK. And so, we have voted through the adherence of antipsychotic medications for individuals with schizophrenia on all of the criteria and we recommend it to the Coordinating Committee.

Female: Thank you. Thank you.

Female: We redeemed our (first).

Female: Well, I was just going to ask you.

Male: We're working on it.

Female: Just a little bit – this is very quick. I wanted to make sure you were all comfortable to that process.

Female: Yes.

Female: OK, very good, thanks.

Female: That's a pretty wildly well known.

(Maureen): Exactly. Yes. So, the next one is adherence to mood stabilizers for individuals with bipolar disorder. This is an NQF-endorsed measure and CMS is the steward of it. Is there anyone here who would say low to the very first item on our algorithm, to what extent does this measure address critical quality objectives of the CMA, Clinical Quality and Measurement domain as an identified program area concept. Anyone would say low? OK. So, it sounds like then we're ready to vote on this one. How many people would say high? OK, it's unanimous. Thanks.

So, to what extent will this measure address an opportunity for improvement and/or significant variation in care evidenced by quality challenges for each program areas? Anybody here thinking a low on that? OK, so we're ready to vote. Anybody would say high? OK, thank you. That's unanimous.

To what extent does this measure demonstrate efficient use of measurement resources? So for example, data collection processes, performance improvement activities, and/or contribute to alignment of measures across programs, health plans and/or other state. Is there anyone here who would say low on this, data collection and data sources, claims pharmacy, other? So OK. So then, my next question is how many people would vote high for this? And did people – OK, and how many would vote medium?

Female: I vote medium because (you mentioned) the other …

Female: That's why …

(Crosstalk)

Female: Maybe it's on my mind, looking at the (PBQ).

Female: We'll pass and move on, thanks. To what extent is this measure ready for immediate use? Any questions that was – so any comments? So, anybody would say low? OK. How many people then would vote high for this? All right, yes, it's unanimously.

To what extent do you think this measure is important to State Medicaid Agencies and other key stakeholders such as consumers, families, Medicaid MCOs and providers? Anyone to say low? OK. So, how many people would vote high for this one then? OK, great.

Female: Once again, just to do a rationale from the committee.

Female: I think it's a similar response actually.

Female: Yes, yes, I agree.

Female: OK.

Female: Great.

Female: Yes.

Female: So, the TEP voted adherence to mood stabilization – stabilizer for individuals who have bipolar (one) disorder to all of the criteria and it will be recommended to the Coordinating Committee.

Female: Very good, thank you.

Female: So the next measure – the next measure we're looking at is to (bill) major depressive disorder, MDD, suicide risk assessment. And this is in the clinical care. This is a NQF measure. Percentage of patient aged 18 and older with a diagnosis of MDD, with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified. This is – or other registry and it's in a number of different programs such as PQRS and so on.

So first question is to what extend does this measure address clinical – or critical quality objectives of CMS quality measurement domain? Is there anyone who would say low? OK. Well, we have one person out but we still have four, we can still vote.

Female: We can vote?

Female: Yes. OK. So, how many people would say high for this?

Female: Four.

Female: OK. So, that's unanimous.

To what extend will this measure address an opportunity for improvement and/or significant variation in care evidenced by quality challenges? Is there anybody who would say low on that?

Male: So, I do think they are going to be – so I would expect small numbers. I would expect challenges with measurements that would lead to, you know, very different to capture variation, especially at a sub-state level.

Female: Yes.

Female: So why would you say low numbers when MDD is substantial population and the issue raised is whether or not a suicide risk assessment was completed?

Female: How are you – so if I do the Columbia Scale, right, how am I – and what if put that in as structured data electronically like – and not only I basically use the Columbia Scale to be some homegrown whatever, right, so …

Female: Are we talking about usability here though is my question? Remember, what we're talking about here is whether or not it addresses – the measure addresses an opportunity for improvement. There is certainly – I think the fair amount of discussion we may want to have …

Female: Right.

Female: … around does it demonstrate efficient use?

Female: No, and that alone.

Female: Yes.

Female: That's something to know.

Female: Right.

Female: I think these questions are helpful. Yes.

Female: Yes. So, where you're really going with this one is you can think about if from the perspective of, though it address multiple quality challenges and opportunities for improvement within a program area, does it have the potential to address variation in care? Does it not address quality challenges? So, let's look at it just from that perspective. And I think (table one) until we get the three – hear all the comments.

Female: Yes.

Female: I think I, well, was saying, yes. So number two, what are your thoughts? Did people have any about – specifically about this?

Male: My concern is …

(Off-Mic)

Male: … especially provider with – not having these …

(Off-Mic)

Female: OK. Another comment about that?

Female: I guess I'm not clear that there would be a small number used == with depression?

Female: No, with the risk.

Female: No, but it's …

Female: No …

Female: But the measure is actually that you are providing the risk assessment, so the MDD (factor).

Female: Yes. I mean, I'm thinking about the fact that if you will look at it from a perspective of what is considered to be a best practice, clinical guidelines, assessment of suicidality particularly in the context of …

Female: MDD.

Female: … a mood depressive disorder would be considered to be standard practice or a standard of care. So that's how I look at it from that perspective.

Female: Right.

Female: If it's hard to deal, then that's the problem from my perspective. If clinicians were not screening for mood suicidality …

Female: That's the problem.

Female: Yes, exactly.

Female: And if not, the measure is not how many people will have a high risk of suicide.

Female: It's whether or not you're doing it.

Female: Whether you're doing the risk assessment, right?

Female: Yes.

Female: So its process.

Female: Yes.

(Maureen): OK. So from that perspective, at this point, do people feel ready to vote on this one, number two? Thanks. To what extent will this measure address an opportunity for improvement and/or significant variation in care evidenced by quality challenges for each program area? How many people say high? OK, so we got three. How many say medium? One medium. So we'll move on to the next one.

So here is to what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities, and/or contribute to alignment of measures across programs, health plans, and so on? So, I think, (Verna), you might want to kick it off with some of your comments earlier.

(Verna): Yes. I mean, I guess, you know, the issue is really how you're going to (track it), you know. I mean, just pulling from zero suicide work we're doing around the country, the ability to get people to put it in some structured data way, never mind to use it the sort of I think system workflow or validated (tool). I guess they're all things I would think about.

Female: So think about it from the perspective of a data sources, other or registry. There is some screening, if one uses the PHQ-9, it's not an assessment, but there's at least the screening because one of the questions in the PHQ-9 is suicide.

Female: Right. The problem is that when you think about screening, a lot of places are now using the PHQ-3. And in their systems, they're actually – they've added three to catch the suicide questions within their systems are still sort of counting and there is a depression screening. So …

Female: Yes, how do you capture the measure?

Female: It has actually created a little bit of discussion. Yes.

Female: OK.

Male: I think it's a really hard thing to (watch).

Female: OK. So, from the perspective, and that's what we've been talking …

Male: Yes.

Female: … about here for a few minutes. So, do people feel ready to vote on this one at this point? OK. So I'm going to – (Verna), are you ready to vote or are you …

(Verna): I'm ready to vote.

(Maureen): OK. Let's vote. So, how many people would say that this measure demonstrates efficient use of measurement resources, data collection processes, performance improvement activities and/or contributes to alignment of measures across programs? Anyone here say high? Do we have any vote for medium? Do we have any vote for low?

OK. So, I think it would be important to note, I'd like committee speak for this committee that we all are unanimous in believing that it is very important to assess suicidality among patients with major depressive disorder.

However, we view that there are some major obstacles to data collection at this point in time with regards to this measure. One of which being it's not always easy to capture that information in electronic health records as (Verna) was representing. And also, that there are so many different kinds of measures out there that there's really a need for a greater standardization in this regard. Anything else anyone would like to add to that?

Female: OK. So, Adult Major Depressive Disorder Suicide Risk Assessment did not meet the efficient use of resources criteria and will not be recommended to the Coordinating Committee.

Female: Correct. Let's go on to the next one. Thank you everybody for a succinct but pertinent discussion about that item, that measure.

Ambulatory care outpatient utilization. Rate of outpatient services such as offices, home visits, nursing home care, urgent care and counseling or screening services at the rate per thousand. It is an Oregon Health System Transformation measure. So, you may have some comments or familiarity with this then. Any other comments, questions about the measure in general first before we go through it?

Female: By itself, it is – I don't consider particularly useful. What is really was used in Oregon was – is the counter measure to reducing emergency department usage so that you weren't simply kicking people out of the system in a sense. So you're looking for increased outpatient in conjunction with lower E.D. or inpatient use.

Male: And ideally with our disparity plans in (SDMI).

Female: Right, cutting through …

(Off-Mic)

Female: … stratifications to see, and especially if we're talking about the mental health SDD population, one of the challenges I think we need to articulate here is that

when people can't get access to care, they can end up homeless, in jail, et cetera. That doesn't necessarily happen to other health care conditions.

Female: So question is in the numerator, does this home visits, nursing home care, does this – is this limited only to behavioral health conditions?

Female: No.

Female: OK. So it's broad.

Female: It's a very broad, yes.

Female: Is behavioral health part of the measure? So in other words, you could have maybe a primary diagnosis of rheumatoid arthritis, with a secondary diagnosis of depression, a major depression right?

So, to what extent does this measure address critical quality objectives of the CMS quality measurement domain? How many …

Male: … that needs to be in this larger (perception) with other major and with the behavioral health …

(Off-Mic)

Female: OK.

Male: That structure being part of what we probably …

Female: Yes.

(Off-Mic)

(Kate): So this is Kate and I apologize. There was a little glitch on the discussion guidance. This measure was actually not quite at the discussion. It doesn't have a high enough score and …

Female: OK.

(Kate): So I – that requires …

Male: Great.

Female: Let's move on.

Female: Right.

Female: OK.

Female: Let's move on to seven.

Female: Which is the?

Female: Which is later for discussion.

Female: OK, good. All right, so please, if there's any other slide back, just …

(Crosstalk)

(Kate): Yes, I apologize for that.

Female: Yes, no worries, no worries. OK. We're also getting a …

(Crosstalk)

Male: Eight was more questionable.

(Off-Mic)

Female: Eight or seven?

Female: So, we're on number seven or antidepressants medication.

Female: And that leads the number that we're supposed to be hitting for measure scores with 1.75.

Female: Yes.

Female: So, that's another little heads up and hint for us. OK, great. So antidepressant medication management, which I believe is a – this is another NCQA HEDIS, yes, HEDIS score. OK.

So with this one, to what extent does this measure address critical quality objectives of the CMS quality measurement domain? Is there anyone here who would say low? OK. So, let's move on then. How many people would say high? We'll do a vote. OK, it's unanimous.

So, to what extent will this measure address an opportunity for improvement and/or significant variation in care addressed by quality measure challenges for each program area? Is there any discussion to be had for that? So, let's vote. How many would say – oh, did you want to …

Male: I just had a quick question.

Female: Yes.

Male: On the HEDIS measures, there is kind of a short version and a longer version of this. So, there's like one – I think that you're adhering for like 90 days.

Female: Yes.

Male: And then another for six months or nine months.

(Maureen): Yes, I think this includes both when I look at the measure description, yes. It's got a effective phase and the continuation phase, so both. Yes.

So with that in mind, then how many people would vote high for this one? All right, we'll move on. Thank you.

So the next question is to what extent does this measure demonstrate efficient use of measurement of sources, data collection processes, performance improvement activities, et cetera and/or contribute to alignment of measure across programs in health systems and health plans? So, I correct that, a health plan and/or state.

So, is there anyone here who would say low? This is claims EHR only and pharmacy data process. Is there anyone who would say low? OK. So, are we ready to vote? How many people would say high for this? One, two, three, four, five, five out of five. Thank you.

To what extent is this measure ready for immediate use? This is on measure that's already being deployed extensively. How many would say high? OK, we're ready to move on that.

To what extent do you think this measure is important to State Medicaid Agencies and/or other key stakeholders, for example, consumers, families, Medicaid MCOs and providers? Any comment about saying that this is of low value? OK. So, are we ready to vote? So, how many people would say high? OK, very good, thank you.

Female: And so just – a sentence or two on rationale for inclusion?

Male: Similar to the prior …

Female: Yes.

(Off-Mic)

Female: Yes, great. And so, the TEP voted Antidepressant Medicaid Management through the criteria and will be recommended to the Coordinating Committee.

And so, one of the things I wanted to point out for the discussion guide is that when we look through all of the data specs, they go in 1 through 63, but we aren't talking about all of those measures. For our next measure, we're talking about -- which is with the higher up is number 11.

Female: Thank you.

Female: So that was a little bit …

Female: Yes.

Female: And so, it's just all the way …

Female: Right.

Female: … number 11.

Female: Yes, OK, very good. Thank you.

So, the next one is behavioral health risk assessment for pregnant women. And this is not an NQF-endorsed measure. It is percentage of patients regardless of age who gave birth during a 12-month period, who were seen at least once for prenatal care who received a behavioral health screening risk assessment that includes the following screenings, depression, alcohol use, tobacco use, drugs use, and intimate partner violence screening.

This is a – the data source is EHR. It is – the steward is the American Medical Association, the PCPI group. It is also part of the Medicaid child core set. So, any questions about the measure before we proceed because this is one that might be of less familiarity for some people here?

OK. So, let's go on. To what extent does this measure address critical quality objectives of this – well, I have a question. I think we've got several (that are these) trying to screening measures. Do we need to be discussing them together or in the context of each other when they're similar measures?

Female: So, we don't. So, that's something that the Coordinating Committee will look at.

Female: Very good, thank you. So, what extent does this measure address critical quality objectives of the CMS quality measurement domain and/or identify program (HSET)? Is there any discussion about that in terms of low, medium, high? OK. So, it sounds like we're ready for a vote. How many people would vote high on this? OK. How many people would vote medium on this? Total, four.

Female: OK.

Female: Did you – how many would vote low?

Male: I'm sorry. No, I meant to vote high.

(Maureen): You did? OK. So, we've got five then for that.

OK. So then, we move on to the next one. To what extend will this measure address an opportunity for improvement and/or significant variation evidenced by quality challenges for each program area? Anyone say low? OK. So, then let's look at this from the perspective of voting. How many people would say high? Five, OK, very good.

Then we move on to the next. To what extend does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities and/or contribute to alignment of measures across program, health plans and/or state?

This is where I began to have some concern because I note that it says E.H. data sources EHR are only. Does anyone else have a concern about that? It is though a Medicaid child core set.

Female: Because the EHR don't have the function – I mean only one actually really has the function to track it over time, and so even a lot of the care management platforms don't. And so that's a humungous problem for some of the places where they're doing a case rate filling. And even for some of the new Medicare collaborative care codes, that that's processed by billing or looking at the PhDs over time.

Even if you put it in the EHR and sort of like a blood pressure, a growth chart, it's still – you still have difficulty doing this. But that would be my only and only because I literally have this conversation sort of 10 times a day with people around the country. So, (time) to figure out how to actually keep a registry and track them before over time, and so that would be my only (pause).

Female: Any other comments that anyone else has about that?

