COMM PARTNERS

Moderator: n\a
April 18, 2017
11:06 a.m. ET

OPERATOR: This is Conference #tara.

Lynda Zeller: Testing one, two, three. So, again, this is Lynda Zeller from Michigan, Commissioner for the state for Services for Substance Use Prevention Treatment Mental Health and IDD Support and Services.

So, going to the next line, please. The Michigan – before I can talk about our state's perspective to inform you and your effort to reduce substance use disorders in our state through measurement, I thought it would be important to highlight just a couple of things in terms of our structure.

So, we are a managed care state in terms of who provides the management (affordable) physical health and behavioral health in IDD. We have about 20 years managed care experience, where we have a behavioral health carve-out, meaning it's not private managed care entities that manage services for person with serious mental illness, SUD, and IDD. It is our public community mental health and substance (abuse) system that manages those through a public system noncompetitive. And then everything else, the physical health and mild to moderate mental health is managed through private managed care entities, competitive private health plans.

So, in terms of measurement and reporting, again, we have 20 years of the PIHP, which is the Public Mental Health and an SUD system, and Medicaid health plan systems for 20 years did metrics and measurements individually. Beginning in 2016, we began a shared metrics quality improvement incentives and withholds where sort of both sides of our managed care system began to

the incentivized from quality metrics together or either performing well together or losing that incentive withhold together. And you can see 2016 that's relatively new, but it has been. I think. the most strategic decision we have ever made in terms of promoting real difference in early identification and early intervention with the cases that are high-risk as well as (high-use) .

And then in 2014, we began – that should say CareConnect 360 not 260. That's just the name of the tool we use. We began using (endpoints) and shared tools to help both the health plans and the providers to have better access to information, claims-driven and encounter-driven and others, and meaningful use-driven through health information exchange. And those shared tools, I'm hoping, will provide some understanding of our state experience in what we're trying to do, to do a better job with reporting.

So the next three or four slide, next slide, please, are some examples of that first tool I mentioned called CareConnect 360, which is basically a lens tool into which pull that real time information from the data warehouse. And so what you're looking at is a client summary screen which tells you that Lynda Zeller is served and what my different areas are in terms of -- there we go -- easy visits, admissions, chronic conditions, sort of (new) algorithm behind the scenes that may suggest a certain chronic conditions. So, that's one screen.

The next slide is another slide which digs deeper into that chronic care conditions and shows both current and history. And remember, none of this is data inputted. This is just a lens tool from which the claims and encounters for Medicaid as well for non-Medicaid. The substance use and mental health (inaudible) includes all the SAMSA, Block Grant (funding). We use the same coding structure for both. So this is telling you and all in the fine print there that Lynda Zeller has a history that may suggest current chronic condition or history of chronic condition; again, algorithm driven.

Next slide, please. Sorry, it's not moving. OK. So, this is a stratified list. So, I told you that in 2016, we began shared metric responsibility across our physical health system and our behavioral health IDD system in order to get to outreach, which is so critical to reducing substance use disorder right in terms of early identification and getting here quickly, we create a disk stream for the

health plan and those providers with the active clear relationship so that they can find higher risk people that may not be currently in treatment.

So, you can see that the columns on there, you know, after identifying the person, the beneficiary, then its total visits, and that can be behavioral health, that can be IDD, that can be physical health, total emergency department visit, psych emergency visit. So, this helps you to see the person's name, which is grayed out, the numbers of visit they had, and then also whether or not they're actually in treatment. So this is a very important tool.

So, next, please. So, this one – and this is one of those animated (inaudible) click a few times. So, go ahead and click again. Oops. I'm sorry. I guess the animation didn't take. That's OK. So the first series of tools that CareConnect 360 was all claims and encounter driven or homelessness management, information system driven or child welfare data; all the data that goes into warehouse that's kind of static, right, and non-clinical record.

The other thing that states are doing, in particular Michigan, is we're trying to actually use and take advantage of Meaningful Use 1 and 2. And this is an example of that. So, in the health information exchange world is where all our providers are exchanging that real time information for a specific clinical uses. This is one of about 200 use cases that are in place in Michigan and one that I think is important to remember is in place in state as you struggle with what measures to promote.

This is state-wide Admission, Discharge, Transfer Notifications or ADT. So, if the animation worked in the slide, you would see the patient first goes to the hospital. The hospital sends an automated registration message that looks for – through this health information exchange evidence of active care relationships which it could include and does include today an active relationship with the psychiatrist or addictionologist.

And then once they have a hit, let's say they find five providers, then those five then that automated system sends a message immediately everyday to every provider with an active care relationship, which – and then it bumps up against what delivery preference do they want and it goes it out. So, that

specialist down at the bottom on the right, it can be an addictionologist to CMH. Today, all 83 counties in Michigan have the ability to get immediate admission discharge and transfer messages from all hospitals in the state assuming they have the relationship.

So this is important to know because, well, Michigan I think is the leader in health information exchange. This is (a law) available and able to be done because of federal framework upon which health information exchange has done through a Meaningful Use. So, I, you know, the more we can take advantage of both CareConnect 360 like things that are claims and encounter driven for our metrics, as well as the use case driven examples, like this one of 200 use cases around ADP. Those I think would be helpful.

Next slide please. So, onto the Innovation Accelerator Program, which we were thrilled to be part of as part of the substance use disorder, we had two measures that we baselined, NQF Measure 0004, Initiation and Engagement of Alcohol and Drug Dependence; and NQF Measure 2605, Follow-Up After Discharge.

And then in our (IAP) project, we are also using those new shared metrics that cross our system to inform. And I can tell you that the baseline 0004, we showed significant variance against the national norm in initiation of treatment for ages 13 to 17. All the rest of them, we were pretty much right in line with national, which doesn't mean we were good, but it does mean we were at least close to normal with the rest of the nation.

So that's all I'll say on that right now. So I can tell you that the (IAP) project, and we only did this substance use disorder once, has been a huge positive in terms of helping push some other things forward. But – and it worked well into some other things we were doing like in 1115, Pathway to Integration. We're trying to build the different foundation upon which to have this entire dual managed care system going. And it includes all the improvements in the state Medicaid director letter for SUD which includes a lot of enhancements to particularly our higher level of residential and withdrawal management in the ASAM criteria. So, that worked really well together.

This – the (IAP) project had a good connection to a large state-wide integration planning project called 298, and connection to super and high utilizer projects with NGA. It was hard for me to think about the fact that I was only speaking to the SUD and not the integration because this all fit so well together.

So, moving forward, so that was sort of the baseline of our (IAP). Moving forward, what are we planning to do for this population to reduce substance use disorders? We want to measure in three main areas -- health outcomes, quality life, and access of care in Michigan. We are – you can see under health outcomes, we are doing what someone said in the first session already. We're not waiting for a definition of what a high utilizer is or person with addiction. We are defining those ourselves and using existing measures to dig deeper to learn what's happening with that group. So we believe there's a lot to be done and we're using that.

We're using (IAP) measures, ambulatory care sensitive ED visits, inpatient utilization, and the epidemiological data listed here to inform health outcomes, health outcomes specific to the population that may have an addiction. And I say that because you don't always know, but you may have some data that suggest there may be an addiction or that we (don't) have an addiction, and that we're digging deeper into that health outcome stratification for those groups.

Quality of life. I have one example there that we're using specifically for persons with addiction disorder. There's a system called Behavioral Health TEDS that stands for Treatment Episode Data Set that SAMSA is using this for a long time. And it's got quality of life measures like data for homelessness pre- and post-treatment, status of working pre- and post-treatment.

So there are some quality of life things you can use that are already reported through the state mental health and substance (use) commissioners. And just in the last year, this started as an SUD related and now is also being moved into mental health same metrics in Michigan and I believe in a lot of states.

Access to care. Of course, (experts in that) are – medication-assisted treatments are two of their high priorities for Michigan.

So I added to the bottom of this slide, when I looked at the new NQF measures, I thought I'd take the opportunity (and weigh in) on what I think is valuable. These two jump out to me. If I were in your unenviable position of fitting three, these are two that have particularly relevance to Michigan substance use disorder treatment penetration. And in that one, the numerator is at least one treatment encounter noted and that can be in patient/outpatient methadone or medication-assisted treatment, and the denominator is all what the treatment need. And then the bottom one, medication-assisted treatment ASAM number two, the numbers receiving that medication-assisted treatment medication and in the three, and then the denominator being opioid and diagnosis.

Just a comment on the top one. Remember, I said the denominator was all with the treatment need. That one is squishy, right, but super important. So if there's any way for you all – and I think there's many ways you can get there. You can even use some prevalence assumptions. You can – if we can get pass the 42 CFR Part 2 challenges. There are other things that can trigger, things way beyond this substance use disorder system that can trigger someone as someone with an addiction treatment need. I think if you can figure out how to fix the quagmire of who is the one with the treatment need, that will be a huge step forward.

So, the …

(Off-Mic)

Lynda Zeller: Yes, yes.

(Off-Mic)

Lynda Zeller: Fantastic questions. So, now that we have shared metric across our physical health and behavioral health. The physical health now who doesn't have any responsibility for treating cares deeply now about how well that growth population is doing. So it would our intent that the physical health side of our

managed care system helps us actually find those people, right. And they're motivated to do so more now than ever. It doesn't mean we can't find them on the addiction side and the mental health side, too, but we're much more likely to find people in primary care settings, in hospitals, and (ERs too). So it's an important metric on both sides, if I understood your question.

Male: And is there some kind of expectation that …

(Off-Mic)

Male: … or somehow establish treatment need?

Lynda Zeller: So, the physical health settings? No, the expectation is that there would be care coordination between the two systems. And as early on as possible, you get the person into the other side if you can. You equip primary care to – through motivational interviewing and other tools. So it's kind of a dual thing. You want to get people wherever they're going. If you can't get them from the primary care setting into the specialty system, then you empower primary care with whatever it takes -- navigators, recovery coaches, whatever it takes for them to deal as well as they can with the population until – and hopefully (bigger finance). So that's what we're working on.

We don't have a magic, you know, a magic idea. But what's happening is because these two sides are now both responsible for the total health with the same person. It's amazing the creativity that's starting to happen at the local level and the variance. And it's also now a competitive advantage for a health plan to do better with our population which the advantage before was to avoid our population as much as we could.

So the final slide here – oh actually, second to the last slide. You asked about challenges. We have structural, philosophical, and environmental challenges. And I could probably talk about challenges all day but I'll try to finish up with these. It's gaps everywhere between Medicaid, the two sides of the systems, between Medicaid and non-Medicaid, especially social supports and prevention, reimbursement incentive alignment or misalignments, resource limitations mostly related to oversight analytics and monitoring, and then 42

CFR Part 2, which is also an environmental and a philosophical challenge to (inaudible) one.

Under philosophical, we have the usual things there, the provider willingness and risk aversion, right? Before I can get a primary care to be willing to do (expert) culture, I very well better have a place for them to go and some strong outreach system in because otherwise the provider has a great deal of risk aversion.

(Stigma), of course, both mental health and addiction, distrust of a private managed care population particularly by the IDD population advocates (inaudible). So there's a lot of distrust overcome.

Environmental, the state federal and local separation of mental health and substance use prevention and treatment continues to be a challenge for us -- separation of systems between social determinants and prevention; treatment access capacity both medication-assisted treatment and psychiatric in part, of particular note; and then outreach challenges. And I wanted to entitle this outreach, outreach, outreach because that's the place if you really want to present substance use disorder and they minimize the impact of those substance (uses), we got to find them much earlier. We can't find them much earlier in just one side of the house. We really have to look at this from not just physical and mental health, but also population health (inaudible).

So final slide there, this is for my – I've been learning a lot about population health. This is a slide we use a lot in Michigan in terms of what impacts Michigan health and of course what reducing substance use disorder as a huge part of positively impacting health. This is just a reminder, this a (CDC) slide adapted for Michigan that on the far left you see at the top most individual effort needed and then at the bottom biggest health impact, and then that companion scale on the right goes from counseling and awareness which is highly individual at right all the way to the bottom on the right, environmental social factors.

And the challenge in what we (weigh) when we decide what to measure is we need to measure things that go – we need to measure individual. We also

need to, in other systems, really be strategic about what we're measuring in terms of environmental and social factors. Because if we don't also pay attention to those environmental and social factors, and making healthy decisions easy in preventative care, then we will continue to make just baby steps, right? So, we really need to be promoting both of those in order to really make positive movement.

Again, thank you very much. I think I'm right on time and I appreciate the opportunity.

(Cheryl): Any questions, comments for Lynda? I guess the one question I have is back at the beginning, what incentive do you – do you have incentives really to get providers to work with this? It sounds like they're getting these reports, but how do you move the providers to buy into this and to do some just care coordination?

Lynda Zeller: So, at the provider level, providers are all networks or all on the network of either the Medicaid Health Plan or the Prepaid Inpatient Health Plan or both. So, remember I said there's a quality withhold incentive money – actual money, a percentage, 1 percent or so depending on the size of contract that is withheld (inaudible) systems. And that they can earn back or lose together between those two systems. So there's real money on the table to begin with. And so, this PIHPs and MHPs then are doing money efforts to try to remove barriers at the provider level so that these providers can be more successful at both identifying people earlier, getting them into treatment. You saw that risk stratification.

So, we found that actually once you just give the providers the tools that they have, that they already have great motivation. And as soon as you start aligning the misaligned incentives starting at the payer level, that kind of unlocks all this creative energy that already exist in the providers that is kind of being missed. Great question.

Any other questions or comments?

(Cheryl): Hi. Thank you. This is really, really interesting. I was wondering, it appears that what Michigan is doing is pretty excellent. And I'm wondering if you

have a sense of how – what your state is doing compares to what's going on in other states nationally in terms of thinking about, you know, if we were to develop a set of measures that would really fit with where your state is at and its journey. Do you think it would also be applicable or readily useable to some other states that maybe further behind in the process?

Lynda Zeller: I think that's an excellent question. And if I didn't emphasize it before, I think if you stick closely to nationally coded things, which NQF has a history of doing before, right? So basically encounters, right, which can go back to codes, if you stick with encounter driven things and/or use case driven things, those are both already national platforms, right? And there's nothing magic about CareConnect 360. It's just using the existing national structure of codes, right?

And the Michigan is just lucky enough that awhile back we decided to use those same codes whether they were Medicaid funded or not, Medicaid funded or – so – but if you stick with either Meaningful Use case driven information which, you know, you have the 17 categories on the registry and all those kinds of things, and you stick with, you know, the codes, HCPCS codes and kinds of things, and I think the measures you're all debating in the last – in the next two days do exactly that.

I think maybe we may be could go deeper into the Meaningful Use stuff. I don't know when I scanned the measures, how much of those measures are really taking advantage of stage two Meaningful Use. So that would be the only feedback I would have. But I think we're all in the infant stage of the health information exchange anyway. So it may just be incredibly frustrating to go there too early.

(Tara): OK, great. Thank you, everybody. So as we pull up our slides, we'll move into a quick overview of the measure scores for the Feds program area, and then we will get started on our actual deliberation.

So you're kind of at slide 14. Great. So this slide provides an illustration of the process of the process that we just used to review measures by measure score. As you know, we have found the mean of all the measure scores and

use that as the cutoff in the SUD area. And that the mean score was fairly low with 0.92. This quickly illustrates the process we used all the measures above the mean, at/or above the mean were retained for further discussion. If a measure fell below that mean score but was identified by a (tech) member as it need of further review, we retain that measure and then move forward. I'd like to add that this group was a very easy one. Of the five of you, only four measures were retained. You all had a – there's a lot of agreement on the measures that we needed to keep. So that was easy.

(Dennis): I forgot. Could you please remind me of what the range of possible scores?

(Tara): Sure. So, the formula we use to the lowest possible score is zero. The highest possible scores is at 2.7. The SUD scores skewed a little lower because we had – we found the most out there of all of the four program areas. But a lot of that was measure concepts. It's really under developing, so we captured. We didn't have a lot of information provided so therefore got a lower score which (dragged) down the average. But the measures that we're looking at today are fairly well developed.

OK. Next slide. This is the breakdown of all of the measures. It's not point of values, but all of the measures that we found by CMS domains. So as you know we categorize all the measures by CMS domains. And the overwhelming majority were clinical care followed then by care coordination. In the actual finalist of measures that we'll be reviewing today, only three domains remains; that is clinical care, care coordination, and there's one measure for patient and caregiver experience. But like (I showed everybody) earlier in the larger groups, if you feel that these are not correctly categorized, we can very well make note of that and correct it moving forward. The categorizations are not set in stone there. A way to organize our recommendations is to organize our discussion.

OK. Thank you. All right. Our next slide, this is just a quick snapshot of everything that we found. We collected 114 total measure and measure concepts. The mean was a 0.92; maximum score at – the highest scoring measures did reach the maximum approach the 2.7. The minimum score was a zero from a measure from a measure concept. We retained the total of 43 –

excuse me, 43 by measure score. And with the updates from all of you, we'll be reviewing 45 measures.

Next slide. Here is the breakdown again by domain. Again, we can move these around as we go through.

Next slide. And here again is this decision logic that you all have in front of you and that we just reviewed. So this is the simplified version of the one that you saw several months ago. We – you have in front of you not only this image but all of the questions laid out along with the descriptions for all of the rankings, the high, medium, and low rankings. So as we move through, these will be the basis for our discussion. We ask that you review every measure individually on its own merit according to this decision logic. And we – I will just want to remind you that we have a lot of measures to get through.

As usual NQF process, (CDC) process, they review maybe 18 measures in the meeting, 20, and we have 45, 47? So, this is not a (CDC) like (Peg) said, just reiterating that. This is not a (CDC). We want conversations to be thorough and robust but also keeping in mind our limitation, and keeping conversation to the scope of the decision logic in order to move forward effectively – efficiently I should say.

OK. And on we go. So, we will now begin the process of reviewing measures. We will review all measures with an overall score that meet or exceed the mean score for the program area, and review measures and scores below the mean that the (TEP) members shows to retain for further discussion. We'll review measure based from the CMS quality domains that they fall into. The six domains are access, care coordination, clinical care, patient and caregiver experience, population health and prevention, and safety. We only had measures in three of these six domains, and those domains were care coordination, clinical care, and patient and caregiver experience.

Within each quality domain, we will review a measure on its individual merits. The discussion guide allows TEP member to view all measures up for discussion under each domain. Member can click on the specific measure for a discussion to get the additional information.

