NATIONAL QUALITY FORUM

Moderator: Benita Kornegay-Henry
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5:50 p.m. ET

Operator: This is Conference # Kate19

Female: And then …

Female: For those who need (some space), just let me know and I'll get something …

(Off-Mic)

Female: Yes, I will.

Female: OK. OK.

(Off-Mic)

Female: I forgot my …

(Off-Mic)

Female: Yes.

Female: And, (Sheila), could we start on (inaudible) some updates.

(Off-Mic)

Female: … (Angela).

Female: Could we start on …

Female: My colleague is director of public policy and prevention at (Inaudible), (Missouri).

Female: Hello.

Female: OK.

Female: Thanks.

Female: We'd like your number.

(Off-Mic)

(Crosstalk)

Female: Yes, he's in …

(Crosstalk)

(Off-Mic)

Female: Yes.

(Crosstalk)

Female: Yes, I …

(Off-Mic)

Female: Yes.

Female: Yes, I think …

(Off-Mic)

Female: Can we start on slide ...

Female: 29 and 30.

(Crosstalk)

Female: Can we just start on slide 35?

Female: Just say day two agenda.

Female: Yes.

Female: OK.

(Off-Mic)

Female: Yes. Slide 35 is what it says.

Female: There we are. So, as I alluded to earlier, we did make some changes to our process last night. We noticed that there was an unintentional consequence of our decision logic. So, originally we had when we had to what extent is this measure ready for immediate use, we had medium and low going into the measure concept.

The intent behind this was to allow some of the measure concepts that weren't fully ready for implementation a fair chance at recommendation. An unintended consequence of which is that some of the measures that are actual measures, NQF-endorsed measures, were rated as medium for ready for immediate implementation within this population and so, were incorrectly categorized as measure concepts.

So, we will need to go back and revisit those to make sure that we do include them as either measure or do not include. And so …

Male: So, you mean instead of just doing low on that area, we did medium and low?

Female: Yes.

Male: OK.

Female: Yes. And then we also updated if we go to page three, this is in logic question four; so we did kind of revamp the language for ready for immediate use to kind of get, to reflect these changes. So now it is can be for measure concepts that are already in use for the Medicaid population, measure is fully specified and tested for the Medicaid population would receive a ranking of high.

For medium, not in use in the Medicaid population but has a numerator and denominator and testing is reliable and valid. So, that's where a lot of the NQF-endorsed measures fell.

And then for low, is not in use in the Medicaid population. It has a numerator and a denominator and no evidence of testing. So, that's kind of where we're looking.

Male: OK.

Female: And so, if we go to slide 38. So, before we kind of go back and look at the NQF-endorsed measures, I want to do a brief summary of what we had done yesterday.

And so, we reviewed …

Female: That's the last one.

Female: Oh, I think we were supposed to, I asked (Shawnn) to upload a new version.

Female: OK, hold on.

(Off-Mic)

Female: OK.

Female: Oh, yes.

Female: If you say 39.

Female: Oh, there we are, and then 38. Perfect. So, here we can see that we have reviewed a total of 29 measures to date. We recommended 15. We recommended both of the access measure as well as eight measures within care coordination. But we've only reviewed 14 of those 23 to date.

We reviewed all the 13 clinical care measures and recommended five, so, left for today is that we actually have 16 to review because we added one from yesterday. We are now reviewing follow-up after emergency department visit for mental health, which wasn't originally slated for discussion.

So, we will have 16 to review today in addition to a brief revisiting of – and if we look on the next slide – these are the four measures that we had rated as a measure concept because they received medium ranking in ready for immediate use. And that was the old convention which incorrectly classified NQF measures as measure concepts.

And so, (Maureen) and I talked about it this morning and we wanted to know, did people want to review these measures and go together voting again, were people comfortable of saying they received medium rankings for ready for immediate use and they're good to be qualified as measures. We wanted to take a pulse on what people's opinions are.

Male: Hi.

Male: Yes, me, too.

Female: Yes.

Female: OK.

Female: OK. So, all four votes now become measures that we're going to implement.

Female: OK. OK. So, I'm just going to say that for the record, so we have it on the record because these are NQF measures.

Female: We have everything on.

Female: (Sheila) already has it set. And so, the TEP recommends depression readmission or response for adolescents and adults for review as a measure to the coordinating committee. The TEP recommends NQF 0418 preventative care and screening, screening for clinical depression and follow-up plan as a measure for review to the coordinating committee.

The TEP recommends NQF number 2599, alcohol screening and follow-up for people with serious mental illness for recommendation as a measure to the coordinating committee. And lastly, the TEP recommends NQF number 2607, diabetes care for people with serious mental illness, hemoglobin A1C for control as a measure for recommendation to the coordinating committee. So, we are set on that.

Female: The one thing that I would add is that my recollection from that discussion the other day is that in some cases, although measures were electronic measures, there were many instances where the data was not necessarily being collected electronically. And there were also manual entries into the electronic record. So, there is still some fine-tuning that we think would be beneficial with regard to some of these measures from that perspective.

Female: And then if we look …

Female: Does that capture some of your thoughts?

Female: So, we are now on measure number 44 in our discussion guide.

Female: We got it, yes.

Female: Follow-up after discharge from the emergency department.

Female: Oh, is it working now?

Female: Yes, it's great.

Female: This is where we were going to put the note about the (suicide) code.

Female: Yes. So, was that number 44 or number 45 that we were doing?

Female: I thought we said 44.

Female: OK.

Female: OK.

Female: It would be 45, yes.

Female: It would be relevant for …

Female: Yes.

Female: OK, 44, follow-up after discharge from the emergency department for mental health or alcohol or other drug dependence. And before we get started on that, I just wanted to check, (Beverly), is there anything that you'd like to add.

(Beverly) would like to from time to time participate in discussion, although not voting, right?

Female: Yes.

Female: So, we wanted to make sure that before we got started if there was anything that you would like to add at this point.

(Beverly): No. No.

Female: OK.

(Beverly): Thank you.

Female: All right. Great. Sure. So, the first one, follow-up after discharge from the emergency department for mental health or alcohol or other drug dependence, so this is the one with both mental health and alcohol. It's an NQF-endorsed measure. It's a Medicaid adult core measure. The data source is claims, so, thoughts, comments about this one before we begin to look at it from a voting perspective, please.

Male: So, I realize it's a separate measure but …

Female: No, go ahead.

Male: Thank you. The next one is a follow-up after the ED for mental illness. It seemed like in some ways it would be better to have a separate one just for alcohol and drug dependence.

Female: I believe NCQA does have it. It's the 2017 – yes.

Female: Yes.

Female: I can pull it up but I was checking that out yesterday.

Male: Yes. I realize we don't necessarily have the ability to be ready to tweak this but otherwise people just do, I mean, you could do a calculation I guess.

Female: Do we know if the SUD TEP …?

Female: I could check.

Female: Follow-up.

Female: Yes.

(Off-Mic)

Female: Oh, yes, the …

(Off-Mic)

Female: For SUD; if they did …

Female: Yes.

Female: I'm assuming that's one of the ones they're reviewing.

Female: Yes.

Male: Probably, yes.

Female: In which case …

Male: That group, I forgot about that.

Female: I'm just wondering.

Female: I can pull it up really quickly so that we can – and do we know the measure title …

Female: Well, there is one called follow-up after emergency department visit for alcohol and other drug dependence that is in HEDIS 2017.

Male: Yes.

Female: Also in HEDIS 2017 is the one that we'll be looking at next which is follow-up after emergency department visit for mental illness. This is the first time I've seen the measure where it's a combination of the two.

Female: So, what would be the value of combining?

Female: Yes. I was wondering that myself.

Female: I am just curious.

Female: Yes.

Male: The way the spec is laid out is anybody can (inaudible) and the numerator looks like it has separate rates for mental health.

Female: Right.

Male: Yes.

Female: Rate one, rate two.

Female: Right.

Male: But it only calls out a single denominator which would be used–

Female: Yes. Then why put that.

Male: Yes, I agree.

Female: Yes.

Male: All right.

Female: It's funky for many …

(Off-Mic)

Female: It doesn't matter how you place that one.

Male: So, we first think about this going with the mental health, and we know the drug and alcohol one already exists.

Male: Yes.

Female: Right. And they are reviewing it.

Female: So, the SUD TEP is reviewing …

Female: So, they're actually reviewing this one as well, the combination and then …

Male: We'll send them a check.

Female: Yes.

Female: The other one is follow-up after emergency department visit.

Female: Yes, there are two. One is follow-up after emergency department visit for alcohol and other drug dependence. So, I'm assuming you're looking at that one. And then the other one we're going to look at a little bit later is follow-up after emergency department visit for mental illness. I've not seen the combo before.

Female: So, they are actually looking at the combo. It doesn't look like they're looking at the …

Female: That would be one only.

Female: Yes.

Female: That's interesting.

Female: Yes. It doesn't say.

Female: So, could we make a recommendation for the record that the TEP consider a separate distinct one given that we're seen at completion of the numerator here but a separation of the denominator or either that would compromise the ability to effectively use the data?

Female: So, is this an NQF-endorsed measure that we're looking at?

Female: It is.

Female: NQF 2605.

Female: I've been scrolling back and forth between this and my HEDIS manual, that's why I'm asking.

Female: And when we're saying follow-up with the provider, do we say which type of provider it is? Is it the primary care provider or do you even specify? I think (inaudible) it says provider but not …

Male: Yes.

Female: So, for 44 I believe it says with any provider, who had a follow-up visit with any provider. So, let's take a look and see how 45 looks; that could be the issue.

Female: Sure.

Male: It says any outpatient visit.

Female: That's what it says for – which one are you on, 44 or 45?

Male: Forty-five I'm looking at.

Female: Forty-five is OK, a primary diagnosis of mental illness who had an outpatient visit in IOP or partial visit or partial consultation for mental illness. So, it would …

Male: You have to have a mental illness diagnosis.

Female: But it could be a non-behavioral health clinician.

Male: Yes.

Female: It would appear. So (inaudible).

Female: I'd almost prefer because if you're integrating mental health and physical health your primary care doctor is your overall physical health, to oversee your overall physical health. And then they could coordinate care among …

Female: Yes. They would have to use the primary diagnosis of a mental health, which the likelihood of that …

Male: Is not great.

Female: Even though they might address it, they might put another reason for visit so that it wouldn't get captured.

Female: OK.

Female: It's interesting, when I look at the alcohol HEDIS measure, follow-up after emergency for alcohol and other drug dependence, it looks like it's a follow-up visit for AOD which could or could not be behavioral health or addictionologist, it looks like as long as there was a visit. And they've got several value sets. You have ET standalone visits value set.

Do you know what those value sets include, (David)?

(David): So, that would be from the initiation engagement in SUD treatment. So, that probably does constrain it to SUD-related providers or services that would at least on its face exist for some management of SUD.

Female: OK. Yes. Every one of the value sets, AOD dependence value set, oh, POS group one value set is another that could be used, but then it says diagnosis of AOD IOB dependence value set, but IET POS group two value set. Would any of those potentially be more than just the addiction?

Male: I'm kind of hearing place of service there.

Female: Yes. So, it will be.

Male: Probably part of kind of a (inaudible) set of things in the IT context. With some imperfections, that measure in terms of especially (inaudible) encounter while you think there's (inaudible) SUD diagnoses (inaudible). So, hearing that, it does suggest to me that these (inaudible) measures are attempting to constrain visits that are either (inaudible) or SUD-related. But other than specialty care potentially.

Female: OK. So, it could potentially be, for example, a physician who is prescribing medication-assisted treatment.

Female: Yes. Yes.

Female: OK. So, it's a little bit broader than that. But it might be not just a follow-up visit with your primary care doctor.

Male: Not without any SUD or mental health diagnosis.

Female: Well, it has to be. But then we have to be treating. So you have to have a primary visit, primary diagnosis.

Male: I'm agreeing with you on that. Yes.

Female: Yes.

Female: So, it could be that person.

Male: Yes. So, my hunch would be that it could be a primary care provider as long as there are other attributes to the visit.

Female: Some management of mental health or an SUD …

Female: OK. I think the problem is they use the E&M codes for the (MAT) as opposed to some more (MAT)-specific codes because of the way they get reimbursed in a lot of places, or because of how they have to be credentialed with the plan so it's easier just to use the E&M than a higher, like for an induction or something.

Male: Right.

Female: So, we're spending a fair amount of time at this one right now; we've had a feeling we would. And I'm just trying to make sure I understand the difference between the two, it looks like the mental health one is essentially for a follow-up for mental health after an ED visit either within 7 or 30 days.

It looks like it can be a provider. If I'm understanding this correctly, it can be a provider other than a behavioral health person, but there are a fair amount of behavioral health components there that are permitted like partial hospitalization, IOP, and outpatient visit that has a primary diagnosis, care setting, behavioral health, yes, inpatient behavioral health, outpatient, clinician office, clinical practice hospital, all of that could be possibly someone who's not behavioral health as long as there's a behavioral health diagnosis.

Male: Right.

Female: Right. So, we do have that broad there and when we look at follow-up after emergency department visit, I'm looking there to see what that says. That one is actually, it still looks like it's got oh, OK, so one of the differences between these two is that the mental illness one is for members six years of age or older, whereas the follow-up after discharge from the emergency department for mental health or alcohol or drug dependence …

Female: Eighteen or older.