Female: Just a comment. Some of the things that are valuable to capture are not currently easily captured. Is there a way for us to express a concern that CMS

looks for ways to capture work with EHR, et cetera, because otherwise we're in this …

Female: So then be like a meaningful – you like to push it in some way.

Female: Right.

Female: Yes.

Male: Yes.

Female: Because, I mean, to really track this over time is something that's going to be …

(Crosstalk)

Female: This is incredibly valuable.

Female: True.

Female: And yet, very difficult. So, how do you package those for NQF, you know, to pay …

Male: Yes. So there is even a code for depression screening, but you're not really supposed to use it when you're doing a full evaluation, supposed to be doing all these like, you know, in the annual physical or initial visit …

(Crosstalk)

Female: Well, it's like the annual wellness visit, so would be part of the annual wellness visit.

Male: Right. So you're not supposed to bill stuff that was (forwarded in there).

Female: No, because it's included in there. But the others, you can, right?

Male: Yes.

Female: They're (96127) to bill above, so you could for that.

Male: Right.

Female: But it still doesn't help you track it over time if you're …

Male: Yes. Well it doesn't help you track the results over time.

Female: Yes, right.

Female: So, at this point in time, it sounds like we've had some discussion about this. I did have one question with this. Does NQF know – this is part of the Medicaid child core sets. Do we know how many states are actually reporting on this at this point?

Female: I will discuss …

(Crosstalk)

Female: About a third, if I had to guess.

(Crosstalk)

Male: Collection of the data?

Female: From some of the child Medicaid or some of the child …

Male: OK.

Female: Yes. I mean that's also (complicated).

Female: Yes, they are. And do you guys have any – that's – so yes.

Female: Yes.

Female: Well OK. So is there – it sounds like we're ready to vote on this. To what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities, et cetera? Is there – how many will vote high? How many will vote medium? How many

will vote low? OK. So, we'll move on to the next measure I would assume and …

Female: Yes.

Male: Yes.

Female: … that would be?

Female: Yes. Please say it for the record.

Female: Yes.

Female: So, the TEP did not vote the Behavioral Health Risk Assessment for Pregnant Women, BHRA, with the efficient use of resources category. And therefore, it's not recommended to the Coordinating Committee.

Female: Correct. (Verna), is there something that you'd like to say from a rationale perspective?

(Verna): I think sort of a summary and the difficulty of tracking the, you know, the outcome measures over time or the scores over time as sort of a functionality deficit in most of the electronic health record nationally, even the (annual) bigger ones.

Female: So we see this as a significant gap. We think it's a very important data element to capture, but from a functionality perspective, very difficult. We would urge additional work be done to close back up from a data capture perspective. OK. Thanks.

Female: And so, we are on number 12.

(Maureen): Number 12. We are on number 12. Very good. Thank you. So, this is depression we had mentioned at six months, which is an NQF behavioral health report phase three measure source. It is – it involves the use of PHQ-9. It is – that the Minnesota community measurement is the steward. Any questions about this measure before we proceed to talk about it?

OK. So, to what extent does this measure address critical quality objectives of the CMS quality measurement domain? Is there anyone who would say low for this? OK. So, I think we're ready for a vote. How many people would say high? One, two. So, how many people would say medium? So, we've got three mediums and two high, so we will continue then with it.

To what extent will this measure address an opportunity for improvement and/or significant variation in care evidenced by quality challenges for each program area? Is there anybody who would say low on this?

Female: I think I'm going to low here just because my experience is that you're really looking at it every six months, then it really doesn't fall attention to any kind of a trend. Like organizations that do it twice a year as an example, it really doesn't seem to do anything in terms of really promoting, you know, this person isn't getting better, it becomes more perfunctory. So, I don't know if I would.

Female: Shouldn't be perfunctory though. I mean from my perspective, if someone isn't demonstrating significant improvement at that …

Female: Right.

Female: … point in time, shouldn't we be looking at ways of augmentation, whether it being (CBP), additional Medicaid …

(Crosstalk)

Female: Yes, I guess that's what I was saying. I guess what I'm saying is that you're only doing the PHQ twice a year, you're doing it every six months, that organization should have that process often don't do anything with the score. It's just like, oh, we have to do with PHQ because your six months is up. But it doesn't actually translate into system or outcome change, I guess is kind of where I was going.

Female: So, they are not doing anything different to try to reach remission?

Female: Yes.

Female: They're not looking at their processes. They're not looking with adherence to clinical guideline.

Female: And I'm not saying all of them but a lot of times, that doesn't translate. It's kind of like the committee on mental health centers, we do the PHQ with a treatment and they say, oh, because I have to do, and then it goes in every three months but they don't actually do anything with the scores over time.

Female: So, that's why you need to have a comparative data.

Female: Right.

Female: So that you can actually see, are other people doing something? Otherwise …

Female: Yes.

Female: … if it's internal …

Female: Right.

Female: … and people don't care …

Female: Yes.

Female: … I guess I was kind of …

Female: Yes.

(Off-Mic)

Female: And, you know, what I'd look at is more of whether or not they're using the PHQ-9. That's the process measure.

Female: Yes.

Female: I think from perspective, if all you do is look at the process measure and you don't look at what are the reasons why we're not seeing more people achieve remission.

Female: Right.

Female: That's where I think this has value. But it looks like you have something you wanted to say.

Male: No.

Female: Yes. OK. So, at this point, are we ready to vote on this?

Female: Yes.

Female: And just say, to what extend does it – which one are we on now? Is it this one or this one?

Female: Yes.

(Maureen): Yes, all right, number two. To what extent will this measure address an opportunity for improvement and/or significant? How many would say high? Two. How many would say medium?

OK. So, it we continue on. To what extent does this measure demonstrate efficient use of measurement resources, data collection purposes, performance improvement activities and/or contribute to alignment of measures across programs, states, and so on, keeping in mind the data source here is EHR only, other, and paper record.

So, if we look at it from that perspective, I'm looking at our discussion guide. So I think it would be really pretty applicable on this one. We're looking at, do you think this measure addresses a broad focus, varying populations? Does it use a multiple state, shared information? So, what's about this one? I have some concerns about the fact that a lot it is other and paper record.

Male: Yes.

Female: Yes.

Female: OK, go ahead.

Female: I agree. I just – I'm concerned that – I'm concerned about this piece of the decision logic being where it is. Because it is going to (wait) all measures towards those that are much more clinical in nature, you know, and captured in claims. And therefore, might not get at the intended goal of quality measurement.

Female: I think that's true. I do think that there is – there are initiatives currently underway to capture more of this as an eCQM measure. What I'm trying to remember is it just an eCQM measure in terms remission or it just eCQM in terms of whether or not the PHQ-9 has been used for screening? Does anyone recall that?

Male: Right.

Female: And so I think there's a movement in that direction to make this more electronic because I think people do think it so important, yes. Other comments about this?

So at this point in time, to what extent does this measure demonstrate efficient use of measurement resources? I assume we're ready to vote. And how many people would say high? Medium? Low, regretfully?

Female: Regretfully, yes.

Female: Yes. So I think --yes. So what is – I think the takeaway for this is that we all believe that this is a very important measure. We encourage the initiatives that are looking at electronic development to capture data with regard to not only screening for depression, using a standardized instrument such as the PHQ-9, but also then monitoring for depression in terms of remission as well.

Female: OK. So we have – did not vote past – did not vote depression rate remission at six months has the efficient use of resources criteria. So it will not be recommended to the Coordinating Committee. And so we're doing 13, next discussion.

Female: So with this one, I'm just checking to see, I think it’s going be the same (queue) in terms of …

Female: It's the same.

Female: Yes. So, I think particularly, do we need to go through this whole process or what would you like to do here in this committee?

Female: So, if we wouldn't mind, just going through …

Female: OK.

Female: … the usual process, it would be appreciated.

Female: OK. So, to what extent does this measure address critical quality objective of the CMS quality measurement domain? How many would say high? So, that was five.

To what extent will this measure address an opportunity for improvement and/or significant variation in care evidenced by quality challenges? How many would say high. Four, five on that, OK.

To what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities, and so on? Is – how many people would say high? How many people would say medium? How many people would say low?

Female: OK. So the TEP did not pass depression readmission at12 months through the efficient use of resources criteria and it will not be recommended to the Coordinating Committee.

Female: One of the things that I would also say about this is that, again, please make a note of what our thinking was and what our recommendation is in terms of electronic capture of this.

Female: So, are we– and just clarification, if a measure can be captured by EHR only versus claims, they are automatically assuming that that's a low?

Female: I don't think that that's the case.

Male: It's not. I mean, that's the conclusion we're coming to routinely.

Female: Yes, but I guess I wanted a little …

Female: This one didn't – no, this one didn't come – just for clarity. This one is not an EHR only. This one is EHR only, other, and paper record. So I think that where there's greater reluctance is when you have to look at it from, particularly, from a paper record's perspective. That when you're talking a Medicaid population that's very difficult to capture that data. I think that's where people are coming from. Is that correct?

So, I don't think that – now, I'm speaking for the group and I want to confirm that this is the case, that EHR only does not necessarily mean that something is going to be low, not necessarily.

Male: Right.

Female: Does that answer your question?

Female: Yes, sort of. I'm speaking that staff already addressed the feasibility. So I'm wondering if it already passed their criteria, then why are we rejecting? I mean in a comparative way, yes, that makes sense. But in another sense, it doesn't to me.

Female: Yes, this isn't …

(Crosstalk)

Male: Well, they averaged – you can tell me their process. They just averaged a bunch of different domains. So you didn't have to meet our cutoff in each domain …

Female: So it was just – it was overall score for all, regardless of domain?

Male: Right.

Female: And when we did the initial rating of the score, we always went for the higher option, so EHR was rated as medium …

Male: Right, you all show that.

Female: Yes. And so, we always ranked this the higher level. So that was it.

Male: Right. You are as opposed to ask, what I can put in the EHR down at zero, not (overtly) at least. And that's going to …

Female: No. I think that – what I saw with this committee was – and at least my concern is, is that it's not just the EHR, it's …

Male: Yes. No, I hear what you're saying.

Female: … so the entire (paper) or other, right?

Male: Yes.

Female: Yes.

Female: But when I was looking – yes.

Female: You know, I wouldn't necessarily, depending on what the other is. It's more of the paper that becomes really difficult.

Female: Yes.

Female: But, go ahead, please.

Female: No, I'm just – because I was looking at my spreadsheet with the feasibility scores, you know, (on these) by staff, it says that there was a disconnect. And it's not that it's inappropriate, but I just want to note it.

Female: Yes. No, I think that – and that's been …

Female: Leading us a particular way.

Female: So we are – that we are leaning to as a TEP towards electronic capture. That's probably true, and away from paper capture. I think that's …

Female: And also note for the third criteria, it's not just the data collection process that we're asking about. It's also the performance improvement activities and/or contributing to alignment of measures across program areas. So, it's not only how we're capturing the data. It's also assessing – if it's aligning those measures across other programs or is it contributing to the performance improvement activity. So it's a more robust consideration than just the …

(Crosstalk)

Female: … is that robustly, so.

(Crosstalk)

Male: I guess you could use either one of those.

Female: Yes.

Female: So with that in mind, is there an interest in either revisiting depression readmission at six months or revisiting depression readmission at 12 months, either of those or both?

(Off-Mic)

Female: Pardon me?

Male: Not on my part.

Female: All right, OK, all right. So, we're going to move on then not to 14 but …

Female: Yes, to 14.

Female: Fourteen, isn't 14 (depression)?

Male: Fourteen …

Female: But it was a – it was detained by someone. It was – and this person is, if you look on the – oh wait. Oh, my apologies. It's not (been working).

Female: OK.

Female: I'm looking at the number 15, depression …

Female: OK. So someone had – isn't our cutoff, 2.75?

Female: Our cutoff is 1.75.

Female: Oh, then got my numbers wrong. Thank you. All right.

(Crosstalk)

Female: That's right. So threshold flow, 1.75. Measure is 2.4.

Female: Oh, we just have – so we did have the depression readmission. You – when you asked for it to be discussed.

Female: And which one is this?

Female: It's number 14. It was the – so we had a low score but there was -- the depression readmission or response for adolescents and adults. It's definitely correct then. That's fine. I apologize if I got that incorrect.

Female: Yes, the 0.151?

Female: Right.

Female: Yes, I don't recall that I …

Female: OK.

Female: … actually – yes..

Female: OK, then that is …

Female: OK, skipping that?

Female: We're skipping that one, yes.

Female: OK.

Female: OK. The next one is then depression utilization of the PHQ-9 tool, right?

Female: Yes.

(Maureen): OK. And well, again, so this is basically whether or not the tool is being used, period, and it's also the Minnesota Quality Measurement steward. And again, it is this EHR only paper record and other.

So we'll go ahead and go take this through. To what extent does this measure address critical quality objectives of the CMS quality measurement domains and/or identify program area key concepts? All those who would high, please raise your hand. OK, five.

To what extent will this measure address an opportunity for improvement and/or significant variation in care evidenced by quality challenges for each program area? I would say high.

To what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities, et cetera and/or contribute to alignment of measures across programs, health plans, and/or state? So, that's the issue that we have encountered in the past with this being a multiple data sources. It can be EHR and so on. Thoughts, discussion about that? We've already have some discussions.

Female: From a collection concept, problematic. From a performance improvement or alignment, maybe more (inaudible).

Male: And we can't suggest any tweaks. It doesn't (matter at all) at this point.

Female: No. Now, we can note what we think is the problem of the measure.

Male: OK.

Female: Which is – which we have noted previously, which is that this – we would strongly encourage electronic development of these measures. And this one is a little different and that it's just whether or not you're even doing it. So, it's pretty basic.

Male: Yes.

Female: But there may be other measures or other tools that people are using to monitor for depression.

Male: Right.

(Maureen): Any other discussion people want to have on that one?

So then, to what extent does it measure efficient use of measurement resources, including across program – I'll read the whole thing, data collection processes, performance improvement activities, et cetera and/or contribute to alignment of measures across programs, health plans and/or states? How many people would say high? How many people would say medium? And how many would say low? I would say low. So, we move on.

Female: Yes.

(Maureen): We're going to continue with it. So, to what extent is this measure ready for immediate use? The Minnesota Community Measurement, it certainly been used and available for use. Is there anyone here who would say high? Is there anyone here who would say medium?

OK. So, we're going to continue with this one. To what extent do you think this measure is important to State Medicaid Agencies and/or other key stakeholders, consumers, families, Medicaid managed care organizations and providers? Any discussion on this other than what we've already have? OK. So, how many people think high? How many people think medium? Is there – I see medium?

Female: I am.

Female: You had the same then?

Male: I was thinking about it, but I didn't vote.

Female: OK, so one. OK. And how many people would say low?

Female: OK. So measure of depression utilization of the PHQ-9 tool did not pass the (importance) of stakeholders threshold and will not be recommended to the Coordinating Committee.

Female: And I don't know, (lunch) will around (12:30), not sure if you want to one more measure, what you thought.