So, this is that link that we sent around again last night. That's going to be crucial to the conversation. So I encourage everybody to have that open and ready. If anybody has trouble navigating the document, please let me know. My suggestion is as you go through, I would – when you open the document it brings you up and you have to the top and you'll have – you'll see the agenda there.

If you just scroll down until you see a gray line that says measures slated for discussion. Measures such as …

(Off-Mic)

(Tara): Oh, I'm so sorry. This is in the – no, I'm sorry. This is in our discussion guide. So this is the webpage that we sent around and we sent an updated version yesterday for everyone's reference.

(Off-Mic)

(Tara): Yes. Yes, we sent the most updated version last night. I can resend it now if anybody having trouble finding it.

(Off-Mic)

(Tara): Great.

(Off-Mic)

(Tara): Great. Thank you so much for sending that. So once everybody is in the document, you'll see it has the agenda to today's meeting. And like I said, if you scroll down, you'll see a bar that says measures, measure concepts slated for discussion. This is the order that we will be reviewing the measures. The numbers associated with the titles are a little out of whack if you'll notice at this portion. That has to do with some coding things from the backend for these discussion guides. But starting at this point in the guide is we'll help you with the other.

If you'll notice when you click on the measure specification for any measure it all – you'll jump down to the measure details for each of these measures. Feel

free to scroll up and down with those. And then when you want to return to the list, you can simply hit back and it'll bring you back to that list at the top so you don't have to scroll through the document ad nauseam.

And is everybody finding this OK?

(Off-Mic)

(Tara): No, that's OK. We want to …

(Off-Mic)

(Tara): It should open with most browsers. OK. I have a workaround for you that I can come over to your computer and launch in just a minute. Is everybody else able to access to document?

Male: Yes. But at some point, before we get started, I'd just like to make a general comment about …

(Off-Mic)

(Crosstalk)

Male: … the group of measures we have and what's missing.

(Tara): OK.

Male: (And propose we discuss that a bit).

(Tara): Is that OK?

Female: Yes.

(Tara): OK.

(Off-Mic)

(Tara): Oh, interesting. OK. So, what I've just sent you …

(Off-Mic)

Female: We can't see access (until).

(Tara): (Cheryl), let me …

(Off-Mic)

(Tara): Great.

Male: Is it a good time for my general comment?

(Tara): Sure. So, we can open – I'll leave it to (Cheryl) to decide that (inaudible) everybody (on time).

(Off-Mic)

Male: I was really concerned going through these dozens and dozens of metrics that I did not find a single metric that was based on outcomes for mainstream intervention or treatment services. And we heard this morning that 20 percent of our proposals could be on measurement concepts. So, I wonder how the group would feel about spending some time deliberating about a measurement concept that would actually focus on intervention and treatment outcomes.

(Dennis): So do you mean – by individual outcomes, do you mean like reductions in the ER use or inpatient care?

Male: Yes, or reduction in the substance use or – I mean I think that would be the gist of the discussion is. And I think in this phase where we're trying to integrate substance use disorder services into a variety of settings, we would ideally want to come up I think with the measurement concepts that apply across all of the settings so we can compare apples to apples (across setting).

(Dennis): Yes, I would be supportive of that, but we might get through the big problem, the big lift first and then we come to that.

(Tara): So I will …

(Off-Mic)

(Cheryl): It can be applicable to a greater population.

(Tara): So, I will just (caution against) trying to create any measure concept that is beyond the scope of the project. We don't really have the resources at that time to really develop something like that out. Once we review these measures, if the committee – the TEP has general recommendations that they'd like to include, we can certainly take note of that and incorporate that. As far as spending time proposing potential measure concepts that are not already somewhere in development, it's just not feasible.

Male: Well, I think even if this group could make a recommendation to NQF and CMS about measurement concepts that really do need development, I think we might be doing the (field valuable) service.

(Off-Mic)

Female: … remaining that we have here …

(Off-Mic)

(Tara): So this measure is entitled, Initiation and Engagement of Alcohol and Other Drug Dependency Treatment. (Inaudible) care coordination, how the measure information is included in the measure specifications of the discussion guide. And so, we post to you the first question in our decision logic. To what extent does this measure address critical quality objectives of the CMS quality measurement domains and/or identify the program area key concept -- high, measure addresses the CMS quality measurement domain and key program area key concept; medium, the measure addresses the CMS quality measurement domain but does not addressed program area key concept; low, measure does not clearly address CMS quality measurement domains or program area key concepts? Those key concepts are also listed on the document that contains the decision logic.

Male: Question, what do we – this is going to come up a lot. What do we do with the issue that this metric uses the term dependence which now is no longer an

appropriate term under DSM-5? I still think it's the useful clinical distinction but the people in charge apparently don't.

(Dennis): Personally, I think this value in using disorder rather than dependence because it's potentially a bigger pool of eligible individuals.

Male: I agree.

(Cheryl): Especially too with younger people from who might meet all the criteria for dependence but may still benefit from treatment, early treatment.

Male: So as we go through it, can we think what wording of these metrics?

(Cheryl): I can't see why not.

Male: We can make suggestions.

(Cheryl): We can make suggestions, yes.

Female: Yes.

(Tara): (I'll ask mine where measurements) seasoned colleagues answer that.

Female: So we can definitely make a recommendation where we sort of state that for this measure why disorder is better than dependence and to be noted. However, any measure that is NQF approved, the terminologies approved so that will go to the coordinating committee of this – of the four (TEPs) to sort of consider and move forward.

And just to point out also your question about measure concepts that are not included. What can happen at the end of these two days is there could a gap list, right, where you can say the measure concept of looking at disorders in younger individuals who are homeless. It's something that's not covered, and that would be put into a gaps list. And that gaps list would then go to the coordinating committee. But the coordinating committee (just took) ultimate sort of adjudicator through what move forward.

Male: Thanks. Well, in general, I would agree that it's best to use the term disorder. However, for adolescence with the minor disorder, I'm not sure that all of this in terms of treatment would be necessary. So, I'm not sure what to do with that.

(Cheryl): (Tara), do you think for the purposes of our discussions since we all see the measure specification to have the individual questions up there so we can be thinking what high, medium, and low. I think that might help. So, we're not (perhaps just looking back) between …

(Tara): Absolutely.

(Cheryl): That will take all of us have it on hard copies. I think that would help.

(Tara): Yes. We are pulling that up right now.

(Cheryl): OK.

(Tara): It is also included in the handout with the visuals; the one I just handed out …

(Crosstalk)

(Cheryl): OK.

(Tara): (They're also there). But we will – there will be up on the screen.

(Cheryl): So, I guess the first, you know, we've got a numerator, a number of different people. I'm not – those who have initiated treatment through inpatient admission, two or more inpatient admissions, as well as outpatient visits, with the denominator of being 13 years old (who's) diagnosed with the new episode of alcohol or drug dependency. So, there again, we're using dependency. So, I think what we want to think about is that to what extent does this address a quality objective that CMS might be interested in?

Female: (Do people have a sense to that)?

(Dennis): Well, this measure is in widespread use. It's a HEDIS measure. If we flex, I think, the quality, the state of the art on a national basis, 40 percent initiate

care, 20 percent engage in care. That's the state of the art because we don't have systems of care. So, I think if we interpreted that way, it's important to CMS, it's important to the field.

(Cheryl): I absolutely agree with (Dennis) on this. It's very widespread. You know, there's a lot of experience out there that's successful with, you know, states and agencies being able to use this measure well. So, I think it's important.

(Crosstalk)

(Cheryl): Yes.

Lynda Zeller: And I also think it's important because we have – we don't have that many measures that really capture our younger – our younger population. Many of them are focused on the over 18-year-olds. So, you know, I think it's also very important that we're looking at out younger population, too.

Female: I would just agree that this is a high measure. As far as reducing substance use disorder, this is the quick capture, quick treatment measure. It's the – within 14 days of being diagnosed with a problem that you can get access to treatment. I mean it's, you know, the measure is perfect but this is one of the better ones in the field at the moment before capturing that.

(Cheryl): Right. And speaking about the domains, you mentioned the word "access," and I kind of wondered if this measure might also be considered access instead of care coordination and that would allow us to hit another domain. And currently we don't have anything in, so.

Female: One that I was thinking could represent access as much as clinical care because it's – our people getting into services once they've had been identified. So this is one that I think we could even say, it might be – it's not so much of care, the quality of the care that's being delivered but our people getting into care in the first place.

(Cheryl): OK. So, sounds like we have – I think we're all in the arrangement that it's a yes, OK?

(Tara): So, we need to …

Male: (In terms of) scale, right?

(Tara): Yes.

(Crosstalk)

(Cheryl): Go ahead.

(Tara): No, I'm sorry. I know it's kind of a – it's a process (inaudible) the first one. But we will need to take a handbook for each of these. And, (Cheryl), if you could, as people vote, once all the votes have been cast, verbally allowed (to read) the vote counts.

(Cheryl): OK.

(Tara): We can't take anything for granted. It all needs to reflect on the transcript for our listeners. So it feels a little silly sometimes …

(Cheryl): That's OK.

(Crosstalk)

(Tara): … each other.

(Crosstalk)

(Cheryl): … we're really learning how (inaudible) how to do this. OK. So, all of those who feel that this is a high qualification, please raise your hand? OK. We have five – five people saying – agreeing with highs. So this will – this moves to the next step. Is that OK?

Female: OK, good. All right.

(Cheryl): OK. So, our next – the next concept for consideration is to what extent does this is measure address an opportunity for improvement or address variations in care evidenced by quality challenges?

(Off-Mic)

(Cheryl): Yes. Can we take a vote without discussion? OK. All have said yes. So we're on high. So we're going to move to the next. Probably helpful that if we're starting with one that's fairly straightforward; less discussion.

OK. So the next is to what extent does it demonstrate efficient use of measurement resources? High? OK. We can take a vote. All, all in favor …

Male: High five.

(Cheryl): High five. We have five with high.

OK. And to what extent does this measure ready for immediate use? So it's already in use. So, can we take a vote on this? We have five that have say high. OK.

And now, we're in – to what extent do you think it's important to state Medicaid agencies and other stakeholders? Take a vote. We have five people saying high. OK.

(Tara): Great. So our first measure, (number 92) on this decision guide – discussion guide, use of – is passage with all highs.

We'll now move to the next measure on the discussion guide, which is measure mark number 96, Preventive Care and Screening: Unhealthy Alcohol Use.

(Off-Mic)

(Cheryl): I've got 93, is that …

(Off-Mic)

(Tara): Right. So, when you hit …

(Off-Mic)

(Tara): So when you hit measure specification that brings you to a separate section with the detail.

(Cheryl): Yes.

(Tara): But that was – (those) measures not necessarily (slated) for discussion.

(Cheryl): Got it.

(Tara): So, back to the main one.

(Off-Mic)

(Cheryl): Oh my goodness.

(Off-Mic)

(Cheryl): OK.

Female: Anything you scroll from that.

(Cheryl): OK. So, this is unhealthy alcohol use, present 18 and older screened, at least once last 24 months for unhealthy. (Inaudible) screening and counseling. So, this is sort of our symbol to (SPER).

Female: OK.

Male: I notice the care setting is behavioral health. It seems like it ought to be …

Female: Primary care.

Male: … also primary care and emergency rooms and general hospitals inpatient units.

(Crosstalk)

Female: (Subject expert). It's been recommended – it's been recommended in a number of settings, exactly.

(Cheryl): So, the measures we (get) 24 months can be problematic for Medicaid as many inpatients do not have (sustained) enrollment for 24 months. (I know

in) Maryland that's quite unique if somebody (is in) for two years straight with one (MCO), which makes it problematic for applying to the population. That would end up (getting) – or may (sit) as very difficult measure (to actually) capture (the data from) because its (charts for) when the patient wasn't your patient.

(Dennis): Well, given the variability and how states operationalize their Medicaid programs, Maryland's issue might not be a problem elsewhere. Oregon is moving to 24 months. They've been using this measure based on 12 months. They're moving now to 24 months because their coordinated care structure seems to do better job of retaining patients for continuous enrollment. So, I think it still has high applicability.

(Cheryl): So, you're saying in the sense that 24 months seem more likely to capture more people rather than if you do it with a shorter period of time?

(Dennis): What – yes, what the coordinated – Oregon's created essentially accountable care organizations. They call them coordinated care organizations for the Medicaid population. They are regionally based. There is overlap in the few regions of the states, but for the most part they're extinct. And so, the CCOs tell me that not all of their patients need an annual primary care visit. So, they really prefer the 24-month look because that's somebody who's available for primary care as needed.

Male: I guess one concern I have about 24 months it's like the opposite of rapid cycle quality improvement. We have to wait a long time before you get your metric, then you're waiting another two years to see if you've improved. I mean for to that reason, I would prefer 12 months or maybe leave that up to Medicaid programs and just (list that as a) consideration.

(Cheryl): You know, it says behavioral – care setting behavioral health, but the denominator is who are seeing twice for any visits or who had at least one preventive care visit during the two months period – two-year period. So, it could be somebody was seeing throughout that time just in a primary care setting. So, it doesn't – you know, even though the setting says behavioral health, it doesn't exclude screening in a primary care setting.

Female: I have a question for Lynda and (Tiffany). What percent of your Medicaid enrollees do you think are continuous for 12 months and 24 months?

(Off-Mic)

Female: Like …

(Off-Mic)

Female: OK. And what about 24?

(Off-Mic)

Female: OK.

Lynda Zeller: Sorry about that. I forgot the mike, for those of you on the phone. I'm guessing around 60 percent for the first group which is 24 months. And – I mean 12 months, and 24 would probably be 40-ish. But that is the total (best).

Female: OK. Thanks.

Lynda Zeller: For the adult population, I would say probably 50 or 60. I'm going to agree to (inaudible) that are continuous for 24 months. Our bigger problem is in – and this is going to vary again by state (inaudible) manage care organizations. Not that they are not necessarily continuous to Medicaid but (because as) they switch managed care organization as well (inaudible) continue their ability to capture this data. So they might be continuous in Medicaid but changing managed care organizations (inaudible).

Some states allow them to do that when they reassess and reenroll every year or every two years. And Maryland has been working on trying to improve continuous (inaudible) of patient's enrollment. But certainly it is – 24 months is longer. I can't tell from the specifications here where the visits can happen and would it like an emergency room visit count or urgent care visit count. (And so, it just seems like) for any visit.

I can't tell which settings do count as (that) visits from our specification. (Inaudible) (everybody in the room knows), but I can't. I don't know. (It's that debate) (inaudible).

Female: So it sounds like you are saying that even among the estimated 50 percent, that, that could get to two years. Your state and maybe some other states may not be able to even track that 50 percent if they move from managed care organization to another from Medicaid?

Lynda Zeller: So we could track it at the state level. But it'd be hard to hold an MCO accountable for a patient that they didn't know.

Female: Right.

(Crosstalk)

Lynda Zeller: … there's a difference in how like we could use it at the state level to track. But as far as actually holding somebody for quality standard if the patient is not theirs because the patient moved to a different MCO, then that's different.

Male: In Wisconsin, people can change MCOs but still be going to the same primary care provider. And I see this is (meant) as a clinician or group practice metric not an MCO metric.

Male: Yes.

Male: Just based on the experience in Oregon, the challenge is get in the patient center primary homes to revise their workflow, so this is being done systematically and not just for the 40 percent of the patients who are Medicaid but effectively 100 percent of their patients. So, yes, it's more of a primary care level that – is the implementation challenge.

Lynda Zeller: Were you going to say something, Debjani?

Debjani Mukherji: I'm going to say the thing that you have clinician group practice that you're looking. So, you're looking at the clinician to look at the patient. So, if they went to different hospitals, if the went to different group practices you would still capture it as long as you're at the physician and the patient and not sort of

just the organization. So, the level of analysis is who you're looking at, so you're looking at the individuals, the clinician here. So, you would – you'd still capture some of this data that you're sort of concerned about not capturing.

(Cheryl): So the questions – and one of the things for people I think about is how is it important for Medicaid to be – how state Medicaids are looking at that level in the measures? And certainly, there is some role for that but how much is it are they looking down to that clinical, the practice level versus their managed care or ACO level (inaudible).

Male: And my sense is states would use it as a population level. They would use it as an MCO level. They would use it as a primary care level. And it would mean different things for each of those level. But I think it's a valuable measure.

(Cheryl): When you said, Debjani, you said it could be at a provider level. If somebody is using fragmented care, though, and they're being (seeing) three times in three different settings, your – who your …

(Crosstalk)

(Cheryl): … which provider are you going to hold accountable …

Debjani Mukherji: So, you're going to get that three times if you're looking if its doctor X, Y, and Z, then you – each of them would have this patient. And you're not going to see the fragmentation at that point, but you're still going to capture that this patient went to three different providers.

(Cheryl): And at some point got the screening and intervention.

Debjani Mukherji: Yes.

(Cheryl): OK.

Debjani Mukherji: And also just to the point of safety using this as a different level, variation is an issue when a measure that is approved and sort of endorsed and tested at a clinical – clinician level is then applied at a population level or MCO level, so

you will get variation of that measure. So the measure is no longer reliable, valid, because it hasn't been tested for an MCO level. And I know in Medicaid that happens a lot. But what it introduces is sort of certain amount of errors that – I guess is better than having no data.

(Cheryl): (It seemed to me) that this is a care coordination domain when …

Lynda Zeller: I'm not sure. It sounds to me like this is clinical care. You know, if somebody is screening …

(Crosstalk)

Lynda Zeller: If somebody is being screened by a provider and having intervention. Yes, because, you know, there's nothing here that requires coordination between different providers or across (systems). We might want to make that as a notation as well. OK. So …

(Dennis): One of the observation, drug use is not mentioned here. Is that by design? Well …

Lynda Zeller: I guess (SPER) was initially developed through for alcohol.

(Crosstalk)

Lynda Zeller: But now it's been expanded to …

(Dennis): Well …

Lynda Zeller: Yes.

(Dennis): And we know that, the preventive health – preventive services task force only recommend alcohol, and yet in practice, Oregon says both alcohol and drugs and tobacco, and depression.

(Cheryl): I guess the question is further on, do we have other measures that include screening for drug use. So that might be something to keep in mind.

Male: (It might end up as a gap).

(Cheryl): Yes, yes, that if we don't find that, that would be a definite – that would be a definite doubt. OK. So do people like they can vote on this first thing about the addressing critical quality objectives? OK. Who of our group agrees that this is a high, this measure of quality domain key concept? OK, we have five people with high.

So let's move on to the next. To what extent does it address an opportunity for improvement and show significant variation in care? We have five people saying high.