Female: … is 18 or older. So, we do have a difference there.

(Off-Mic)

Female: For me?

Male: Yes.

Female: Yes.

Female: It's a high rate.

Male: Yes. I would argue for bringing youth into the mix.

Female: Yes.

Female: It's actually ED.

Female: Yes.

Female: It's a good signal of lack of outpatient services.

Female: Yes.

Female: And it says here care setting for this one, behavioral health; outpatient, clinician office, clinic, physician practice, this is for the alcohol one. I think we definitely want to look at the second one, and I think one of the things we really like about that is that it has that lower age. But is there any reason why we wouldn't want to consider number 44, the one focusing on mental health or alcohol drug dependence?

(Off-Mic)

Female: Because you're looking at both.

Male: Yes.

Female: But we could recommend it to the committee, right? And then let them capture that.

Male: Yes.

Female: Yes.

Male: Can we send them like comments, with our recommendation?

Female: Absolutely. Absolutely.

Male: We're not sure if this is necessary in addition to the two individual measures, but we're forwarding that for your review.

Female: Yes. And also because it's not clear; I want to double-check with (Kate).

(Kate), did you say that the ambulatory follow-up after emergency department visit for substance abuse or alcohol or other drug dependence, that that one alone …

Female: No.

Female: … that the other committee isn't working on?

Female: They aren't working on one that's all of.

Female: Well, in that case I think we definitely should include this from my perspective.

Male: yes.

Female: The follow-up after discharge from the emergency department for mental health or alcohol or other drug dependence would I think potentially make the point that there is a measure, a HEDIS measure that focuses on alcohol or other drug dependence follow-up after ED visit.

Female: I agree.

Female: And that it might be a cleaner concept ultimately to have that measure and the measure on mental health as your true measures as opposed to combining them together, because that way you'll have a little bit more specificity.

With this one, is there a way the percentage of ED visits for mental health, percentage of that for alcohol but it does seem to if I've got it correctly; it does seem to have both in there, is that right? Can you break it out separately is what I'm trying to sort to?

Male: The numerator text reads if you could but the denominator doesn't specify separate denominators for the two conditions.

Female: So, you're back to not knowing.

Female: And you've got your combined …

Male: And it could be with more details that maybe there are separate denominators.

(Off-Mic)

Female: Like because it's, and (Jeff) mentioned we can look up some more detailed denominators.

Female: Would you like to do that?

Female: Yes.

Female: Yes.

Female: Before we make a recommendation.

Male: You really should have two separate.

(Off-Mic)

Female: Yes. Yes, I'll look it up right now so we can have the more detailed denominator.

Female: Yes. Yes.

Female: One moment.

Female: And I wonder, this online thing if there was ever way to upgrade it so that you could link into the measure specs at a detailed level right from in here.

Female: Yes.

Female: That would be enormously helpful.

Female: Yes. That's a very good–

Female: So, maybe while waiting on that, we can at least vote on a couple of components of this to move it along.

Female: Yes.

Female: To what extent does this measure address critical quality objectives of the CMS quality measurement domains and/or identify program area key concepts? How many will vote high? OK. So, that's unanimous.

To what extent will this measure address opportunity for improvement and/or significant variation in care evidenced by quality challenges for each program area? How many would vote high?

Female: Two.

Female: How many would vote medium? OK. So, it passes from that perspective on.

To what extent does this measure demonstrate and this is a claims measure.

Female: OK.

Female: To what extent does this measure demonstrate efficient use of measurement resources, that is 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? OK. So, that's a five.

To what extent is this measure ready for immediate use? How many would say high? OK. Now, here's where I think we might want to have a little bit more information about the denominator.

Female: OK. We are pulling up the denominator details. OK. I'm not seeing anything that specifically tells us …

Female: Yes.

Female: Oh, here, denominator, all information …

Male: I have found a document that says there are separate denominators.

Female: Oh, good.

Male: I don't know – and it also says that NCQA is the measure steward but it's also in NQF 2605.

Female: Yes.

Male: It's literally the same as the HEDIS. I mean, NCQA is also the steward.

Male: Yes.

Male: So, maybe this is what, HEDIS 2017.

Male: No way to know.

Female: Yes. I'm not seeing, you have to scroll through a lot. We have description, OK, four rates are reported, seven days for mental health; 30 days for mental health; seven days for alcohol or drugs and 30 days for alcohol and drugs. So, one would assume …

Male: Yes, actually …

Female: So then what's happening with the denominator.

Male: I was interpreting that (inaudible).

Female: So, what happens with the denominator, though, does anybody know what that looks like?

Female: It doesn't look like it's parenthesized.

Female: All right. So, that's with description.

Female: (Paul), do you think this is because there are so many co-occurrences?

Female: Oh, here we go. No, that's the numerator for each one.

Female: Look at details.

Male: It tends to be ED visits for alcohol or other drug. So, the document I have actually does identify there are different denominators for mental health for alcohol or drug.

Female: Oh, here we go.

Female: You can still somehow separate out that …

Male: So, if we're looking at the same text of percentage of emergency department visits for mental health, I would view that as that saying the denominator is visits (inaudible). So, I feel like that's calling out a mental health denominator for the 7 and 30-day follow-up.

And then the next two bullets (inaudible) I feel like it's at this description here which means it implied condition-specific denominators.

Female: OK.

Female: Yes. It's not really very clear to me here, I mean, I'd have to really take some time to dig into it all, but it looks to me by the denominator, I don't see it as being as clear as one might like at least in here.

Male: I agree.

Female: What's that?

Male: I agree because …

Female: OK. So, I mean, I think we clearly are saying that – so, let's go back to where we are here. Let's go and vote and then we can have the discussion. To what extent do you think this measure is important to state Medicaid agencies and other key stakeholders, consumers, families, Medicaid managed care organizations and/or providers? How many would say high? OK.

And so then I think we have met our …

Female: Yes.

Female: OK. So, my last question for you then as a group is, is there any comment you'd like to make about this in light of the discussion that we just had?

(David), I'm going to look to you first.

(David): So, with HEDIS I certainly I get that nexus of mental health care and connectedness to mental health (inaudible) treatment-related services. So, it is a high priority measurement area, and as long as if the denominator issue, so this may essentially be identical to number 45. If it isn't then I think we'd probably encourage folks to look at the condition- specific measures that are potentially more precise and especially the accountability metrics that might be aligned to mental health or SUD aspects of the Medicaid (inaudible).

Female: Anything else anyone want to ask?

Female: Right.

Female: OK.

Female: Hey, (Carrie), you got what you need?

(Carrie): I did. So, based on the criteria the TEP voted follow-up after discharge from the emergency department for mental health or alcohol or other drug dependence as a recommended measure to the coordinating committee for review. Now, are we reviewing 45?

Female: Good. Good. We're going to 45, follow-up after emergency department visit for mental illness. This is not an NQF measure.

Female: OK.

Female: It is one though that is a HEDIS 2017 measure. It is an NCQA-stewarded measure. So, at this point, is there any discussion? We certainly had some discussion already. So, I'm going to start by then voting, to what extent does this measure address critical quality objective of the CMS quality measurement domains and/or identified program area key concepts. How many would say high? Five. OK. Thank you.

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? High? OK. Thank you.

To what extent does this measure demonstrate efficient use of resources? And this is a claims measure.

(Off-Mic)

Female: Right.

Female: Is that because of …

Female: That was because we could not find the information.

Female: But it should be the same, right? It should be claims?

Male: That's definitely claims.

(Crosstalk)

Male: I just wanted to raise one comment which also applies to the prior measure and some others but something I just thought about, which is these are measures for Medicaid programs.

Female: Yes.

Male: There are some services that people get under Medicaid that don't fall into this bucket that are clinical like ACT or other alternative services of Medicaid programs.

Female: So, an ACT follow-up wouldn't be included in this?

Male: No.

Female: It wouldn't fall under …

Male: That's not a usual outpatient code, I mean, I don't know what codes they listed. They're using different codes than …

Female: Right.

Female: Oh.

Female: Yes. In the ACT teams, we also talked about life sciences, quite a few services that actually some of the …

Male: Right. And a lot of people …

Female: … mobile crisis actually, services, a lot of them.

Female: I think that we need to make a note of that.

Female: Yes. So, I absolutely agree. Yes. So, I think for both 45 and 44, OK.

Male: (24) hours.

Female: Quite all right, our brains are still kicking in; we're getting back into our sea legs of doing this again so to speak.

Male: Yes.

Female: Will that comment actually be how actively relates to the …

Female: There will be examples.

Female: Oh, our comments will be definitely proactive to the coordinating committee.

Male: Yes.

Female: Yes.

Male: (Inaudible) I mean, the downside of doing those is you can't necessarily compare rates between states because states might use different codes for different services or have different services. But one potential way to think about it (inaudible) we recommend that the state do these which are the traditional codes that everybody has and then the states consider doing supplemental measures that include clinical services that they have available …

(Off-Mic)

Female: (Angela), just to follow-up, also (Maureen) sits on our coordinating committee.

Female: Right.

Female: So, all the conversations as well in addition to being provided we'll have our …

Female: Right.

Female: Right.

Female: Yes. Oh, yes.

Female: So, part of the issue, too, is I think we need to make sure that we are communicating that for 44 and 45 that there is a concern that there are codes presently not included in these measures that we think would be appropriate to include, such as ACT team – what was that?

Female: Mobile crisis.

Female: Mobile crisis.

Female: Lifeline is something so in other words there's been a lot of talk because of the effectiveness of the Lifeline. When you get discharged, one of the things you get is call the Lifeline if you have a problem or one of the systems like Lifeline as an example.

Female: Right. Yes.

Female: I mean, but also the suicide, so there's codes in the ER that are probably not going to be captured and things like the ACT team mobile crisis, all of those.

Female: Kids wrap around team, that kind of thing.

Male: Right.

Female: Yes.

Female: Health home services.

Female: Yes.

Male: They maybe even want to consider case management.

Female: Yes. Well even any of the health homes.

Female: Right.

Male: Right.

Female: Any of the new collaborative care codes wouldn't be included.

Female: Yes. See, I think that they need to …

Female: And that would absolutely count, so none of those folks would be counted either.

Female: Yes.

Male: Yes.

Female: Yes.

Female: So, are the school-based codes counted there?

Female: So, one of the things we said though is that because of the nature of the school-based health centers that if the company has done – well, it depends on the school and center is going to send an ELB home, then a lot of times they don't draw up the claim. So, if you're depending on claims data then a lot of those visits aren't going to be picked up by the …

Female: So, I think that we may need to make a note of some of this because these are the kinds of things that should be under consideration for NCQA as they look at these measures.

I think also the next question then 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/or states. How many would say high?

How many would say medium? Yes. And I think the reason at least from my perspective for why it's a medium is because of these deficits in terms of capturing data for services that we think are highly relevant and should be encouraged in many instances for some of the consumers who are leaving the hospital and, therefore, we would like to see them included in the numerator. Make sense? OK.

To what extent is this measure ready for immediate use? It's already being deployed. So, how many would say high? All right.

To what extent do you think this measure is important to state Medicaid agencies and other key stakeholders, consumers, families, Medicaid managed care organizations and providers? How many would say high? One, two, three, four. How many would say medium? One. And, again, it’s for that very reason we were just discussing.

Female: And I think our comments here is we wanted to capture that physical down to six years of age and (inaudible) concern about capturing children and youth.

Female: Yes. And I think that's a really good point. Thank you and we should make the note that one of the deficits that we see for 44 is that it only starts at age 18.

Male: Right.

Female: Yes.

Female: And when you're talking alcohol and drugs, 18 is not …

Male: That's way too high.

Female: Right.

Female: OK.

Female: Even mental health, I mean, there's a ton of ED's …

Male: Oh, sure.

Female: Sure.

Female: So, I think but the other …

Male: Actually the people you're really worried about there are the people between 12 and 18.

Female: Yes.

Female: OK. OK.

Female: Right. Do you have the information that you need?

Female: I do.

Female: OK.

Female: So, based on the criteria, the TEP recommended follow-up after emergency department visit for mental illness as a measure for the coordinating committee to review.

So now we're at 46. OK. So follow-up of 46, ah, it's a classic, follow-up after hospitalization for mental illness. Many of us have lived that one for quite some time. It has a measure score – Sorry.

Female: I didn't mean to do that.

Female: Most of the scores 2.7 on a threshold of 1.7 but it is a NQF-endorsed measure. It's the measure that I think many of you are familiar with that deals with 30-day and 7-day follow-up after discharge from a hospital. This is part of the HEDIS health plan measure set. The data source is claims in EHR which makes it positive and you'll see it sometimes in health plans and in integrated delivery systems.

Care setting, now this is behavioral health, inpatient behavioral health, outpatient and clinician office, clinic or physician practice. I've always understood that this had to be follow-up by a behavioral health provider; has that changed?

Female: That's how a lot of the payers count it and we've run into huge problems because you could come in, see a primary care provider, get your meds which we do quite frequently.

Female: True.

Female: And it doesn't get counted on our quality measures as a follow-up behavioral health visit.

Male: The NCQA measure includes behavioral health.

Female: Yes.

Female: It says with a mental health practitioner.

Male: Yes.