Female: We've got enough for three minutes or so.

Female: We can roll with three minutes.

Female: OK.

Female: So, let's keep going.

Female: OK.

Female: All right, so make sure the next measure would be the HBIPS-5.

Female: Yes.

Female: Patients discharge a multiple antipsychotic medications with appropriate justifications. This is a NQF measure. It is endorsed. It's at draft, yes. And it's EHR only. It's paper record as well. It's a joint commission measure. Any discussion about this measure at this point in time before we vote on it?

Male: The only thing I was going to say was, yes, we made it a measure that was – we're just looking at multiple antipsychotic medications. And, you know, for some people, it's appropriate, so you would expect the number to be zero. But if you just made like how many people got more than – I'm just thinking this, more than one antipsychotic, and you don't know, there's nothing electronic you can do easily from all these different (hospitals).

But if you did something like number of people who had two antipsychotic – two or more antipsychotic filled within seven days after discharge, you could at least get a flavor of whether or not (a hospital) is (discharging) everybody on, well, an antipsychotic or, you know, where the variation might be. So you could restructure in a way. It wouldn't be a perfect measure because you'd be

imputing that was related to what happen in the hospital which (wouldn't) always be true.

Female: Well what you're thinking is, is that if this were changed to be a utilization rate, then it could be used at least for comparative purposes.

Male: You need to come up with something. If you took out the appropriate justification.

Female: Right.

Female: So, what's happening right now is, is that in order to be able to use this, you're looking at potentially paper record as well.

Male: Right. And for (JCH), that's fine. They're going to – like to the hospital, so they can record.

Female: Right.

Female: Well, and you're also talking a population that is going to have a high use of antipsychotic. So you're talking Medicaid population.

Male: Yes.

Female: So you're talking about a lot of paper record review potentially.

Male: Yes. I mean the general population is not that high, but among people discharged from hospital, it gets much time.

Female: Right.

Male: I mean, among the general population, so we looked at like six percent, seven percent.

Female: Right.

Male: But among people discharged from the hospital, I just got like 20, 30.

Female: Yes, particularly you're talking Medicaid population.

Male: Right.

Female: Yes. Yes. So to what extent does this measure – I think we're ready to vote.

Male: Yes.

(Maureen): Does this measure address critical quality objective of the CMS quality measurement domains and/or identified program area concepts? How many people would say high? How many people would say medium? Four. OK. Is that five? That's five. OK.

So, to what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities, et cetera and/or contribute to alignment of measures across programs, health plans, and/or state?

How many people would say high? Yes. How many would say medium? And how many would say low? Yes. OK.

Female: So if you wouldn't mind just providing (some sort of) or rationale as to why everyone voted low really useful?

Female: There's our rationale guy right there.

Male: Why we think it would be useful?

Female: No, I think …

Male: I'm sorry.

Female: The rationale as to why everyone voted low on opportunity for improvement, just having a sentence or two so that …

Male: Oh, got it. OK. I think mainly because we thought it would be very difficult to collect the rationale information in any systematic …

Female: OK.

Male: … efficient way.

Female: OK. So the TEP did not vote into the five patients discharged on multi antipsychotic medications with appropriate justification through the opportunity for improvement. Criteria, it is recommended to the Coordinating Committee.

As of that, I think that we can take a break for lunch.

Female: OK.

Female: So we will be having lunch on the (A4). We'll just go over to our collaboration space. So (we will) to get it and then bring it back here. There are also are restrooms available on this floor. And I neglected to mention earlier that we also have an office space available, if anyone needs to take a call or has something going on, I'll indicate where it is when we go for lunch. (This is become) step out would like some privacy.

Female: OK.

(Emily): And I don't believe we have any members to the public on the phone right now. But we will be taking a break and coming back shortly.

Female: How are we doing (Emily)?

(Emily): We're doing really well, actually.

Female: Are we now?

(Emily): Yes. Yes. We really pick it up. Yes, yes. So I think we're right on target, yes.

Female: Wonderful …

Female: Yes, great.

Male: We're finding what we can do …

Female: So we'll ask everyone speaking even more loudly just because we only have the one speaker. And I see, I'm going to see …

Female: Are you having a little difficulty hearing some of this?

(Emily): So I think, my concern is that, we will be able to get some people, their voices …

Female: OK.

(Emily): On the transcript though. Everyone would find …

Female: Trying …

Female: … little speaking a little loudly.

Female: Try to be more mindful when speaking loudly. What I did too is I turned my laptop so that it's not blocking that.

Female: Oh, slow down.

Female: OK, so some of you who may, and some of you who don't speak into your laptop will be my suggestion.

Female: Yes.

Female: OK. So, it sounds like we're ready to proceed again.

(Emily): We can go back to measure 14.

Female: Yes. Let's go to 14 if we could, please. I'll ask for indulgence here because I found my comments on the measure that was depression mission remission over response for adolescents and adults. This is indeed an electronic measure now. It's the first year measure, it is developed by NCQA so it's a HEDIS measure if I recall correctly.

And the reason why I was suggesting that it's for consideration even though it fell below the threshold was because it is an e-measure. It is also an outcome measure. And that it measures the patients are responding to treatment, which

I think is the important component here. Too much of what we're doing in the area of depression is just screening and not enough to monitoring to see what the response is.

It can help accelerate the treatment of depression for symptom (emission) scores obtained through this e-measure which will then address opportunities for improvements in the use of evidence based care for better patient outcomes.

That is to say, if a patient is scoring – showing improvement, then one can look at, for example, the use of additional – evidence based care such as cognitive behavioral therapy as not yet being employed. You can also look at medications to augment potentially current medications that are being used for depression or even look at, it can trigger as examination as to whether or not you've got the right medication with the right dosage for that patient.

And also use this patient reported data. That's one of the things I do, like about the PHQ-9 in medicine the standardized tools that actually is, which the patient is giving information. And I would note that in, among the measures that we'd looked at, there seems to be a relative lack of measures available that actually employ patient reported information.

So that was why I had suggested to the committee that they take a look at and consider this measure. I'll open it up for discussion at this point in time and then we can take it through the logic which would be correct, right.

Female: Yes. OK.

Female: Any thoughts, discussion about it?

Male: Are we allowed to do that, because that using a purely electronic measure, (providing) people with whom you can access electronic measure which is not really how this one is written, right or?

Female: How, what's written, please?

Male: That the difference to PHQ-9 measures.

Female: I'm not understanding your question. Try me again.

Male: So, you're reviewing the measure, right from NCQA?

Female: Correct.

Male: But it's somewhat different than what we have.

Female: Oh, no, no, this is the measure.

Male: Oh, it is exactly.

Female: This is the actual measure. Yes.

Male: OK. All right …

Female: This is the actual measure. This is a first year measure that is an NCQA measure. It's actually in HEDIS 2017.

Male: OK.

Female: And it was in our list. It was a list that didn't need the threshold.

Male: Right.

Female: And you may recall earlier from this at home. I think report this as only one to do.

Male: Yes. OK.

Female: And I did not recall my – that I had done or why. And then as I look into my spreadsheet I found this little yellow comment which I had made all my comments and realize that I did. So I just share with the group what my rationale was for why.

Male: OK. Why you put it back.

Female: Yes, exactly, yes. It is a piece 2017 measure first year measure. Other comments, thoughts about it? You're smiling.

Female: Yes, I'm just glad.

Female: Oh because that …

Female: And we've got a measure that is actually electronic, yes. OK. So let me take the group through them. To what extent does this measure are just critical quality objectives of the CMS quality measurement domain and/or identified program area as to contact. Is there anyone who would (inaudible)? We got five of them. What extent …

(Off-Mic)

Female: … evidence like quality challenges to each program area?

Does anyone want to discuss this from a low perspective? OK. How many people say high? OK. So that moves on. So, to what extent does this measure demonstrate efficient use of measurement resources data collection processes, performance improvement activities et cetera and/or contribute to alignment of measure the course program, health plans and/or states. Is there anyone who would say low at this point or would like to discuss it from that perspective?

Male: I have a question.

Female: Yes.

Male: I don't know if you know the answer to it or not. So we would do this, this measure pertains for those, for whom electronic information is available?

Female: That's my understanding, yes.

Male: That's correct.

Female: I've got the measure specs right here in front of me. Let me pull them up. The percentage of discharges for members, oops, I'm sorry, I'm looking at the wrong one. I've got several screens open for this measure. There we go, thanks.

So the percentage of members 12 and older with the diagnosis of depression and then elevate the PHQ-9, who had evidence of response of remission within five to seven months of the elevated score. Four (rates) have reported one, (ECDF) coverage. The percentage of members 12 and older with the diagnosis of major depression or (dyspnea) for whom a health plan can receive any electronically clinical data.

Male: Right.

Female: So it's actually starting to just record from the plan how much are they actually, even able to get at this point, too.

Male: Right. I guess that was kind of my question was, do we have any sense with that number is because I think, because that number is 10 percent then my reaction to this question might be a little different than if it's 60 or 70 percent.

Female: I don't have any answer to that. It's a first year measure.

Male: Right.

Female: I don't know.

(Crosstalk)

Female: Yes. I know it's a good question.

Female: But if it were, (Don) is, I mean, definitely I'm to spend help in a sentence potentially? Is that like electronic?

Female: Yes.

Female: Yes.

Male: I do you wonder about -- so this is a major test kind of built in regression and it mean characteristics with dominator. Where I think about those who'd be lose the follow up maybe disproportionally those who -- are struggling with (ignition) like their care and they don't have the (six) month follow up. We

worry in the short run at least, which is probably basically a few years about, our ability to actually get the measure and we'd probably never the years before foreseen Medicaid program could do a lot with this.

Or this is could be collecting university nothing, we say to and something to go on plan, plan based reporting which really limits what kind stratification, kind of regional (needs) (hit the floor).

Female: Yes.

Male: I definitely like the idea, like the measures that will pull data collection in a positive direction. It's like, might be minimal to that – like a medium or something on this one.

Female: Yes.

Male: I just think it's going to be maybe some years before we'd actually implement. And I actually do wonder about the – the (asymmetric) properties and regression to mean and lots to follow up or what the actual experience is going to look like.

Female: Legitimate questions and it being a first year measure. I did think one other that impact, is that (inaudible) and one of the things I'm having to remind myself other way is, we're not here to endorse the measure. We're here to identify what would be a reasonable group of measures to have in your menu, so to speak, to select as supposed to be in a core data set or an endorse measure. So I'm trying to remember that as I go through this process.

Female: For me it's challenging.

Female: Yes. So at this point then to what extend I'm going to move to vote her if everybody is OK with that. To what extent does this measure demonstrate efficient use of measurement base such as data collection processes, performance improvement and activities, et cetera and/or contribute to alignment of measures across program, health plans and/or state. Is there anyone here who would vote high for that? Is there anyone who would vote medium? Oh, yes he's …

Male: … (Karen's) kind of 80/20, 20 percent kind of aspirational.

Female: This kind of falls into that more, yes? Yes that's a good reason.

Female: Yes.

(Crosstalk)

Female: OK. So we're going to move on the next one. To what extent is this measure ready for immediate use? Is there any discussion that anybody wants to have on this?

Male: I'm guess you can't get the electronic? I'm guessing it's hard to collect electronic (information) from at least half the providers, not in every (instance).

Female: So that – the certain extent it depends on some of what we were talking about earlier about whether or not you have an electronic medical record and if you do, whether or not it captures that information.

Male: Right.

Female: Yes. So, go ahead.

Male: I was just going to say, we got pass the third decision point. So we have to go medium, we can't go low

Male: Because otherwise we wasted our time …

Female: Yes.

(Crosstalk)

Female: Well, the medium is there's a specialized numerator and denominator and data and maybe feasibly extracted from this data (source) so …

(Crosstalk)

Female: Yes.

(Maureen): So to what extent is this measure ready for immediate use? How many people would say high? How many would say medium? All right five, OK.

So the last question is to what extent to you think this measure is important to State Medicaid Agencies and other key stakeholder, consumer, families, Medicaid, NCO's and providers? How – do we need a discussions about that? OK, so how many would say high? OK there you go.

OK. So the measure – depression remission and response to adolescents and adults pass all the criteria and we recommended to the coordinating committee.

Female: Thank you.

Female: All right. Can you think you could help us by knowing which is the next one …

Female: I sure do, it's number 19, para-natal depression screening.

Female: Absolutely wonderful, thanks.

Female: And (James), this is a measure that you put for – up for discussions, I believe.

Female: Because it's 1.2 with a threshold of 1.75.

Female: And this is one of the Pennsylvanian measures.

Female: OK.

Female: (ITRO) measure.

Female: Do you think it is helpful a little bit more?

(James): Yes. Let me pull back up.

Female: Sure.

(James): So I've really write it up really because as the same reasons we were talking about the other internal depressions screen. Which is it's a key, it's of critical clinical importance and Pennsylvania is actually now requires all the health plans with (kind of) collects a kind of common data set on everybody who is pregnant, which includes the depression screening.

So it is being pretty widely collected, at least whether or not people are getting it done. I don't know if they collect this for but at least collecting whether or not …

(Off-Mic)

Female: Looks like you would …

(Off-Mic)

Male: Right.

Female: Yes.

(James): So that really just why I brought it up to talk about it. And there may be no other state likes requires so it's not really practical for this.

Female: So what is your team doing with it?

(James): Oh we really just nudge provider to make sure they are doing it.

Female: And I (OK) it's another paper work or EHR only one?

(James): No, no they have to collect it in a – I mean, they have put in electronic system.

Female: Oh, they do, OK.

(James): Yes.

Female: All right.

(James): (That's electric). It's been paper that were then process and moving they required the state and requires everybody to use in electronic version.

Female: Is it publicly reported so that you can compare that (just MBA) field?

(James): I don't think it is. It's not yet, but I suspect once electronic could start this.

Female: That it will be.

Male: Will move in that.

Female: OK.

Male: So, it maybe something or like reviewing two years, which not particularly could do this (can).

Female: OK.

Male: But really I just brought it up for -- It seems very important clinically, so I just want to …

(Off-Mic)

Female: How much feedback are you getting from the NGOs are in terms of they're being able to use this system?

Male: They use this.

Female: OK.

Male: I mean, some more than others, some of the (O.B) providers that actually push to enhance access the treatment for depression.

Female: So you got (O.B.)

Male: Positive, they should like they should do something about it.

Female: And you got (O.B.) so you really get the medical folks using this as well.

Male: Yes, the (O.B.) are doing the screening.

Female: All right.

Male: The (O.B.) practical student screening they may have submit.

Female: OK, any other discussion about this one?

Male: All right. So, I'm OK, if we pass on this, because this probably is. Just be a little (niche) but just wanted to bring it up here

Female: Well, I think, we really need to vote this.

Female: Yes. We do

Female: Yes, OK. So, what – to what extent does this measure address critical quality objective of the CMS quality measurement domains and/or identified program area key concepts? Anyone say high, five, OK. So, the next one is to what extent will this measure address an opportunity for improvement and/or significant variation in care evidence like, quality challenges for each program area. Any discussion of that or shall we vote? High, OK, so, we've got five on that.