We'll move on to the next. To what extent does it demonstrate efficient use of measurement resources, data collection, performance, or contribute to the alignment on measures across programs, health plans, other states, and not duplicative of an existing measures within the measure itself? We don't know yet.

(Dennis): Well, I think it basically meets the definition for high, except this is not an easy measure to implement at a primary care level.

(Off-Mic)

Lynda Zeller: So, it's the coding part and I know, you know, how is this captured by coding. And I don't know if this measure specification had a specific thing in there (inaudible) by chart.

(Crosstalk)

Male: (Hold on), that means very (tight space) depending if …

(Crosstalk)

Male: … et cetera.

Lynda Zeller: Right. And let's see. So that's definitely affects some of its efficiency.

(Off-Mic)

Lynda Zeller: Yes, right.

(Cheryl): Yes, access in different area – different data sources may make it less sufficient, OK? Medium doesn't apply to – it doesn't look at efficiency, though; so it's interesting.

(Off-Mic)

(Cheryl): Yes. OK. So can we vote on how many people feel that this high measures of – efficient use measure resources? We've got …

Female: I mean we don't know …

(Off-Mic)

(Cheryl): Yes, medium doesn't – it just is not duplicative of other measures.

(Off-Mic)

(Tara): Yes, it's – medium – yes. We just need a (definitive vote) …

Female: OK, OK.

(Tara): As far as the duplicative aspect of it, just to reiterate, (just seems that) every measure …

Female: Yes.

(Crosstalk)

(Tara): … don't worry if we review (a like) measure, the coordinating committee will review the entire (set) later on.

(Cheryl): And we can always go back and say, wait a minute.

(Tara): Right. But, yes, just each measure individually.

(Cheryl): So who agrees that this is high? We have three people for high. OK, so it can move on. We have three out of five.

(Off-Mic)

(Tara): … to take the remaining votes …

(Cheryl): OK.

(Crosstalk)

(Cheryl): So, who votes this is medium? We have two people saying that it's a medium criteria. So we're still moving on.

To what extent is it ready for immediate use? It's an NQF-endorsed population measure. Yes. So, how many people feel that it's high? We have five people voting for high.

OK. To what extent do you think it's important to state Medicaid agencies and other key stakeholders? How many people feel high? We have four people (saying) – voting high. Who feels it's medium? We have one person voting medium. It's the language care.

OK. So, we are in high and medium, OK? Next criteria is …

Female: (That's the end).

(Cheryl): Oh, that's the end of it. OK. All right. So we have accepted that measure. OK, what's the next measure?

(Tara): Next measure is number 89 on our list. It is HBIPS-5, Patients Discharged on Multiple Antipsychotic Medications with Appropriate Justification.

Male: This seems it belonged in the mental health.

Male: Yes. How is that as substance use disorder? I don't.

(Off-Mic)

Female: Right.

(Off-Mic)

(Tara): OK. So this does assess for the possible misuse of the antipsychotic medications, but it's the (gut feel) that it's not relevant. We can note that it should be included. This will – we do need (inaudible) in the process, but this will (fail) the first question …

Female: OK.

Female: … (the decision logic).

(Cheryl): OK. And this is just – I agree this is just looking at antipsychotic medications. It doesn't really say anything about other (inaudible) substances, alcohol, and tobacco, OK. So we can vote on to what extent does this address critical quality for our key – our (areas of) substance use? Who votes that this is high? Who votes that this medium? Who votes that this is slow? We have five people voting low on this.

Male: Lower than low.

Female: Lower than …

(Off-Mic)

(Cheryl): Right. And I think this is one that is probably clinical care in the mental health. So I – we can recommend that they consider it in (there) (inaudible) back to the care …

Female: Yes, well, absolutely.

(Crosstalk)

Female: … (coordinating).

Female: OK.

(Off-Mic)

(Cheryl): All right, on to our next one.

(Tara): On to our next measure, this is number 91, HBIPS-7, Post-Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge.

Male: And this looks similar. I don't know why it says continuity of care …

(Crosstalk)

Male: … after (D-shock) …

Female: … after (D-shock).

Male: … because there's …

(Cheryl): It's just psychiatric.

(Off-Mic)

Female: … so you recommend this …

(Off-Mic)

(Tara): Yes, absolutely.

Male: Yes.

(Cheryl): OK, so let's have our voting here. To what extent does this address critical quality objective? All those voting high? All those voting medium? All those voting low? We have five people saying low. So we are not going to vote for it, but we are recommending that it also be considered along with the other one for mental health. So it's just care coordination in psychiatric care. It doesn't say anything about substance.

(Off-Mic)

(Cheryl): OK, moving along …

(Crosstalk)

(Tara): OK, yes, we are. Next, number 87.

(Cheryl): OK, 87?

(Tara): Yes, follow-up after discharge in the emergency department for mental health or alcohol or other drug dependence.

Male: OK.

Lynda Zeller: So this is still in our care coordination. So this is 18 or older had a visit to the emergency department with mental health, alcohol or other drug dependence, again, who are dependents, and had a follow-up visit with any provider with a corresponding primary diagnosis mental health, alcohol, (and other drug) dependence within seven and 30 days of discharge.

Female: It feels a lot like the first measure that we looked at except the ones that substance abuse and mental health folks together. So, it feels like it's …

(Crosstalk)

Female: … emergency …

(Crosstalk)

Female: … difference that we have here.

Male: Some are especially concerned this is subject to (gaining). It's very to easy for ER docs to say, wait, we won't make these formal diagnoses so we won't be held responsible for referral. They can diagnose intoxication, they can diagnose withdrawals, but if they don't diagnose drug dependence, then they're not held responsible under (mismatch).

(Cheryl): Any other comments?

(Dennis): It's – when I look at the Oregon Medicaid data, it's clear that people with an alcohol or drug problem is twice as much emergency care as those without. However, the systems of referral are weaker in emergency departments especially for people with drug and alcohol problems. So, they're maybe

value to what in showing the lack of connectivity, the lack of coordination but that's what it would show.

Male: I guess I don't know if it's even worth our time to make recommendations from improving the metric, but if the diagnoses were broadened to consider any alcohol or drug-related reason met someone from the emergency rooms, such us intoxication, such a substance-related injury, then this would be less susceptible to (gaining) and actually more clinically relevant.

(Dennis): Of course, then you get into the insurance laws that may deny reimbursement if it's noted that its intoxication.

Female: It also says the follow-up visit is with the corresponding primary diagnosis of the mental health or alcohol or other drugs. So, you know, they may come in with something, but the follow-up visit, they're defining what that follow-up visit is supposed to be for specifically. So, (if you'd like, you have it reword it).

Female: Yes. I think there's a concern that the follow-up visit instead (inaudible) with that. And then it's looking at two different rate at seven days and at 30 days, and lumping them together. And it's not clear why they're doing this, why they're doing the seven-day rate if there are also (within three days).

(Off-Mic)

Male: I couldn't decide which was better, so they did both.

(Cheryl): Several rates. They have rates – they talk about outpatient, intensive outpatient, or partial hospitalization within seven. And then they have the same 30 days. I suppose it's either one. I guess the question beyond (gaining) is just to do we fill that this measure addresses "quality objective"? I mean do people feel it's important that we should be – that patients who are coming in with, say, a real diagnosis – if they were really diagnosed with alcohol or other drug use, would we think it's important? Do we think it's important to a quality measurement that we – that they be identified as being referred within seven or 30 days? I think separate from the whole (gaining) issue if we could

do this, would this been an import – will this capture an important domain. I think that were going separate that.

Male: I think in general, yes. But I wish the measure had been constructed differently so it would actually do a better a job of capturing this important (role).

(Dennis): The other thing I know here is that under key words it says continuity of care after detox. This is not a detox setting.

Male: You're going to copy and paste there.

(Cheryl): OK. So, let's vote on whether we feel it addresses the quality measurement and program area key concepts, which is care coordination here, which I think with – OK, who feels that this addresses at high? Who feels that this addresses medium (inaudible)? OK, we have five people voting medium. OK.

So, we can move on to the next area. To what extent does it address an opportunity for improvement or significant variation care? Who feels that – you feel like you vote? Any comments? OK, who feels that it addresses multiple quality challenges and opportunities for improvement at a high level?

(Off-Mic)

(Cheryl): Three out of six vote for high. Who feels medium? And we have two voting for medium. So, I think (don't move along).

OK. Next concept. To what extent does it demonstrate efficient use of measurement resources and/or contribute to alignment about – of measurements across programs, health plans for states?

Male: So, this is a hard measure because you look – we have to look at ER data and then treatment data. Is that what this question is asking? And I don't have a good sense of what this question is asking.

Female: Yes. I mean you're right. You're linking the ER data with outpatient visits, not even referral. It's outpatient visits or IOP visits or PHP visits.

Male: On the other hand, that's where care coordination is all about.

Female: Right.

Male: Well, but I think it reflects the awkward operationalization of this particular measure. So, I would say this measure is going to be difficult to interpret.

Female: The other key part here is the effectiveness of combining mental health and substance use problem into one group. No, it's not – it's the mental health rates or the alcohol or other drug dependence?

Male: It's really four separate measures.

Female: And that could have – its not one and that's the – it's combining them all together, which is going to make it very difficult to understand and it could be a very challenging for some states depending on how they (stick) to have a various carve-outs or carve-ins and is there substance use treated on the behavior health side or the primary care with the medical side, if they have a – which we can make some states not be able to apply even if they wanted to.

Female: Right. And I think that, you know, in terms of thinking about how you would use this information to make a policy change, it sort of like if you're finding that there's this disconnect between the charge and initiations of treatment is that because of referral wasn't happening or maybe a referral happens and the person just didn't follow through or was it an issue of, you know, an adequate capacity on the referral side. You know, if there are sort of not enough details to really be able to pinpoint a problem to address, you know, it's just – it's too broad.

Male: Actually, the other side of the coin is it's something I like about this measure, it really holds the system responsible that people actually get care and the system has to identify and overcome those barriers.

Female: But they don't know how.

Female: Well, so do you think …

Male: We'll help drive them to do so.

Female: Well – but don't you think it would be better if it weren't so broad to a specific substance abuse get substance abuse treatment, mental health gets mental health treatment? You know, I think that, that might work to the aligning when we're talking about alignment of program.

I mean I agree it's sort to like a lump in a group of diagnoses, but you don't – you're not even sure whether something is going to get the proper treatment that it needs. It could be that somebody with a substance use just ends up in mental health treatment because that's all there is.

Male: So, could we consider this as four separate measures and refer the two mental measures to the mental health people and just vote on the two …

Female: No.

Male: … substances measures?

Female: No, I think we just have to help that maybe further along. That's something that's more specific. It is more specific than this. I think we have to look at this at face value and say, "OK, is this going to be efficient use of measurement resources if this is bundled together?"

Female: OK.

Male: So, why wouldn't just be four separate metrics? Aren't the rates different? Are they combining these rates somehow into a single index?

(Off-Mic)

Female: Yes. Yes.

(Off-Mic)

Male: And (this is) not an efficient use of resources.

Female: Yes, especially if you're going end up with data that you're not quite sure what you're going to be able to do with, yes.

(Cheryl): OK. Are we ready to take a vote on this? How many people feel that this addresses high, the measure high, concept high? How many people feel that it addresses it in the medium? OK, we have one for medium. How many feel that it addresses it in a low? We have four for low. So, we're going to eliminate this measure.

And I think – you know, if we think about gaps, maybe along the way we should be keeping notes of the fact that something like this might be useful if it were specific. So, substance abuse treatment, mental health, mental health treatment, because we may find at the end of our list, we don't have anything that looks like this and it maybe something that could be recommended for a measurement concept. OK.

Female: OK. I think we're on to 90?

Female: Yes.

Female: OK. This is post-discharge continuing care created.

Male: And this also looks very mental health-ish.

Female: Yes.

Male: Even though its keyword is continuity of care (after detox).

Female: Yes. They're assuming that this inpatient psychiatric setting is detox, but that's – I don't think, you know, it's not – it's not – yes.

(Off-Mic)

(Cheryl): Yes. OK. So, why don't we just move straight to a vote on this one? How people feel that it addresses this concept high? Zero. Medium? Low?

Female: We have five.

(Cheryl): Five people voting for that, so we're going to – this perhaps could be considered in the mental health group, OK.

Female: OK. Next is …

(Off-Mic)

(Cheryl): Ninety-three, opioid therapy follow-up evaluation. OK. So, we're still in care coordination. So, this is about all patients 18 and older. I wish they'd include some 16-, 17-year-olds here. That's my bias here. (They log it) in six weeks duration with a follow-up evaluation conducted at least every three months during their opioid therapy documented in the medical record.

Male: I don't understand why would somebody have a follow-up evaluation at three months if they've only been prescribed opioids for six weeks? Am I missing something?

Female: What was that?

Female: That's a good point.

(Off-Mic)

Female: … for longer than six weeks duration.

Male: (And while) even if they had two months …

Female: Right.

Male: … of prescribed opioids, why would they have a follow-up evaluation in three months? It just doesn't make sense. I like the overall concept but the numerator – I mean the denominator seems way off. So can we suggest the change or do we have to just describe the measure?

(Off-Mic)

Female: No.

(Off-Mic)

Female: I know, yes. We're not supposed to change the measure.

Female: No, we can't really change measures as they exist now. We are noting all of these recommendations that can be included in the report to CMS.

(Off-Mic)

Female: I believe so …

(Off-Mic)

Female: And this one is not NQF endorsed.

Female: OK.

Female: So we have even less control over measures that have sort of not – have not come through, so we can recommend that they look for a measure set (next).

Male: It's amazing this made a the cut at PQRS, you know.

(Crosstalk)

Female: Yes. And it's from the American Academy of Neurology. I'm not (restored).

(Off-Mic)

Female: Yes.

Female: So, not everything in the Medicare and Medicaid program is NQF endorsed. There are some measures even in our Medicaid core sets, adult and child, that are not NQF endorsed. So, we make recommendations to CMS. But at the end of the day, it's their discretion what they (poll) depending on their needs.

Female: OK. So do people we can move ahead with this? OK. So, to what extent does the measure address critical quality objective? Who feels it's a high? Who feels this is a medium? And who feels low, does not clearly address quality? OK. So, we have five people saying low. So, we are eliminating this measure.

(Off-Mic)

Female: OK. And I guess we can make a recommendation. That would be nice if we had one that was – for after three months – 90 days then we have …

Female: Yes, I've noted that will recommend – the committee recommends making the denominator …

(Off-Mic)

Female: … (90 days).

Female: OK. So the next is 95. And this still care coordination? It's about outpatient visit within three days of discharge from – I'm trying to figure out were there inpatients discharged with the diagnosis of substance abuse?

(Off-Mic)

(Crosstalk)

Female: That's denominator. And numerator is one or more outpatient visits within three days of their index discharge.

Female: Does anybody know why it's set up three days?

(Off-Mic)

Female: … if you're discharged Friday, you have to be seen on Monday.

Female: Right.

Female: And that's assuming you can get an appointment?

Female: That's right.

Female: If you can get the appointment which is so unlikely.

Male: I'm not – I'm still not clear on the setting. I mean this says outpatient rehabilitation, but that could apply to the numerator. I'm not clear what kind of inpatients the denominator applies to. Is it alcohol and drug treatment?

(Off-Mic)

Female: … (substance abuse) diagnosis …

(Off-Mic)

Female: It's from the VA. Look at the Department of VA.

(Off-Mic)

Female: Inpatient. It could be anywhere.

(Crosstalk)

Male: … not necessarily detox.

Female: It could be …

(Crosstalk)

Male: It could be liver damage.

(Crosstalk)

Female: … liver failure.

Male: Yes.

Female: Right.

Female: Yes.

(Dennis): So, in theory, it's a good idea.

Female: That they get into some kind of …

(Dennis): But I would – yes, I would feel more comfortable if this was discharged after detox (vacation) after withdrawal management because that is essential that they continue. And even their three days might be a very high bar.

Female: But it says primary or secondary diagnosis of substance abuse. I mean what's that? That could be anything. I mean they may not necessarily mean they need detox. I think they're just saying, "You got that diagnosis. Are they going to get in to care at some – are they getting into some kind of outpatient care?" But it doesn't – it's very non-specific.

Male: So it sounds like this is an excellent measure for the VA? It's less applicable on a primary, you know, Medicaid population.

Female: Yes. We have a – I mean the VA is relatively closed system. You can get somebody …

(Off-Mic)

Female: They can walk into the clinic. You know, it's a walk-in clinic kind of setting.

(Cheryl): OK. So, any other – any more discussion? OK. So, to what extent does this measure just critical quality of the CMS – quality objective CMS quality measurements? Who feels that it addresses this highly? How about who feels it addresses at medium? And who feels it addresses in a low? Three of five people with low? OK. So, we're moving to the next level.

That's number 98. Referral to post-detox services. So this is a measure concept. Patients from the denominator records contain documentation of completed detox and the referral or transfer to a less intensive level of treatment. And it denominates all patients discharge from the state-funded substance abuse treatment program.

Male: What is CQAIMH?

Female: It's the Center for Quality Assessment and Improvement in Mental Health.

Male: Thank you. Never heard of that one. OK.

Female: (Is this a Texas commission)?

Female: It's a state-funded substance abuse treatment program. (So that only) – that wording does not clarify to me as that inpatient or outpatient or both because I know we have state-funded outpatient substance abuse treatment programs along with inpatients.

Male: Where are you going to get very little outpatient detox in the state systems? This is – the question is, would this be applicable to Medicaid if it were rewritten to be (broader)? I think as it stands it's not applicable to Medicaid.

Male: Yes, I agree it's very confusing. And there are some – yes, some people who don't get detox, they don't need it. And some people who get discharged or they're already at the lowest level of care and they don't necessarily need to be transferred anywhere.

Male: Some people get detox over and over again.

Female: Well – and if your detox are not through state-funded, there could be other resources through Medicaid. I mean I know Medicaid – but this sounds like it's a particular state-funded program. It's very limited.

Male: Yes. I mean this is a major a cost to Medicaid. There are hospitals that make their living off of drying out alcoholics again and again and again. And Medicaid is paying for it. So, it's a big issue but the way this measure is framed, it's not applicable.

Lynda Zeller: You're saying that that if we had a measure that – that it's a big issue because they're not getting into the next level of care? Less intensive level of care but …

Male: Nationwide, only about 20 percent of the people complete detox get ongoing care. So this is a big waste of money for both commercial and public health plans. It's not a waste of money it's just inefficient use.

Female: Can we interpret state-funded program (to me), it's Medicaid? (Or do you mean) it's detox? Because that's – the problem here is it doesn't actually say

it's state-funded. It doesn't say it's for detox. The denominator doesn't say detox, the numerator does.