Female: Yes.

Female: It does say mental health practitioner.

Female: Yes.

Male: Yes.

Female: Primary care, yes.

Female: So, this actually, you're right, it flies in the face of …

Female: This is a huge issue because in a lot of kind of places around the country there's very few psychiatry prescribers and the primary care providers are generally in those communities the ones who might renew that first script after somebody gets discharged, because they might only get 30 days or 10 days or whatever it happens to be.

So, many times that follow-up visit is with primary care in those communities. And it's been a big issue.

Female: So, that's really interesting because this is an important measure, but if it hasn't been updated to reflect what we're trying to do, which is integrate care and the realities of there being prescribers …

Female: Yes.

Female: Yes. And on the one hand you could say that you don't think that while it is an important measure, it is not necessarily an appropriate measure from the perspective of integrating health with behavioral health, except for the fact that hopefully even if they're seeing someone who is a psychiatrist or a psychiatric nurse practitioner or a psychologist, social worker or IOP, that does fall within the scope of this measure. If there is some sort of problem one hopes that they are then integrating back with the healthcare professional. So I think we've got a bit of a dilemma here on …

(Angela): So from a patient perspective, this is a good measure regardless …

Male: Yes.

Female: Right.

(Angela): Because you're getting good care. From a primary care perspective, the challenge is …

(Crosstalk)

Male: It's not …

Female: Well, I think even from the patient perspective in a lot of places there is no way for you to get your meds unless you go back to the emergency room. So if you happen to get them from your primary care doctor, that's actually really helpful because you probably know that person and they're accessible to you as opposed to maybe a three-month late to see a psychiatric provider in some communities to get those medications, so …

Male: That's not necessarily a bad measure, but it's somewhat incomplete.

Female: Yes.

Male: So maybe we could suggest we consider an additional measure that relates to the follow up of mental health or another – or any licensed practitioner.

(Off-Mic)

Female: Any – yes.

Female: I think that would be good.

Female: Yes.

Female: And also, or modify the specifications of this to include …

Male: Any practitioner …

Female: Exactly, any healthcare practitioner.

Female: OK.

Female: Yes.

(Angela): I guess it gets to sort of a core issue is in one sense we are evaluating things in terms of their current existence and applicability, but we're actually trying to shift entire systems, different models of care and that creates a bit of a disconnect.

So it would be helpful if NQF were somehow more fluid in terms of being able, willing to change measures to reflect the realities of (inaudible) care that's being delivered and what we're looking for in the future.

Female: Actually delivered …

Female: Yes, that's …

Female: I think the challenge historically has been that when somebody leaves a hospital for psychiatric condition, they've been hospitalized, they really should be getting specialist care.

Female: Yes.

Female: And that's part of the reason I think why this has been limited like this. But the reality is particularly in some areas, rural areas or in areas where the person feels like they've got the best relationship with their primary care physician–

Female: Right.

Female: That maybe the most helpful way to get back with …

Female: I want to also dispute that because I would say if you – we just had a 63-year-old hospitalized following an initial suicide attempt, discharged, followed in primary care with collaborative care, high touch, right, focused treatment in primary care, totally appropriate, totally right-touch totally appropriate

clinically, medications, follow ups, care coordination the whole nine yards, that's a totally appropriate follow up, so I think …

Female: Oh, absolutely. I'm going to …

(Crosstalk)

Female: Yes.

(Off-Mic)

Female: So, I mean, I think that that's now …

Female: Time to revisit. That as we're going through these transformative models and as we're looking at what are the needs of individuals with – in communities where there are shortages, scarcities and as we look at the whole issue of patient-centered care and patient preference in some cases, patients prefer to see someone who is their primary care physician that they've maybe had a long-term relationship with from a person-centered care perspective, patient-centered care perspective.

Female: Right.

Female: So I think we've got a number of …

(Off-Mic)

Female: The preference will be the patient wants to see someone outside of the primary care setting because they may be embarrassed that they have a situation.

Female: Sure.

Female: Yes. Absolutely.

Female: Unless, there's a …

Female: And that will get caught. That will get captured.

Female: Yes …

Female: Get picked up here.

Female: Yes, in this measure it's just that they decide to do something other, that's not captured.

Female: Yes, right.

Female: Good point.

Male: Perspective that it will be desirable (inaudible). We do know from our experience that this measure (inaudible) constructive has a really strong relationship to a failure to get timely post discharge care as defined by …

Female: Sure.

Female: Yes.

Male: Currently very strong …

(Off-Mic)

Female: That's …

(Off-Mic)

Female: Yes.

(Off-Mic)

Male: Right.

(Off-Mic)

Female: Right. Yes.

Female: All of this input the same-day next-day, like we're on the same-day next-day.

Female: Yes.

Female: So when you talk about – were you talking about the seven-day or the 30-day measure for that?

Male: Both, until we see a signal with both. We've done folks on seven-day when we …

Female: OK.

Female: Yes. Interesting. Yes …

Female: A lot of places have switched to five.

Female: Yes.

(Off-Mic)

Female: And then you also said though you're at one or two.

Female: Same-day next-day.

Female: Yes.

Female: For scheduling in general, but same-day next-day hospital or general discharge.

Female: Yes. OK. So it sounds like – uh-oh, help me.

(Off-Mic)

Female: I have my hands here and I'm worried we've got so much discussion as to whether or not, where we are on it.

Female: And so we have not begun.

(Off-Mic)

Female: I have my hand …

(Angela): Eventually.

Female: I was telling people earlier that I decided that the way to keep track was back to when I was in first grade and you just read along and you keep your finger in the right spot, but my finger moves with the discussion.

OK. So let's get started on 46. We are looking at follow up after hospitalization for mental illness. To what extent does this measure address critical quality objectives of the CMS quality measurement domains and/or identified program area concepts? How many would say high?

OK. 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?

Female: OK.

Female: OK.

Female: 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 to that?

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

OK. Being deployed quite extensively. To what extent do you think this measure is important to state Medicaid agencies and other key stakeholders, consumers, families, Medicaid MCOs and providers? How many would say high?

OK. Thank you. All right. Looks like we're finished with our review of this. And you've got considerable notes …

Female: I do. I sure do.

Female: Yes. Oh, OK.

Female: So the TEP review, follow up after hospitalization for mental illness through all the criteria recommends it as a measure for consideration by the coordinating committee.

Female: And I just wanted to provide one point of clarification. So NQF can't change any specs to the measures we get and therefore what we're able to review.

(Off-Mic)

Female: But we can provide feedback and so that's what we'll be doing.

Female: And I think that was our intention also, was to be providing the feedback.

Female: Yes, yes.

Female: Yes. Yes.

Female: OK. The next item is 47.

Female: Yes.

Female: And that has a score of 2.1. Follow up after hospitalization for schizophrenia and it's a 7 and 30-day measure. It is 1937 is the endorsement number for NQF. And let's see, does it – and it has to be a mental health practitioner.

So, again, we note the issue that we have previously with regard to keeping it focused on mental health practitioner to either consider a broader measure down the line being developed, or having two measures, one just looks at mental health practitioners and one that looks at both potentially.

Female: And do we have the same issue with lack of capturing ACT?

Male: Yes.

Female: Yes …

Female: Et cetera. Other mental health services that may not fall under …

Female: Yes.

Male: Yes. Traditional.

Female: Yes. Excellent point.

Male: Yes …

Female: So we'll make sure that that's noted please and hospitalization on ER …

Female: Right.

Male: Yes. So like …

Female: Yes, yes.

Female: Might be ideal …

Male: Yes. For some people, but …

Female: Yes, mobile crisis.

Female: Yes. I mean there is a lot.

Male: Right.

Female: Yes.

Female: Yes. Is this for people that are homeless too?

Female: Yes.

(Off-Mic)

Female: And maybe you have …

Female: Made an effort to try to find them …

Female: Actually (AOT) wouldn't be on here either.

Female: No.

Male: No.

Female: (AOT).

Female: Yes.

Female: Outpatient …

Male: Involuntary Outpatient Commitment services …

Female: Oh, you're right. Yes.

Female: Yes.

Male: But New York has a separate set of services …

Female: Yes.

Female: Right. Yes.

Female: OK.

Female: Yes. OK. So it's noted that there is a number of things including (AOT) that wouldn't be in there. All right. So we're going to go ahead and get started with voting on this one then, unless questions?

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

OK. 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?

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 with the claims measure? How many would say high?

(Off-Mic)

Female: How many would say medium?

Female: I'm waffling. I guess I'll go with high.

Female: You will. OK. So it's five for high. OK. What was your reservation?

Female: The fact that it's omitting certain things.

Female: Yes. Fair enough.

Female: I agree.

Female: Yes.

Female: And that's why we've had our comments, so I understand, yes. To what extent is this measure ready for immediate use? It's already in use (inaudible). Where is this being used?

Female: Yes.

Female: So I could not find – oh. Usability, no indication in use.

Female: Because this is just for schizophrenia.

Male: OK.

Female: But it is – OK, so …

Female: But it's NQF …

(Off-Mic)

Female: Yes.

Female: Yes.

Female: Yes.

Female: But it is an endorsed measure. So one would think that it is then therefore ready for immediate use if it is an endorsed measure.

Female: OK.

Female: So to what extent is this measure ready for immediate use? How many would say high? How many would say medium? I'm going to say medium.

Female: I'm going to go with medium …

Female: OK. So we're going to have three high. OK. We've got four – how many medium?

Female: I'm going medium.

Female: OK. So we got three medium. How many high?

Female: All right.

Male: Two.

Female: Two? OK …

Female: Yes.

Female: All right. To what extent …

(Off-Mic)

Female: To what extent do you think this measure is important to state Medicaid agencies and other key stakeholders, consumers, families, Medicaid managed care organizations and providers? How many would say high?

OK. High. Thank you. Yes. I think that the message is that there are some key pieces, I hope that that's really coming through, that are not being measured here that should be included in our opinion.

Female: And so based on the criteria, the TEP voted follow up after hospitalization for schizophrenia, 7 and 30-day as a measure for review to the coordinating committee.

Female: Which one, 40 …

(Off-Mic)

Female: Forty-seven. Oh, right, no, 48.

Female: Forty-eight.

(Off-Mic)

Female: You've been so good with all these things keeping track, still are. Major depressive disorder, percentage of medical records of patients ages 18 and older with a diagnosis of major depressive disorder and a specific diagnosed comorbid condition – diabetes, coronary artery disease, ischemic stroke, intracranial hemorrhage, CKB, stages four or five, ESRD or congestive heart failure being treated by another clinician with communication to the clinician treating the comorbid condition.

There is no NQF number so it's not endorsed. It is in the measure concept stage. It is an AHRQ measure. It has been used in PQRS. The steward is PCPI. And let's see, so evidence and gaps – I was hoping at the staff preliminary review, unsure, there does seem to be an evidence linked description.

It is the feasibility is medium – paper, record, medical record, EHR, pharmacy laboratory, registry, pharmacy laboratory, scientific acceptability, medium. Any evidence of (RV) testing or testing in Medicaid project is underway.

Usability – high use in federal programs for accountability, so it's currently being used for PQRS. OK. But it's used as a – but it's got paper record as one of the EHR. It's not a claims one. Yes, because you're having to …

Female: And it's a measure (inaudible) communication …

Female: OK, so thoughts about this, discussion about it please.

(Angela): I'm assuming it's also under consideration in the high – I can't remember the other TEP, was that comorbid high complex needs.

Female: I can check right now.

Male: that might be a better fit or a good fit.

Female: And where does this – we had another one that we had looked at yesterday if I recall it's dealt with whether or not there was communication received.

Female: That was the referral.

Female: Referral, whether you …

Female: That's a closing the referral …

Female: Yes.

Female: Yes.

Female: Closing the referral …

(Off-Mic)

Female: And how did we land on that? Does anybody recall …

(Off-Mic)

Male: I think it was a measure concept …

Female: Right. We recommended it as a concept.

Male: Because of the paper …

Female: On the other hand, this is our care coordination …

(Off-Mic)

Female: Beneficiaries of complex care needs are not reviewing this measure. But I did want to – so I believe and we may want to go back because we – I believe we had closing the loop recommended as a measure, but I do want to go …

Female: Yes. I thought it was a measure, but I just want to double check. We can always revote, so I just want to make sure that we …

Female: And I think in part it was because it was a high priority measure on the part of CMS already.

Female: Yes. I think there were a lot of …

Female: OK. So there were comments.

Female: Yes. Operational nightmares, yes.

Female: Yes. Oh, we, no, we didn't recommend at all.

Female: Yes.

Female: Right …

Female: That's what I remembered because all the operational problems and because of there were just – yes.

Male: Right.

Female: So we're in the same situation here from that perspective and in here interestingly enough it's listed as a measure concept.

Female: Yes. OK.

Male: OK …

Female: So, yes. It was just staff preliminary analysis and that was because (AHRQ) said it was being released, the measure is being made available without any prior testing. So that's why we listed it as the measure concept.

Female: OK. So the issue is, OK, how many people who have depression and also have some severe or I mean serious life threatening conditions …

Female: Yes.

Female: How many cases is there communication with the clinician treating the patient? So it's saying yes, percentage of medical record both have something documented is saying that there is communication. So it's a similar one. So unless there's anything more to be asked about it, let's go ahead and vote on it.