(Off-Mic)

Female: I mean what is potentially (extended demonstrate) this should use of measurement from resources whether selection processes, performance improvement activities et cetera. And/or contribute to alignment of measures across programs, health plans and/or state. Any discussion about that from that perspective?

(Off-Mic)

Male: We're moving towards (like that).

Female: Yes.

(Off-Mic)

Male: No, it's going to be …

Male: Recording (education).

Male: It does specific reporting application

(Off-Mic)

Male: That would be, yes. So, it's still in the low category.

Female: Yes. OK, so how many people would say for high, sounds like we're ready to vote? How many would say medium? How many would say low?

Female: OK.

Female: OK, so with the (note) that we think that this is important measures. However, the concern of the committee was or the TEP was that – it would simply be difficult at this point in time to capture the information until it is available from an electronic.

Male: Like stores.

Female: Yes, electronic source

Female: Yes, an electronic sound

Female: OK. So the staff members voted down perinatal screening base on the efficient use of resources and will not be recommended to the coordinating committee.

Male: OK.

Female: And next measure again number 19 with of P.S. this is not the formal vote. So, it's not for the committee but aren't we glad that now, we do have an electronic one because and maybe if you're a woman who's pregnant you'll get screened using electronic record on, you know. Not – but not necessarily by (what we done).

Female: Right..

Female: So there's still a gap. OK, so number 19 preventive care and screening, screening for clinical depression and follow-up plan. This is an NQF endorse measure, (present) of patient age 12 and older screen for depression using an appropriate standardize tool and follow-up documented. It is for the Medicaid core set.

(Off-Mic)

Female: Interest, I see. As we look at this from a perspective in stored the CMS, it looks like it's used in a number of different programs on looking for a how do we capture the data, measure type office. OK, but the claims other paper records. So there is some claims but there are these others …

Male: Yes.

Female: … as well, on paper record. Comments about this on measure.

Male: I know we're not able to effectively report it

Male: Yes.

(Off-Mic)

Female: OK.

Female: And a lot school based health centers. If you come in, they claims (doesn't) go because it's not – if you a third party and the family is going to get an (ELB). They don't drop the claims.

Male: (Not listening) well, in Medicaid they use …

(Off-Mic).

Female: Yes. Well, it depends. Even if and whatever the plan is going to drop, it won't …

Male: Right. They won't.

Female: … they won't drop the claim. So, I notice it used in art.

Female: Yes.

Female: Can you tell us a little bit more about it?

Female: It was a challenging measure there. So the state contacted with an outside organization, quality review organization, keep going and pull from chart, do a chart review for the follow up, please. And I think that's realistically, the only way we try to have some institute that can come in – because it's very labor intensive. The thing they worry I think that, I guess there are going to be certain places where you (can't do it) like the school based clinical because that's not going to come through.

But for the plans, they were able to get the screening if with the follow up this – that was really challenging. But the state also wrote in requirement around being able to do that in their contacting with the manage Medicaid plan. So, that helps.

Another thing that (Oregon) done, again I know that's outside the preview this specific test but nevertheless would like they articulate it. And that is that Oregon the states help authority. Have a monthly in person learning collaborative on quality measures with medical directors of each means per organization. And that was – that seem to be very important to help educate medical directors about the quality measures, about best practice, how other people were able to make them work.

And then by aligning signing of things with that, you start to get people able to overcome what previously would have been insurmountable challenges this (FYS).

Female: Thank you. So at this point then, answering the question to what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities, et cetera, and/or contribute? What? I have to start at the very beginning. Oh, good. That's what I'm talking. I felt we've been through all that. I'm sorry.

Female: Don't worry.

Female: OK.

(Crosstalk)

(Maureen): All right. So what extent does this measure address critical quality objectives of the CMS quality measurement domain? How many people say high? To what extent will this measure address an opportunity for improvement and/or significant variation and care as in like quality challenges for each program area? How many people say high?

To what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities, et cetera, and/or contribute to alignment of measure across program health plans and/or states? How many people would say high? How many would say medium? And how many would say low?

OK. So let's still move on. OK. To what extent is this measure ready for immediate use? What is an NQF endorse measure? How many would say high? How many would say medium? Three. How many would say low? So it moves on

All right, let's move on. To what extent do you think this measure is important to State Medicaid Agencies and other key stakeholders like consumers, families, Medicaid MCO's, and providers? How many would say high? How many would say medium? How many would say low? OK. So it moves on.

Female: Yes. So, the TEP voted preventative care and screening. Screening for clinical depression and follow up plans through all the criteria and be recommended to the coordinating committee, so our next one is 22.

Female: Ah thank you. So number 22 is – and it will be the last in the group of clinical care, so we'll need to then pause for any comments after that. But the last one is substitute employee, percentage of patients. Now this is a 1.5.

Female: So, (Angela) (is the lead with this).

Female: Thank you. The (processes) disorder, percentage of patients aged 18 years and older, with the diagnosis of current substance abuse or dependence to which screen for depression within the 12 months period. So, would you like to comments on that?

Female: Maybe, maybe not. We just think that time (relates) of co-occurring disorder and the lack of recognition of that in any sorts of care from primary to specialty care. And there's such high (rates) of hospitalization especially when mental health and substance abuse disorders are combined so the HRQ physical based on that are pretty significant.

Female: And, does this measure, is this only – so this is also, yeah, so this is not just behavioral health clinicians. It's an (ASM) measure so I assume …

Female: Right.

Female: … it would be medical as well.

Male: Sounds like – which one are we on?

Female: We're on 22.

Female: 22.

Male: OK.

Female: Substance use disorder.

Male: Right, got it.

Female: Yes.

Female: OK. So any other comments about that? You've mentioned why you wanted to bring it to the table, and I'm looking here, I think that the reason why it almost didn't make it was evidence in gap unsure …

(Off-Mic)

Female: … unsure, that's NQF. Any comments about that?

Female: Sure, but just kind of general comment on – it was the information that staff was able to collect that was probably available to us, so for many of the non-NQF endorsed measures, it was challenging for us to find the extent of the testing since measure developers submit testings directly to us, we have all that in our repository, and for non-NQF measures it's just more challenges since we're unable to find this mentioned.

Female: So the measure source is ASAM but there's three (stores), APA, NCQA, PCPI. That's a little unusual I think. That three measure (stores) …

Female I'm guessing maybe that it's been adopted perhaps unless that's an error.

Female: But I will – I'll check right now to see.

Female: OK, great.

Female: But it also with ASAM as well as the measure source, so I'm just kind of curious.

Female: One moment

(Off-Mic)

Female: That is because we could not find testing of reliability and validity testing so we qualified it as a measure concept. But it seems a little unusual if it's got three measure (stewards). Something is not …

(Off-Mic)

Female: But sure, there's a real challenged in terms of (the area) with substance abuse and screening.

Female: So, I will …

(Crosstalk)

Female: … yes, with depression.

Female: I'm pulling up the pricing right now, I got it from the (ARC).

Female: Great.

Female: And so …

(Off-Mic)

Female: So it does look like there are several different developers for it.

(Off-Mic)

Female: So it doesn't have it on the clearing house information but let me see if I can..

Female: It also says that data (source) is varied hybrid administrative paper record, and EHR. What does the EHR only mean when it says that too, does anybody know?

Female: So that is a – (when Louise comes back) I'll ask her.

Female: OK.

Female: It's a qualification we have on measure developers, submit, they mark what type of – so maybe, there may be one of the measure developers are doing it just using EHR. Does it make sense for us to go on to another one or do you think that we should just (delete it)?

Female: Oh for sure.

Female: OK.

Female: So stewards, we put the stewards and the developers together. So it's APA, American Psychiatric Association, the National Committee for Quality Assurance and Physician Consortium for Performance Measurements.

Female: They are developed it?

Female: Yes, all three.

Female: OK, and then the APA submitted it. Where does ASAM come in? Do you know?

Female: I do not know, let me see. So I actually do know, so it was – we found it on the ASAM website.

(Crosstalk)

Female: So that's where we found it but there are the three developers, APA, NCQA and PCPI.

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

Female: So any other questions about this measure before we discuss it.

Female: All right. Well …

Female: Yes.

Female: Just let me add one other thing, historically one can go but still very common particularly, I might add (in oral) and (sanitary) areas, but you often get alcohol and drug abuse treatment that doesn't believe in mental health conditions for treating them, and therefore this becomes contextually more important, you know, because of the historic device.

(Off-Mic)

Male: From both direction.

Male: Yes. Even if they don't (win) people off their treatment or divert them or something. Most of our mental health services – acute mental health services is related to people on (substance abuse).

Female: Yes.

Female: Do you have anything about what their name when they say data flow (initiative) type of record EHR only?

Female: So the EHR only is – I can read exactly what we have from the website. And that may provide – so it says data source, administrative clinical data and then electronic health/medical record which is what we classify as EHR only. And then paper medical record, so those three different sources.

Female: OK, so back to that again. All right, which is not surprising. So, unless there's any further discussion shall we take a vote?

Male: Yes.

(Maureen): To what extend does this measure address critical quality objectives of the CMS quality measurement domains and/or identified program area, key concepts, how many would vote high? To what extent will this measure address an opportunity for improvement and/or significant variation in care as implied quality challenges for each program area? How many people were both high on that? OK.

To what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities and/or contribute to alignment of measures across programs, health plans and/or states. How many people would vote high on that? How many people will vote medium on that? And how many people would vote low? I know, OK, so that mocks it up at this time.

Male: We're going to need the minority report.

Female: I do think we need the minority report, absolutely, and I think, you know, on this one I'm going to start and then please add anything additional. The committee believes that, or this panel believes that screening for depression among individuals who are living with a substance abuse, or substance abuse disorder is imperative and it is indicative of a best practice within clinical care, however, the objection that we had to this measure is that at this point in time it is a measure where the data sources are administrative, paper records,

and electronic health record, and so it creates an additional burden to collect that information.

Female: And so, anything you would add to that? OK.

Male: One thing I had. Another area you had a (national) (set) of criteria for identifying (populations) (where this should be written) (we just apply that to range of other factors). So we wouldn't necessarily need …

Female: Yes.

(Off-Mic)

Female: A separate measure.

Male: Yes.

Female: Yes.

Female: I concur, that's so smart to do that stratification.

(Off-Mic)

Female: All right. OK.

(Off-Mic)

Female: Do you have that recording or do you have …

Female: Yes, so we have it recorded and so the TEP did not pass substance use disorder …

(Crosstalk)

Female: Based on the (opportunity) forum approved by (ITS) will not be recommended to the coordinating committee. So this does end our – care domain discussions. (Tara), I don't think we have anyone on the public line?

(Tara): No.

Female: OK.

(Off-Mic)

Female: OK. (So this afternoon) is full of comment. And – so we're going to move on to the care coordination.

Female: OK, very good.

Female: And the first one we're talking about is – call screening and follow up. It should be 25.

Female: OK, number 25 is alcohol screening follow up for people with serious mental illness.

(Off-Mic)

Female: Number 25?

Female: Under care coordination?

Male: Under care coordination.

Female: It is.

Male: Twenty-five, yes.

Female: So yes, so we're going back up one domain on this discussion guide, so it's number 25.

Female: It's a challenge for me as I'm looking at the spreadsheet where I test it out. I know nothing is lining up …

(Crosstalk)

(Off-Mic)

Female: Domain care coordination, OK, now I think I'm back. OK, so in care coordination domain its number 25, alcohol screening and follow up for people with serious mental illness. The overall measure score was 2.1, and testing them with threshold is 1.75. And also just as a processing, the discussion guide is new for us, and so we're working on improving aspects of this so it's important for us to know things like we'll take notes in the Excel file and it doesn't have to transfer …

(Crosstalk)

Female: (PQI) perspective, we take that and then this perspective, continues quality improvement perspective, yes.

Female: So if we – so the way to find it is if you go to the very top where we have the agenda.

Female: Yes.

Female: Measures slated for discussions and domain care coordination should be the first one that pops up.

Female: So, domain care coordination.

Female: Yes, the area.

Female: Health screening for people.

Female: Got it. I don't know why I didn't.

Female: So is everybody there – does the alcohol screening and follow up for people (someone) mental illness, it is an NQF endorsed measure, essentially people, patients 18 and older with a serious mental illness who are screened for non-healthy alcohol use and received brief counseling or other follow-ups there, if identified as an unhealthy alcohol user.

And note that this is a – the health, the health plan measure is adoptive from an existing provider level measure to the general population. So you actually then have some additional potential alignment in that perspective.

It is originally endorsed in 2014 and it is currently stewarded by the AMA, AMA-PCPI. Any comments about this before we begin to take it through the (window), difficulty is tracking the screening …

(Crosstalk)

(Off-Mic)

Female: Well, not only that but I could use the one question screener, right? As part of my – right after my PHQ and before I ask you about family (violence) or I could do one of the two rules, right, and I could count that as screening. So -- and then how do you practice if you don't use like the h-screening code, like how do you report it. It becomes really messy.

(James): The other thing is the numbers are going to be so low that – I mean it will be helpful from like a consciousness rating perspective but not in actually doing I think any clear interventions to say (FAQ) has engaged initiation and engagement measure for alcohol use now.

Female: Excellent.

(James): And the numbers are like – and that's when people have a claim with the diagnosis so it's not like …

Female: Right.

Male: … they use – (not like) screening and people actually submitted a claim with that as their diagnosis, and the follow up still like really dismal. So, maybe it's worth doing it for consciousness rating but it would still be hard to actually – I don't think this will allow you to discern quality among the providers with everybody, at least for …

Female: Is this the equivalent of expert?

Male: That's my reading.

Male: Yes …

(Crosstalk)

(Off-Mic)

Male: Yes.

Female: OK. So, on my limited perspective being (org) in here. When expert was introduced as one of those quality tools measures there, expert utilization was zero across the state. It took us over a year of intensive working with medical providers to get them to even understand why in the world do they do this especially when there's no mental health providers. But once they finally got it …

Female: Right.

Female: They started implementing it and the key piece was not the referral to treatment but the brief intervention with your primary care provider basically …

Female: Sure.

Female: … impacting …

Male: Right.

Female: … so given the high rate of alcohol and (drug use) in our nation and the lack of treatment. And I think initiation engagement is an important measurement piece but this is even more critical in my mind because it's more preventive. And again, I would prefer that they were simply experts for everyone and then do your slices by population groups rather than this level of specificity. But given the high level of co-occurrence and the lack of treatment in interventions of any sort.

Female: I think the problem is experts, so a lot of times people are thinking about the expert code (without) which is a simply useless code to use. And (prime measure of) behavioral health because financially they don't make anything.

And so, I think that you get a lot of symptoms that don't use them. But do the screening, the brief intervention, the referral, so some people use the code that fits through those things so that you can paint an accurate picture. Because what really matters is that you're screening, you're doing some recent intervention, right, and you're getting people to some places they need to get. That's what we care about at the end of the day, right?