Female: Right.

Female: And that's my biggest problem with it. I mean I'm not …

Female: Yes.

Female: Like, did I pass the baton for a patient who am I detoxing is different than did I pass the baton for a patient who just graduated from my suboxone program to someday else. That's the difference. I meant it's different. And right here the denominator doesn't specify.

Lynda Zeller: My question is who gave it the title, referral to post-detoxification services? Did they – is that what they call their measure? Because it's almost implicit in their denominator that it's a substance abuse detox program or – I don't think they would have – they would have called it that. So, you know, we can say that it's sort of implicit in the denominator.

Male: Yes. This would make much more sense than if the denominator were patients who were in detox rather that substance abuse treatment. And maybe it's just some wording issue.

Lynda Zeller: Yes, because they're calling it referral to post-detox services. So we could …

Male: And, again, it may reflect that in Texas, detox is their treatment as well.

Lynda Zeller: Right, right.

Female: One other question concern – wait, one other question, the numerator, it's (sounds) referral or transfer care. It's not actually looking (at) if the patient – like it doesn't – it includes not only if the patient showed up with a specific provider (inaudible). And that's ideally working out …

Female: Yes.

Female: … if the patient actually made it.

(Crosstalk)

Female: … because otherwise we can always get 100 percent.

Female: Yes.

Female: We can always check the box that (inaudible) (when we were discharging).

Female: You know, and in that sense, care coordination really means is they're actually – is it being accomplished rather than just we've got good intention.

Female: (Tiffany) and I were thinking the exact same thing there. I mean this issue is a really important one. And I really like to see us get a measure like this measuring this issue in here. I'm just not sure that this is the right one.

Female: But this is a gap that unless we come up with another measure, this could be under critical – clinical care at some point.

Male: There might be more similar measures coming.

Female: Yes. OK. Let's try to vote on this one. Does this measure address a CMS quality measurement highly? How may people agree? We have no one saying high. Medium, does it address CMS quality measurement but does not – no one says medium. How many people vote for low? We have people saying it does not clearly address CMS quality measurement domain. OK.

Female: OK. So, it is 12:30, which is our lunch time on the agenda.

Female: Wow. We've just been moving.

Female: I know we have. So, just a quick status update. We have the option to pause and take real lunch break or continue to discuss measures while over lunch. To date – so far, we have reviewed 10 measures which is good progress actually.

Male: And the measures are going to get worse as we go along.

Female: Well, we switched domains, we'll get better again and then they'll get worse again.

(Off-Mic)

Female: … we have a couple of more sessions …

(Off-Mic)

Female: Yes.

Female: We have two to three more sessions tomorrow.

Female: All tomorrow until 2:00, we'll be doing this. And so …

Male: We might be able to come late tomorrow.

Female: Well, yes, that's always on the table if we made good progress.

(Off-Mic)

Female: Yes. We did (toss) out a few, so maybe …

(Off-Mic)

Female: We did …

(Off-Mic)

(Crosstalk)

Female: So we'll see how this afternoon goes. But it's up to all of you, if you'd like to take a working lunch or take a real break and check up on your e-mails.

Female: (Who would like to get to working lunch)?

(Off-Mic)

Female: OK.

Female: OK.

Female: Why don't we take like, say, 15- to 20-minute break? And then we'll come back and (we'll work).

Female: Yes, excellent.

(Crosstalk)

Female: Everyone, (help yourself for lunch).

(Lunch Break)

Lynda Zeller: So let's just have two-minute warning? Get start again in two minutes.

(Off-Mic)

Lynda Zeller: Before we get started back with the measure (sites), I forgot to introduce the rest of our NQF colleagues in the room. We have Alexis Morgan and Debjani Mukherji. Would you guys like to introduce yourself?

Alexis Morgan: Sure. Good afternoon. As Sara said, my name is Alexis Morgan. I'm the managing director in the Quality Measurements Department. And what that essentially means is I do the day to day operations of the department. Thank you all for joining us.

Debjani Mukherji: Hi my name is Debjani Mukherji. I'm a Senior Director here in Quality Measurement Department. My portfolio contains the Medicate Adult and Child Core Sets, and the dual eligible beneficiaries. And I've also worked on some measurements on projects such as variation in quality measurement, which also is very prevalent in the Medicaid world, so. And just as a background, I have 15 years of work experience in like methodology, regulatory affairs, biotechnology, biosimilars and things like that, and guideline development. Thank you.

Yetunde Ogungbemi: Hi, my name is Yetunde Ogungbemi, and I work at NQF obviously. And I'm just a project analyst and helping out with – helping (Tara) out with your discussion and facilitation. Thank you.

Female: OK. Thank you. When everyone is back in the table, we can go ahead and move on to our next measure.

(Off-Mic)

Female: That's correct.

(Off-Mic)

Female: So we two more measures in our care coordination domain. And then we'll move on to clinical care where there are 33 measures. So we'll spend the rest of our time there.

Female: This is 99 referral to post-detox services for children. I think this is similar to the one we just did except it's identifying kids under the age of 18. Did we vote at that other one (down), didn't we?

Female: That is correct, we did.

Female: That's too bad because this is like one of the only ones that's got somebody under the age of 18.

Male: But how often are they post-detox?

Female: Right. Yes, we'd like to see them in treatment programs but not necessarily detox; exactly, yes. But we could say this is a treatment (process).

All right. So, do we have any discussion about this? Concern? Does it have the similar – I think it has similar concerns as the other one. OK. So, we can probably – we can probably move ahead to vote on that one. So, does it address critical quality objectives? How many people feel high? How many people feel medium? How many people feel low? I think we have five on the vote. All right. So, we will – are not going to be including that one. OK.

So our – and I think maybe here we want to say a similar thing in terms of gap; that it's important to address our under 18 population. But you want not

referral, you want an actual visit or evidence (step) a contact – there has been true care obtained. I think we're feeling like its one thing to refer. It's another thing to actually make – accomplish a visit.

OK. It keeps doing this. Now, when I go back, it keeps doing that. OK.

Female: We're at measure 97 …

(Crosstalk)

Female: … Primary Care Visit Follow-Up. It's the last on this care coordination domain.

Male: So this is below the mean?

Female: Oh, OK.

Female: Thank you so much for (inaudible). So this measure was one that was retained. (Cheryl) emailed in. (I entertained that). So as part of our process, if your name is on here as a lead discussant, it's one of the measures we retained, and as part of the records, we will require some kind of rationale. So, (Cheryl) here will serve as our lead discussant, perhaps open up discussion on this measure with reason why you felt it should be retained for further discussion. And then we'll move in to the broader conversation.

(Cheryl): Can you give me the number again of this chart?

Female: Sure, 97 …

(Crosstalk)

(Cheryl): Ninety-seven. OK. All right. OK. Let me just get my notes on why I wanted this one to change. OK.

(Off-Mic)

(Cheryl): Well, you know, I felt that this one was – I didn't realize this was – I thought it was a different – just the ASAM number four, OK. Is that what this one?

Female: This is number six. On the bottom, it says ASAM number six.

(Cheryl): Oh, OK, number six. All right, OK. You know, I felt that I thought it was important for follow up with the medical home. Primary care could be care coordinator. I wasn't sure what they meant by an F substance use disorder treatment encounter. But I felt it was important to have some kind of discharge planning and hold sort of the care team accountable.

So, it could be that I'm looking for something that wasn't in this measure, but I – you know, I felt it raised some important sort of continuity of care after detox. I thought it was going to be – it would be nice to include all – it said all ages. So it didn't exclude our under 18, which I thought was important.

So it was more – not just referring, but it was the extent to which they assure that they're getting some care after they've had some kind of treatment sort of getting people back into the primary care setting. So that's where I was coming from on that one.

Female: Another question. Do we know what they are counting as their primary care visit? Was there any visit to an outpatient – like how was, you know, that definition or that numerator actually?

Female: I just figure just a (vivid) to a primary care provider. Now, it could have been urgent …

(Crosstalk)

Female: … it could've been acute. It could be routine but it's connecting back with their medical home.

Male: Yes. I have the ASAM measures here. And it says that, once it's been documented that individuals who engage in SUD treatment have had suboptimal involvement with the health care system, and it developed other comorbid conditions that require retention. And so, the addiction specialist position is responsible for ensuring that all comorbid conditions are addressed concurrently with treatment of their patient's addiction.

So, giving the – these are measures for the addiction specialist position, but I think you can broaden them to say these are good measures for health care providers generally. And, yes, you know, the specialty addiction treatment system, they should be referring to primary care. That isn't happening now I would say by and large …

Female: Yes. And …

Male: … because it's not well-operationalized.

Female: Yes.

Male: I like the overall concept. But I'm concerned if there's truly an active effort to engage people in primary care, it shouldn't say six months. It should be one month, two months.

Female: Yes, yes.

Male: And really (the bristle effect) part of the measure.

Female: You know, and I was also thinking in terms of use of resources. So, these folks end up in emergency rooms. They cycle through emergency rooms because they're not – they either don't have a primary care or they're not using the primary care, or they can't get a hold of them. And I was just thinking if there's someway to make sure that they make that connection with their primary care provider, they may be less likely to be using emergency services. So, in terms of looking at sort of inefficient use of resources, but I agree that, you know, six months is – there could be three emergency room visits in that time.

Female: Yes.

Female: And then I was wondering about whether there are maybe some overlap here with the integration group looking at the physical and behavioral health because it's kind of (straddles) those two worlds as well.

Female: Yes. I agree. I see what you mean. Do you think it still falls under the SUD? The SUD test should weigh in on this measure? Or do you think it should be referred?

Female: I think it can. But I would be really surprise that that group didn't return with the measure that looks something like this given what their charge is.

Female: Also, do you think they might be limiting the integration of physical and mental health, not including substance use with behavioral health?

Female: I believe it's primarily focuses (on) behavioral health …

(Crosstalk)

Female: Which does, you know, but it's unclear.

Female: (Dennis), do you know from that what their time period is? Then the denominator says all individuals with SUD encounter within a specified time period. Do we know what the specified time period is?

(Dennis): It doesn't say here. It does say the six month period was based on consensus, and then we expect more research to clarify the death timeline.

Again, this is relatively preliminary. It's a good concept. It's not operationalized in any detail at the moment, but it should be.

Female: I mean we have – we also have the option of having it returned to being a measure concept, right, (Tara), there's a way to do that.

(Tara): Yes. So in a decision logic, for the question, is the measure ready for immediate use? If the test votes no, the measure will not automatically be excluded. It will move to the next question but can only earn the distinction of recommended as a measure concept, so they will be noted separately in the recommendation.

Female: Yes, because if it's not ready for immediate use, if we think it's important …

(Crosstalk)

(Tara): … continue to move forward if the concept itself looks promising. But it will be recommended as a measure concept. And as (Karen) spoke to earlier, we want to focus more on measures. But, again, we're evaluating everything as it stands now against the decision logic.

(Cheryl): And for recommending it as a concept, can we specify what our thoughts were around the concepts?

(Tara): I will note whatever it is that you say.

(Cheryl): OK.

(Tara): So no problem …

(Cheryl): So that's like – I mean we've kind of turn around the – within six months of initiations concerning – I would say most of the medical community sticks with 30 days as kind of a good length of time where you should have been (linking) that link and you can get the patients to pass that initial detox. But if they have unmet diabetes or hypertension problems and you're ignoring it, while you're trying to take care of their (OPD) disorder, you could be letting them die for something else while you're stopping them from dying from drugs.

So, I think that would be one of the things would be to put that 30 days instead of six months for getting them linked to appropriate medical care to supplement their addiction care. And I mean, the denominator can be anybody within like the year you had substance use disorder.

(Crosstalk)

Lynda Zeller: … yes. Over the course of the year.

(Cheryl): Over the course of the year.

Lynda Zeller: And then you're looking at six months from that particular time …

(Cheryl): Yes. Thirty days from what they …

Lynda Zeller: Yes, right.

(Crosstalk)

Lynda Zeller: But this one is just (for the six months) …

(Off-Mic)

(Cheryl): Yes.

(Off-Mic)

(Cheryl): And I would say they need to do it through claims. Their resource, they left blank.

(Off-Mic)

(Cheryl): … through claims. That should be doable.

Lynda Zeller: You know, I think this – you know, when I added this back in, we weren't having the discussion about, can you change the measure? So, I mean, given that, we're not supposed to be changing the measure, you know …

(Off-Mic)

Lynda Zeller: I know. I like that. So, can we change the measure when it's part of a concept? You know, that's the question.

(Tara): So you're now recommending the measure concept be changed. You're more like making a recommendation that a concept that looks at linkage of medical and substance care should consider a shorter time span for follow-up, should consider claims data. So, you're not making anything with respect to this specific, but you're making a recommendation with respect to the overall concept?

Female: So how do we get to that?

Female: So we'll …

Female: Yes, because they're recording it.

(Tara): In the notes, yes. It will be – so we'll talk about this measure. And then on the bottom, it'll say that the (PEP) recommended that the concept be X, Y, and Z.

(Cheryl): The other thing is to make sure that now that some substance use disorder treatments happening on the primary care settings are they still captured, both the denominator, and it's happening at the same time as other care and the numerator. We have a provider seeing a patient for a chronic condition and for substance use disorder that they're getting kind of (in both).

And that's like – that's a new – with some of the current treatments out there but not some of the – it's to make sure that one day, we develop this concept more that they will get that to make sure that part of the population isn't getting excluded.

(Dennis): It's more generally, as we move – as we achieve some levels of integration. I think you move from (SPER) to (SPIT), screaming persistent intervention and treatment.

Lynda Zeller: Right.

(Dennis): Right.

Lynda Zeller: Yes.

(Dennis): And the role of primary care is the persistent intervention.

Lynda Zeller: Right, right. Yes. We got to get those providers' status right.

(Cheryl): Definitely, definitely. OK. Anymore discussion? Should we move ahead to – OK. So, to what extent does it a measure critical quality objectives? Who feels that it measures in a high degree? How about a medium degree? OK, well, four out of five. And low? We have one (which is) low.

OK, so we move on to the next concept of – does it address an opportunity for improvement and address significant variation of care evidenced by quality challenges? Who feels that it does this in a high? We got three for high. Medium?

(Tara): Is that four? Sorry, (Christina) …

(Off-Mic)

Female: … I'm actually medium.

(Tara): Medium. OK, thank you.

(Cheryl): Two for medium. So we're moving along on that. OK, to what – the next question is, to what extent does it demonstrate efficient use of measurement resources? Data collected source. It doesn't say data set, but it could be claims or contribute to alignment of measures across programs, health plan, or states, and it's not duplicative of existing measures. Who feels this – does this demonstrate efficient use? High? We have five out of five, OK.

To what extent is this measure ready for immediate use? Who says high? How about medium? How about low? OK. So now we're …

(Crosstalk)

(Tara): (So this) question will be the same, but now the measure is being considered for potential inclusion as a measure concept.

(Cheryl): Great. Do we have to say whether it's – do we think it's important to state – yes. To what extent do you think it's important to state Medicaid and other key stakeholders? Who says it's high? We got two who say high – we got four who say – five who say high.

(Off-Mic)

(Cheryl): OK. And – all right. So, this is going to – we're going to recommend this as a measure concept with the caveat that we feel it needs to be much shorter period of time than at six months, following treatment. And that we need to it

– we also need to include the fact that the treatment could be in the context of the primary care setting. One year, OK. And data source would be – could be claim, claims data …

(Crosstalk)

(Cheryl): … claims (encounters), OK. All right. OK, our next is going to be – so we're through with …

(Tara): So that brings us to the end of our care coordination domain. So what we do now is we will open it up for public comment briefly. Since we do not have an operator on this line, anybody who is on the call should be able to unmute themselves and give a public comment.

We're also be using the chat box for anybody who is a little shy and doesn't want to talk. So we are monitoring chats. Are there any public comments at this time?

OK, I think we are alone on the phone. So, we will move on to our next domain.

(Off-Mic)

(Crosstalk)

(Tara): Exactly. We – I'm not sure about the phone lines, but on the web portion, nobody is looking at our slides right now except our transcriptionist; so hello transcriptionist. So we will now move to measures that have been classified as – under the clinical care domain.

Lynda Zeller: OK. This is where our biggest chunk is of measures. OK.

(Tara): OK. The first measure is number 45, Preventive Care and Screening: Tobacco Use: Screening and Cessation.

Lynda Zeller: What number then did you say?

(Tara): 45.

Lynda Zeller: OK. So this is the percentage of 18 – patients 18 years and older, screening for tobacco use one or more times within 24 hours – of 24 months (annual) receive counseling if identified as tobacco user.

So the denominator, people seen at least two visits, one of them being preventive during the measurement period which she doesn't specify. And then, the numerator are those who are screened, and we see some kind of conflict which included either counseling or pharmacotherapy. OK?

(Dennis): Very reasonable medium, yes. It's important. Well specified.

(Tara): Any other?

(Cheryl): OK. So to what extent do we feel it addresses critical quality objection – objective? OK. And you all feeling high? We have five for high.

(Off-Mic)

(Cheryl): … we haven't got to the marijuana yet.

Female: Yes.

(Cheryl): OK. Now, to what extent , we'll talk about lunch – addressed …

(Crosstalk)

(Off-Mic)

Female: That's right.

(Cheryl): That's right. To what extent does it address an opportunity for improvement and significant variation care evidence like quality challenges?

All those voting high? OK. We have five will voting high on that one, OK.

Does it measure – does it demonstrate efficient use of resources and contribute to alignment across programs and not duplicative, all right.? All those voting for high? We have five votes for high. OK.

Next is, is it ready for immediate use? Looks like it. Yes, yes. High, we have five people for high. And do you think it's important to state agencies – no, the key stakeholders. All those who feel high? OK. We've got five that was high. OK. So we'll include that one. OK.

(Dennis): One thought on this particular measure is that technology has changed. Should this be more broadly nicotine usage?

Lynda Zeller: And should people under the age of 18 ….

(Crosstalk)

(Dennis): Yes.

Lynda Zeller: I don't understand why these measures are not because – because it's actually, (JACO), anybody over the age of 11 or 12, you have to ask this question in every visit. Kid walks in. It doesn't matter whether they are 13, 14, or 43, they all have to get this question asked and it has to be documented in the medical records. So, why being excluded when it's actually a hospital, hospital requirement.

(Dennis): And the good news is, you can (actually get the status) of electronic health record because it's part of meaningful use.

(Cheryl): Right, right.

(Dennis): And we should …

Female: OK.