Female: Yes.

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

Five. OK. To what extent will the measure address …

Female: I'm sorry.

Female: No, I was going to go with medium …

Female: I'm sorry. I thought you said …

Female: Yes.

Female: OK, medium.

Female: Yes.

Female: Four high, one medium. I stand corrected. Thank you. To what extent will this measure address an opportunity for improvement and/or significant variation and care evidenced by the quality challenges for each program area. How many would say high? One, two, three. One, OK. And how many would say medium? OK, four. Thank you.

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 measures across programs, health plans and/or states? How many would say high? How many would say medium? How many would say low? I think – and again, the issue here is that the data source is HER-only which means that there would be data that might not be captured.

Female: And how are you defining communication.

Female: Yes.

(Off-Mic)

Female: How are you defining communication? I think there's concerns about the fact also that this is in the measure concept stage according to this. And so given all of that and the feasibility as originally reviewed by the NQF team is medium because evidently it can be paper. It can be a medical record. It can be an EHR, so there's just too much, and lack of priority …

Female: We're talking about integrating care in an integrated system. It wouldn't be measured or reported. The only way to really look at it is some of the new EHR functionality where you can tell if you looked at the provider note before.

So in other words if I reviewed the medical provider note is sort of how some of this is being measured, but other than that, that's really how that communication would happen potentially.

Female: So what if somebody is in a community mental health clinic. They've got MDD and – I mean because people are dying.

Female: Right.

Female: All the time.

Female: Right, right.

Female: So I guess my concern is how do you capture …

Female: A case conference note – with the case conference code is what you should do if …

(Off-Mic)

Female: If you're really …

Male: The other way you capture some of the things that I think we talked about yesterday which (inaudible) our individual set of …

(Off-Mic)

Female: That way versus communication …

Male: So this is a process …

Female: Yes.

(Crosstalk)

Male: Right. You …

Female: Versus the end point, right?

Female: Yes.

Male: That we already have to measure …

(Off-Mic)

Female: OK.

Female: Yes.

Female: Although, I think we voted down a lot of that, but …

Female: We (inaudible) but I think we …

Female: But we have …

Female: Yes.

(Off-Mic)

Female: OK. All right. Yes.

Female: So we did – OK, did vote in the – we've voted in – four of the diabetes care measures, hemoglobin – two for hemoglobin, one for medical (inaudible) neuropathy, one for monitoring people with schizophrenia and then one for screening for people with schizophrenia and bipolar disorder.

Female: Yes. And I'm trying to clarify here. It says here data source is EHR, but here it says feasibility data source medium, paper, medical, pharmacies.

Female: So that was – thank you for bringing that up …

Female: Yes.

Female: So we had EHR and then it was our category of medium and these are all of the issues that medium can encompass. So it can include paper …

Female: OK.

Female: Yes.

Female: So this is really an electronic health record.

Female: Yes.

(Off-Mic)

Female: So on these things – this is simply the definitions, not the actual requirements for the measure. I think that might be confusing to …

Female: Yes. So …

Female: Members, future …

Female: Yes. That's a very good point.

Female: Yes.

Female: Yes.

Female: No, I think that's a really good point.

Female: Yes.

Female: And the staff PA that we need to clarify that these are definitions …

Female: So let me ask you something then. In line of the fact that the way this gets captured is the EHR. Do you have any different thoughts about this to what extent does the measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities and/or contributed to alignment of measures across programs. Any thoughts about that?

(Off-Mic)

Female: Pardon me?

Male: It's not very efficient, I think …

Female: Because?

Male: It's hard to collect it.

Female: It's hard to collect it even in the EHR.

Male: Yes. The other thing I wondered is how much value this measure has because you can meet this measure just by sending a piece of paper for communication, it doesn't mean anybody read it.

Female: Read it

Male: So one thing that we've done in some privates (inaudible) is an alternative, but we've set a standard that you have to have evidence to reciprocal communications like (inaudible) phone conversations.

(Off-Mic)

Male: Or you send a letter and the other person sends the letter back, so there has to be some evidence that there is actually …

Female: All right.

Male: Rather than just sending a letter.

Female: That will be a nice proposal.

Female: Yes.

Male: Yes.

Female: Effective meaningful communication, not just communication.

Male: So that's really a …

Female: Yes.

Female: Yes.

Female: So …

Male: And people are able to do it …

Female: Yes.

Male: The agencies are able to do it at least …

Female: Sure.

Male: It requires someone doing it.

Female: Yes. So at this point then, is there any desire to revisit this? Or do people feel comfortable with it staying as it is?

Female: OK. Thank you.

Female: All right. So the next one I think is medication reconciliation post discharge, correct? This is a care coordination measure that has an overall score of 2.7. So it's surpassing the threshold. It is an 0097 NQF-endorsed measure.

So it's essentially a reconciliation in the outpatient record. It's broad enough that it can be a prescribing practitioner, a clinical pharmacist or registered nurse. So that's positive from the …

Female: They took it out of the transitional care management visit. They took med recs out. Yes, because it doesn't have to be done by an RN now, so if you're going to build for that transitional care visit, it can actually be done by a non-RN and they took med rec out.

Female: That's unfortunate and I think we should …

Female: Yes. I mean I didn't change it internally, but just …

Female: No.

(Off-Mic)

Female: No, but we should make it – yes, make a point of that in the notes.

Female: Yes.

Female: Because it's really – it's really a focus, yes.

(Off-Mic)

Female: Yes.

Female: Yes.

Male: My question about this is people who will get follow up, in a small and medium sized primary care practice that wouldn't happen.

Female: To do the transitional – oh, to do this.

Male: To do …

Female: Yes, yes.

Female: Even prescribing, so I go back to see my prescribing practitioner and he's not going to ask medications I was on versus when I was in the hospital.

(Off-Mic)

Male: Right. …

Female: Yes.

Female: I think also does the EMR have the functionality with the little box to check that you did med recs, the little box.

Female: OK, med rec …

(Off-Mic)

Female: Well, I guess from my perspective is is that fix your EMR, I mean frankly that would be my perspective …

Male: Yes, you can argue this is really important.

Female: Yes. Yes.

Female: I think this is really important.

Male: Yes …

Female: Yes – no, (inaudible) this is the …

Male: This is like the only – OK, maybe the only post discharge activity. They're really coordinated …

Female: I'm sorry. Pardon me?

Male: This is maybe one of the very few post discharge activities that actually there's that evidence that …

Female: Yes. Increase …

Male: No, decrease …

Female: Decrease, yes, yes. That makes sense to me. So it sounds like we've got enough discussion here to go ahead and vote on this, to what extent does this measure address critical quality objectives of the CMS quality measurement domains and/or identified program area key concepts? How many would say high?

To what extent will this measure address an opportunity for improvement and/or significant variation in care evidenced by quality challenges to each program area? How many say high? We got five 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?

Have one is saying high. How many would say medium? Yes. Again, the caveat is that there's certain data capture challenges with this that should be remedied.

To what extent is this measure ready for immediate use or it's already being used? How many would say high? OK. That's unanimous. To what extent do you think this measure is important to state Medicaid agencies and other key stakeholders such as consumers and families, MCOs, and providers? How many would say high? OK. Thank you.

And so, based on the criteria, the TEP recommended medication reconciliation post-discharge to the coordinating committee to review as a measure.

Female: All right. Great.

Female: So then how many have we gotten done? It's 10:30? I'm just trying to get a …

Female: Yes.

Female: About how much time we're spending for measures.

Female: So we're actually going pretty quickly.

Female: OK. So we only have one, two, three, four, five. We only have two measures left to review.

Female: OK.

Female: So we're moving along. And at what point would people like to have a break? It is almost 10:30. We've been at it since about 9.

Male: That's OK with me.

Female: To have a break? People are comfortable with that? About 10 minutes break?

Male: Yes.

Female: All right. We want to do a 15 minute break or …

Female: We got time.

Female: All right. So just 15 minutes. OK. Thanks.

(Break)

Female: So we are – is there anything we need to discuss before we get started again?

Female: I think just double-checking that no one from the public is on the line to make any comments, if you are, please do so now. I don't see anyone though.

Female: OK. All right. So we're on – I think PACT, is that correct?

Female: We are.

Female: But it's a score of 1.05. But I think that there was someone that could have been, I think both you and I who requested that the committee to look at it if I recall correctly.

All right. So we'll go to number 50. PACT Utilization for individuals with schizophrenia. (Angela), this is essentially the number of patients in the denominator who are enrolled in a PACT program in a program for assertive community treatment.

It does not have an NQF number. It's CQA IMH, measures data – measure source, the steward is the American Psychiatric Association and administrative other is the data source. Do we know what that means? Oh, but then somebody else said high administrative/claims.

Female: So that's the same thing with – for the staff PA the high is our definition of what we consider to be high since it was administrative and we went up, it became – we get a high ranking, but that's just a definition of what we have for high.

Female: What does administrative means? Administrative – so that was the classification that – did we have … We refer to them as administrative claim in NQF. And so, I think that they are conflated to be the same thing for us.

Female: I see. OK. Thank you.

Female: So are there any comments that you would like to start off by making, (Angela)?

(Angela): So sorry. I was looking at something else, but I have my notes that there was high feasibility, it's claims data. Is that incorrect?

(Off-Mic)

(Angela): That is correct?

Male: Yes.

(Angela): OK.

Male: My concern about this is that lots of place don't have …

Female: Pardon me?

Male: Lots of places don't have (ACT team).

(Angela): Correct. And …

Male: So you could, I'm worried that will require a lot of interpretation …

(Angela): Our concern …

Female: Right.

(Angela): Yes, yes. On the other hand it's an evidence-based practice.

Male: It is.

Female: Yes.

(Angela): And I think the biggest concern I had is the AHRQ data on readmissions for people with schizophrenia are horrific, four times more likely to be readmitted within 30 days as for other conditions and it's the most common reason for readmission for the same condition. And given that this is essentially a wraparound cord for people who are most at risk for rehospitalization and already have disproportionate rates, it seemed a reasonable thing to draw people's attention to the fact that this is the best quality of care …

(Off-Mic)

Male: Right. Sure.

Female: Yes. I have noticed that the American Psychiatric Association had identified assertive community treatment as a successful intervention to help reduce relapse among individuals living with schizophrenia in its treatment guidelines with schizophrenia.

And then, I don't know, I was thinking about it and I thought, OK now just because you're in an assertive community treatment team program, does that mean that you're going to have your care integrated between health and behavioral health? Well, maybe not. But I did find at least one study though.

Female: Yes. I did …

Male: It should be …

Female: Yes. It should be.

Female: Right.

Female: And I did find at least one study that spoke to the advantages of ACT for integrating health with behavioral health.

Male: Yes.

Female: So there are some entities out there that are doing that and one would think that that should be continuing.

Male: Yes. Yes …

Female: And some …

(Crosstalk)

Female: Yes.

Male: I'm sorry (inaudible) that it's really not feasible in the rural areas. There's not enough density of population to have it, (ACT team), you can do some variation, but there is …

Female: Right.

(Off-Mic)

Female: Yes.

Female: Yes. That's interesting. I know – I've spent some time actually in some of the rural communities in Ohio and some of those community mental health centers in rural areas did actually have ACT teams but they just had a broad reach.

Female: Yes.

Female: Not that it is entirely impossible, but it depends on your population whether you've got enough and how fast you can get to them.

Female: Yes.

Male: Yes. And some of the counties we work with in Pennsylvania are like pretty rural and they just, they wouldn't have enough people.

Female: People to do it, yes. So what you do instead as a substitute.

Female: Mobile crisis.

Female: That's what I was thinking …

Male: Yes, yes, some local services. You probably use a lot of case management, which is not the same thing.

Female: Yes.

Male: But people tend to hit case management which are hopefully tied into clinical services.

Female: Yes.

(Angela): But the elements of ACT are kind of basic components.

Male: But they're not actually …

(Angela): Case management, prescribe – exactly.

(Off-Mic)

Male: It's not billed as an ACT service.

Female: Right.

Female: Yes.

Female: So other comments about ACT – you have ACT and …

Female: Yes.

Male: We do. So my general concern with a measure like this where the numerator treatment is not the only appropriate modality for those who qualify in the denominator, I would have generic concerns about a measure that would be prioritizing one of potentially multiple forms of treatment for those who meet the denominator. So I would – I mean that's not (inaudible) this, but this measure has that feature. That's something problematic.

Female: But there could be other interventions that could be appropriate.

Male: It's prioritizing one of multiple appropriate forms of treatment for those who meet the criteria. So, folks could be receiving appropriate treatment and to some degree this rural capacity discussion enters as a component of this concern, so I would tend to not favor of measure of this nature.

(Angela): That makes a lot of sense to me. I will just say that the data clearly shows people are not doing anything effective.

Male: Yes.

(Angela): So I …

Male: What …

(Angela): It doesn't mean that this is the right answer.

Female: Right.

Male: Sorry. Would it make sense, maybe – we do have that follow up after discharge for folks with schizophrenia, what's …

(Angela): That's your signal.

Male: Right.

Female: Right.

Male: So I wonder if it's worth seeing what that number is to start with because if that number is low, we need to make sure they get something before we maybe drill down to make sure they're getting treatment. Just a thought.