And so it's the actual expert, whether the expert code, that's often I'm signing when I'm working because to use those codes is not – you don't – I mean, why would we?

Female: Because they're not paid?

Female: Well, one they're not paid, but also if I'm a primary care provider and I'm seeing the expert (folder) attached to a 15-mintue timeframe in which I'm not doing anything but expert. So if I'm a primary care provider I would use an E&M code to get my threshold rate as opposed to an expert code, get a non-threshold rate. And if I use it in addition, then I'm spending an extra 15 minutes. I'll use a higher E&M code because I'm not going to get paid that additional expert money and it would be the same for the behavioral health provider.

So there's very few circumstances even if the expert codes are turned on, that for primary care and behavioral health providers that make financial sense to use those expert code.

Female: And I'm maybe wrong on this but I know in Oregon a lot of primary care providers, the vast majority of the screens were half to being at intake or even on iPads, and so weren't even impacting really, because only those positive screens were then dosed …

Female: Right.

Female: … and then …

Female: Right.

Female: And basically tracking those screenings anyway with the codes so that they can track everybody they screen, because you want to know all of the screening that you did not just the positive screen.

Female: Correct, right. So if you use an H code and capture that activity, I mean we're getting off target here but if you use …

Female: OK.

Female: Yes, if you use the H code as incorrect data activity, that's what's important, and then if you track it every step of the way that works better than using the specific code which may or may not have them.

Female: It looks also, I'm understanding this correctly, that the care setting, the care setting is only behavioral health, outpatient, clinical office, physician practice. It's not a non-behavioral health setting, which you would use the behavioral health …

(Crosstalk)

Female: Yes.

(Crosstalk)

(Off-Mic)

Female: OK, very good, thank you for clarifying that.

Female: Yes.

Female: OK.

Female: So, at this point in time then, to what extent does this measure address critical quality objective as a CMS quality measurement domain, and/or identified program area key concepts. How many people would say high? OK, four. How many would say medium? OK. To what extent will this measure address an opportunity for improvement and/or significant variation in care

evidence by quality challenges for each program area? How many would say five about that? How many would say medium? One, OK.

To what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities, et cetera, and/or contribute to alignment of measures across program, health plans and/or state? So this is an EHR only paper, claims EHR only paper workgroups measure.

So how many people, we've had some discussion about this already, how many people would say high to that? How many would say medium?

Male: By medium using the or, the conjunction …

(Maureen): OK, so – or, OK – or contribute to alignment of measures across programs, health plans, and/or states. So how many people would say medium for that, medium? How many would say low? It moves on. To what extent is this measure ready for immediate use? How many would say high? It is an NQF work measure.

Female: OK.

(Maureen): It appears not to be being used in any fields or any programs right now, although endorsed. OK. So, to what extent is this measure ready for immediate use? How many people would say high? How many people would say medium? How many would say low? So, it stops at this point.

Female: So it will actually go on to the …

(Crosstalk)

(Maureen): Thank you. This is the first one. To what extent do you think this measure is important to State Medicaid Agencies and/or other key stakeholders like consumers, families, Medicaid, managed care organization and providers? Shall we have discussion about that or people are ready to vote? I'm just going to take that as you're ready to vote. How many people think that this

measure is important to State Medicaid Agencies and/or other key stakeholders and say high? We have two.

How many would say medium? OK. Four medium, so record – at high medium it says recommend measure concept for inclusion and program area measure set, yes.

Female: OK.

Female: So yes, so alcohol (training and follow up) with serious mental illness will be recommended to the coordinating committee as a measure.

Female: As a concept. OK, very good. So then moving on, do we go – doesn't look like annual physical exam is the next one.

Female: No, it's on number 29.

Female: Twenty-nine.

Female: Which is body mass index.

Female: OK, BMI, so body mass index screening as follow up for person, people with serious mental illness which is care coordination. It is an NQF measure, it says it's endorsed, 2.1, it's got a threshold – with sort of his threshold. It is a claims only, electronic health record only and then also paper record, so it could be done either of those three ways. Are any discussion about this measure?

(Off-Mic)

Male: Maybe it says, or we're missing it. Does it say what the follow-up care involves?

(Crosstalk)

Female: And follow-up.

Male: Right, so what is follow-up?

Female: It does not appear to be …

Male: I mean it could be a referral to a dietitian. It could just be some discussion between a nurse practitioner and the patient.

Female: Or also (the why).

Male: Right.

Female: I can follow up the measure steps right now.

Female: Yes, that might be helpful, thank you.

Male: So it could be anything, you just have to read the term.

Male: Or it's getting ready to check and see if that's the case.

Female: Yes.

(Crosstalk)

Female: Because it is an NQF endorsed measure, it just so happens. That case is going to have that information for us.

(Crosstalk)

Female: This preliminary review for – a refresher for everybody. It was identified as all addressing evidence and gap, there's evidence information you're going to find. Now here it says feasibility is high, administrative/claims yet within the context it says claims, electronic health records, paper record, so people might see that a little bit differently.

Scientific acceptability is high and that it is currently endorsed, and usability low. No indication of used in field or any programs.

Male: So we do implement the claims on the (version)? We don't do (live) reporting with it, it's a very low rate …

(Off-Mic)

Female: OK, there is (I was going to say), so what you do with it and …

(Off-Mic)

Female: Got it, good.

(Off-Mic)

Female: But there's no incentive to improve performance in this area, so was the quality indicator in New York on the state mental health system in their …

(Off-Mic)

Female: And how its performance, it's quality flagged.

Female: Yes.

Female: Quality flag means it's not doing well.

Female: Yes, it means that you should theoretically do something about it.

Female: For the alert.

Female: OK. Is it tied to any kind of paper performance paradigm?

(Off-Mic)

Female: Yes.

Female: OK.

Female: So I can read aloud the follow up, so follow up document is in three months of screening for patients with a BMI greater than or equal to 30 kilogram, is two events of counseling on different dates for weight management such as insurance exercise counseling, with the provider who did the screening or another provider including a health plan clinical case managers. Or one of them is counseling and one fill up medications. (One was stat), for weight management, so those are the follow up.

Female: So with (day 1) the problem is they have to code it as the follow-up, in other words they would have to use like one of the prevention codes or somehow coded as the follow up unless you use it as a reason for visit or prescribe the med which many providers or not going to do.

Male: OK.

Female: OK.

Female: They may do the counseling. I just don't know how you get the information without really looking at the charts just because of what the (PCPs) would most likely do.

Female: OK. So if I recall, I think we have to go through the whole process on this.

Male: Yes.

Female: Right?

Female: We do.

(Maureen): All righty, so to what extent does this measure address critical quality objective of DMS quality measurement domain and/or identified program areas for concepts. How many would say high? How many would say medium? OK, so there are no loads. To what extent will this measure address an opportunity for improvement and/or significant variation in care, this evidence by quality challenges for each program area? How many would say high to that? How many would say medium? OK, moves on.

To what extent does this measure demonstrate efficient use of measurement resources? Data collection processes, performance improvement activities, et cetera, and/or contribute to alignment of measures across program, health plans, and/or state. Any discussion, anybody wants to have about that prior to voting on it? How many would say high? How many would say medium? How many would say low? OK, it's high, it's unfortunate.

Female: I mean I think it's crucial.

Female: I think it's one where we would know that this is a gap because …

Female: There's not an easy way to capture this data. It comes in multiple ways, multiple forms, and as has been noted by (Berna) there are challenges also with the coding for this. What I like about this measure is that it addresses the BMI issue prior to perhaps someone actually developing, you know, a metabolic condition that results in diabetes, but the problem is that there are some challenges with measurements.

Female: OK.

Female: OK.

Female: And so the TEP members voted on body mass index screening and follow-up for people with serious mental illness. The measure did not pass the efficient use of resources criteria and will not be recommended.

(Off-Mic)

(Maureen): OK. So number 30 is cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed anti-psychotic medication. This is endorsed as NQF 927. It received a measure score of 2.4 surpassing the 1.75 threshold, enumerated being individuals who have one or more LDL screenings during measurement period. This I believe, yes, this is a NCQA measure. It has four – three different sources claims, electronic health records for pharmacy. Any discussion of this measure at this point?

Male: Except with me.

Female: All right, so …

Male: Do we have to vote?

Female: Yes, this is measures address critical quality objectives of the CMS quality measurement domain and/or identified program area concepts, how many would say hi. OK, to what extent will this measure address an opportunity for

improvement and/or significant variation in care addressed by quality challenges for each program area? How many would say high?

To what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance, improvement activities and/or contribute to alignment of measures across programs, health plans and/or state. How many would say high?

To what extent is this measure ready for immediate use? How many would say high? OK.

To what extent do you think this measure is important to State Medicaid Agencies and/or other stakeholders? How many would say high? OK, so it's just a couple of kind of – sentences of rationales to why this was included.

Female: All right, (pretty widely)

(Off-Mic)

Male: Yes.

Female: So the (widely) standard of care, you know, recognize, report it on? Addressing a key health risk …

Female: Yes.

Female: With individuals who are living with schizophrenia or bipolar disorder who were also taking anti-psychotic medication.

Female: OK. And so, the TEP voted through cardiovascular health grading for people with schizophrenia or bipolar disorders who are prescribed anti-psychotic medications. It will be recommended to the coordinating committee.

Female: All right.

Female: Our next one is actually 31

Female: OK, 31 is cardiovascular monitoring for people with cardiovascular disease and schizophrenia, and it is an NQF-endorsed measure. It's looking at percentage of people who are 1864 with schizophrenia and cardiovascular disease who had an LDL test during the management year.

Is there any need to discuss this one, anyone has anything they want to discuss? (This is on) Medicaid by the way now, so to what extent does this measure address critical quality objective with the CMS quality measurements domains and identified program area key concepts. How many would say high?

To what extent will this measure – so that was unanimous. To what extent will this measure address an opportunity for improvement and/or significant variation and care evidence by quality challenges for each program area? How many would say high? Thank you, that was unanimous.

To what extent, and again, just looking at data sources, business claims, EHR and laboratory. To what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities, et cetera, and/or contribute to alignment of measures across programs, health plans, and/or state? How many would say high? I guess unanimous.

To what extent is this measure ready for immediate use? How many would say high? To what extent do you think this measure is important to State Medicaid Agencies and other key stakeholders such as consumers, families, Medicaid managed care organizations and provider? How many would say high? OK, we pass that. So I think that's it for that one.

Female: Just need a couple of sentences right now.

Female: Again, the issue is that monitoring with an LDL-C test during the year is considered to be a customary practice for individuals who are living with cardiovascular disease and schizophrenia.

Female: OK.

Female: So the test coded cardiovascular monitoring, people with cardiovascular disease and schizophrenia through all the criteria, will be recommended to the coordinating committee.

Female: All right.

Female: So next, we have measure 33.

Female: OK. So 33 is closing the referral loop, receive a special support. This receives an overall measure of 1.5. I was the one who brought it to the committee's attention, and I will share why once I can open my – I believe because in the quality payment program, the (Maxwell) program, this was a high priority measure in the CMS quality payment program, thus from CMS' perspective, it addresses critical quality objectives of the CMS quality measurement domain.

So that's why I brought it to everybody's attention because CMS had already indicated that this was a high priority measure within the quality payment program aka sometimes referred to as (macromit) which is for Medicare part B, it's in baby provider. So, any thoughts or discussion about this one please?

Female: I think it addresses an important gap.

Female: OK.

Female: Widely held belief that there is a lack of closings, referral (list) especially with mental health providers.

Female: Other comments.

(Off-Mic)

Female: Yes.

Male: State Medicaid program.

Female: Well (interesting), the measure sources, Wyoming's PCMH program, isn't that interesting? Yes. Data sources EHR, electronics health record only.

Female: But then some of the issues that we've spoken about previously about how do you coordinate all of them.

Female: OK, great. Are people ready to vote on that?

Female: Yes.

Female: OK. To what extent does this measure address critical quality objectives of the CMS quality measurement domains and/or identified program are key concepts. How many would say high? OK.

To what extent – that was (then), to what extent will this measure address an opportunity for improvement and/or significant variation and care evidence by quality challenges for each program area? How many would say high to that? That's unanimous.

To what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities, et cetera, and/or contribute to alignment of measures across programs, health plans and/or states? How many would say high? Three. How many would say medium? One. How many would say low? OK. So it still moves on if I recall from this.

Female: Yes.

Female: The measure lives. To what extent is this measure ready for immediate use? How many would say high? None. Well, (awesome).

Female: How do we determine that?

Female: Let's go back and look at our discussion guide here for a second.

Female: That's a numerator, denominator, and data maybe feasibly extracted from its data source would be a medium.

(Off-Mic)

Female: So, help me understand this.

(Off-Mic)

Female: Is it feasible to expect that from the EHR?

Female: What do you guys think? I know you look a lot of EHRs here.

Female: It can be (distracting).

Female: Yes, I'm just going to stick with the medium.

Female: OK. Any other questions about this before we vote on it from this perspective? So, I believe we're on this right here, right? To what extent is this measure ready for immediate use? How many would say high? How many would say medium? Three, the measure lives, OK, but it goes on now to what extent do you think this measure is important?

(Crosstalk)

Female: And other key stakeholders, consumers, families, Medicaid, care, managed care organizations and providers. Any comments anybody wants to have about this before we go on to vote for it?

Female: I think from a consumer perspective is enormous important. Unless you make this kind of information readily apparent, people don't fall for problem or the lack of communication. And I definitely saw this changed in Oregon once they became some required measure. It was not this measure but again it was the DHS custody and it was that lack of closing referral list that contributed to abysmal scores in terms of mental health screening for a case in DHS (custody).

Once they start closing the referral loops, those numbers skyrocketed. So, just saying that I believe that this is in the sense of a process but it can get to some much needed collaboration. It may not be at the Medicaid, you know, playing level but definitely at a local level, and certainly in smaller communities, so this can be even more impactful.

Female: So from a managed care organization perspective, anyone have a comment from that perspective on this before we vote on it, or from a provider perspective.

Male: I just, yes …

Female: Yes.

Male: I just think it will be difficult to track down and maybe to some degree to react to it.

Female: And to react to?

Male: To.

Female: OK, what do you mean when you say, "react to?"

Male: Well, I mean you're going to be making a clinical judgment about the meaning of the self.

Female: Yes, and of the specialty with specialist report that you get.

Female: Right.

Female: Yes, and have very little value sometimes.

Male: Right.

Female: Yes.

Female: Other than to know that this certain team which …

Male: Right.

Female: A little bit helpful …

(Crosstalk)

Female: Yes.

Female: I have a question.

Female: Yes.

(Off-Mic)

Female: The intent is really to get information back to the referring provider with maybe recommendations or diagnostic results, right? I mean it's meant to close the loop.

Female: Right, OK.

Female: I can look it up …

Female: Or it's nothing else than really – the measure is really closing the loop.

(Off-Mic)

Female: Or that the information came back.

Female: OK.

Female: I mean that's really what you're looking at more so that – I mean they have to go but if they go the loop got closed, that's really …

(Off-Mic)

Female: Yes.