(Dennis) … advocate for more of that.

(Tara): Right. So does anybody change their vote based on these comments?

(Cheryl): No.

(Tara): OK.

(Cheryl): It's still important.

(Tara): Yes. And …

Female: What I – but, you know, a gap is we're not asking this of the whole range of nicotine products. Now we've got e-cigarettes. You know, is anybody asking about that? Or why we're excluding under 18-year-olds doesn't really make any sense, particularly for tobacco. OK.

(Off-Mic)

(Cheryl): That means they can't get it, right, because they're not (buying). Well – and as far (why this is duplicative), I actually thought this was part of the core set until this is like – because it's – I don't think (part of any) state is not looking at this measure. So I'm not sure how much they (they feel in) of getting free recommendations.

(Crosstalk)

Female: Does intervention – is intervention included in that? Or is it just screening?

Female: Screening cessation, (cancelling), I thought that was for adults.

(Crosstalk)

Female: Was intervention included in the core …

(Crosstalk)

(Cheryl): (I thought the) cessation was used by mistake. I didn't realize it until we get it, but it wasn't part of the core set …

(Off-Mic)

(Crosstalk)

Lynda Zeller: There's NQF number here.

Female: Debjani, do you know if this is used in the core set?

Debjani Mukherji: So this one is not part of the Medicaid core set if that's what you're asking and also the other reason why it's not under 18 is because some of the these programs – some of these measures that have PQRS and some of the other MSSP came through the Medicare side. So they – or, you know, it's come through map which is more Medicare focused. So you don't necessarily see the broad age ranges for this.

(Dennis): But there are kids with Medicare for …

(Crosstalk)

Debjani Mukherji: … eligible beneficiaries. And that's an issue that we always bring up in our duals – workgroup brings up. But a lot of these measures that we look at don't have that. And one way to get at the QI is you can stratify a measure when you're implementing it within a close system. But you can't use stratification for anything else other than QI because otherwise it wouldn't be reliable and valid.

(Tara): OK. So, just again, are there any changes, any votes based on the conversation?

OK, no. All right, we can move on. Thank you.

OK. Next is Measure 64, (TOB-2) Tobacco Use Treatment Provided or Offered in a Subset Measure TOB-2A Tobacco Use Treatment.

(Cheryl): So this is referring to hospitalized patients, again, 18 years or older, provided during the hospital stay, offered and refused. And then there's a subset; only those who received treatment during the hospital stay.

So it's a number – numerator is those who received or refused counseling to quit and received or refused FDA's medication during a hospital stay. And then there's a number that said (practical) (inaudible) – to quit and receive FDA's cessation medication during the hospital stay …

(Off-Mic)

(Cheryl): And one who received (inaudible) and then who received, OK. So this is inpatient units, people identified as current users is the denominator. Any (discussion)?

(Dennis): Well, the challenge in this is that it's based on the EHR data. And so, I don't think that's available at a statewide level generally.

Female: There is a HEDIS measure that is in the Medicaid population on tobacco use cessation and treatment. And it's (baked) – (inaudible) to the hospital. That's right. It doesn't (inaudible). But it is the one in 2017 HEDIS measures.

Female: Does it say any setting?

Female: I don't have them. I'm trying to find how much (specifications) I could get …

(Off-Mic)

Female: It doesn't have the full specification. Let me see.

(Off-Mic)

Lynda Zeller: There was evidence of testing in the Medicaid population …

(Off-Mic)

Lynda Zeller: … given our concerns about (inaudible).

Female: (High use in federal programs for comorbidity).

Male: I guess I'm not so concerned about feasibility. I mean it's easy for hospitals to add a field to their EHR. And certainly tobacco is a leading preventable cause of death in country. So it seems to be (inaudible) EHR (that's not there).

(Off-Mic)

(Dennis): Well, my understanding is the hospitals would report this to the Medicaid as a quality indicator.

(Crosstalk)

Female: So they chose to adopt it.

(Cheryl): But how is this going to – and so the HEDIS measure title is Medical Assistance with Smoking and Tobacco Use Cessation. So how would – and – but I don't have the specification because I don't have access to our state (participants) …

(Off-Mic)

(Crosstalk)

(Dennis): Well, I guess in terms of relevance, the Medicaid – yes, I mean …

(Cheryl): I mean …

(Dennis): … many – almost every Medicaid patient is seen as an outpatient, rather or few are seen as an inpatient. So if they have robust metrics for outpatients maybe the inpatient measures are not as important.

Female: Well, certainly tobacco use cessation, I would think, would happen on an outpatient (inaudible) (inpatient side).

(Dennis): What do you think about that, Lynda?

Lynda Zeller: The way in Michigan we do the HEDIS measuring is – oops, sorry. The way in Michigan we do the HEDIS measure is through the often prescribed assistance, right, and the aid to cessation. So there's no reason you couldn't do that in the inpatient setting as well, but it does seem like more of an outpatient (issue).

Female: Another thing. (Inaudible) duplicity is the question. Like I feel like it …

Female: Right.

Female: Even though it's looking at the hospitals, I don't see that there's a big added benefit to making sure that they got into the hospital as long as they got it.

Male: Well one argument for the hospital is that if somebody's (administrating) for asthma, I mean it's better to kind of intervene when people are facing their negative consequences.

Female: And you don't know that that person in the hospital is going to get any care either.

(Off-Mic)

Female: But suppose it doesn't have to be medication, it can be – right?

Male: Yes.

(Crosstalk)

Male: Yes, could just be the annual counseling.

Female: Right. So there's no way you would capture that, right? If it were medication, yes.

Female: You'll also have a code for the counseling. You have a code for the groups, right? So I mean technically (inaudible), but, you know, that's not speaking to your question, but (one of those) duplications that the HEDIS measure …

(Off-Mic)

Female: … let's see (if it fits the priority).

Female: Yes.

Female: (We can finally get you to put forth a few). Tobacco is being addressed or ready in the Medicaid …

(Off-Mic)

Female: But it's not the – some of the other things aren't being addressed as much. Not that the measure itself is fine. (It's just again a very) (inaudible) (slide) …

(Crosstalk)

Female: … compared to what we're concerned about, like the inpatient hospital with tobacco is a much smaller size of substance use disorder concern …

(Off-Mic)

Female: So I don't know how we're supposed to vote on it if that was (like) (inaudible) (that we have).

(Tara): So there is no limit or no minimum for number of measures that you can recommend?

Female: OK.

(Tara): The TEP is weighing in on each measure individually as (it tends against) this criteria, and then later the coordinating committee will meet and review the set as a whole. And we can (note) prioritization to share with them. If you'd like to do that, but the set itself will be reviewed by the coordinating committee to reduce this kind of redundancy.

(Cheryl): And like I think (Peggy) said it, it's a menu. If somebody wants a (hospitalized) something, you know, a measure for hospitalized, if we feel it's good enough that we want to endorse it here or whatever we're doing here, agree to having it here, then it's just means that it's available as the range. I don't think we are really – we have to feel constraint by a minimum, you know, not having more than a certain number.

Female: Oh, and I think (it's a good way) if we – if the options are prioritized. You know, at the end of our process …

Female: Yes.

Female: … that's available, then that will allow us to have that opportunity (inaudible). You know, these are some measures that what we think are of the greatest significance and they're likely to be ones where we don't see very much overlap and all.

(Crosstalk)

Female: And I think we need to look at each one individually. But I think at the end of the day, you know, we'll have a list. And at that point, we can all say, you know, in looking at all this, we have some that are – we feel are really important versus some that have lower priorities. It's hard to know that because we don't know the whole universe of yet, of what it is that we're going to, you know, agree are good measures. So we should just sort of take this one on its own merit.

(Tara): Yes.

Female: Yes.

(Tara): Yes. And sorry (inaudible) I realized I never answered your question about testing in the Medicaid population. And if you'll see it, it's – the same ranking applies if a measure is NQF-endorsed. So that's how it receives that ranking, that includes both NQF-endorsed or testing in the Medicaid population …

(Off-Mic)

(Cheryl): OK, so let's vote. To what extent does this measure address critical quality objectives of the CMS quality measurement domains? All those voting for high? All those voting medium? OK, we have five voting for medium.

All right, next is to what extent does it measure an opportunity for improvement or address significant variation in care for each area? All those voting for high? We've got four. Medium? We have one.

OK, lead to the next concept. To what extent does it demonstrate efficient use of measurement resources, is it data collection, performance improvement, and contribute to alignment of measures and that the measure is not duplicative of existing? So we've got high (opinion efficiency), duplicative, and alignment. Who votes for high on that one? Medium? I think we're all sort of – we've got five people voting medium on that.

All right. And to what extent is it ready for immediate use? It's already in use in the Medicaid populations I think …

(Off-Mic)

(Cheryl): Can we vote on that? I'm trying to …

(Crosstalk)

(Dennis): … for general hospitalized patients but not specifically Medicaid patients.

(Cheryl): So do we – does that mean it's already in use since it's in all population that's already in use for -- it doesn't make a distinction between none Medicaid or Medicaid populations. OK. So who would vote on high, already in use in Medicaid populations? I feel like …

(Tara): Yes …

(Crosstalk)

(Cheryl): I feel that it automatically includes them.

(Tara): Right.

(Crosstalk)

(Tara): No, I understand your conclusion on that. I think we can – let me refer to the decision (inaudible) real quickly because this is a specified measures. So if we were to answer this with like an artificially low ranking, it would qualify the measure concept (but not) necessarily be accurate. So, yes, I think since this is (a fully fledged) measure and it's the type of (career set that's) ready for use in a Medicaid population, we can give it a high ranking so that it won't be classified as a measure concept.

Female: Because it says usability (high used) in federal program for accountability. Does that include Medicaid under this preliminary review?

(Tara): They're not part of the core sets specifically, so the adult and child core set and (they're voluntary). So just because the measure is in the core set, it doesn't mean a state is going to use it, but …

Female: Oh, already in use.

(Crosstalk)

(Tara): Yes.

(Crosstalk)

(Tara): So this one is part of hospital compare and also the inpatient psychiatric (inaudible). So, it is (tied to paid) – in IQR and hospital compare, so it's looking at all hospitals. So presumably they might have a Medicaid patient population. I mean they're not saying (dish) versus (non-dish, or, you know, they're not specifying what kind of hospitals. So I think if you were to say, is it already in use? Yes. So the general population, hence potentially for Medicaid it'll be useful, but it's not …

(Cheryl): That's been targeted specifically for Medicaid.

(Tara): Yes.

(Cheryl): OK. So I'll change my vote to medium because it sounds like it's not really targeted for using the Medicaid population. OK, so no for high. How many feel medium concept? OK, we have five for that. So to what extent do you think it's important to state Medicaid agencies and other key stakeholders? High? All those feelings that it's important? Medium? Important to state stakeholders, state Medicaid agencies? We have five people voting medium. Oh now does that – where does that (put off)?

(Tara): (Inaudible) at the next measure.

(Cheryl): Oh is that …

(Crosstalk)

(Tara): Yes, so we have completed that, went through that measure.

(Cheryl): All right.

(Tara): It's recommended to move forward.

(Cheryl): OK. All right. So our next measure is?

(Tara): Next measure is number 65, TOB-3, Tobacco Use Treatment Provided or Offered at Discharge and the Subset Measure TOB-3a, Tobacco Use Treatment at Discharge.

Male: So my understanding is this strongly overlaps with the previous measure but it's focused on services delivered at discharge rather than during the hospitalization. Is that correct?

Female: Well, yes, at the discharge. This is a subset. It is a whole series of these TOB measures (who've got) …

Male: Yes, these are all joint commission.

Female: Yes, yes, tobacco use screening, treatment provided or offered during the hospital stay, possessing status after discharge. (The room is extended). So it's the same idea just …

(Off-Mic)

Female: Right.

(Crosstalk)

Female: … (x) discharge.

Male: I'm think of this identically as to the last one.

Female: Yes, yes.

(Cheryl): That sounds like …

Female: Yes.

(Cheryl): … one is during the hospitalization. OK. So why don't we go ahead and vote on this one. Again, to what extent does it address critical quality objectives? Who's voting for high? Who's voting for medium? OK, we have five voting for medium.

To what extent does it address an opportunity for improvement? Voting for high? We have four for high. Medium? One for medium. OK.

To what extent does it demonstrate efficient use of resources? Voting for high? Voting for medium? I think we have five voting for medium.

To what extent is it ready for immediate use? Voting for high? Voting for medium? We have five voting for medium. OK.

And to what extent do you think it's important to state Medicaid agencies? Voting for high?

(Off-Mic)

(Tara): Just to clarify, it's state Medicaid agencies and other key stakeholders.

(Cheryl): And other key stakeholders. OK. I'm going to vote high on that one. I'm changing my vote. Medium?

(Tara): So one high.

(Crosstalk)

(Cheryl): We have four voting medium.

(Off-Mic)

(Cheryl): OK, so we have accepted that measure.

(Tara): So, yes, that measure is recommended …

(Cheryl): OK.

(Tara): … as a measure concept.

(Cheryl): OK. Our next one.

(Tara): Next measure is number 66 on the discussion guide, TOB-1, Tobacco Use Screening.

(Cheryl): Within the first day of admission for – this is (hospital today), the during, and the discharge, OK. So here we are again. I think this is kind of the same thing, right? OK. I think we – everybody rate it. Any discussion? Does anyone want to weigh in anything more that we've said about?

(Off-Mic)

(Cheryl): It's on the first day of admission.

Female: (Sort of) just screening.

Male: It's just screening.

(Cheryl): Screening, yes. But it's not being offered.

(Off-Mic)

(Cheryl): OK. So to what extent does this measure address critical quality objectives of the quality measurement domain? Voting for high? Voting for medium? We have five voting for medium.

To what extent does this address an opportunity for improvement, significant variation in care? Voting for high? Voting for medium? We have four people voting for medium. One person is voting for low?

(Off-Mic)

Female: I guess, yes.

(Cheryl): Yes, OK. I got to see your hand there. OK, one person voting for low.

(Off-Mic)

(Cheryl): OK. To what extent that these measures demonstrate efficient use to resources, alignment, and that is not duplicative of existing measures within the measure set? Measures – so voting for high demonstrates efficient use? Voting for medium? OK, we've got two. Two people voting for medium. Low, voting for low? I think we're …

(Tara): The measure of (sales on).

(Cheryl): The measure of (sale is on) …

(Crosstalk)

(Cheryl): … duplicative.

(Tara): So we will move to the next measure.

(Cheryl): OK.

(Tara): The next measure is number 14 on the discussion guide, Alcohol Screening and Follow-Up for People with Serious Mental Illness.

(Cheryl): Number 14 …

(Off-Mic)

(Cheryl): OK, this is alcohol screening and follow-up for people with serious mental illness. So these are patients, 18 and older, with the serious mental illness, who are screened for alcohol use and (seek) counseling or either a follow-up care is identified. So the denominator here are people with at least one inpatient visit or two outpatient visits or schizophrenia or bipolar disorder, or at least one inpatient visit for major depression. So we're looking at an inpatient or a couple of outpatient for mental illness. And then we're looking at people who are screened for unhealthy alcohol use during the last three months of the year prior to the measurement year to the first nine months of the measurement year. OK. And received two events of counseling is

identified as an unhealthy alcohol user. So they're using this screening and brief intervention.

(Dennis): And I forget, did we approve the measure already that focuses on routine screening and intervention for everyone? And does that apply to patients in behavioral health settings?

(Off-Mic)

(Cheryl): It was specific. Was that the one …

(Dennis): I just wonder if we can use the same measure across the variety of setting just better than having separate measure for (deep setting)?

(Cheryl): Can you – (Tara), can you look back to see this? This measure is – so the other measure looks at alcohol, screening for alcohol for the whole population. So, this one is focusing on specifically patients with behavioral health problems for screening. It doesn't have to be – the screening has to be done in behavioral health setting. It's just patient who have these diagnoses. Do they also get the screening? Because we know there's a significant overlap of these major mental health problems with substance use disorder including alcohol.

(Dennis): And does it say what settings that other measure applied for …

Female: No.

(Dennis): … or applied to? Because if it's just for like primary care in general hospitals and it looks like (inaudible) by the letter of the law which they do. It wouldn't apply to behavioral health settings, and we're – they're ought to be on measure for behavioral health setting.

(Cheryl): It doesn't set – it doesn't specify.

(Off-Mic)

Male: Well, down below, it says care setting behavioral health outpatient.

Female: But it doesn't specifically say that the numerator but …

Male: No, no.

Female: Right.

Female: The care …

(Cheryl): So this measure is looking specifically at the sub population, this higher risk sub population, which – that it could be redundant of the measure that we have previously approved covering …

Female: Great.

Female: covering everyone.

(Cheryl): … everybody.

Female: Cover that one.

Female: That would be but there might be benefit to having the separate higher risk population put out because they are extremely high risk which hasn't choose disorder. I do when they get things emergently just alcohol.

Male: Yes, that's right.

Female: That's be like they're lack within either as they're looking at the general population versus the high risk.

Female: Right. But it's not something about the site in which this would take place that would allow us to capture those people better than we were with the blond.

Male: Well I looked back, we already approved metric 96 which does apply to behavioral heath, but it’s kind of strange and it doesn't necessarily by the primary care in hospitals.

(Crosstalk)

Female: So this one doesn't specify where they're being screened.

(Dennis): But I think that's the practical issue here, is that people with – people who were diagnosed as seriously mentally ill are shunted off into a mental health treatment setting system where access to primary care maybe reduced. So this is really I think trying to bridge that gap.

Female: Yes, I see this as really focusing on is there a gap in care for this high risk populations to about half of them will have a substance use disorder problem. And is there a gap in care for them getting screened for because they are the patients who don't come in or extremely difficult to work with when they do come in because of the mental health problems and they're often not compliance. And are they still getting their screening and getting this high risk that they have address?

Female: I guess, one thing I'm wondering is this, because I agree with you 100 percent about the difficulties and reaching this population and treating them the high comorbidity. You know, is that a question of analysis in terms of stratification and making sure they were paying attention to that population or is that really that we need a separate measure?

Female: So that's how (inaudible). It's a separate when they pull out on that.

(Cheryl): Right, exactly.

(Crosstalk)

(Cheryl): But it's reporting it, so that way, there'll be a national reporting so otherwise it's less reachable to pull it out.

Female: Right, so …

(Cheryl): So this is us giving – saying, yes, we want …

Female: Yes.

(Cheryl): We want it to be a separate pull out to look for disparity and of quality.