Female: So are you meaning that we should look to see if we've got data on that which I don't think we do.

Male: Look to see like what the results look like for that, wait a year or two.

Female: Oh. And see what that looks like …

(Off-Mic)

Male: Yes. And see if they're getting some follow up then we try to come up with a way to determine what the correct type of follow up is.

(Off-Mic)

(Angela): I …

Female: Really, this has an interesting denominator …

(Angela): Yes. It does.

Female: Go ahead.

Male: It does.

(Angela): I'm sorry. I mean because it's two inpatient or four ED visits.

Male: It does.

(Angela): So this isn't just a simple – it's a small "and" I presume, I would hope.

Female: But you know, one of the things that you may want to think about is you're absolutely right that there are multiple kinds of interventions that could or would be appropriate for someone with schizophrenia who has just been hospitalized.

But I think the interesting thing about this measure is that it's kind of a flag. If you have somebody who has had four emergency room visits and they're falling out as not having PACT then the question is what is it that they're getting? And is it effective? And let's say you're in a rural area and you see a spike and you see a substantial number of people who are falling out this way, wouldn't that then be suggestive that maybe really a PACT program would be appropriate for them.

Male: Right.

Female: Right. It's almost like a utilization flag.

Male: Although it's – if this is the measure used by a state you don't have that level of …

Male: This is probably a state level decision to fund the Medicaid program state plan situation.

Male: Yes …

Female: So then they would have to go down and take a look and do a – they'd have somebody like you or a member of your team maybe taking a deeper dive to see, well, where are these pockets that we're seeing this and maybe there is a health disparity that needs to be addressed perhaps.

Male: So I agree with the analytical piece that you're laying out as accountability measure, I think that's, it's a different kind of use case.

Female: That's …

Male: This could …

(Off-Mic)

Female: So where this will be captured as an issue might be on readmissions, it would be part of a readmission measure.

Male: Right. The observation of my readmission rates indicated poor care for …

Female: Right.

(Off-Mic)

Male: … possibly should include a subset.

Female: But it wouldn't capture – I don't think there are any measures out there for capturing multiple emergency department visits period. We've got multiple discharges without follow ups, which is really sort of the more fundamental as you – the measures you were describing.

Male: Yes.

Female: Yes. But this is multiple inpatient stays or ED visits in a 12-month period.

Female: Yes. Let me comment – sorry, you've been kind of quiet here, uncharacteristically so. Yes. I'm checking to see if you get any other thoughts …

Female: No. I'm listening. I'm not – yet.

Female: OK.

Female: Believe me I'll chime in.

Female: (Beverly), any other thoughts on this one? Or (Kate)?

Female: It almost seems like this should be the opposite, patients who are – schizophrenia patients who are not using PACT but they are eligible for PACT, but you can't change the measures though.

Female: Yes. It's utilization. So you're trying to say better performance, higher numerator is indicative potentially of better performance or higher ratio overall is indicative of better performance.

Female: Right.

Female: Yes. So.

Female: OK.

Female: So any other comments? Any others that you'd like to make at this point?

Female: It's just an observation that there's so poor quality of care and particularly for – this is a super high risk population. And what we traditionally see is a lack of available care that's appropriately intense and sort of writing this population off.

Female: Right.

Female: Yes. This is some interesting work out there, (Reys) and several other projects that have gotten multiple outcomes now that are very positive.

Female: Yes.

Female: Yes. Yes.

Female: Yes.

Female: For first psychosis.

Male: (Inaudible) a broader effective of appropriate intensive services of high risk. I could endorse that, but because it's just …

Female: Yes.

Female: It is a particular intervention.

Female: Yes.

Female: So I get where you're coming from, I just need –

Female: I mean like …

Female: To capture.

Female: On track would be – or the first psychosis whatever they have …

(Off-Mic)

Female: Would be …

(Crosstalk)

Female: Totally appropriate things.

Female: Intervention. Yes.

Female: And actually preferable …

Female: Yes. It would be.

Female: It …

Female: Yes. And so to me that's why I was kind of …

Female: Because it's really just focusing on just one …

Female: Right.

Female: So I'd be willing to see this as not maybe in the threshold in being an inappropriate measure, but the whole notion of capturing appropriately intensive treatment for somebody who's had multiple ED visits or inpatient stays would be a high priority.

Female: Right.

Female: Priority. Yes. I agree, so this may be really something that we vote on as a measure concept perhaps. I'm hearing from – which is how it's described here at stage as measure concept. Is anybody using it at this point? Doesn't look like it …

Female: Yes.

Male: Measure concept framed in the words that you just used.

Female: More on the numerator.

Male: Yes …

Male: But at the broader appropriate.

Female: In intensive …

Male: Intensive services.

Female: Evidence or …

(Off-Mic)

Female: Yes.

Female: OK. So, and then keeping the denominator two hospitalizations or four emergency room visits within all the diagnosis of schizophrenia in the past 12-month period. It sounds like that's really acceptable. It's more the numerator that becomes the issue. Is that correct from people's perspective?

Female: Do you have the diagnosis of in schizophrenia for (Reys), I mean a lot of times, gee, you got to have that six months.

Male: Right.

Female: Before you can even make the diagnosis, you've got the psychosis.

Male: I don't remember. I think it may be something.

Female: So I think that's another …

Male: I don't know if it's a diagnosis of schizophrenia.

Female: … problem, too, is if the measure specs to this are absolutely a diagnosis of schizophrenia, then you're automatically being more reactive versus intervening early.

Female: Oh. So what other – what others would you consider? What other diagnosis would you consider?

Female: Any kind of clinical …

(Off-Mic)

Male: Disorder.

Female: Yes. Non-substance abuse would do.

Female: Even bipolar.

(Off-Mic)

Male: Yes.

Female: Yes. Well, maybe we make it broader and just say serious mental illness, SMI.

Male: Yes. Yes.

Female: Right. If you're paying the EV this much in inpatient, then something's wrong.

Male: Right.

Female: Yes. That's true.

Female: And you have some kind of mental health diagnosis regardless, then there should be an intensity of intervention.

Female: Yes. I just pulled up (Reys) and what they talk about is experiencing first episode psychosis. Now, in the title, "Recovery After an Initial Schizophrenia Episode" is (Reys) …

Female: Yes.

Female: … they are broader in terms of talking about a psychotic, you know, episode, so OK.

Female: Right.

Female: All right. So do people feel ready to discuss – to vote on this? OK. To what extent does this measure address critical quality objectives of the CMS quality measurement domains and/or identified program area key concepts? How many would say high? Four. OK. Right. Five, five, OK. OK, four and one. OK. All right. All right.

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? Three. How many medium? Two. OK, two medium. Thank you.

To what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activities and/or contribute to – and/or contributes for alignment of measures across programs, health plans and/or states? How many would say high to that? And remember that this is – the way this is captured is administrative and other, so that's where it starts to get messy, yes. So how many would say medium? Two, three, four. How many would say low? Would that be you or …

Female: I'll go with medium.

Female: OK. So that's a five medium. To what extent is this measure ready for immediate use? How many would say high? How many would say medium? How many would say low? OK. So there we're now into a different – if I'm correct, we're now over here.

Female: Yes, so it's still very, very important to stakeholders, it's just that they're not …

Female: Yes. To what extent do you think this measure is important to state Medicaid agencies and/or other key stakeholders such as consumers and families, Medicaid managed care organizations and providers? How many would say high? Five.

So it looks to me like we are now at the point where we are recommending this as a measure concept for inclusion in program area measure set and that the concerns that we have identified include, first of all, that in the denominator we're suggesting a broader spectrum of diagnosis to include giving consideration to psychosis, giving consideration to a diagnosis of SMI, so that is that component. And with numerator, we are stating that there should be other kinds of treatment programs, intensive treatment programs also considered in the numerator. And do you have any specifically that you wanted to suggest?

Female: I mean we had just talked about the first psychosis, whatever you're – you know, the states call it, but that first episode of psychosis …

Female: Yes.

Female: … as an evidence based, really totally appropriate.

Female: OK. So you have what you need?

Female: Yes.

Female: OK. OK.

Female: So based on the criteria, the TEP recommends (TAC) utilization to individuals with schizophrenia as a measure concept for review to the coordinating committee.

Female: Thank you. Now, we're on 53.

Female: Fifty-three. Thank you.

Female: Did you want to say non-SUD SMI or just SMI is fine.

Female: Well, that's open to a discussion. How do people – what do people think about that? I mean the challenge is is that you can have SMI so often that's co-morbid …

Male: Yes.

Female: … with substance use.

Male: Yes. True.

Female: Oh, yes. You would allow concurrent, yes.

Female: Oh, yes.

Female: That was my thinking, too.

Female: OK.

Female: OK. All right. Thank you for clarifying this, yes.

OK. So we're now on to preventive – potentially preventable emergency room visits for persons with – no, that's a point six. I don't think we're onto that.

Male: Fifty-three.

Female: Fifty-three.

Female: Fifty-three. Timely transmission.

Female: Timely transmission of transition record discharges from inpatient facility to home, self-care, or any other site of care which is a 2.7 rating right now so expand – it's beyond the threshold. It is an NQF number. So it's a percent – so it is endorsed.

Percentage of patients regardless of age discharged from an inpatient facility, for example, hospital inpatient or observation, skilled nursing facility or rehab facility, to home or any other site of care for whom a transition record was transmitted to the facility or primary care physician or other health professional designated for follow-up care within 24 hours of discharge. So this is broader than just behavioral health it looks like. I don't think it's just a behavioral health diagnosis. That's right. Yes. And it's essentially focusing on coordinating.

Male: So the (inaudible) vast majority of discharges would be not from psychiatric.

Female: Right.

(Off-Mic)

Female: Yes.

Female: The other thing is that the data source is claims but is also paper records, other. And I think this is AMA PCPI.

Female: Most of them are going by fax I think.

Male: A little less precise to our (focus), yes.

Female: Yes.

Male: And this looks like this is maybe a measure from New York being referenced correctly. Maybe there's some ED information that's there.

Female: It's a different information.

Male: Yes, that they can pull from there that’s maybe not available other place.

Female: Well, yes, the HIE stuff.

Male: Right.

Female: So we get the electronic event notification.

Male: Right, and the details of that might vary.

Female: By thousands everyday.

Female: Yes, and it looks like it's hospital compare, then it's an inpatient psychiatric facility quality reporting measure, Medicaid. So it looks like this is primarily a hospital-based one although it could be broader based on the specs, process measure. Any other comments that anyone has about this?

Female: This seems like one where I would go back to your slicing of, you know, if there were SMI or co-occurring for SUD populations. Is that what we would really want to get at? Is there any disparity in terms of those transition records?

Male: Yes.

Female: Because I think that is really what …

Female: We'll check it, yes.

Female: To presume this test would be here and anecdotally, we had a huge problem with this. Primary care got this notification from hospital discharges, mental healthcare, yes.

Female: So it sounds like what I'm hearing from this group is two things. Number one, there's a concern about the lack of specificity, that it's very broad and then most of what's going to be in that measure that's captured is going to be non-behavioral health quite possibly.

Female: Yes.

Female: I think the other concern that I'm hearing is that it may be difficult to capture this information, it's claims, paper records, other, it says for data source. Somebody else had originally viewed it as high administrative/claims, but what you're saying is thousands, maybe even millions of pages of record is being faxed every day, yes.

Female: All by fax.

Female: Yes. I mean if you don't have an HIE, what are you going to – how are you going to do it? Most – I mean if you're in the middle of Wyoming, you're probably getting it by fax if you're getting it all for anything, right?

Female: Yes.

Female: OK. Anything else you want to add?

Male: No. I agree with all of it.

Female: OK. So it sounds like we're ready to vote on it.

Male: Yes.

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

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? How many would say medium? OK, so we've got – how many would say low?

(Off-Mic)

Female: Right. Exactly. So I think that we're actually – we're actually stopping at to what extent will this measure address an opportunity, right there, given that we've had four people say low. And I think we all would – we don't want to have a comment, notes made about the stratification issue, that without stratification it's difficult to make sense of this measure from that perspective.

Female: The other way to frame that up would be that it would be useful with stratification.

Female: Oh, very nice.

Female: Right?

Female: Yes.

Female: I like that better. Thank you.

Female: Yes. Yes.

Female: Very nice. OK. So the TEP have decided not to recommend timely transition of transition records to the coordinating the committee based on its, the measure's inability to pass the opportunity for improvement criteria.

Female: We're now on 54.

Female: OK. Very good. Thank you. The next one is an NQF measure. It is endorsed. Tobacco use screening and follow-up for people with serious mental illness or alcohol or other dependence. For people 18 and older, there's two rates, percentage of patients 18 with a diagnosis of SMI who have received screening and follow-up, percentage of adults 18 and older with a diagnosis of alcohol or drug who have received screening for tobacco use and follow-up. It's been an adopted measure. Any questions, comments, discussion about this one?

Female: I mean this is to me is a tracking issue because how are you coding because like there are codes for the screening, right, but they are not sort of widely used.

Female: Isn't that part of meaningful use now? Meaningful use includes …

Female: If you're a meaningful use provider.

Female: Oh, yes.

Female: Right, right, versus, not behavioral health which is not use small practices.

Female: Yes.

Female: I sat in Texas recently and I asked about meaningful use, they didn't even know what it was. I had to pull it up and read it to them. So I'm not like I make it up.