Female: Yes. This is – I can pull it up if you like. It's from the quality payment program, it just takes a moment. It's qtp.cms.gov if you've been able to do it.

Female: Finally got it.

Female: Explore measures and it's called closing the referral loop.

(Off-Mic)

(Crosstalk)

Female: It's more difficult is that you have a lot of like – I go to primary care but I get my pack someplace else at my GYN provider which is routine care and not sort of a referral. And that might not get back for all your diabetics who don't have eye coverage who go to the (vision ban) like if …

Female: Right, but this is basically – is this specific to physical and mental health providers? I have the keywords there but I'm not sure if that's in the measures.

Female: No, here we go, so I can just give you a little bit more information. It is the percentage of patients with referrals regardless of age for which the referring provider receives a report from the provider to whom the patient was referred. And it is a part of a lot of specialty measure stack within CMS. I would say at least 20 and it includes mental health but it also includes our cardiology …

Female: Eye exams.

Female: Emergency medicine, OB/GYN, neurology, hospitalist, physical medicine, preventative medicines, rheumatology, plastic surgery, vascular surgery, this is – I mean it's …

(Crosstalk)

Female: … is it part of many specialty measure (stat) and it is considered to be a high priority measure. The data submission method is the EHR and we know, you know, it isn't really electronic …

Female: Yes.

Female: … but it does have some challenges.

(Off-Mic)

Female: Getting that information, so, you know, if you go get a mammogram because you're relatively, you know, able to go deep so you get it, who's your primary care provider, I don't know, I forgot, I don't have the name, I don't have the number. You get it done. That never actually gets back even though they might have referred you, you know, like it's a – and it has to go into the place in the E.R. the order, and then that order has to be closed and I have to note

that I got to consult back. So not only that we went but that I actually got the report back.

(Off-Mic)

Female: Right. So not – yes, did you go get your (pap)? Yes, I did, check. You get the report.

Female: Now get the report, yes.

Female: Yes.

(Off-Mic)

Female: Right.

Male: … about 50 events that qualify information …

Female: Right.

Male: … when it comes to the year whether things were (forgotten).

Female: But as primary care provider, I should want to know if I just heard somebody.

Female: Right.

Female: The outcome was …

(Crosstalk)

(Off-Mic)

Female: Dominantly manual, the other problem is and we're experiencing this coded in the EHR.

Female: Yes.

Female: And because that's how you get the reports, the reports come from 50 different directions. The other problem with this, is now you have a shared EMR, so

like anybody that has that has EPIC you have care everywhere. So I can go in and see what happened. I don't get the report back but I have to have some way to now report that I saw the report.

(Off-Mic)

Male: I forgot.

Female: So there's some focus there.

Male: Yes.

Female: OK.

(Off-Mic)

Female: And how is it then determined that you are – but if – you don't have to be the primary care. You just have to be the doctor who did the …

Female: Did the referral.

Female: Right, but that was …

(Off-Mic)

Female: No, but then when I'm doing their (preventive), so we may (apply them) a Planned Parenthood provider, right, and you don't have a primary care provider if I referred you. Or I'm asking about your preventive health and I would order a mammogram and get your mammogram results.

(Off-Mic)

Female: Right, yes, so whoever …

Female: Yes.

Female: So, we're really at that point now, OK.

(Crosstalk)

(Off-Mic)

Female: As long as – if you're saying that we can do that from a process perspective.

Female: Absolutely.

Female: OK. To what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities, et cetera, and/or contribute to alignment of measures across programs, health plans and/or states. So, given the ensuing discussion, how many people are – would like to vote high for this? OK. How many people would like to vote medium for this?

Female: I'm going to do a medium.

Female: We got two, and how many people would like to vote low? So we got three lows, all right. So, given that it is – it stopped.

Female: Yes, OK.

Female: So, the text failed, she passed, goes in the referral loop, receive a specialist report through the efficient use of resources criteria, it will not be recommended to the coordinating committee.

Female: And a notation that there was a discussion noting that the concept has been valuable but it is the feasibility that was the issue.

Female: And I think that it should even be further noted that the feasibility issue is that although it is an electronic health record measure, the perception is that number one, there are an array of different electronic health records that are closing challenges, and also if I'm capturing this correctly from some of you, this idea also that there are some coding challenges in being able to consistently note that this was – the data was actually captured and that many times although it is captured in electronic health records, there are some manual processes that have to be followed in order to …

Female: Yes.

(Crosstalk)

Female: Because they have to be stand and attached to the original order to close it out.

Female: Yes.

Female: And your system has to have the ability to do that.

Female: All right. Why don't we take a break for about, how much, 10 minutes?

Female: Ten, 15 minutes.

Female: Ten minutes, it will be 10 minutes because we're on a roll. We try to get as much done today as we can. The more we get them today in our first day, the more we'll be able to breathe.

Female: Thanks.

Male: We're about two-thirds of the way through.

Female: OK, great.

(Off-Mic)

Male: You get paid more, right, if we're quicker.

(Crosstalk)

Female: Help them out.

Female: Onto measure 34.

Female: Yes.

Female: Measure 34, and before we get started, I just want to go to thank all of you because each of you are bringing different perspectives to the table and communicating them in an efficient and respect – efficient way and I think each of you are listening respectfully to each other's perspectives and I think

we're trying to find common ground, and where there isn't common ground, making very sure that we're noting where the differences are. So thank you, all of you for that.

Female: Thank you.

Female: Sure. So we're all on to controlling high blood pressure for people with serious mental illness. It received an overall measure score of 2.1 surpassing the threshold score of 1.75. It is an NQF endorsed measure.

It's looking at people from 18 to 85 with SMI, serious mental illness who had a hypotension diagnosis and his blood pressure was adequately in control during the measurement year. And it is probably an adoptive measure from an existing health plan measure using a variety of reporting programs to the general population, so that's NQF 0018.

And the specifications to the measure have been updated based on the 2013 (ANCA) guideline, so there's been some updates but also NCQA is going to submit the revised specification to this for 0018 in the first quarter of 2014, so this should be done, right, since the revision?

Female: Yes.

Female: OK.

Female: So, this is a claims, it is an EHR but it is also a paper records measure, it's another paper list.

Male: Obviously, most paper record …

(Off-Mic)

Female: Yes.

Male: Some other people thought it was worth it.

Female: Yes. Let's see, who is feasibility high, this is administrative/claim in the NQF preliminary review but yet we do see some paper.

Female: I guess I was interpreting that as that is a way, it's not that – paper is part of …

Female: Well, I think what it is …

Female: You just have to …

Female: Yes, from my perspective, my understanding would mean that when you're looking at creating your numerator, you're looking at claims, you're looking at electronic health records. You're looking at paper record. If you choose not to look at one of those in your data captured process then you may be getting a lower score as a result of not maximizing your data. That's how I would look at it, anybody differ?

I think the other thing about this is just to note is that user-related programs was unsure and someone had indicated in the staff preliminary review, usability low. No indication of use in field or in any program.

(Off-Mic)

Female: Yes.

Male: It's the same reason that we don't use the current version of this measure.

(Off-Mic)

Female: Just one thing to note whether or not there is actual screening of both measure or monitoring. Another thing to note whether or not it's under control, because we don't have these separate issues.

Female: Yes.

Male: Another concern I have about this measure is, this looks to me like not the best training for an SMI proxy, so I wouldn't want to put this forward at the measure that one might look to, to take the SMI criteria from this matrix, which is connected to – this is more restrictive than I would want it to be.

Female: Schizophrenia and/or – schizophrenia or bipolar one …

(Crosstalk)

(Off-Mic)

Male: This would be more valuable. It's not like you think if it was everybody with results and depression …

(Off-Mic)

Male: So the trend would be, yes …

(Off-Mic)

… it's not the definition of (SMR) that I would want to have a major …

(Off-Mic)

Male: Because I think it's more restrictive than we would want it to. We want to allow for example (images).

(Off-Mic)

Male: Think about any claims …

Male: Right.

Female: Yes.

(Off-Mic)

Male: Right.

Female: Right, the denominator is too narrow, yes.

Male: Right, yes.

Female: Yes.

Female: And I think there would be some people who would also say that one inpatient visit with major depression isn't necessarily serious mental illness.

Female: Right.

Female: Some people might, but others might not, that's one of those areas …

Female: Yes, I would say in many cases, yes.

Female: And this sort of backs to your original contention net, there may be some value in measures are more broadly applied across the whole populations for population health reasons and then doing that slice of SMI, (SUV) so that you can capture disparities.

Male: Right, exactly.

Female: OK.

Male: I mean that context is a given organization is able to measure …

(Off-Mic)

(Crosstalk)

Female: Exactly, yes, it has to have …

(Crosstalk)

Female: Yes.

Female: And especially given that we have so many people with SMI who didn't even get screened for any number of clinic health positions that …

Female: Yes, OK. So it sounds like people are ready to have a vote on this. To what extent does this measure address critical quality objectives of the CMS quality measurement domains and/or identified program area concepts? How many people would vote five for that? How many people would vote medium for that?

(Off-Mic)

Female: Exactly …

(Off-Mic)

Female: … yes.

Female: OK. To what extent will this measure address an opportunity for improvement and are significant variation in care evidence by quality challenges for each program area. How many people would vote high on that? Medium? So we got three. How many vote low? Two, OK.

So to what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities, et cetera. And/or contribute to alignment of measures across health plan and/or states? How many people, and keeping in mind this is a claims EHR only or paper records measure. How many people would vote high for that? How many would vote medium for that?

(Crosstalk)

Female: Medium, OK.

Female: And how many would vote low?

Female: OK.

Female: OK, so the measure does not move forward.

Female: Right. So the TEP did not vote controlling high blood pressure for people with serious mental illness through based on the rational of efficient use of resources. And let me quickly double check for process, everyone said medium for addressing the CMS domains in key concepts, no one had low?

(Off-Mic)

Female: OK.

Female: Yes.

Female: And I think what we would want to add, and please let me know if anybody has a disagreement or further to add to this, is that controlling high blood pressure for individuals with serious mental illness is an important component of care particularly when you consider the higher risk, the greater risk that this population has for cardiovascular disease.

The challenge from our perspective is two folds. One, we thought that the definition for serious mental illness was too narrow and in the measure, and number two, we were concerned about the fact that the data source could create challenges particularly when you're looking at paper records and when you're looking at the fact that there are differences among electronic health records which might not lend is too easy data (packets).

Female: OK.

Female: Anything anybody to add to that? And so the next one is 36.

Female: OK. So yes, 36.

Male: Very similarly.

Female: Diabetes care for people with serious mental illness, blood pressure control, OK, so it's very similar. Now this has an NQF number. I'm not sure, did the other one just say …

Female: It did, yes.

Female: It did too, OK. So this has an NQF number, it is again a claims laboratory paperwork with pharmacy measures, and it's looking at a more specific population. It is adoptive from existing health plan measure used in a variety of reporting measures programs for like the general population. So, it's adopted from NQF 0061 endorsed by NQF, instituted by NCQA.

Comments about this prior to our – looking at this rather than our voting on it? It has been identified as high-end evidence, feasibility, high administrative claims although we did note the issue with regard to paper records. It is

endorsed. No indication of use in field or in any program at this time. So, is there any additional discussion about it at this time?

OK. So, to what extent does this measure, just critical quality objective of the CMS quality measurement domain and/or identified program area key concepts? How many would vote high? How many would vote medium? OK, so that's unanimous. To what extent will this measure address an opportunity for improvement and/or significant variation and care evidence by quality challenges for each program area? How many would vote high? OK. How many would vote medium? All right it goes on. All right.

To what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities, et cetera? And/or contribute to the alignment of measure (request) program, health plans, and/or states. How many would vote high for this? How many would vote medium for this? How many would vote low for this? Five, OK. So this does not continue.

Female: And so, is the rational similar to the previous measure as to why?

Female: That is correct. And I think that the committee would certainly, I think, know that blood pressure control is particularly important for individuals with serious mental illness with co-morbid diabetes, particularly for risk factors from perspective of cardiovascular disease, including risk of stroke.

However, the ease with which this can be implemented is challenging and also there was, again the concern as I recall, yes, about the limitations of how SMI is being specified here.

Female: OK.

Female: My only concern is …

Female: Yes.

(Off-Mic)

Female: But I didn't notice this earlier but the dominator is the same for a number of these NQF. So, if we're trying to capture, the physical health concerns for people with serious mental illness would – throwing them all out the door under our current …

Male: Not necessarily, we're looking at the next one that's going to come up, it won't have the concern of not being able to measure the metabolic pressure control (early). My perspective would be amenable to claims (encounter alleviation). For me that will shift the – probably might fell to consideration to overcome the concern about the SMI definition being too restrictive where I could probably (go to medium).

(Off-Mic)

Female: Well, but the next – even when you're talking diabetes care and you're talking eye exam, that's also claim paperwork with your pharmacy or EHR. Do you still have the paperwork that's conforming?

(Off-Mic)

Female: Pardon me?

Male: We do have an administration application that's feasible here.

Female: OK.

(Off-Mic)

Female: So …

Male: Basically just looking for (bread or knife answers here) …

Female: And the concern you had about the previous one was …

Male: Yes, and see whether …

(Off-Mic)

Female: Well, you can look at through them, if you're looking at a medical record just like we're talking up here.

Male: With the medical record only versus playing …

(Off-Mic)

Female: Oh, you have to go …

(Crosstalk)

Female: Eye exam, yes or no versus you have to go into the medical records, yes.

(Off-Mic)

Female: True. OK. So I'll just summarize, the text did not pass diabetic care, people with serious mental illness, blood pressure control based on the criteria of efficient use of resources. So it will not be recommended to the coordinating committee.

Female: Yes. And would you like to restate that last statement which I think, you know …

Female: Yes.

Female: If you wouldn't mind.

Male: It requires electronic health record or medical record with the committee chair, the numerator …

Female: OK. Got it.

Female: And I think again the caveat that we think – do we think it's an important measure, I mean it's not that's what we …

Female: Yes.

Female: … agreed in the beginning, that it was …

Female: Yes.

Male: Yes. Major (conflict), yes.

Female: Yes. But we've got two here now, one with controlling high blood pressure and the other is blood pressure control for people with diabetes. So we had controlling high blood pressure for people with serious mental illness controlling high blood pressure essentially for people with serious mental illness and diabetes. In both cases you're not simply looking to see whether or not something has occurred, you're looking also to see whether there's control which then requires really have to go and get some sort of medical record review.

Male: And those are literally the measure, not the standard key measure but just different populations to try to …

Female: Yes.

Female: Exactly.

Female: Yes.

Female: OK. Any other …

Female: No, that's wonderful.

Female: OK. So we're on number 38, if I can recall.

Female: So we're doing 37.

Female: Oh 37. Thank you. Yes. The eye exam. So this is also an NQF measure, 2609. Patients received an eye exam during the measurement years 18 to 75. This measure is adopted from a health plan measure. So, it's essentially adopted from NQF 055, the Comprehensive Diabetes Care Eye Exam.