(Crosstalk)

Female: And again (inaudible) because you think maybe they won't do that stratification …

(Crosstalk)

(Cheryl): Right. Maybe if they do do it, there's not anyway to compare against unless there's – everybody doing it. So like I can't see how is Maryland doing compared to Oregon if it's not a national measure because there's the new national comparison.

And so, then I can say well, we're doing horribly – or we're doing wonderfully because we have 30 percent. Great because is that good or about? I don't know …

(Crosstalk)

(Cheryl): … other people are doing. I think there's benefit in looking at the folks that are higher risk as we know. It's like having a measure that pull out for patients who are on disability or on take – or having to pull out for patients who have – or homeless – that's, you know, are and other types of measures, because we know there's a high risk.

Male: I agree that it's important in the subpopulation. I just don't want to be recommending so many metrics where the numerator is the same, but the denominator is different. We already have a metric where the denominator is all encompassing. And, I guess I – it makes me feel that these measures are somewhat duplicative and would lead to inefficient use of resources.

Female: How about the numerator? Because the numerator is focusing on alcohol too, I mean …

(Off-Mic)

Female: … other substances. Yes, it's sort of just getting analysis and then look in some of the other types of substances.

Female: Hoping the other measures will be further down.

Female: Yes.

Male: Yes. That's …

(Crosstalk)

(Cheryl): The one that we – can you review – the one that we accepted.

Male: Yes.

(Cheryl): Was that just alcohol or was that all other substance?

Male: Yes, that was just alcohol.

(Cheryl): Just alcohol, OK.

Male: What one proportion was screened and if they screened positive, do they get an intervention?

(Cheryl): OK. OK.

Male: So it's really sounds like very much the same numerator and just in (other words) denominator.

(Cheryl): Right. And the question is, would that narrow a denominator going to help with cross state comparison?

Female: It would help in in many Medicaid where there is a discrepancy in quality of care for the mental health patients. Whether or not we want a limit it to – whether or not we think it's worthwhile because it's just so limited or that, it's different. But there is definitely, if there's a gap in care between patients with mental health disorders and not in the (inaudible) try to identify that gap.

Male: Is this measure also being reviewed by the mental health folks?

(Tara): Well, I'm not sure if this measure is specifically is. But I can find out. They can also be a recommendation. I note that we include …

(Off-Mic)

(Tara): Yes.

(Cheryl): You know, and I think, keep in mind to that if you're looking at a menu and you're from a mental health, you know, you may say, I don't care about something that's more general. I'm looking specifically in this population and I want to know if there's one rather than saying whether you can take this one and how I'm going to stratify it? You know, so it may serve a purpose for those who are just – want to look specifically at that population.

(Off-Mic)

(Cheryl): Discussion. OK. So, how do we go ahead and vote? To what extent do this measure address critical quality objective of the CMS quality measurements domain? High? We've got five people voting high. OK.

To what extent will it address an opportunity for improvement or significant variation in care, evidence by quality challenges? We have five people voting high. OK.

To what extent does it demonstrate efficient use of measurement resources, performance improvement activity that contribute to alignment across program and not duplicative of existing measures within the measure set? Voting high? Voting medium? Yes, we have one person voting …

(Off-Mic)

(Cheryl): OK, one. Who else?

OK, one person voting high. Voting medium? We have two people voting medium. Low? We have two people voting low. So where does that put us?

(Tara): The most contentious measure so far, that moves us forward. We still have a 60 percent.

(Cheryl): OK.

(Tara): Vote for high and medium. They are looking at mental health.

Female: They are looking at it …

(Crosstalk)

Female: They are looking at it.

Female: Well, let's just do our vote. Let's see if they – yes, let's see if they vote for it.

Male: Well, they're not. They're not looking at a screening intervention measure for alcohol across the general population, so they'll think this is not important.

(Tara): They'll think it's – yes, yes. OK, do we have to go – we have to go to the next concept?

Male: Yes.

(Tara): Let's proceed to the next question. OK. Next question.

Female: No, wait – no, no, no. No, no, no.

(Crosstalk)

(Cheryl): OK. To what extent is it all – is it ready for immediate use? Let's see here. It has an NQF members, so that mean, it's probably ready. OK. So, who is voting high? OK, we have five people voting high. To what extent do you think it's important to state Medicaid agencies and other key stakeholders? Voting high? And we have five people voting high.

OK. We voted to approve it.

(Tara): This measure passes …

(Crosstalk)

(Cheryl): … see if mental health folks.

(Tara): I've reached out for my colleague in the mental health and then we'll see …

(Cheryl): OK.

(Tara): … if they're all …

(Off-Mic)

(Cheryl): OK.

(Off-Mic)

Female: It sounds like they'd have their redundancy issue with the (concerns).

(Cheryl): Yes.

(Off-Mic)

(Cheryl): OK. Next, what's the next number we're looking at here?

(Tara): Our next measure is number 35, Pediatric Psychosis Screening for Drugs and Abuse in the Emergency Department.

(Off-Mic)

Female: 35.

(Tara): Is everyone able to see this measure?

Male: So with denominator, is kids with psychotic symptoms, how is that measured?

(Off-Mic)

Female: … something psychotic. They do the screen for urine and alcohol.

Female: Are we worried about that?

(Off-Mic)

Female: Do we think kids who are psychotic aren't kid – do we think kids who are psychotic aren't getting screened? Do we need this measure to look at this is what they're proposing?

(Cheryl): You know, it's usually we have to – usually it's the other way around. If anybody comes in with psychosis, the first thing they get …

Female: Yes.

(Cheryl): … is a screened, medical.

Female: Right.

(Cheryl): The first thing they'll get is a medical screen. And then if it's negative, then they'll go. OK, let's get the psychiatrist in. So that was huge, it's rarely, rarely the other way around unless the person already has a diagnosis of psychosis and they're coming in made with an exacerbation for somebody saying, is they not taking a medicine (inaudible).

Female: That was sort of my impression …

(Cheryl): Yes.

Female: … of my knowledge at the medical system and where there is issues. And so, I'm not sure if this addresses a gap in quality. And that's what – do we think there's a gap in quality for patients who are – who kids were psychotic not getting tested to see if it was from drugs.

Female: Oh I would hope.

(Crosstalk)

Female: You know, perhaps, and I mean many emergency rooms are not manned by pediatric emergency people. But you'd think that at this basic level that, you know, this is sort of – likes this comes going to (inaudible). Yes.

Female: If you weren't a pediatric specialist though, you would definitely probably do this because you wouldn't think about what is child pediatric problems could be.

Female: Yes.

Female: We just think they'll probably on drugs.

Female: Yes.

Female: I mean …

(Cheryl): Well especially …

Female: Yes.

(Cheryl): Five to 19. You know, you're worried about, you know, ingestion.

Female: Yes, I'm (on) …

(Cheryl): Yes.

Female: … South Carolina and in our rural hospital system, I don't think this is a given at all, unfortunately.

(Cheryl): Wow.

Female: Yes.

(Off-Mic)

Male: Putting you on drugs.

Female: Oh there's no drug.

Female: But no – well, yes.

Male: Well, the well to do family doesn't want it in the medical records.

Female: So, the question is, so (inaudible) point of care, so they're not necessarily even built. It depends on how they're reimbursed. I mean they're probably – dependent on the reimbursement is setup. How well they actually get …

(Crosstalk)

(Off-Mic)

Male: I'm not sure they're point of care.

Female: Well, they can be.

(Off-Mic)

Female: They can be also …

(Off-Mic)

Female: Right. But they can also do a point of care once depending on – I mean that's not just – but they can't (see).

Male: (Inaudible) is a lot cheaper.

Female: I mean I don't know the medical gap here well enough and say whether or not there's a need of measure.

Female: Yes, is this like a best practice like something that's probably in the guidelines?

Female: God, I hope so.

Female: Something that will be sort of in practice but, you know, sort of …

(Crosstalk)

Female: … standard of care.

Female: Yes.

Female: … but it's not …

(Crosstalk)

Female: … seen as a problem.

Female: It's standard of care.

Female: If it's not happening, it's definitely a problem. We're just not sure that there's remaining instances where it wouldn't happen. Because I mean this is the lowest level, easiest thing to do to assess the patient is this. So if you did nothing really for the patient, you would probably do this because this is by far the easiest thing to do. Much easier to do than psychiatric workup or like brain workup to see what's actually going on.

I mean that's the – this is a whole lot, anything that they knew about stuff is. And a whole lot cheaper.

Male: This is also a pretty narrow niche of kids coming through emergency rooms.

Female: Yes.

(Crosstalk)

Male: And not a huge public health problems.

(Off-Mic)

Female: Screening and breath intervention.

(Off-Mic)

Female: I thought it's brief intervention.

(Cheryl): Any other discussions about this? I do feel the point you're making with Debjani is that, this almost sounds like this is really standard of care. This isn't – I mean it's the quality metrics about standard medical care provided in the emergency setting. So that's what, you know, that's what they say, but I'm not sure, that's not – that's particularly what we should be.

Male: It's almost like if somebody comes in coughing and short of breath, you should listen to their lungs.

(Cheryl): Right.

(Off-Mic)

(Cheryl): It's like aspirin. We have recommendations and measures on aspirin use. I mean technically, that is something especially in the cardiac world.

Female: Yes.

(Cheryl): Everybody gets an aspirin depending on …

Female: This is …

(Off-Mic)

(Cheryl): Right. Because, you know, you don't …

Female: This is like clinical thought behind why some patients may or may not need aspirin or why – and like there's more – there is actually more behind aspirin.

Male: More controversy.

Female: Yes.

Male: Yes.

Female: It tend to do …

(Off-Mic)

Female: Well – and we don't like to give the diagnosis psychosis to somebody underage of 18.

(Off-Mic)

(Crosstalk)

Female: They're doing drugs and narcotics.

Female: Yes. Yes. Yes.

Female: They want them to be doing drugs and not actually psychotic. That'd be difficult.

Male: Well, why don't we vote in just to see how it turns out?

(Cheryl): OK. So, to what extent do this measure addressed critical quality objective of the CMS quality measurement domains and identifies program, area key concepts? All those voting high? All those voting medium? All those voting low?

OK. We have four voting low. One voting medium. Thank you. We have not recommended it.

Female: OK. So we're going to move on to measures 61, subconscious screening and intervention composite.

Female: Sixty one. OK.

Male: Oh this focuses on drugs screening and intervention. We've been waiting for this.

Female: We were asking about this one.

Male: So it looks like this could subsume measure 96.

Female: Get down there.

Male: Which I think we all voted highs on throughout.

Female: Right. Which one are we in now?

Female: We are in 61.

Male: Sixty one.

Female: Thanks, guys.

(Off-Mic)

Female: This remaining composite version.

(Cheryl): Subconscious screening and intervention composite. OK. Last 24 months, so this 18 and older again, who screened at least once in last 24 months for tobacco, alcohol, prescription drug use, illicit drug use, and who is aid in intervention for positive screening results. So this is your set of your expert or SBIRT.

Male: And again the one thing that should be made clear at some point is that cannabis is always not illegal.

Female: Right.

Male: And so you have to ask the question differently.

Female: For 18 to 21, it is. Under 21, it's illegal, for recreation use.

Male: Right. Right. But …

(Crosstalk)

Male: … people don't perceive it's illegal. So it needs to be called out separately.

Female: Yes. A few prescription drugs not used correctly. Did I (bar some of) these measure?

(Cheryl): And so, our denominator, people seeing twice for any visits. They then say where or who have one preventive visit during the 12 months measurement period. So could be two emergency room visits, two urgent could be anywhere? OK. And then got the screening at least once during that time and got an intervention.

Female: The care setting is outpatient.

Female: Yes. So that could be emergency room. Right. Yes, emergency or urgent care or, you know, the primary care (got to).

Female: Increase behavioral health on …

(Off-Mic)

Female: Is there any outpatient?

Female: Yes. I don't it – yes, I don't think it specifically says, if you look at the numerator and denominator.

(Off-Mic)

(Cheryl): Yes. Right. I think that's in the outpatient.

Male: Debjani, it says behavioral health call an outpatient, does that – could that improve primary care?

(Off-Mic)

Male: OK, good.

Female: Just of note, we created our own impression of this in Maryland because we wanted to measure so badly. So we would be happy in Medicaid – in Maryland Medicaid to have this because we were doing our own.

Female: Sorry, I didn't catch that (first thing).

Female: So we're doing our own version of this at Maryland Medicaid. So we'll be happy to have this via a not homegrown measure.

Male: So if we approve this with flying colors, it sounds like we will, can we go back and then say that measure 96 is redundant and lower its efficiency score?

(Off-Mic)

Female: So, you know, I'm not sure that, that would be, you know, at some point, the coordinating – we all come together and, you know, we have to kind of justify

a little bit what we have. And part of the discussion I think at that point is to look at some redundancy and whether the group of measure is down, so.

Female: Yes. So just to give a little more context, we don't really consider that, recommend measures based on how they pass the decision logic noting priority. And I think at the end of the day, as part of the summary, at the end of the day, we will run through and prioritize some of these recommended measures. And it will be – the coordinating committee is passed with making the final recommendations. And (Cheryl) is the member of the coordinating community (inaudible) to the deliberations today.

Female: We would – this would be higher than the individual assessment for each part – individually assessing tobacco or alcohol or illicit drug use. Combining it together would be higher, I think, in most (inaudible) as far as prioritizing.

Male: Can we vote super high?

Female: You know, and I think the other thing to keep – I think when they asked about duplicative, I think they are also asking about is the duplicative with what's already out there, what that would being – that's being used, not necessarily duplicative with what we've just – we're reviewing.

Female: Exactly. This question – we've gone back (and for them), this alignment at least in NQF speak and please jump in if I'm wrong, but alignment refers to kind of this, like alignment of cross measures set, across existing measure sets. So, Medicaid core sets, stuff like that.

When we talk about measures within the measure set, we usually talk about that in terms of the related measure. And that is something that we are not – it's not asked to – they're not asked to look ever whether measures of related or competing, that will be the job of the coordinating committee. So, alignment is across these measure sets

Female: OK.

Female: I heard something about the denominator, the focus is on to be seen twice for any visit and how much that may …

(Crosstalk)

Female: … the denominator?

Female: Yes.

Female: Or one preventative, but I was just curios what the rationale is for limiting it to two, people with only two or more visits.

Female: I think it's to eliminate patients who may have just gone in one time for any acute reason and may have been too sick too to really be worrying about (inaudible) as an asthma attack, you may not be doing the full effort.

Female: Right.

Female: You know, if they're not breathing, they're going to be working on them breathing or if they come in …

Female: Right.

(Off-Mic)

Female: So this is population we're trying to measure here.

Female: This is the population that was actually getting some of level of care versus the one who – the one time a year walk through your door. They didn't get everything done in one visit when you didn't know, you ultimately see them once.

So they only came in to (inaudible) my other (inaudible) stroke or a heart attack.

(Off-Mic)

Female: Yes.

(Cheryl): And if my doctor be identifying, we know so many people coming with more frequent visits don't have the med – don't often don't have a medical problem with behavioral health or (inaudible) to capture that, I don't know.

Female: If you could.

(Cheryl): Yes. Yes.

(Off-Mic)

(Cheryl): Yes.

Female: I mean it's unfair to judge the provider if the patient only got engaged once in the entire year in the medical system. It's very difficult to judge the provider. And if they didn't do everything at one visit because that one visit was likely for an issue problem. And likely the provider (inaudible), may or may not have done some of the other stuff that (inaudible) come with. And it's not necessarily bad medical care because there walked into the urgent care one and got seen for their broken arm.

Female: All right.

Female: And they didn't get an expert (inaudible). I mean I have to say like maybe they did and maybe it was relevant, and maybe they got it. But maybe they didn't then were they wrong in the medical system, so it's not gotten that done with one chance.

Female: Right fair enough and those kind of some level of engagement with the healthcare system and that's what the denominator …

(Off-Mic)

Female: … that came from a fair shot of actually making that connection …

(Off-Mic)

(Cheryl): Well, I think you hope that those two visits are with the same provider. They may not be, but the level analysis is the clinician or the group, the practice, the

amount of screening that's being done. So if you got a practice, I think that's a really good point that one shot, you may never see him again especially in a two-year period because it's 24 months.

OK, so do you want any other discussions? You want to go ahead, vote on this? OK, so, to what extend does it address an opportunity? I think we're all five high, super high, five on the high. To what extent does it measure an upper – you're moving along there, hold on a minute.

We didn't do our second. We didn't do our second vote, no. OK, so to what extend does it – does an opportunity for improvement? We've got five with high. To what extent does it demonstrate efficient use of measurement resources, data collections? We have five at high. Is it ready for immediate use? And so, the high, we got five with high. And do you think, it's important to Medicaid, the state agencies and other stakeholders?

(Off-Mic)

(Cheryl): Yes, OK, we have five with high.

Female: OK. So your passes.

Female: Can I make one note?

(Crosstalk)

Female: Yes, it says EHR only – it's possible to capture SBIRT billing claims.

Female: People stop doing.

Female: In some states.

(Off-Mic)

Female: Yes, so some states do allow people to code and claim it.

Female: Thank you.

(Cheryl): And could I also just make uplift for also just not constantly excluding our under 18 year olds. This is prevention of substitute disorder. That's the (TEP) we are. And the only way you're going to prevent is to get those people early and do prevention or early intervention.

Female: And I mean, there's a whole separate (AS) for the adolescent. And they're should be getting it done.

(Cheryl): Yes.

Female: And later, there's not a separate one for the adolescent population, the same measure, except for the adolescent population, 11 and up should have the same measure done and it starts with age 11.

Female: Actually, (Inaudible) is nine.

Female: Alcohol.

Female: Alcohol, yes.

(Crosstalk)

Female: Yes, the AAP – but the (Inaudible), they're two-step, they are new – actually new, it came out a couple of years ago starting at nine.

Male: Wisconsin Medicaid reimbursement for experts starting at age 10.

(Off-Mic)

Female: Yes. I don't …

(Off-Mic)

Female: But look for AAP first.

(Off-Mic)

Female: Yes, yes AAP. Yes, AAP is older because it's hard to get a nine year old on their own. And these questions you need to be able to ask confidentially, not

to many nine year olds are going to be talking to their pediatrician on their own. Yes.

Female: OK, so.

Female: Next one.

Female: Quick update for everybody – that measure that we discussed was – it was reviewed by the (P&H) TEP, it actually failed on resource use. It went down, they could not feel that it …

Male: Resource use, wow.

Female: … measure resources.

Male: So these are mental health people who don't really think alcohol and drugs is that important?

(Off-Mic)

Female: I'm sorry, on efficiency.