Female: It's interesting. I guess where I'm coming from on this is that this is an area where there has been underutilization of screening and intervention with people with SMI. There has been some misunderstandings I think on the part of behavioral health clinicians about screening and intervention with people.

Female: Their responsibility to address them.

Female: And their responsibility to address. Absolutely. And, yet, I've read at least one study that says that individuals living with SMI would very much like to have screening and intervention.

Female: No question.

Female: So I would – I would at least – I would probably be troubled by our not including this one. But …

Female: No, I'm not – I'm just saying that when we start talking about how are we really going to track this then, you know, I think that there's some issues. It doesn't mean people shouldn't learn the code and use the code, you know.

Female: Yes, this is one Oregon adopted and it was highly problematic for them, I mean in the EHS. And then there's a statewide backup quick line in (Essex) didn't …

Male: Right.

Female: … connect up with that and therefore …

Female: Although it can. We'll help you.

Female: Oh, good. Good. There were issues, but nevertheless I mean Oregon I think appropriately consider this as such as a huge …

Female: Yes.

Female: … health risk factor.

Female: Oh, no question, yes.

Female: I think that sort of overrides, it's like OK.

Female: Yes.

Female: Figure it out.

Female: Yes.

Female: Well, I mean that's kind of how I feel, you should figure this out.

Female: Yes. Awesome.

Male: So maybe this would be something that would fall down in the promising concept.

Female: I don't …

Female: It's not really ready for PDH use.

Female: Well, I think it is.

Female: I'm more on the line of it's difficult, but you should figure it out.

Female: And for a long period of time now since really some of the early stage of meaningful use and I understand some entities are still at the early stage of meaningful use and some aren't even there, but even in the very early stage there were meaningful use measures that spoke to the issue of being able to at least document if you were screened for tobacco. So this is not something that's a new concept. It's been a while. It's been around for a while.

Female: Yes.

Female: Well, the other thing that happened in (Portland) is sort of it doesn't speak directly to a measure, but the measure accelerated attention to the issue and as a result the state actually stated that management of case plans had to cover all tobacco cessation like products and not put to restrictions and that actually opened up – we started (inaudible), oh, no there are a couple of plans that were like, no, you can't have it or this or that. And so it actually is really useful in terms of …

Female: Helping to promote parity access.

Female: increasing – yes, increasing access.

Male: Like …

Female: Go ahead.

Male: I feel like we have a consensus on it.

Female: OK. Thank you. Very good. Let's go. All right. So to what extent does this measure address critical quality objectives of the CMS quality measurement domains and/or identified program area key concepts? How many would say high? All right. OK.

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? Five. OK.

To what extent does this measure demonstrate efficient use of measurement resources, data collection processes, performance improvement activity – performance improvement activity 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? How many would say medium? How many would say low? OK. So we've got – it moves on then. OK.

To what extent do you think this measure is important to state Medicaid agencies and other key stakeholders, consumers, families, Medicaid managed care organizations and/or providers? How many would say high? Five. OK. So it looks like it has passed through the threshold.

Female: Yes. So based on the criteria, the TEP recommends tobacco use screening and follow-up for people with serious mental illness or alcohol or other drug dependence as a measure for review to the coordinating committee. And the next one, 55.

Female: OK. All right, 55 is transition record with specified elements received by discharged patients, discharges from an inpatient facility to home self-care or any other site of care. That was very much like the other one we did, doesn't it? But this one is NQF-accredited or endorsed.

Female: And it's received by patient versus a communication to –

Female: Yes, which means that the patient has a record of what has transpired with their care and they can potentially communicate it to any other entities.

Female: Med labs, patient instruction, follow-up care.

Female: Yes, yes.

Female: They just seem like isn't this already done?

Female: No. No.

Female: You would think.

Female: OK.

Female: What I've seen generally is that patients will get a discharge plan which may include and hopefully includes all of these elements, but this is talking about transition. Well, they may be getting it, but a lot of patients aren't necessarily getting it.

Female: Well, this seems like this would inspire self-management.

Female: Yes, or be conducive.

Male: Yes. To me this is similar to 63.

Female: Same issue.

Male: Very broad in terms of qualifying the (inaudible).

Female: Yes.

Male: Less focus on a particular program area.

Female: Yes.

Female: Yes.

Female: It's really broad and it would be hard to act on it from the perspective of, I guess if you're looking at it from the perspective of behavioral health or medical, you can say that it's an issue, but the challenge is going to be –

Female: This was actually something that was with the CMS secure transition and we changed it to say to just report on the patients who had a transitions of care visit and we actually applied the code because that meant that there was some preliminary conversation and transition work done and they had the follow-up visit. So we actually now just report on when patients who actually had the visit and the code got used.

Female: So that might be a comment as opposed to …

Female: Right.

Female: We can't change the measure, but we can provide that comment. I guess the other thing, too, was that this stratification comment that you said earlier …

Female: Yes.

Female: … would also apply because then you could take a look at anybody who had a primary or secondary diagnosis with a behavioral health condition and then could begin to do more from a quality perspective in that regard, yes.

Female: Yes.

Female: OK. So it sounds like we're ready to vote on this. To what extent does this measure address critical quality objectives of the CMS quality measurement domains and/or identified program area key concepts? How many would say high? How many would say medium? 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? How many would say high? How many would say medium? How many would say low? That's a three and a two. It goes 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? Now, this is claims, paper records, other. How would this be a claim?

Female: They must use the TCM code. That's the only way.

Female: But a lot of times it would be …

Female: And those are really not widely used quite frankly.

Female: OK.

Female: And there are only certain payers.

Female: OK.

Female: So …

Female: Yes. I bet.

Female: So how many would say high to my question to what extent does this measure demonstrate efficient use of measurement resources? How many would say medium? How many would say low? OK. So that measure will not.

Female: So the TEP voted not to recommend transition record to specify elements received by discharged patients to the coordinating committee based on the measure's inability to pass the efficient use of resources criteria. And that concludes this section of care coordination.

Female: It does.

Female: So you may have some comments. You may open it up for comments. I just want to check to see if anyone on the line may have any comments. OK.

And, (Beverly), do you have any comments at this point?

(Beverly): No.

Female: OK. Thanks.

So we're now going to move on then to patient and caregiver experience and we have two in there, one is a 0.6.

Female: We're only reviewing one of them.

Female: OK.

Female: We're reviewing number 56, right?

Female: We're reviewing 57.

Female: Fifty-six is a 0.6. Fifty-seven is still below threshold, but it sounds like someone has recommended it.

Female: Yes.

Female: OK.

Female: Yes.

Female: (Angela), you recommended. So let's take a look at it first and then I'll ask you to give a little comment if you would please.

Male: That's 56?

Female: Fifty-seven.

Female: Fifty-seven.

Male: Fifty-seven.

Female: Yes.

Male: Thank you.

Female: Patient experience of psychiatric care as measured by the inpatient consumer survey, measure score of 1.5, threshold of 1.75. It is an NQF measure. So it is endorsed by NQF. It was developed to evaluate the patient's evaluation of their inpatient psychiatric care. It has six domains, outcome of care. And it has a question. I'm able to deal with crisis. My symptoms are not bothering me as much. I do not – I do better in social situations and I do – I deal more effectively with my daily problems. And it's got a second measure, dignity. The provision of mental healthcare services should be in an atmosphere where patients feel respected and treated with dignity. And the question there, if I'm (inaudible) believe that I can grow, change and recover. I feel comfortable asking questions about my treatment and medications and I was encouraged to use self-help support groups. Measure three addresses rights. I don't know that I'll go through and read all of this. It's like a little bit long.

Female: Yes. I think I always had questions about like fear with retaliation and there's like some literacy like, you know what I'm saying like this particular measure, right? So I'm not sort of disputing, but I've heard some conversations about the literacy level, so I don't know what people, and I don't know enough about the patients.

Male: Anybody aware it's being used?

Female: It is.

Female: It says here no indication of use in field or program. It is NQF endorsed.

Female: Right. NRI Inc., they did the research for the National Association of State Mental Health Program Directors.

Female: It's odd that you would think then that it would be used particularly by hospitals that might be primarily funded by the state, so I think of …

Female: Yes, but the problem is those aren't Medicaid eligible and so …

Female: Those are, sure. Like I'm thinking, for example, UMK, University of Missouri – Kansas City has a strong …

Female: Right, the acute versus the long-term state hospitals.

Female: Yes. Yes. That's what I'm thinking of, the acute.

Female: Yes.

Female: Yes.

Female: Well, this is kind of interesting.

Female: So it's odd and I understand that it's cumbersome.

Female: And why is it low in feasibility? Says low PROPM.

Female: So we rated patient reported outcomes – (inaudible) patient reported outcome as well as the feasibility because they're so time-intensive.

Female: Well, they're time-intensive by the patient.

Female: Right.

Female: But also by staff, I mean you have to find it, get it, give it, get it back.

Male: Are these surveys fielded while the patient's in the facility, versus post discharge?

Female: Yes. Well, I think they're done …

(Off-Mic)

Female: Yes. I don't – I don't know.

Female: Yes, it doesn't …

Female: Do we have the – there's an evidence link description.

Female: Yes, we should look at that.

Female: And is this considering the entire survey as a measure or performance of the survey?

Female: This is considered the entire survey as a measure. And my guess is if I had to guess how it prints out or scores out, it's on multiple domains, and probably scores by domain I would think. And it's not an e-measure?

Female: It's not.

Female: Oh. Let's see.

Female: It's not an e-measure.

Male: All the questions here are in the past so I'm guessing it's a discharge follow-up survey which is probably sort of gets at the thought of–

Female: Yes. I'm wondering if this is a telephonic survey, I mean some of these it's like CAHPS. Some CAHPS are done paper and pencil.

Female: Yes.

Female: But some are done where you actually have a caller.

Female: Yes, you contract with them.

Female: They're very trained to do it, yes.

Female: So the setting says the – the performance measure is based on all surveys completed during the month. Patients complete the survey at the time of discharge or annual review and are asked to respond to the survey or annual review.

Female: Oh, that's some slippage there. OK. Go ahead.

Female: Yes. And it just says based on their experiences during the entire hospital stay, but there are two areas in which it could be.

Female: OK. So we know that patients who have been discharged from a hospital, customarily they may be selected for CAHPS survey so there are some surveys occurring that way. But it's, again, a broad – it's a broad denominator and a broad numerator, whereas this is more specific but it is not necessarily – there's some slippage with it. It is – it is NQF-endorsed though, isn't it? So obviously, do you have anything – and that is what you've got there from NQF. So obviously there was enough interest in this on the part of NQF to feel like it could be adopted. Got some thoughts for it, I can tell. You're mulling a little bit.

Female: I am mulling, yes.

Female: So what I like about it is that – is that it is behavioral health specific. I do think that there's some – I had some misgivings about the fact that it can be either given to a patient at discharge or follow-up because …

Female: Yes.

Female: … you've got some temporal issues there that could potentially affect it. However, one would assume that NRI has some done testing on that and looked at that issue, but I don't know that for sure.

Female: I think some of the questions, too. Feel free to complain without fear of retaliation.

Male: Yes. I mean the questions are fine, it's just …

Female: Well, from a literacy level though, my complaints and grievances were addressed. There's a couple of questions with atmosphere.

Male: Yes.

Female: Yes, they were talking …

(Off-Mic)

Female: Yes, I mean I guess when I'm just thinking about these questions compiled in and somebody's ability to go through them, right, to really understand what does retaliation really mean, right?

Male: And possibly, you know, typically we do some kind of satisfaction survey so they all have already got their own survey.

Female: Right.

Female: Yes. The problem …

Male: That's a little bit challenged to like mandate everybody to use the same thing.

Female: Right.

Female: Yes. I think the struggle that I've got is that, you know, whether or not they'll, how relevant are those surveys to …

Female: Right.

Male: See, I'm not saying there isn't a better survey or …

Female: Yes. I still better think this sort of the – I like the different domains. I like that idea, but I don't know about being wedded to a particular survey.

Female: How can you then compare across various …

Female: Yes, I mean that's the other issue.

Female: If you don't have it?

Female: Yes.

Female: To me, that is consistent.

Female: Yes. That's the other problem. Right. That's different.

Female: You've been kind of quite there, (David). What are you thinking?

(Off-Mic)

Female: It's an NQF measure so we're not in a position to really call it as a measure concept if I understand this correctly. We're kind of in a spot where we're going to have to make …

Female: So one of the reasons that I suggested we consider it – is that anecdotally the responses we get from people who've experienced inpatient, psych inpatient are horrific.

Female: Oh, no question.

Female: Just horrific and it's having a negative impact in terms of follow-up engagement in our patient.

Female: Sure. No question.

Female: So …

Female: I'm not saying this is going to fix that.

Female: Right, there are huge disparities in terms of psych inpatient versus other inpatient. So I guess that was the impetus for saying …

Male: Yes.

Female: Right. Right.

Female: There needs to be something …

Female: Yes.

Female: .. to show me. I would like to actually – because one of the big problems is that people actually don't get treated when they're in the hospital, right? And so to me I would be in favor of measures that actually looked at treatment expectations or something in a hospital unit as opposed to, because the patient, we already know, right? I mean it's terrible, right? I mean that to me is like a last ditch effort for any of our patients, right?