And it is endorsed by NQF. It is stored by NCQA, but it actually looks (a lot) with NCQA.

Female: Yes.

Female: OK. So, discussion about this one?

Male: With your prior point, it also used the generic definition of SMI, but it is at least – it's very feasible to do them (accurate).

Female: I'll just say paper record but what you're saying is that for the most part …

Male: Yes.

Female: … you can deny them on claims.

Male: Yes.

Female: Yes.

(Off-Mic)

Male: Hybrid version is available which could …

(Off-Mic)

Male: Right.

Male: You can go get …

Female: Yes.

Male: You could use paper to supplement it if you wanted to.

Female: Right.

Male: You probably wouldn't really have to.

Female: Yes.

Female: OK. So at this point in time then it sounds like we'd be ready to vote on this. To what extent does this measure addressed critical quality objectives of CMS

quality measurement domains and/or identified program area key concepts? How many people would say high? So that's three.

To what extent will this measure addressed an opportunity and …

Male: We want medium.

Female: Oh, I'm so sorry. OK we had three high, we can (move up). So, OK. Well, thank you. I'm just glad somebody is paying attention to our protocol here. So to what extent will this measure addressed an opportunity for improvement and/or significant variation in care? Evidence by quality challenges for each program area. How many would say high to that? Well, I'm the only one. OK. How many would say medium? We've got – OK, four mediums. So we move on.

To what extent does this measure demonstrate efficient use of measurement resources? Data collection processes, performance improvement activities, et cetera and/or contribute to alignment of measures across programs, health plans and/or states. How many would say high? How many would say medium? Five mediums.

To what extent is this measure ready for immediate use? How many would say high? Five. OK. To what extent do you think this measure is important to State Medicaid Agencies and to other key stakeholders such as consumers, families, Medicaid, NCOs and providers? We'll pause for a moment, see if there's any comments anybody would like to have.

I would note that this doesn't appear to be any indication of use in field or in any programs at this point.

Male: So people aren't jumping on it?

Female: Right, that's what it would appear.

Male: The thing I would say is that we do produce the current measure …

(Off-Mic)

Male: I would just make the comment. You know, we're – we've been talking about lots of trying to measure really the quality of – trying to get some sense of quality issues using claims and this is focused – this is a quality measure focused on a relatively high-risk that can't be easily measured. So, you know, we've been trying to do some outcomes assessments of our homework and population or people with SMI.

And, you know, that was really trying to replicate HEDIS measures and the claims basis, it's like one of the easier …

Female: Right.

Male: … and more helpful things to do.

Female: People are just focused on the overhanging diabetes measures. Like if I think about mental health providers, they're still trying to get their systems in place to do the other diabetes measure …

Male: Right. But the plans at least can do this …

Female: Yes.

Male: … pretty easily.

Female: Yes. And this is – this measure – the comprehensive diabetes care eye exam measure, that eye exam one is actually found in a fair number of other measure sets. So I believe it's helpful not only in the health plan but I think it's also in the ACO1 now too.

Female: Yes. Yes. The MSSP ACO. Yes.

Female: I'm sorry. You were going to say something? You were shaking your head.

Female: Yes. No, I was just thinking about sort of what's happening in like the mental health centers. So just – like they're not – as the eye exam, like if you're primary care you're all have the diabetes eye exam. If you're a mental health provider you're still trying to make everybody's got their lab then you know who your diabetics are.

Male: Yes, right.

Female: Yes.

Female: So, what this does is it helps to …

Female: Oh yes.

(Crosstalk)

Female: … from an integration perspective …

Female: Yes, no questions. Yes.

Female: OK. So, let's see where are we on this one? So we're voting for (stakeholders).

Yes. Anything you would want us to add to that?

Female: No, I just think it's important. And to your point there's now move forward, you know, the certified community, behavioral health centers which would mirror (SQACs). And I think it's important for us to sort of check the thinking away from mental health specialty care that doesn't have anything to do …

Female: Yes.

Female: … with primary care and I think this kind of measure …

Female: Right.

Female: … gets there. The whole problem with EHR is in 42 CFR part two, et cetera.

Female: Right. Yes, no. I guess – I met with them last week with that group of the (conference). And I guess I'm pessimistic because we did the quality meeting with them and so I guess I …

Female: Well …

Female: … over you but I don't debate that is important. I'm optimistic.

Female: Well, and I think from a provider perspective …

Female: Right.

Female: Behavioral health care doesn't want to (text) this stuff. They've never had to. They never had to, they've never been incentivized to, they never were part of meaningful use. So, I don't blame them.

Female: Right.

Female: But from a consumer perspective, I say I don't care.

Male: Right.

(Crosstalk)

(Off-Mic)

Female: Yes. Care managers. So, if you're saying (MBA) but you've got a health plan that's saying, we want to know what's happening here and we want you to help. And then when you're on the phone with the patient and you're talking to them about their medication, you can also talk a little about have you seen your doctor yet? And would you like me to help you get an appointment?

Male: Right.

Female: All right. So, it sounds like we're ready to make some decisions about this and vote on it. To what extent do you think this measure is important to State Medicaid Agencies and other key stakeholders such as consumers, families, Medicaid, MCO's and provider? How many think high? How many think medium? Medium. So it looks like it moves into our major concept state then.

Female: Yes.

Female: OK.

Female: So the test vote is, diabetes care, people with serious mental illness eye exam through all the criteria and it would be recommended to the coordinating committee. The next one is 38.

Female: And you get your rationale?

(Off-Mic)

Female: I do.

Female: OK, very good. OK. So 38 is diabetes care, for people with serious mental illness, hemoglobin A1C control less than 8 percent. This is an NQF endorsed measure. It is – it surpass the threshold of 1.75 at 2.1. It is a claims EHR lab, paper record pharmacy measure. Sounds like your comments (James) might be similar to one ones on the eye exam.

Male: Yes. And I think they can – this number …

(Off-Mic)

Female: Right.

Male: There are (good value) that could pick up the control. They're very – they're not …

(Off-Mic)

Male: OK.

(Off-Mic)

Male: … and at least currently the control, the feel value would tell us about the level of control or one to two percent reported.

Female: So would you get a little bit more data given that you'd have laboratory as well and pharmacy that could also be getting you some data? So it's not just that it comes in.

Male: (Encounter) data, it would have to be from H.R. or (record).

Female: OK. I don't have visibility with the data source pieces of all these. But I do know that this was one of the core measures in Oregon for the quality poll. And what I can say is not consistently throughout the state but in some areas we had the directors of medical clinic, primary care clinic, meeting monthly on their quality measures. And starting to share clinical levels data with each other and sharing best practices for getting us diabetes for control under, you know? So …

Male: But this might be good for the measurement concept bucket.

Female: So, it was just kind of striking that some other things that are difficult from a plan level at a practice level really started to change the interaction between different physicians, clinics and sharing of data, the stratification.

Female: So, I just – yes. OK. So I was just thinking, there is a measure called diabetes screening for people with schizophrenia or bipolar disorder, who are using antipsychotic medications. We do have that one as well. And that is lab pharmacy claims or EHR. We haven't gotten through that yet. That's going to be number 43 it looks like. Yes. That's the screening one. Hopefully we get it that way. I don't know this is a monitoring afterwards. No, I'm on.

Female: This 42 is diabetes monitoring.

Female: (That is) again.

Female: Diabetes and schizophrenia.

Female: Yes. It's a different …

Female: So there's no monitoring for bipolar is what you're saying?

Female: (What we'd like to hear), I mean we'd have scroll through all of them.

Female: Oh no, this diabetes screening, I don't see – let me look at on the next one, it doesn't look like it. Yes.

So, at this point in time, was – knowing that we're going to have two here. We're going to have the one about this control. And then the next on is going to be for control. So I'm thinking that the end – which is Medicaid Adult Core Set measure. Is this the Medicaid Adult Core Set measure also?

(Off-Mic)

Female: No.

Female: What? Are we on 39?

Female: No, I'm 38. I'm just sort of comparing the two because one is …

Female: Right.

Female: … one is control and the other is core control. So I'm just contrasting the two.

Male: Definitely feels like we only need one of these two.

Female: Yes. Looks like I think the field is moving towards the flipping at more core control. In control. Yes. Based on some of the measures I've seen. Yes.

Female: OK. So, unless there's any more discussion needed from anybody's perspective I think we'll go to this one, 38. The question is, to what extent does this measure address critical quality objectives with the CMS quality measurement domain and/or identified program area key concepts? How many would say high?

Male: So, given the 38, 39 are …

(Off-Mic)

Male: … it's just sort of almost a disjoint range …

(Off-Mic)

Female: Well, no – I mean, actually there has been a time, if I recall correctly, that this measure – both measures have been part of comprehensive diabetes care

measure within the HEDIS data set. I'm not sure that they are currently. But I have seen them involved. I don't think you necessarily have to choose one or the other. You could choose both if (so you choose).

(Off-Mic)

Female: Yes, it's a menu. So, does that help you with making a decision about what extent?

(Off-Mic)

Female: OK. So, for this one, how many would – or to what extent does the measure – I guess critical quality objectives of CMS quality measurement domain, and/or identified program area concepts? How many people would say high? Two. How many would say medium? OK. So, it moves on.

To what extent will this measure address an opportunity for improvement and/or significant variation in care evidence by quality challenges for each program area? How many would say high? How many would say medium? How many would say low? OK.

To what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities, et cetera, and/or contribute to alignment of measures across program of plans and/or state? How many would say high? How many would say medium? (It's this claims) EHR laboratory paper records pharmacy. How many would say low? OK. So, this will not move on at that point.

Female: Correct.

Female: OK.

Female: So diabetes care for people with serious mental illness, hemoglobin A1C control, less than eight percent, did not pass based on the efficient use, refocus criteria and will not be recommended to the coordinating committee.

Female: Thank you.

Female: All right. Let's go on to 39 then. 39 is diabetes care for people with serious mental illness. Hemoglobin A1c poor control, OK. And it is an NQF-endorsed measure. It is adaptive from existing health plan, and existing plan measure, which is part of the CDC comprehensive diabetes care measure, poor control, graded as a nine percent. It's (instituted) by NCQA, data source claims, EHR laboratory paper records pharmacy. And, it's got a score of 2.1. No indication of use in any field at this point. Is this one that you've seen in Oregon through? I just want to check on that.

Female: It wasn't – (it doesn't need) for people with serious mental illness. It was just diabetes (for) control.

Female: Any discussion anybody want to have with this?

Male: The only comment I want to make is that – and you alluded to this. The number of people who are in this group is going to be much smaller than the last one. So in some ways …

(Off-Mic)

… it's not very big. Because they have to be hospitalized, probably.

(Off-Mic)

Female: Yes. I think the thought I had about it is that when you're looking at a threshold of, does this measures address an opportunity for improvement, this would fall more into the category of yes for me …

Male: Yes.

Female: Because it's a smaller group and it's a group that's have serious risks.

Male: Exactly, right.

Female: Yes.

Male: And particularly in terms of trying to change the provider culture to get people to think about diabetes, I think would be a …

(Off-Mic)

Female: Yes.

Female: OK. Does anybody have anything else they want to say before we vote on this one? OK. So, to what extent does this measure address critical quality objectives of the CMS quality measurement domains and/or identify program area of key concept? How many would say high? Four, OK. And how many would say medium? OK.

To what extent will this measure address an opportunity for improvement and/or significant variation in care evidence by quality challenges for each program area? How many would say high? Three, OK. How many would say medium? OK.

To what extent is this measure ready for immediate use? How many would say high? Three. How may would say medium? Two.

Male: Actually I'm going to exchange to medium.

Female: Medium. So we've got three mediums and two highs. So …

Female: Yes.

(Off-Mic)

Female: Didn't we just do this, to what extent is it ready for immediate use? And we've got three people said medium and two said high.

Male: Yes.

Female: Oh, sorry about that. I think I missed the efficient use of resources.

Female: Oh, did I make a mistake in this? OK. I thought we have it. OK, to what extent does this measure demonstrate efficient use of measure resources, data collection processes, performance improvement activities and/or contribute to alignment of measures across programs, health plans (in those state)? So, how

many people would say high to that? How many would say medium? Three? Oh, four. OK. So it does go on there.

And then we had – to what extent is this measure ready for immediate use? And we have some back and forth a little bit on that. So we'll do it again in line with the other measure, we have a vote. How many would say that it is ready for immediate use? OK, I'm changing this on our previous discussions. How many would say medium?

OK, so let's then move on to, to what extent do you think this measure is important to State Medicaid Agencies and/or other key stakeholders such as consumers, families, Medicaid-managed care organizations and providers? Any discussion for us on that? I would say that I think this is a group that is very important to identify and (intervene with).

So I think what we'll do is we'll vote on this at this point. How many would say that it is important and would say high? Five, OK. So it's going to be a measured concept.

Female: Yes. So, based on the criteria, the TEP recommend diabetes care for people with serious mental illness hemoglobin A1c for control to the coordinating committee for review. The next one we're doing is number 40.

(Off-Mic)

Female: So this is testing.

Female: Yes.

Male: Can we have 40?

(Crosstalk)

Female: Yes. Diabetes …

Male: So I'm going to look at it in the record.

Female: Pardon me.

Male: I'm going to look in the medical record.

Female: You can if you want, but you can get a claim. Yes. Diabetes care for people with serious mental illness, just testing NQF 2603, so it is endorsed, we're looking at people.

Female: Now, again, one of the things to keep in mind is we do have those narrow – as we've seen before, narrow definitions of serious mental illness as we've seen with all these. So that is a reservation we have for all of this.

And you can get this potentially from claims, you can get it from other ways, but a lot of people can – pretty easily get some claims because it's just a testing one. But you can also get it from lab, you can get it from pharmacy, on the EHR, and if you have to you can get it from (paper) but you don't have to.

Comments about this measure? If there's no indication of use (in the field) in any program, I guess it's because of just with SMI, certainly very commonly used in the overall HEDIS measure set. So any comments at this point? It looks like people are ready to vote for it or against it.

To what extent does this measure address critical quality objectives of the CMS quality measurement domain and/or identified programs, area, key concepts? How many would say high? Two. How many would say medium? Three. So it moves on.

To what extent will this measure address an opportunity for improvement and/or significant variation in care evidence by quality challenges for each program area? How many would say high? OK. How many would say medium? OK. So let's move on.

To what extent does this measure demonstrate efficient use of measurement resources? Data collection processes, performance improvement activities and/or contribute to alignment of measures across programs, health plans and/or states? How many would say high? How many would say medium? OK.

To what extent is this measure ready for immediate use? How many would say high?

And then to what extent do you think this measure is important, to State Medicaid Agencies and/or other key stakeholders, consumers, families, Medicaid-managed care organizations and/or providers? How many would say high? OK, five. OK.

OK, so based on the criteria, the (test) voted to recommend diabetes care for people with serious mental illness hemoglobin A1c testing to the coordinating committee for review.

The next one is medical treatment …

(Crosstalk)

Female: Forty-one.