(Off-Mic)

Female: … resources.

(Off-Mic)

Female: Yes.

(Off-Mic)

Female: Efficient, I'm sorry?

Female: It's a science-based measure?

(Crosstalk)

Female: Show me the other thing to spend their money on.

(Crosstalk)

Female: OK, we're going to duke it in the coordinating committee.

Female: All right, so, next? What's our next one?

Male: Sixty nine.

Female: Yes.

Female: Sixty nine.

Female: Measure 69 is Tobacco is screening and follow up for people with serious mental illness or alcohol or other drug dependence.

Male: This is like the same alcohol measure before.

Female: This is separate.

Male: Oh that's true, but it's (SMI) plus dependents and focused on tobacco use, never mind.

(Off-Mic)

Male: … seems to be if you have serious mental illness or alcohol, drug use that's already screened for tobacco.

Female: Yes.

Male: So we've agreed everyone should be screened …

(Off-Mic)

Male: Yes. I mean these are higher risk.

(Off-Mic)

Male: What if (inaudible) were supposed to consider each measure separately.

(Off-Mic)

Female: Yes.

Female: (Kelly) did we suggest that they do an SBIRT version separate for the – they can pull out the sub-group of the mental health patients and SBIRT looking at all of it …

(Off-Mic)

Female: Yes, right.

(Cheryl): Any discussion on this? OK, all right, let's go ahead. To what extent does this measure address critical quality objectives as with CMS quality measurement domains? All those voting high? All those voting medium?

Female: There is one high and four medium.

(Cheryl): One high – I'm sorry one high and four medium? OK. To what extent will address an opportunity for improvement significant variation of care? All those voting high? We got five people voting high.

To what extent does it demonstrate efficient use of measurement resources or contribute to alignment of measures across progress? All those voting high? All those voting medium? We have five people voting medium. It is the middle over …

(Off-Mic)

Female: Yes.

(Cheryl): … kind of group. To what extent is it ready for immediate use, already using the Medicaid population? Is it NQF number? Just looking to see whether we have some information on that, using related programs not applicable, NCQA (steward)? Is NQF, does that mean it usually already in use for Medicaid population. Does that kind of – that …

(Crosstalk)

Female: Not necessarily, (Cheryl).

(Crosstalk)

(Cheryl): OK. Do we know the extent? I don't know if we know the extent.

(Off-Mic)

(Cheryl): Yes. OK, so.

(Off-Mic)

(Cheryl): Yes. OK. So to what extent is it ready for immediate use? All those who feel high? We got three voting for high, medium?

(Crosstalk)

Female: We got four, four of high.

(Cheryl): Four for – four for voting high and?

Female: I'm voting for medium.

(Cheryl): We have one voting for medium, OK? And to what extent do you think it's important to Medicaid state agency is not a key stakeholders? Voting high? We got two voting high. All voting medium, we've got three medium.

Female: Thank you. The measure passes.

(Cheryl): OK.

Female: So we move on to the next one. Our next measure is measure 10 in the discussion guide, adult local current smoking prevalence.

Male: I appreciate the thought behind this but I mean there's so much variance and smoking prevalence across the country, I just don't think it's useful enough measure.

Female: Does it – how is this some measure and not just a population statistic?

Female: Yes.

(Crosstalk)

Female: Not actually a quality measure.

Male: Most like – they're almost thinking of smoking as a sentinel event that, you know, it's a poor quality indicator in and of itself when somebody is smoking, but I don't think – I'm not comfortable with that logic.

(Cheryl): We have national surveys that look at this. We've got with the national survey in drug use and health. NHIS, so many of these things.

Male: Only in markets.

(Cheryl): No. Right, and in some – you can do some state level data, but you're right not drilling down, below, below state.

Male: Purposely that gets broken down to counties. But even so, I mean, I just don't think it's relevant as a quality metric.

(Cheryl): Do you think people are interested in at lower – at less than a state level or looking any of that something that's relevant?

Female: No, not – it might be relevant but not as a quality measure. So, there's like, so knowing the prevalence of the number of people – adult who smoke might be beneficial for me to know, but not as a quality measure.

(Crosstalk)

(Cheryl): Is that one of our populations? Is that one of our domain?

Male: But it's more of a …

(Crosstalk)

Female: I mean, I would look at the BRFSS data, one of the other – I mean this is where you look for that kind of information and for the general population.

(Cheryl): County level.

Female: Yes.

(Cheryl): OK.

Female: And even not at this – and even you might have (how many percent of that).

Male: The way this place up in organ is that the coordinating care organizations conduct county needs assessments. And they'll factor that into their health planning.

(Cheryl) OK, but you're saying this is not the kind of data that they would be looking for or they have other ways to get it?

Male: Not as a quality metric.

(Cheryl) OK. Got it, OK. All right, any other discussions regarding this one? OK, so let's vote. To what extent does this measure address quality objective of the CMS quality measurement domains or identified program key concepts? Voting high? Voting medium? Voting low? OK, this is not recommended.

Female: The measure is not recommended and we move on to our next measure, to measures 32, mental health substance abuse. In the end, our patients change course on the substance abuse subscale of BASIS-24 survey.

Male: I look up BASIS-24 the first time I went through these metrics, but I don't remember at this point what it is. Does somebody know?

(Cheryl): Basis 24 sounds like it got 24 questions. OK, so this is going to assess change score.

Male: Oh here we go. This is a proprietary behavioral and symptom identification scale. So, do we even want to consider a metric base on a proprietary scale?

Female: On its own by a specific person.

(Cheryl): Yes.

Male: Yes, company, yes.

Female: OK, she's not in the room though.

(Cheryl): Yes. So, let's – then let's go to the process. So this would be looking at change score on the subscale. It sounds like it has use as well as some functional type stuff, functional questions. Beginning with the treatment episode of – on that treatment episode of what, I'm not sure an episode – beginning of psychiatric or substance abuse treatment. OK. And then at another point in the process, I guess, that's to be determined by the clinician. So, it's just looking at the – it's just looking a change course.

Female: All right, I mean, I appreciate the spirit of this and that it gets to outcome, you know, back to your comment from early on in the discussion, but this is going up (inaudible) the proprietary instrument is so specific.

Male: I'm only aware of one program in the U.S. that is doing this routinely.

(Cheryl): I mean people are using things like the PHQ-9.

Male: Right, yes.

(Cheryl): To monitor progress overtime and it's widely available and nine questions.

Female: Right.

(Cheryl): I mean we have three and then like …

Female: Right, yes, three.

(Cheryl): … three, three yes.

Female: That's great.

(Cheryl): Yes, you can just download it from the internet. So, you know, there are other ways that you can get. You can look at outcome change overtime from the AHRQ clearing house which is interesting because if it's an AHRQ, it should

be – if it's federally funded then it should be available but there's thing, it's proprietary so it's interesting.

(Off-Mic)

Male: … a registered trademark after …

(Off-Mic)

(Cheryl): Yes. Yes.

Male: The metric is free but the survey cost money.

(Cheryl): Right. OK, so any other discussion?

Female: OK, this is relating to high feasibility.

(Cheryl): High feasibility.

Female: This rank as having high feasibility and make sure there was something we missed there, I mean that.

(Crosstalk)

Female: … very concerning for me.

(Crosstalk)

Male: … feasible, but it's yes.

Female: OK. (Inaudible).

(Cheryl): Probably because it was administrative claims, so if somebody paid for it.

Female: Yes.

(Cheryl): Then you could – I mean somebody actually did pay for it …

(Crosstalk)

Female: How would you know unless the state creates a specific code just for this survey. It wouldn't – you wouldn't know that you were – and they must be paying specific cost for this survey somewhere.

Female: Yes, because it just not screening.

Female: Well not (today) or for this (scenario) assessment tool, they must have a specific code for that tool which most of the time there is not a specific code per tool. It's usually like a general …

Female: Screening.

Female: … screening tool. And so, that thing like that would make this not feasible as a specific thing anyways, because how would you even identify what do they do PHQ-9 or is it BASIS-24 or combination of, you know, (cage) and, you know, opiate risk assessment and, you know, like, the other five tools.

Female: Yes.

Male: I think we're scoring this differently than NQF scored it.

Female: Right, yes.

Female: Not feasible, it's not …

(Off-Mic)

(Cheryl): Yes. Yes if somebody is scoring it and they just – and they're, you know, you want to look at somebody's charging for a screening then you can get that through claims data, but it's not going to get at the specific, the specific tool, right.

OK, any other comments before we move ahead with this one? OK, to what extent do this measure address critical quality objectives of the CMS for the measurement domain? So, voting high? Voting medium? Voting low?

Female: OK, five votes low and the measure does not – it's not recommended. And then this can make …

(Cheryl): And sort of interesting, we don't have a whole lot of measures that I identified that really looked at sort of outcome of treatment. You know, like, how effective has – I mean, there's a, you know, how effective is the treatment been in improving patients symptoms? We don't have – we don't have them. We don't have (them). And this is like, one of the only – this is one of the few that we have. So, it's unfortunate that it's a proprietary measure when, you know, this is – we got a lot of process measures. We don't have too many outcome measures.

And this is – so this would be – I think we can identify this is a potential gap that we don't have there in many through outcome measures that measure the effectiveness of other substance abuse treatment, mental health treatment. You know.

Male: And if this is the CMS priority, they can cut a deal with the BASIS-24 people.

(Cheryl): Right, right.

Male: I don't know.

Female: Yes, yes.

Female: So, we've noted that the measure fails but that it's uses and outcome measure is preferable.

(Cheryl): Right, right. Because it does identify an outcome looking at the effect – looking at the effectiveness of care, yes.

Female: Great. Our next measure also with the BASIS-24 survey, so we have some more discussion that is measure 34, mental health substance abuse, mean of patients overall change on the BASIS-24 survey.

(Cheryl): So, this was – I'm just looking back up to this one. What's the difference? This is subscale, the first one was the substance abuse subscale of the BASIS.

Male: Yes, 34 is the change on the whole survey.

Female: If I have a 30 – 32 or is a subscale, right?

Female: Yes.

Male: Since 32 is change on the substance abuse subscale and 34 is change on the score of the entire survey.

(Cheryl): Oh I'm just looking at 33. 33 got a zero, but then it was – it's the same thing. And then 34, OK. Yes, overall change.

OK, so we have the same, same issue here. So let's vote for this one. To what extent this is just critical quality objectives. Voting high, no? Voting medium? No one? Voting low? We have five people voting low.

Female: OK.

(Cheryl): So we can say the same.

Female: Measure fail with the same comments from measure 32.

All right, our next measure is measure 12 on the discussion guide, alcohol and drug misuse, screening, brief intervention and referral for treatment, (Inaudible) OHA 001.

(Off-Mic)

(Cheryl): OK.

Female: Oh this includes the 12 year olds.

Female: All right, we got some on …

(Crosstalk)

Male: It's from Oregon.

(Crosstalk)

Female: Thank you, thank you.

(Off-Mic)

Female: Yes, you made her day.

(Cheryl): Yes, you made my day.

Male: You have teenagers out there?

(Cheryl): They're only in Oregon.

(Off-Mic)

Female: OK, so this is people have a qualifying outpatient visit or home visit. And of state of full standardize screening tool, because they had riskier, problematic substance use during brief annual screen.

But those are not numerator …

(Crosstalk)

Female: … denominator.

(Off-Mic)

Female: Yes.

Male: It's the same that – I mean we voted on this measure already. This is just happens to be the link to the calculation that Oregon uses to do it. But it's the same concept, to everybody who's eligible, you know, I think Oregon is – Oregon has been using 12 months that have expanded in 24 months. They've expanded the populations, they've expanded, you know, they first start with adults, they now include teens and now they're doing E.D. and I think pediatrics and everywhere else.

(Cheryl): So …

(Crosstalk)

Male: Well this is a little different though because this I think is our first metric that looks at brief assessment for people who screen positive. There's other metrics look at intervention for people who screened positive.

Male: I think it's the same intent. This is a brief intervention.

Male: No.

Male: What gets paid for here …

(Crosstalk)

Female: No.

Male: No, this is the numerator would be the people who completed the full standardize screening tool such as the (RMA) and the (Inaudible).

Male: And who received a brief intervention. That's how – that's how it's been operationalize in this state.

Male: Well that's not what this says.

(Cheryl): It sounds like they got a brief annual screen. So everybody got a brief in your screen …

Male: Correct.

(Cheryl): … and they identified people who then needed more advance using the (AUDIT or DAS) which is a more comprehensive assessment.

Male: That's correct. And the billing code that apply to this, is the 15-minute brief intervention.

(Cheryl): Oh yes. Because it says screening and brief interventions are keywords but boy it doesn't say in the description.

(Off-Mic)

Female: The numerator if I'm understand incorrectly, is the number of patients who had a positive screening and we received – and how they claim for a 15-minute brief intervention.

(Off-Mic)

Male: … policy.

Female: Right. Who has a claim for the 15-minute brief intervention go with their (effort) over and the denominator would be all patient who had the outpatient visit who were 12 years old and older during the measurement here.

(Cheryl): That had the positive screen, brief screen.

Male: OK. Everybody who screens yes, essential the brief screen is do use – do you drink or do you use drugs. And then the next question – and then if you say yes, then you go on to do AUDIT and the – and whatever. And if you screen positive on that.

(Cheryl): Then you get a brief intervention.

Male: Then you get a brief intervention. And that's the CPT code they're using to assess whether or not they're meeting this metric.

Female: Who is the denominator? I'm trying to figure out who is the denominator?

Female: Everybody who comes in to get screened.

Female: So is it anybody who has an outpatient visit who's 12 years and older during the measurement year?

Male: Correct.

(Off-Mic)

Female: … with an outpatient …

(Off-Mic)

Female: … positive …

(Off-Mic)

Male: Right, but they expanded it to include …

(Off-Mic)

Male: … outpatient …

(Off-Mic)

Male: … is well-known.

Female: But the denominator – so, is the denominator only those who have the positive initial screen or is it all who have a visit?

(Crosstalk)

Female: Like are you able to capture – is there a separate claim for that positive initial screen that you see? So id any visit?

(Crosstalk)

(Cheryl): Is this all done at one time?

(Crosstalk)

(Cheryl): Is this all done at one time?

Male: Yes.

(Cheryl): OK. So somebody comes in they get the first three questions.

Male: Correct.

(Cheryl): And then they go to a – and then they do the (Inaudible) AUDIT? Or like in our case we do the CRAFT.

Male: Correct.

(Cheryl): And then if it's positive then you get your intervention?

Male: Correct.

(Cheryl): OK.

Male: Is there another quality metric for SBIRT beside this one, because I'm concerned, I mean you clearly ought to know these measures like the back of your hand yet …

(Off-Mic)

Male: … intervention is not mentioned at all. I mean, you know, description here. So what are we do with this discrepancy.

Female: I feel differently about this path than I do about …

Male: Yes.

Female: … what you're telling me happened.

(Cheryl): Yes.

Female: So we have to …

(Crosstalk)

Male: Right.

Female: Yes.

(Crosstalk)

Female: All right.

Male: So we – this is …

(Off-Mic)

Male: … SBIRT OHA 001, is there an SBIRT OHA 002 or.

(Dennis): The real world, this metric has been redefined several times because of the problems with implementation and clarification effort to clarify where exactly it stands there, I'm not certain. It's been use as a performance metric. So that the CCOs get more money if they meet the performance level, that's what set it 13 percent originally, now I think its 7, 12 percent.

And it simply means that 12 percent of the people seen in primary care in the past year test positive or it get the brief intervention. And that's based on my read of how they're interpreting the CPT codes that the CPT code they use to drive this metric is the CPT code for the 15-minute brief intervention.

Female: So my concern is the denominator is looking at the one is looking at everybody not just those who has the positive screen.

Female: Right.

Female: Because you what – because you don't know how many patients of that screen positive. So you don't know what number is. So, there's no way to know how many in my patients should have a brief intervention if I don't know how many of them screened positive.

So, that's my problem with the denominator including all visits and not those who screened positive is now the numerator isn't referencing the right thing, it's referencing.

Female: Combined.

Female: It's referencing everybody. So I don't know if 12 percent actually 100 percent of those screen positive can only 12 percent of the patient I've screened or screened positive or 12 percent, half of the patients we've screened positive for brief intervention or 12 percent of the patient who screened positive, because everybody was positive.

I mean I'm not saying …

(Dennis): Right.

Female: … such a problem.

(Dennis): Right. And so maybe this is a badly articulated version of it.

Female: Yes, if you'd like to provide more information on this specific measure, we can follow-up with the TEP …

Male: Sure.

Female: … to weigh in because it sounds like it might be a promising deliberation with some more details on that …

Female: Right.

Female: So we'll follow-up after …

(Crosstalk)

(Cheryl): The other thing I would say is that, you know, the AUDIT and the (DAST) take time. Take much more time than CRAFT which takes much more time than the single questions that I have recently been validated by a group in Boston. They found that single question can really identify low medium and high risk kids.

So, in terms of resources, you know, to ask somebody did do an AUDIT is time consuming when then and – if it's positive then they need to do an intervention. So, that's one of my concern is that the AUDIT and the (DAST) aren't real – just not practical in a clinical setting.

When we have more, we have validated tools that just really are much briefer and can get at some of the same information.

Male: I agree. And one of the problems of measures is they don't keep up with changing science.

(Cheryl): Yes.

Male: And so then they have to be rewritten and re- vetted, so that's a problem. But …

(Cheryl): And I'm speaking to the pediatric population, I'm not speaking to the 18 and out in terms of the AUDIT and the (DAST) and it maybe relevant.

(Crosstalk)

Male: And in pediatric settings, they are using the CRAFT.

(Cheryl): Yes, yes.

Male: For more detail on this Google SBIRT Oregon and you get a separate website to try to explain how to do the Oregon expert.

Female: Oh yes, thank you.

Female: So, how should we proceed Tara given that we …

Female: So.

Female: … want to clarify this?

(Tara): I've noted that we're not going to vote on this measure, just yet and we'll follow-up with more information.

Female: OK.

(Tara): An e-mail and if everyone is OK with an e-mail vote on this measure.

Female: OK.

(Tara): Yes. Thank you.

All right, so that takes us to our next one which is number 13. Alcohol and other drug use the sort of treatment provided or offered at this charge.

(Cheryl): OK, so our denominator, hospitalized patients. Identified with an alcohol and drug used disorder. Doesn't say where.

Male: Because it's a joint commission measures, so it's intended mainly for general hospitals.

(Cheryl): General hospital in-patient.

Male: Yes.