Female: Yes.

Female: And so to me I would be more in favor of going – I don't think this does anything, you know, I don't think this is going to move us in a direction that's going to, I don't know.

Female: Well, sounds like people feel ready to roll on it and says …

Female: Yes.

Female: … I'm hearing ambivalence about this measure. To what extent does this measure address critical quality objectives of the CMS quality measurement domain sand/or identified program area concepts? How many people would say high? OK, two. And how many would say medium? Three.

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? How many would say medium? So it's two and three.

To want 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 the states? How many would say high? How many would say medium? Two. And how many would say low? Three. OK.

So I think that it becomes really important to make a statement about the importance of gaining patient perspective from that on how they experience psychiatric care. And I'd like to ask (Angela) to make a statement and (Verna) if you wouldn't mind, too, because I think both of you had some important points.

Female: Not that the rest of you didn't, please feel free to chime in, but I'd like to make sure those notes are –

Female: I think this still (inaudible) a patient consumer – I can't remember what the damn thing's called.

Female: Patient experience of care.

Female: Patient experience of care is extremely important. I think it's most unfortunate that there are no adopted measures in it. While this measure seems imperfect, I think the concept of capturing patient's experience in psych inpatient is very important, there are huge quality issues as well as basic human dignity questions that somehow need to get captured and corrected.

Female: I think I'd like to see, again, not minimizing a patient experience but as opposed to a post-discharge, patient experiences around treatment and encouraging treatment and treatment outcomes during an inpatient experience.

Female: Really something moving more towards like we now have a, we now have a cancer CAHPS, a psychiatric CAHPS kind of thing.

Male: And that's the idea.

Female: Yes.

Female: Yes.

Male: Yes.

Female: Anything else anybody would add? OK. We're at the patient and caregiver experience conclusion and yes.

Female: So the committee decided not to recommend patient experience of psychiatric care measured by the inpatient consumer survey to the coordinating committee for review based on the measure's inability to pass the efficient use of resources. And as we are in this domain, I did want to test to see if there's anyone on the line who wanted to make any comment.

Female: OK.

Female: All right.

Female: So we're now going to go on to discussion of safety. And let's see, it looks like the first question there might be documentation of current medications on the record and then they're collected, right?

Female: Sure. So we have, what number is that, it's 60.

Female: I think 59 is the first. Which is the combined readmission rate.

Female: Yes, even though …

Female: Combined.

Female: Right, 50 (inaudible).

Male: Yes, (inaudible) 20 and, you know, maybe that just somehow addressed adequately some of the other indicators. But one thing that the state Medicaid (inaudible) is track specifically all readmissions for individuals with serious mental illness. So not just the mental health readmissions, but to look at all the readmissions for the population which we just started doing it over the last year. So I don't really have a sense yet of its value, but intuitively.

Male: And we're doing this as well, using essentially the HEDIS PCR with SMI and other stratifications. It's something very much like this.

Female: (Verna), are you seeing anything like this?

(Angela), what are your thoughts about this one?

(Angela): (Inaudible) Medicaid or the Medicare project.

Female: Yes, I assumed everybody was going to drop this.

Female: Pardon me?

Female: I think this is important. We have very high readmission rates.

Female: Yes.

Female: Yes, and I think this speaks to the whole issue also of integration of health and behavioral health whereby you've got individuals, I recall, yes.

Female: Right, because this is a readmission regardless of diagnosis.

Female: Right.

Female: So – but the denominator is just people who have a behavioral health diagnosis, correct?

Female: Primary diagnosis.

Female: Right. So you're going to capture people with co-occurring conditions, and so in a sense it kind of gets to those comorbid health conditions as well as SUD.

Male: Yes. Right.

Female: Right? It's going to be high risk for …

Male: Right.

Female: Yes.

Male: I mean just by the fact that serious mental illness, risk of smoking and obesity that would (inaudible).

Female: Exactly.

Female: Right.

Male: Even if they don't yet have diabetes or COPD.

Female: Yes. So are we in a situation then where what we're saying is that this will track anybody who has a behavioral health condition and it will track their readmission within 30 days regardless of whether it was for a medical or behavioral type readmission.

Male: Right. And it could be from mental health to physical health or vice-versa.

Female: But it wouldn't be physical health, it'd be also behavioral health readmission.

Male: Any inpatient.

Female: Because that isn't what I heard that's why I was asking.

Male: I must have missed–

Female: So it would be any readmission.

Male: It's any readmission.

Female: So it's a readmission, it's not necessarily transition of care.

Female: Right, it's a readmission.

Male: Yes.

Female: Well, so if I am stabilized in ICU because of a medication overdose and then transferred to a psychiatric ward, that psychiatric ward's going to be a readmission? That won't count.

Female: No, no. That's transition.

Female: That's a transfer, yes.

Female: Good.

Female: Yes.

Female: OK. It sounds like we've had some discussion on this, do people feel ready to vote? To what extent …

Female: So I can just – I just …

Female: Yes.

Female: But somehow I'm not clear.

Female: If it was any readmission for any diagnosis. So it's any diagnosis with a readmission for any diagnosis.

Male: Yes.

(Crosstalk)

Male: But it shouldn't include it. It should not include it. It counts whether or not people are going to sort that out.

Female: OK. I just want to make sure if it was physical and behavioral on both ends.

Male: Yes. Most admissions are not planned, right. So it's not perfect.

Female: Well data cleansing, maybe go through and check that.

Female: Right. So here, it doesn't specify what it does in the description, history of SMI.

Female: Right.

Female: Is this a complete …

Male: That's an oversight.

Female: Denominator description?

Male: The denominator should say all discharges of people with serious mental illness.

Female: So that's …

Male: Where the denominator says includes all discharges from (inaudible). So this references – this is referencing – I pulled this from another document and …

Female: Where there was content.

Male: There was other content previously and reviewed it carefully.

Female: Oh, OK. So basically though that the intent of this and the way it is (inaudible) in the denominator you have either a primary or secondary diagnosis of behavioral, of serious mental illness or can it just be a primary SMI?

Male: I would say maybe primary, secondary otherwise you mess your …

Female: You miss a lot.

Male: Yes.

Female: OK. All right. So any other discussions, questions, qualifications?

Female: So we're voting on it as clarified?

Female: Clarified, that is correct.

Female: That the denominator is kind of …

Female: We want to make sure that …

Female: Yes. So all – and (Jean) connected with someone from your team on this. And I'll ask for her for additional clarification because you connected me to someone that had some of the measure sets and I'll ask her.

Male: OK. If you have troubles just let me know.

Female: OK. Yes. But I'll make sure that this is clean.

Male: OK. And we can connect. I think we have – we'll have the information …

(Crosstalk)

Female: OK.

Female: So to what extent does this measure address critical quality objective of the CMS quality measuring domains and/or identified program areas key concepts. How many would say high? Five, OK.

To what extent will this measure address an opportunity for improvement and/or significant variation in care as it affects quality challenges for each program areas? How many would say high? OK.

To what extent – and let's see, is this a claims based?

Female: I don't think I was able to ascertain.

Female: So I assume this is through claims?

Female: Yes. This is a readmission.

Female: 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? Five, OK.

To what extent is this measure ready for immediate use? So it's being used in Philadelphia, you're using something – or Pennsylvania, right? You're using something like it, but it's not the same. So do we have measure specs on this? How long has it been out for?

Male: Not very long.

Female: OK.

Male: We just have the baseline year results in the first year …

(Off-Mic)

Female: OK.

Male: And it's actually tied to a P for P program.

Female: Oh, interesting.

Male: For the health plan.

Female: So it's tied to – wow, that was fast. When you think about the fact you have a baseline and this is going to be the first year.

Male: Well it came out. I mean that was part of the plan.

Female: OK. SO it was announced and everybody sort of planned on that, OK.

Female: And, yes. So just one of the things that we wanted to highlight. So the measure is already in use in a state.

If you look at the decision logic that's been modified from yesterday, it says that since it's already in use in a state, we can recommend it as a measure or as a promising concept because it's already in use in the Medicaid population and so – but it's not a fully – it's like it is kind of …

Male: It's not necessarily fully.

Female: Right. It's like an asterisk of – it's an asterisk measure. So just something to keep in mind as we're going through.

So what extent is this measure ready for use? If we said low, it would fall in as a concept or a promising concept.

Female: Well if we said low it would fall in just as a measure concept. But if we said high, as it's already in use in a couple of places, it would fall into this promising concept.

Female: Oh, thank you. OK. All right. Thank you for pointing that out.

Female: Yes. And that was an alteration from yesterday.

Female: Because we have it already in use but not …

Female: Right. So it wouldn't be a …

Female: … fully specified and tested. OK.

Female: So it's a little asterisk measure.

Female: OK. So I think we're at to what extent is this measure ready for immediate use? How many would say high? How many would say medium? OK.

So to what extent do you think this measure is important to state Medicaid agencies and other key stakeholders? Consumers, families, Medicaid MCOs and providers. How many would say high? Five.

OK. How many would recommend that this measure be considered than – I guess I have to ask whether or not – so it's already because it's not fully spec'd out.

Female: So we're just saying it's a measure.

Female: OK. So there's no more voting needed. All right, we're good. So it's going to be a promising measure concept, is that right?

So these combined behavioral (inaudible) 30 day readmission rates for individuals with SMI eligible the population will be recommended as a promising concept to the coordinating committee for review.

Female: All right. Very good. Thank you. Thanks for bringing that to the committee.

Male: You're welcome.

Female: OK. So now we're on to documentation of current medication for the medical record which is 2.7, this is another safety domain, measure NQF 0419. So it is endorsed, are there any comments about this one?

Female: What number is this?

Female: This is number 60.

Female: Oh, OK. I thought we …

Female: Documentations on medications. The data source is claims, other, and registry. Is this one considered to be – I think this might possibly be a high priority measure for CMS already in quality payment programs.

Female: It's used in a lot of these.

Female: Yes. (Inaudible) it's in the savings program, yes. So this is highly used. So any discussion about this one?

All right. To what extent does this measure address critical quality objectives of the CMS quality measurement domains and/or identified program area key concepts, how many would say high? 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? 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 states. How many would say high? How many would say medium? You're not sure.

Male: So source, this is like …

(Off-Mic)

Female: Well it says here claims only, that you can also get this from claims.

(Crosstalk)

Female: Yes. I don't know how that would happen.

Female: Go ahead. We could basically look.

Male: Just consensus only.

Female: Electronic health record only, paper records, patient reported data, pharmacy, provider tool. So there appear to be a multiplicity of ways that this can be collected. Pardon me?

Female: None of which have to take it.

Female: Wait, I think we're looking at two different …

Female: Number 60? Oh, you're right. I'm looking at this …

Female: So the data source is (inaudible) only, other, and registry.

Female: OK.

(Off-Mic)

Female: Claims only, other (inaudible) so this is done. No, unless it's got one of those (Reys) (inaudible) because it's none even like I'm attesting to med reconciliation, I'm attesting …

Female: There is an e-measure version for this. If you look at what it says in numerator, the numerator statement for the most recent versions of this measure is as follows. For both the 2015 claims and registry version and the 2014 e-measure version, eligible professional attests to documenting, updating, or reviewing patient's current medications using all immediate resources available on the date of the encounter.

Female: Yes. It's a med – you're checking the med rec button. I mean, that's essentially what it is.

Female: If we check yes or no, it's not a list.

(Off-Mic)

Female: Yes. Because there is an – yes, OK. All right. So I think where we are is now to what extent is this measure ready for immediate use? How many

would say high? How many would say medium? Three, four. How many would say low? One would say low. OK.

So, 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? How many would say high? Two? How many would say medium? Three? OK.

Female: So the committee decides to recommend documentation of current medications in the medical record for review to the coordinating committee.

Female: And so just FYI, we have lunch scheduled for one and so I wasn't sure. I know we have three more measures left to review. So would the committee like to – and do we have any that we have to revisit or anything like that?

Would the committee like to go ahead and take a break or would you rather finish up these three?

(Crosstalk)

Female: OK. So thanks for the update. So we're looking at number 61, are we, because that is below the threshold.

Female: It's 1.8.

Female: Oh, it's 1.75, that's right, just made the cut. OK. So medication reconciliation. I'm used to seeing so many other than 2 – they're higher, you know.

So medication reconciliation, number of unintentional medication discrepancies per patient. And this is a safety domain, it is an NQF-endorsed measure.

Female: And it's any hospitalized adult patient. So this is not stratified.

Male: Random sample of 25 per month.

Male: And your point, for large state agency it's hard to do a randomization.

Male: Yes, I can't see us ever using a measure like this.

Male: Twenty-five people.

Male: Wouldn't get a mental health.

Male: Could be one person with, two people with a substance use disorder, three people from rural areas with head injuries.

Female: You're not going to get …

Male: Four people had head injuries.

Female: Interestingly, the care setting to this is hospital. But the steward is NCQA.

(Crosstalk)

Male: Let's see if we can knock on out on the first …

Female: Because I'm looking how many …

(Off-Mic)

Female: And I will point out that the beneficiaries of complex care need interview in this measure as well.

Female: Oh, they are?

Female: Who can handle this?

Female: We're surfing.

Male: I just wanted to make a comment to NQF, I want to applaud your all's use of people with complex condition as opposed to super utilizers.