Female: Yes.

Female: Yes, but again just making sure we're aware that with all of these, the definition of SMI is, from our perspective, limited.

So looking at this one here, this is, again, an NQF-endorsed measure. It has been part of the comprehensive diabetes care measure that is endorsed by NQF and stewarded by NCQA. It has the data sources or claims, EHR-only laboratory tape of records for pharmacy. So there are number of different ways that it can be collected. It's – (score) of 2.1.

Is there anything anyone wants to discuss with this one? OK. All right. How – to what extent does this measures address critical quality objectives of the CMS quality measurement domains and/or identified program area, key concept? How many would say high? Three, OK. How many would say medium? OK.

So we move on. To what extent will this measure address an opportunity for improvement and/or significant variation in care evidenced by quality

challenges for each program area? How many would say high? Two. How many would say medium? Three. Okay. So we move on.

To what extent does this measure demonstrate efficient use of measurement resources, data collection processes, perform improvement activities, et cetera, and/or contribute to alignment of measures across programs, health plans and/or states? How many would say high to that? How many would say medium? OK, so it moves on.

To what extent is this measure ready for immediate use? How many would say high? Four. And how many would say medium? One, OK.

So, that was like the measurement then.

(Off-Mic)

Female: Oops, last one. To what extent – so we've got – how many did we say high on this?

Female: Yes. So four high, one medium, so …

Female: Yes.

Female: OK. To what extent do you think this measure is important to State Medicaid Agencies and all the key stakeholders, consumers, families, Medicaid-managed care organizations and providers? Who would say high? God bless you.

Male: Thank you.

Female: How many would say high? How many would say medium? OK.

Female: OK.

Female: Moving on.

Female: OK. So, and please – I know they are also more measures, so if you don't mind getting assistance to do the rationale.

Female: For this one?

Female: Yes.

Female: Is there something you want to add?

Female: I think it's a fairly widely accepted use standard of care.

Female: OK. For individuals?

Female: Yes.

Female: With diabetes?

Female: Yes.

Female: And this is a high-risk population?

Female: Exactly.

(Off-Mic)

Female: Yes.

Female: OK. So, based on the criteria, the TEP voted to recommend diabetes care for people with serious mental illness medical attention for neuropathy to the coordinating committee for review.

Female: OK.

Female: So, then it's the next one, diabetes morning for people with diabetes and schizophrenia.

Female: Yes.

Female: OK, very good. That's number 42, all right. So with this one, it is an NQF-endorsed measure, so people 18 to 64, we're looking for both and LDL test and hemoglobin A1c test in the measurement year. It's most of the way just collect the data, claims, EHR lab, paper records pharmacy. Comment about

this, I would think that this is one that's fairly – collect the data fairly easily through claims.

Female: OK..

Male: Yes.

Female: It is use actually by Arkansas Medicaid if it turns out. OK. Any comments about this before we vote? All right, to what extent does this measure address critical quality objective of the CMS quality measurement domains and/or identify program area of key concept. How many would say high? I think that was unanimous.

Female: Yes.

Female: To what extent will this measure address an opportunity for improvement and/or significant variation in care by quality challenges for each program area? How many would say high? Five unanimous. To what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities and/or contribute to alignment of measures across program, health plans and/or states?

How many would say high? OK, so it's unanimous. And then to what extent is this measure ready for immediate use. How many would say high? OK. To what extent do you think this measure is important to State Medicaid Agencies and other key stakeholders, consumers, families, Medicaid-manage care organizations and providers? How many would say high? Yes, OK.

(Off-Mic)

Female: Yes. Basically, this is a high-risk population that has both two serious life threatening co-morbidities, diabetes and schizophrenia. And with already being identified as having these two conditions monitoring of for two risk factors, one high hemoglobin A1c and also high level of cholesterol is accepted standard of care.

Female: OK. So based on the criteria, the TEP recommends diabetes monitoring people with diabetes and schizophrenia to the coordinating committee for review.

Female: Very good.

(Off-Mic)

Female: All right. So we're on to diabetes screening for people with schizophrenia or bipolar disorder.

Female: Yes.

Female: Who are using antipsychotic medications, which is number 43. OK. And are we supposed to take a break at some point?

Female: Yes. So we can either take a break. I think we have on schedule. Oh we have scheduled 2:45.

(Crosstalk)

Female: I'm just sort of wondering, I'm noticing a little bit of a lull with the group. So I'm wondering if we want to get through this one and then a break.

Female: Yes.

Female: OK.

Female: All right. So …

Male: They all blend together.

(Off-Mic)

Female: Yes. This is an NQF-endorsed measure. We're looking at screening now. OK. So, this is people who have bipolar disorder or schizophrenia, and they're also taking antipsychotics. This is part of the Medicaid Adult Core Set and this claims, electronic health record lab pharmacy. So, this should be relatively easy to collect this data since we're talking screening here. So, why

don't we go ahead and get started. Are there – is there any discussion anyone would like to have on this?

OK. So let's start with the first question then. To what extent does this measure addressed critical for the objectives of the CMS quality measurement domain and/or identified program area key concept? High. How many would vote high? OK. So that would be unanimous. To what extent does this measure address critical for the objective of the CMS quality measurement domains and/or identified program, area, key concepts? High, how many would high?

OK, so that was unanimous. To what extent will this measure address an opportunity for improvement and/or significant variation in care. Evidence by quality challenges for each program area, how many would vote high? Five unanimous.

To what extend doses measure demonstrated efficient use of measurement resources, data collection processes, performance improvement activities and/or contribute to alignment of measures across programs, health plans and/or states? High? So five out of five, OK.

To what extend is this measure ready for immediate use, how many would vote high? Unanimous. To what extend using both measure as important to State Medicaid Agencies and other key stakeholders, consumers, families, Medicaid Management Care Organizations and/or provider? High? OK. Thank you.

Time for a break for about 10 minutes. We'll come back about 3:20 then, OK?

Female: Thank you.

Female: All right, thank you.

Male: Thank you. You're doing a great job.

Female: Oh thanks.

(Crosstalk)

Female: So, based on the criteria the TEP recommends diabetes screening for people with schizophrenia and for bipolar disorder who are using antipsychotic medications to the coordinating committee for review.

Female: So maybe – to maybe be clarified tomorrow.

Female: Forty-four is follow-up after discharge from the emergency department from mental health or alcohol or other drugs dependence. 45 is follow-up after emergency department visit for mental illness. So it would appear that one of these is just focused on mental illness, the other is water. And …

Male: That's probably (not) – I guess we voted for the one that combine …

(Off-Mic)

Male: So I would probably rethink my vote.

(Off-Mic)

Female: Do you remember which number that is?

(Off-Mic)

Female: We haven't voted for …

(Crosstalk)

Male: No, no. I mean, contribute things that (brief) the scores. But did we …

(Off-Mic)

Female: So which one?

(Off-Mic)

(Crosstalk)

Female: That one is purely staffing. And then …

(Off-Mic)

Female: Yes.

Female: I think one question that's come up a lot is whether or not the new suicide code actually get carved in to the mental illness because the emergency rooms are being encouraged to use those codes as oppose to, you know, a bipolar diagnosis. And so there's been a lot of concern that they're not carved in and that they would get (missed) as a mental health emergency room visit. It's actually been coming up quite a bit. And has anybody filed, you know, statement with NCQA about that, you know?

Female: Oh I just have it reported onwards, no.

Female: Yes. Not me personally. But you said it's been coming up …

Female: Yes, it's been coming up a lot like the (SAMHSA) suicide grant, you know, emergency room follow up grants, the Lifeline Center Grant, and some of the other emergency room follow-up projects around the country. So, that's actually sort of just came to mind.

Female: So I'm looking at these measures, we've got follow-up after emergency department visit from mental illness, follow-up after emergency department visit for alcohol and/or other drug dependence. I don't see at least within the HEDIS health plans measures that, one that seems to combine them.

Male: Right.

Female: Right.

(Off-Mic)

Female: Forty-four combines and it has the higher score for this (follow-up) …

Male: Yes, I think 45 was likely the one that we want.

Female: Yes.

Female: So 45 …

Female: Yes.

(Crosstalk)

Female: The reason I have the lowest score is because there was less information, I believe it's 2017 HEDIS measure.

Female: Yes.

Female: I think it might be …

Female: If that …

(Crosstalk)

(Off-Mic)

Female: And so what I'm hearing is that we would like to have this pulled up for discussion tomorrow, 45.

Female: OK.

Female: Forty-four and forty-five, yes, if you got …

Female: Yes, the 40 …

Female: And look at the two of them.

Female: Well …

Female: Yes, go ahead, please.

Female: Yes. So that – so that will be up for discussion because originally it wasn't retained, but we will bring it up so that if we go to …

Female: I think it makes more sense.

Female: OK. So we'll bring it up …

(Off-Mic)

… OK. That's good.

Female: Yes.

Female: And then the – and you look to see which – So the suicide piece that you guys mentioned – (Verna), is that for the HEDIS one or is that for number 44, which is the broader one?

(Verna): I mean it could be either, right? Because it would be – you're talking about 44 being the – the substance abuse, right?

Female: Well …

(Verna): And the mental health.

Female: It's either or.

Female: No. So this 44, which is broader …

(Off-Mic)

Female: … yes, this does come from – these are Medicaid specs. This is not, you know, a HEDIS health plan typical spec.

Female: Right.

Female: So I think we'd have to pull that up differently to know. I'm just kind of curios as to whether or not, were both of these claims – well, there's actually 45 which is the emergency department visit for mental illness, which is a HEDIS health plan score.

Female: Right.

Female: We have another measure. We have another measure that is follow-up for, I believe, it's alcohol or other substances, which is follow-up visit for alcohol and other drug dependences.

Female: Forty-five is the one that was I was saying, sort of just prepping initially.

Female: OK, so 45. So there, the question is, looking at the specs, do you remember what the code is for that? The CPT code, let's say?

Female: There's a couple of them. Yes, so like then I would …

(Off-Mic)

Female: Yes.

Female: Yes. I've actually got the specs right here in front of me. So that's the one I'm sort of asking about. Let's see. HEDIS 2017 specs, this is emergency department. OK, so I've got the second in front of me. I'm trying to see if I can find – so like the P1491.

Female: Oh, I don't see this …

(Off-Mic)

Female: Yes, I'm not seeing – OK, organizations may have different methods for billing in terms of outpatient visits and partial hospitalization. Some maybe comfortable with outpatient with several claims for each date of service. Yes, I'm not …

(Off-Mic)

Female: Yes.

Female: Oh, yes. Is it in the mental health diagnosis suicide?

Male: That's the question you're saying. It's not …

(Crosstalk)

Female: Yes, so like it's not, right? So in other words, the emergency rooms are being encouraged to use the codes and then they're not included in the (S.M.) but you would want it. So if I'm not (for suicide), is that you want to follow those follow-up guidelines.

Female: So tomorrow, we want to be sure that we comment on that …

Female: OK.

Female: … when we have (discussion processes). And oversight that I'm sure with this information, it will be observed (discussion point) I would think by NCQA so there will be …

Female: I would hope.

Female: Yes.

Female: Yes.

Female: They'll be able to see these comments, yes.

Female: And I just wanted to – so I'll provide a better summary tomorrow, but we – the 29 measures and recommended 15 of them …

Female: (Thank you).

Female: … for those coordinating committee for review. And I'll do a little summary tomorrow morning about what those measures were and what domains they fell in.

Female: That would be great.

(Crosstalk)

Female: That's less than I thought.

(Off-Mic)

Female: It seem likely, but I guess not, about 50 percent.

Female: Yes.

(Off-Mic)

Female: Oh, yes.

Female: Yes. And I think the other thing that comes to my mind is anything that may be emerging. So for example, one thing that really seems to be coming to my mind is that there are measures that we think are particularly valuable, but it's difficult to pull the data from an electronic perspective. And the concern is that it just places too much burden on the entity to be able to get that data well and very easily.

(Off-Mic)

Female: Yes.

(Off-Mic)

Female: So providers either have to submit the data or they have to make themselves available in their office for some of the command and actually (electronic) records. And so that is the implication on them, it can absorb a substantial amount of time.

Male: Yes.

Female: Yes.

(Off-Mic)

Female: Yes.

(Off-Mic)

Male: … 5,000 people or so within the diabetes …

(Off-Mic)

Male: The challenge would be how many points of accountability are we taking down …

(Off-Mic)

(Crosstalk)

Male: And that's where it becomes …

(Off-Mic)

Male: And that means the category …

(Off-Mic)

Male: … at least to then kind of put fire providers to be more – or could be pushed back.

Male: True.

(Off-Mic)

Female: Yes.

Male: … need to overcome …

(Off-Mic)

Female: That's probably, yes.

Female: Yes, yes. All right. Any other comments that anybody wanted to make today? Pluses, minuses, what might we want to do differently tomorrow as kind of – and we proceed with our following 15?

(Off-Mic)

Male: I think having them grouped …

Female: Yes.

Male: … you know, with like measures together is really …

Female: Yes, having them not only grouped from the perspective of domains but also grouped from perspective like, this is a natural stopping point because we're looking at all the emergency ones all at once …

Male: Right.

Female: … all the diabetes ones were together and so on.

Female: Yes.

Female: It's very helpful.

Female: That's a very good point. I can see how challenging it would be to switch back and forth …

Female: Yes.

Female: … as you said previously in this diabetes issue …

Female: Exactly, exactly.

Female: Yes.

Female: Yes, yes. Anything else anybody wanted to add today?

(Maureen): Well, I want to thank all of you because you've been a great, great group, you've been participatory and we've really worked to try to get to the essence of what our concerns are in a succinct way and I want to thank all of you from …

Male: Yes.

(Maureen): … NQF for everything that you've done today to help organize those and help us to stay on track and I really thank everybody for helping me to stay on track.

Male: You've did a great job.

Female: Yes.

Female: Thank you.

(Crosstalk)

Female: And thank you, (Maureen), this was …

(Maureen): I'm glad to do it.

Female: Yes, thanks. But I appreciate it. I'll see you guys all.

Female: Yes.

Male: All right.

Female: Well, is anybody going to go dinner?

Female: Yes.

Female: I'll go. I'm going to go dinner about 6:00. Yes, anybody else that would be available for dinner?

Female: No. I understand. It's OK.

Female: So you're going to dinner. So I'm going – So I am …

Female: It's OK.

Female: I'm going to go …

Female: I don't know if I'm going to see anybody I know because everybody is getting (pork) and I'm like …

Female: So I am – I'm planning to go over there and get a drink. But I am unable to stay for dinner. So that's around 6:00 in the (office).

Female: OK.

Female: So I have a conference call at 5:15, but I think it will wrap up by about quarter of.

Female: OK.

Female: Yes.

Female: And I'm trying to remember where is this.

Female: OK, so (6:00). So it is right on the corner of …

(Off-Mic)

Male: That's good.

Female: Yes. I mean if my call doesn't go long, you know, and I – what I might do is go and take it nearby and then if it ends at, you know, some time …

END