Female: OK. So in our work with CMS they started using complex …

(Crosstalk)

Female: … beneficiaries with complex needs.

Female: So as we're going through this, are there any other questions about it from feasibility perspective or any other perspective?

So I had one question, you had said (inaudible) this is my question for you, how could then medication discrepancies, just medication discrepancies that are unintentional be captured and do you think there's value to looking at that issue?

Male: So I think it has value but probably not at a state program level, but like at a facility for individual program volume. I do think it has value but I think it's …

Male: I think it's really hard to measure.

Female: That's not where I'm going, I'm not asking is it hard to measure, I'm asking which is I think number three. But I'm really just trying to get a feel for whether or not you think at some level – I'm really at number one asking for your thoughts on that.

Male: Right. It also seems to me kind of somewhat esoteric to point at an intention. I guess it's kind of medication discrepancies …

(Off-Mic)

Female: Yes. I think what I'm seeing is the admission orders that compared to the preadmission medication list which makes sense to make sure that there isn't some sort of error there.

Female: Right. That's what I was assuming. The unintentional, we switched your medications intentionally versus a mistake was made.

Male: So, I mean I could vote for this as medium in terms of the importance. But I think I'm going to vote low.

Female: Yes. Yes. Thanks. Thanks for giving me that feedback. That's what I was hoping for. OK. So to what extent does this measure address critical quality

objectives of the CMS quality measurement domains and/or identified program area key concepts? How many would say high? How many would say medium? OK.

To what extent will the 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? How many would say medium? Four? And how many would say low? OK.

Male: Not much variation.

Female: I see where you're going, yes. 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 health plans and/or states. How many would say high? How many would say medium? How many would say low? The measure does not go forward.

Female: So the TEP decided not to recommend medication reconciliation, number of unintentional medication disparities per patient to the coordinating committee review based on the measure's inability to pass the efficient use of resources criteria.

Female: OK. So 62 is reconciled medication list received by discharged patients. So discharges from an inpatient facility to home self care.

Female: Med rec.

Female: Yes. It is.

Female: Yes. I mean if you're doing med rec at a visit, right? I mean this is med rec and this is part of a transitional care visit.

Male: But it says before discharge …

(Crosstalk)

Female: Yes. Yes.

Female: Oh, I thought it said discharged from an inpatient. So I was thinking it was a follow-up visit.

Female: Who received a reconciled medication list at the time of discharge.

Female: Oh. So it's – yes. Not once you're back in the doctor's office, then it says time of discharge.

Female: So is this psychiatric or is this broader? It looks like it's broader, it's anyone. And we could pick the same issues that we've talked about with regards to stratification continues to be present.

Female: Yes. And I will note that the reason that we included it is that the staff of (SAMHSA) recommended it as a suggestion in their national behavioral health quality framework which is why.

Female: Do we have any information about why they recommended it?

Female: So that is a good question.

Female: Well there's a lot of drugs that will have time and indication, for psychiatric drugs too. Like the physical health drugs they will have those indications, will cause an adverse event.

Female: Yes. If you combine them, yes.

Female: Right. So maybe that's why it's there

Female: Interesting. So I'm looking at their national behavioral health quality framework and they're recommending recommended and future measures and so this is one of their recommended measures and just in their …

Female: Measure concept. OK. Is it 0640

Female: So if you had this stratified, would that, that seems like that would be more actionable information.

Male: Exactly.

Female: Right. Because just in general it seems like a basic issue, but you'd want that stratification.

Male: Yes. Otherwise most of the information doesn't pertain to the population.

Female: Yes. And that's SUD, right.

Female: And that's the challenges that you're going to have such a large group of people who may not have behavioral health conditions included in this measure and without stratification you can't really tease out which are the ones who have both the behavioral and the medical, so that you can have actionable data really in both areas. I mean you'd want to act on it from the behavioral health perspective but certainly also from a medical as well.

Female: Do you have any measure like this that you're using now? No? And we can't change this.

Female: No. We can make a decision about what we're going to recommend, and then if we decide regardless of which way we go with it, we can also make some statements. It's also claims and paper records.

Male: Yes. I mean we have some programs, we do this ourselves (inaudible) but we don't have any strategy for measuring.

Female: OK. Any other comments before we vote on it? All right. So the measure is reconciled medication list received by discharged patients, discharged from an inpatient facility to home, self care, or any other state of care.

And to what extent does this measure address critical quality objectives of the CMS quality measurement domains and/or identified program area concepts? How many would say high? One. How many would say medium? Four?

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? How many would say medium? Four. 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 would say high? How many would say medium? How many would say low? OK. So the measure does not continue based on that.

Female: And would you mind just the group writing a couple of sentences or rationale to why it's not an efficient use of resources?

Male: Require very intensive record reviews.

Female: And – go ahead.

Male: Especially to get a large enough sample.

Female: And (David), did you want to say anything about the issue of how broad it is in terms of …

Male: Mostly information collected wouldn't be specific to populations (and clinical).

Female: And a measure that you have perhaps collected this data but also allow stratification. Yes, the stratification so that you could identify anybody with a primary or secondary behavioral health condition and then stratify back to see whether or not they were getting a discharge with a medication list.

And so the TEP did not recommend reconciled medication list received by discharged patients to the coordinating committee based on its inability to pass the efficient use of resources criteria.

The next one and I believe the last one is 30-day all-cause unplanned readmission following psychiatric hospitalization in an inpatient psychiatric facility and this is NQF number 2860 and the steward is CMS. I don't see what programs, it's not being used in any programs right?

Male: Maybe in Medicare fee for service.

Female: Or dementia and Alzheimer's.

Female: Oh, OK.

Female: I noticed the denominator is all Medicare.

Female: OK. Target population is Medicare fee for service beneficiaries age 18 and older, discharge from an inpatient facility with a principle diagnosis of a psychiatric disorder or …

Female: What number?

Fmeale2: Sixty three, right? For me?

Female: Yes, 63. Yes. Or dementia, Alzheimer's.

Female: These are measures for Medicaid, would this capture duals or …

Female: Well it doesn't – I don't know. Where did you get the dementia? Like I don't have it …

Female: It's somewhere in here. Yes.

Female: Oh got it. Yes. But it's not in the denominator, got. Your question again please?

Male: It's the fact that it says Medicare in the denominator is confusing.

Female: Even if it was focused on …

(Off-Mic)

Female: Well it is eligible index submissions and require enrollment in Medicare Parts A and B. So this is a Medicare measure. It is not in fee for service.

(Crosstalk)

Female: Well, yes. I mean I think it addresses an objective of CMS. The question in my mind is would it do it any better than the other one that we just

recommended as a promising measure concept. And what I liked about that one was that it was looking at any kind of readmission, what is this is, all …

(Crosstalk)

Male: That's after a mental health reading measure. The other one after readmission. So it's readmission after a physical (inaudible) for people with SMI, this is only after mental health, after mental health admission.

Female: In other words, is it specified as in (that), right? Is the population?

Female: Correct. And this one is just saying psychiatric disorder.

Male: Dementia Alzheimer's which will bring …

Female: So then you've got – yes, you've got a broader …

Male: An odd mix.

Female: It is.

Female: I think it's a Medicare. I think it's the wrong target population.

Female: OK.

Female: And inpatient psych with Alzheimer's, dementia and …

Male: We generally don't use that.

Female: No. It just feels …

Female: I've seen in the commercial world where you have patient with dementia as well as Medicare or duals. I've seen that, but I haven't seen it in Medicaid.

Female: I think the intent was correct.

Female: Yes. So let's start with the very first one unless there's any more discussion. To what extent does this measure address critical quality objectives of the CMS quality measurement domains and/or identified program area key

concepts? How many would say high? How many would say medium? One. How many would say low?

So I was going to vote low on the next one, the one that deals that the measure addressing an opportunity. OK. So it looks like we have finished with that and I think basically the issue is from our perspective, this measure is more appropriate for Medicare than for the Medicaid population and we think it was probably designed based on the specifications that we've read for a Medicare population, not a Medicaid population.

Female: OK. So the TEP decided not to recommend 30-day all-cause unplanned readmission following psychiatric hospitalization based on the measure's inability to pass the key concept criterion.

And we've finished this, is there anyone on the line who wanted to comment? OK.

Female: So I guess a couple of things come to my mind, first is, is there anything that anyone feels at this point in time that they want to go back and revisit?

The only thing that I had come to my mind that I wanted to ask you about whether you observed was we did generally have some reasons why we would not approve certain measures because they appeared to be more focused on paper records, and less on some way of electronically capturing something. And when we looked at that, we would see data source claims, paper records or others. Are there anywhere we – and then later on we learned that, "Oh well, perhaps when we're saying claims we're really meaning that that's probably the primary approach to capturing that data."

Are there any that based on that you think that we may have had any kind of misunderstanding about that is from that perspective?

Female: So in my recollection it was for one very challenging paper-based people often rate it as medium except I thought – especially because they look at other criteria of the alignment across programs or other feasibility.

So I think that there was – from my memory I don't recall anyone – anybody else have inputs about that?

Female: The other thing that came to my mind was that there were some cases where we did say that although it did do some electronic capture, there were challenges with capturing the data electronically, or even if you were capturing it, what did it mean, because it wasn't giving you – it was not giving you data that was going to be easily actionable was the other thing I heard.

Female: OK. All right. I just wanted to check on that. (Beverly), was there anything else that you wanted to say?

Female: No.

Female: And how about anybody else? You have anything else you want to …

Male: No, you did a great job.

Female: Thank you. You all did a great job. We all did a great job. All right. Thanks. (Kate), you did a great job.

Female: No, I really appreciate everyone's time. We know you're very, very busy and it's very important to us that you're able to dedicate this time.

Male: I can do it every day.

Female: Right. It was a nice diversion.

Female: And so we are taking a pulse in the groups. It looks like all of the groups are going to be ending a little early which would be very nice – and we do have lunch scheduled for 1:00 which would be just a box lunch here. And actually – OK. So, so far it looks like we will be reconvening upstairs after lunch, so around 1:30.

Female: OK. So lunch will be up on the ninth floor?

Female: So it will actually be here because we had planned for …

Female: We planned for you not being as efficient.

Female: It's better to begin this spot than some others.

Female: Yes. And so I know that – so there's about 15 minutes before lunch and I know that people probably have other work to do in between. So we also have a couple private offices in case you would like to take calls and let me think, we have the Skype thing.

Female: Skype room and there should be two additional …

Female: So – and the lunch will be at the same place it was yesterday. Yes. And so you can just take your lunch and go back to your office. But we will – we can send an email out to people because I know that some people will stay here and work and some people will like to have some privacy. But I'm thinking that we're going to be reconvening at 1:30 on the ninth floor.

Male: I was going to ask, can they call in?

Female: Sure. Of course. The call in number is …

Female: Because we're looking at an end time of for those of us who might want to (inaudible)

Female: So we are looking to, so if we reconvene at 1:30 instead of 2:30, it looks like we'll be ending closer to 3:00 instead of 4:00.

(Crosstalk)

Female: Yes. I'm just trying to, so that says 2:30. So do we think that we're going to still be concluding around 3:00?

Female: That would be my guess. I can a hundred percent say. I'm going to head my bets a little because I know that we will be reviewing some of the – like the measures that came out from all of the TEPs and so that we'll all be done so we will be reconvening upstairs at 1:30.

Female: So it's not a guarantee.

Female: It's not a guarantee. So it may be more like right now we're scheduled to adjourn at 4:00.

Female: Right.

Female: And I would have a hard time seeing us use that until 4:00 just because we will be moving everything up an hour.

Female: OK. But if we need a place to work after that. I have a car service coming to take me to the airport at 4:15 for a 7:00 flight.

Female: We absolutely have offices. And then the only – because coordination between two floors is a little challenging so we would have to, you can't get up to the ninth floor from this floor without having a key card.

So I think what would be best is for those who are able to stay, if we met in this lobby at 1:30 then we could just – because I have the (inaudible), I can go. So it's a security thing.

Female: OK. So reconvene at lobby at 1:30, lunch is at 1:00, conclusion hopefully 3:00 or 3:15, we don't know for sure and you'll call in. And is there any – you will be too?

OK. And is there anything else that you wanted to share in terms of summary? How many did we finally approve? Do we know yet?

Female: So I can do a quick – I will be getting it for you in between. But I think that we had 15 yesterday and then starting …

Female: But we have more than 15 yesterday, didn't we?

Female: We recommended 15. And then – and we, so I believe we recommended 25.

Female: Twenty five? And does that include the measure concepts? And so I will be providing you all of the measures and measure concepts recommended along with just a sentence or two of workgroup, just a summary. So in preparation for when we get together in the larger group.

Female: Oh, good. Yes, that would help. Looks like I'm going to have to say something about it. And then – and also if you need to head out, please do take a lunch.

So for those of you who may be leaving, I just want to say again thank you all so much for everything.

(Crosstalk)

Female: Yes, absolutely. Yes, absolutely. And thanks for all your good work and ability to make some great comments and to do it in a way that was succinct. Thanks and have a safe travel.

Male: Thank you. You too.

Female: And if anything changes, if anything with the time, I'll email everyone.

Female: OK.

(Off-Mic)

Female: Great. Thanks.

END