(Cheryl): Yes. OK. So, and then a numerator who received or refuse to start a prescription for medication for treatment of alcohol or other drug disorder or see to it it's referral for addiction treatment. And then there's another one that's the patient refuse the prescription for medication. That's the different sub-A.

Male: Well, there's two of our measures.

(Cheryl): Yes.

Male: One of them just allows for patients to refuse.

(Cheryl): Refuse and one – yes.

(Off-Mic)

Male: The others.

(Cheryl): One is they got a referral.

Male: Yes.

(Cheryl): Yes. OK. So this is some you're offered a prescription or you're just referred.

Female: Right. And this doesn't actually check to see if you got outpatient treatment, it just check if you got a prescription.

(Cheryl): This is similar to maybe some of the questions we had about us earlier one where it was great idea in description, are they going to fill it, have they filled it or have they actually made it to the appointment.

Female: Right.

Female: So the question, does this one look at the prescription – the prescribing practice and the EHR or is this – which is what it looks like as EHR hybrid not the claim of the prescription.

(Cheryl): Right. Which is …

(Off-Mic)

Female: Because it looks like – this looks like based on the data source, that's it looking at the providers – what the provider did, not what the patient actually did or received which is …

Male: Yes. Total process of care.

Female: Right, which is a process – yes, it's a …

(Cheryl): Yes. A facility is the level of analysis.

Female: Right. It's a process of care for …

(Off-Mic)

Male: It's also if you just look at this measure in isolation, it would be easy to game this measure by just not making a diagnosis of an alcoholic drug use disorder, but this measure is intended to be use with the other measures on screening. So, I guess we should say …

(Cheryl): But you could just give somebody a prescription on the way out and not even give them any education …

(Crosstalk)

(Cheryl): … about the value of taking, yes.

Female: You can refer everybody, not tell them to.

Male: It gets at the problem that we're short on outcome measures.

(Cheryl): Yes. Yes.

Male: Because these measures only get you so far.

Female: Well, and I know in many areas it might actually be trying to make a referrals but there may not be (bad) or providers who may not – outpatient or providers who want to take them immediate or, you know, quick fashion. And so, you know, it's the not that they get to care, this is to the (duty for all).

Male: On this also a review article on the about 2,000 patients and 10 studies half of which got SBIRT including referral is warranted and the other half didn't. And they could not demonstrate that patient who got services were more likely to go to treatment.

So it shows that referral to treatment actually is really not effective for most patients and we need to get other kinds of resources to patients.

Female: Are there …

(Off-Mic)

Female: … that is such a problem right now, but first measure like this to be useful, it would need to be and tandem with measure of receipt. So …

(Cheryl): There are some kind of …

Female: … you know, are we seeing prescribing and then are we seeing a claim, you know. Because then that would also allow to us to see, you know, what percent of these are actually being taken up or they taking up the prescription and are they taking it, you know, it really can't tell us a little bit more about where the problem actually lied, how much effort needs to go and trying to increase prescriptions and how much it needs to go into, you know, really it and it start to follow-up to get people to …

(Cheryl): Right.

Female: … follow through. And I understand that we're looking at this in isolation but seeing this issue keeps coming up again and again in terms of, you know, how important this process and the provider side and how important is outcome, I mean I think they're both and would be ideal if we can walk away at the end of tomorrow if the measure set allow us to kind of triangulate and look at that whole picture.

Male: Yes, and clearly I agree and this has a lot of short comings on the other hand, we would much prefer hospitals to perform high on this measure …

(Crosstalk)

(Cheryl): Well, you know, you almost feel like you're not going to – they're not going to – unless you start working with the provider to start thinking about this. You're never going to get any outcome. And whether, you know, like your saying the next step might be do you need something like care coordination so that that they got the prescription but somebody is making the phone call to make sure that they're either getting the prescription if not, why not, or are they, you know, is there some effort being made to get them into treatment.

So – but you got a – I think you got to start with somebody recognizing there's something – that it's a problem and that's at the provider. That's at the provider level.

Female: (Inaudible) question, I think, as a payer level, at the Medicaid's level means is this the measure we'd want or is it, you know, linked to care, is it the care coordination that this isn't measuring that is really what we want, because I know – personally I would much other see a care coordination for discharged linkage to care than do they get the prescription – well actually or did they get the prescription at a minimum. This is – did they get offered a prescription which is not the quality measure I particularly care about compared to did they get a prescription.

If this was a claims-based measure, not an HER-based measure, I would feel much more comfortable with it being beneficial as a state Medicaid agency. Because I would be able to at least say at least the hospital was doing the right thing and the patient got the prescription. The hospital was doing the right

thing and the patient – they offered the patient the prescription, well you could have gotten somebody involved to convince the patient to at least pick it up.

Female: Right.

Female: I mean that's the – because there's a lot of underprescribing particularly around the prescriptions for alcohol abusers who could be benefit – benefit from some of those prescriptions out there. There's a lot of underprescribing as that. And, you know, what are offering the patient a few days if they've been detoxed …

(Off-Mic)

Female: … and also or controlled in-house on the opiate that they get offered something so they didn't get those (free) drugs, are they waiting for (them or anything)?

(Off-Mic)

Male: And because of what your saying there was actually a fourth measure in this series, which call on hospitals to have follow-up phone calls with patients a few weeks after discharge and see are you taking your medicine, did you go to treatment but there was such a political uproar from hospitals. We don't have a staff to do that kind of follow-up. So.

Female: Right. And that's the – but that's looking – again, it's looking at stuff like, this is like looking the hospital measures, holding a hospital accountable, which is why it's just looking their process what they control.

Female: Right.

Female: That's their money and their process not looking at actual patient.

(Dennis): Yes.

(Off-Mic)

(Dennis): Right. Well, that's why I think the AFIM measures are more useful from our population management perspective.

Female: Yes.

(Cheryl): Yes, because it sounds like ideally what you wanted to measure that says did what – did they get screened? Did they get a prescription or oral recommendation? And with somebody available there to follow-up so that they got – they got that care. I mean that's everything from – is it something that clinicians doing to care coordination, to, you know, and we sort of broken down the little pieces but all together it's only all together, does it have some meaning?

Female: Right, I mean ideally we could track a process that will allow us to pinpoint, you know, intervention point for change, but we're probably not going to be able to do that and, you know, you're back against the wall and you can only check one. You know, you want the claims because you want to see what the outcome was.

So if I had to vote, that's what I vote for, you know, so this in and of itself probably not sufficient.

(Tara): So just to give you a little bit of history, I actually pulled out a report, the committee evaluated this measure. So it seems as though they had the same concerns that you all had about the prescription. So ultimately, they decided to recommend the measure for NQF endorsement because it allowed patients to either receive the prescription or referrals for treatment.

(Off-Mic)

Male: Let me go back to measure 92, the first one of the day, which I think we all rated highly and that was the one. The denominator was people 13 years and up, diagnosed with the new episode of alcohol and drug dependency, and the numerator was the proportion of those folks who actually initiated treatment. So we had mentioned in our outpatient visit et cetera, and that's more the kind of metric, OK. I think we all agree is much better.

(Cheryl): The denominator was in a substance use for treatment or that wasn't just general hospitalized, right?

Male: Well it says inpatient, does that mean general hospital inpatient or?

(Cheryl): Oh maybe it was.

Male: Alcohol drug treatment inpatient.

(Off-Mic)

Female: Inpatient – so you're saying, it could be the plain old hospital inpatient or residential.

Male: It could be a discussion in …

(Off-Mic)

Female: But could it also be in general hospitalized, that it could be. So it could be the whole range of anything, OK.

(Off-Mic)

Male: But again was …

(Off-Mic)

Male: … the big change …

(Off-Mic)

Female: OK. So do people feel that we have to, you know, we're better off to something that looks at whether not just was it given, but was it obtained. OK.

Male: And we have to look at this one separately so we just won't rate this as highly as the other one.

(Cheryl): Right. OK. So to what extent this measure address critical quality objective of the quality measurement domains. Voting high? Voting medium? We got five voting medium, OK.

OK, next question is, will it address an opportunity for improvements and their significant variation in care evidenced by challenges? Voting high? Voting medium? We got five voting medium, OK.

To what extent does it demonstrate efficient use of measurement resources? Performance improvements contribute to alignment of measure across program health and not duplicative of existing measures? OK, those voting high? Voting medium? We got five voting medium on that.

Is it ready for immediate – to what extent is it ready for immediate use?

Male: Yes, it's NQF approved.

(Cheryl): So it's already used in Medicaid population. Those voting high?

Male: Hospitals are already using it.

(Off-Mic)

(Cheryl): Not Medicaid. All right. Measure has, OK – those voting medium? OK, we got four medium. Those voting low? We have one, OK.

So to what extent do you think it's important to state Medicaid agencies and other key stakeholders? High, meaning it's important to state Medicaid agencies, consumer family. Those voting high? Those voting medium? Important to stakeholders and state, OK. We have four. OK. And then, and those voting low, we have one voting low.

So what does that give us?

(Tara): The measure passes – and passes as a measure concept.

(Cheryl): Concept, OK.

(Tara): So we can move on to the next measure.

(Cheryl): And in the implication of it being a concept, that it needs to like be relook at and maybe undergo more, more a validation before it reaches a point where it's a measure set.

(Tara): So actually no, this is something an issue that I tend to take back to the NQF team. And measure concept, yes. The purpose of this project in NQF speak, the measure concept has not been fully tested and it's not ready for use. This measure is NQF approved, endorsed, so it is ready for use, the caveat being it might not be ready for use in the Medicaid population. And based on the way that these question as a ranking – these questions are laid out, I see why it fell into medium, but there have been three measures that have fallen into this kind of trap of being designated as measure concept, even though they are fully pledged endorsed NQF measures.

So we'll come up with some other designation for them. They are ready for use. They are fully pledged measures. They are not measure concepts. But we can note that they did not received high marks, who are ready for immediate use.

Female: You know, given the discussion, given the issues that we have with it. Yes, OK.

(Off-Mic)

Female: … do you have anything else?

Debjani Mukherji: I was going to say that, this measure going through the maintenance process now, so every couple of years, you have to submit data. And what the measure developer is sort of highlighted is that, this measure is looking at the elderly and the older population because when physicians get younger patients, they tend to do more of the alcohol drug and they tend to discount the elderly. So that's where sort of the measure concept is unique. So moving forward, there will be that measure concept where they are recommending instead of the measure as it’s specified.

(Off-Mic)

Female: That's right, that's Medicare. Yes.

Female: So that would not make it up, but it is – if that measure was for the older population, it would not make it applicable to the Medicaid population, because over 65, the patient who (inaudible) Medicaid would also be on Medicare and Medicare patient hospitalizations. So that would make the measure not applicable to the Medicaid population if it was just for the older adults.

(Cheryl): And I think it would have helped, as if were specified more for older population because we're looking at 18. You know, it wasn't clear that it was focused on which we might interpret differently.

(Tara): Thank you.

(Cheryl): And this, you know, it's interesting, the keywords were continue care after detox.

(Off-Mic)

Female: Yes. And I was like there's no detox in here.

Female: Yes, yes.

Female: Not.

Female: OK.

(Cheryl): So just to give ourselves a little – we have time for break right now, we're a little overdue for a break actually. So we have a 15 minute break, so why don't we reconvene here at (3:20). Thank you.

(Cheryl): Thank you for keeping us on our break time. We're just (steaming) along here.

(Off-Mic)

Female: I think it's 4:40, 4:30.

(Off-Mic)

Female: Right, yes.

(Off-Mic)

(BREAK)

(Tara): OK.

Female: By my calculations, we're halfway done.

(Tara): We are just over halfway done. We have the one measure that we are waiting more information and Debjani made a great point over the break. No need to wait until for me to follow-up the e-mail. We can move it to tomorrow.

For some reason, I forgot we were doing this again tomorrow. So I will pull that information together tonight and we can move that one, discuss it tomorrow.

(Cheryl): I want to thank everybody for their attention so far. We'll see how we proceed here. We might be able to end a little bit early. If we really plug onward, yes, because we've got several sessions tomorrow.

(Tara): Yes, so …

(Cheryl): And we all have to end at a certain time to go through the wrap-up and stuff, so.

(Tara): Right. We'll reconvene tomorrow at 9:00 and our joint session again begins at 2, I believe. So we have all that time dedicated to breakout groups. So it is up to the group how they wish to break up that time whether it's ending early today or starting early tomorrow, or using all of your time, that we have a little bit of flexibility there since we're on a good pace.

(Cheryl): OK. We can still – we can sort of see how people feel, you know, because it's – this is, you know, taxing. So if people are starting to feel like they're flagging here at the end of the day. I know some people are in different time zones. We're 3:30, so let's – so let's just move along and see – and we'll just – let's just check in as we get closer to 4:30, OK?

Female: That is very acceptable.

(Cheryl): OK.

(Tara): OK. So we left off at measure 13 and we will now be moving to Measure 23, Documentation of Signed Opioid Treatment Agreement.

(Cheryl): All right. So this one is about people 18 or older prescribed opiates for longer than six weeks, to present who signed an opioid treatment agreement at least once that's been documented in the medical record.

I'm assuming our numerator and denominator would be all those who've been treated with opiates towards the six weeks and our numerator would be those who have signed the agreement. That's kind of what I'm …

(Tara): So, sorry, I just want to chime in here because it seems to be a mistake that that information is missing, the numerator, denominator.

(Cheryl): Right. So that why I was just sort of like trying to …

(Tara): Yes.

(Cheryl): … sort of glean that from the description.

(Tara): Right. So I'm just trying to find this. I believe the numerator and denominator. And I think (inaudible) this is a PQRS measure, the numerator statement is patients who signed an opioid treatment agreement at least once during opioid therapy, with the option performance met, documentation of signed opioid treatment agreement at least once during opioid therapy or performance not met. No documentation of signed and opioid treatment agreement at least once during the opioid therapy.

And I don't think the denominator is clearly stated but I can …

(Cheryl): That's got to be to present to …

(Tara): Yes.

(Cheryl): … opioid treatment.

(Tara): Oh, I'm sorry. All patients 18 and older are prescribed opiates for longer than six weeks duration.

(Cheryl): OK. OK, discussion.

Male: Do we know if this aligns with the CDC guidelines?

Female: It does.

(Off-Mic)

Female: It does. It's also standard just best practice from (inaudible) versus standard of care. Kind of on that line. It's been out there for a long time as appropriate practice if you're doing chronic opioids to have this. But not many people are checking on it, which was the – and this is, you know, getting to the – are you educating your patients on risks and benefits? Because if you're making those signs something in theory you at least did something. And hopefully …

(Cheryl): Is the – a treatment agreement, is that fairly standard? I don't use them. But is that fairly standard? Is that – or is that sort of up for …

Female: Providers can make up their own and there are free ones, samples out there. If you just Google opioid treatment agreement, you can pull up a bunch.

Female: OK.

Female: So they're – it's not like …

Female: And a lot of the EHRs already have them built into the EHR, like where you can print them off. But we can sign off and use them.

(Cheryl): OK.

Female: And my entire clinical career, these have been recommended for use. I mean …

(Off-Mic)

(Cheryl): So level of analysis here is going to be individual. It's going to be both provider giving them and then the individual signing them. Is that where our – it says unsure what the level of analysis is. I'm just wondering it could be – or practice plans.

Female: Oh, yes.

Female: Yes.

(Off-Mic)

(Cheryl): OK.

Female: How would this be measured?

Female: Chart review.

Female: Chart review.

(Off-Mic)

Female: It would – if they sign the …

(Crosstalk)

Female: … part of the medical record.

Female: Yes.

(Off-Mic)

Female: This is more (labor).

Female: As the chart review, it's more labor intensive.

Female: Right.

Female: So there is that tradeoff.

Female: Yes.

Female: We do the tradeoff.

(Off-Mic)

Female: This is important enough towards that.

Male: Yes.

Female: I think it's an appropriate measure and it's not like they wanted to do it.

Female: Right.

Female: Because they already do the chart reviews as part of other measures and – but they do – you do pay for each individual chart review and it's quite a bit of money. They are expensive. So a state would just decide whether or not this was – this (inaudible) for them.

Female: Right. I mean I agree and I like the fact that I'm looking at (inaudible) more prevention focus because a lot of hat we've been looking at today has been very treatment focus.

Female: Yes. Hopefully, there are people like upfront before they develop kind of …

Female: Right, exactly. That's just to show other resources involved. But I mean I agree with all their numbers so I can (barely see the value in it).

Male: One especially with the opioid, most people feel that this the least we can do.

(Cheryl): Right, right. OK.

So any other discussions? Do I move ahead? OK.

So to what extent does it measure critical quality objectives? All those in favor of high? We have five for voting high. OK.

Opportunity for improvement and significant variation in care. Voting – all those voting for high? OK, we have five.

Does it demonstrate efficient use of measurement resources, contribute to alignment of measures across program health plans? All those high? OK.

Next. Ready for immediate use. It sounds like it. OK. So voting – all voting high? OK. Five out of five.

Do we think it's important to State Medicaid and seasonality stakeholders? All voting high? OK.

Female: OK.

(Cheryl): So we're recommending that one.

(Tara): Measure 23, Documentation of Signed Opioid Treatment Agreement, is recommend.

(Cheryl): Do you have a quick tally on how many we've recommended and how many we voted down out of our 25 now we've done?

(Tara): I do.

(Cheryl): Sort of giving our idea what's our acceptance rate here.

(Tara): I think we're at 11 of our 25 item have been recommended.

(Cheryl): Eleven. OK. So less than half. Not bad.

(Tara): There's no right or wrong.

(Cheryl): I know. OK. So we're not like rejecting everything and we're not accepting everything. So I think this is a – yes. OK.

Next is …

Male: I don't see the difference between …

(Cheryl): Documentation.

Male: … Measure 24 and the one we just did.

(Cheryl): Yes. Documentation.

Female: So …

(Tara): Sorry, I'm – what is everyone looking?

Female: Number 24.

Female: Number 24.

Female: And number 23.

Female: I think it was supposed to be 25.

Male: Oh.

(Tara): So, next – yes. You might be …

Male: And we're supposed to skip 24. It's not on the master list.

(Tara): Right. Yes. So we moved from now 23 to 25. If you're in the section that just measures slated for discussion that makes the jump automatically.

Female: OK.

(Tara): But if you're looking at the appendix, it won't.

Female: So we're on 25.

(Tara): Twenty-five, Evaluation or Interview for Risk of Opioid Misuse.

Female: Using one of these tools also aligns with the CDC recommendation.

Female: The chart review?

Female: So using opioid risk (score), the catch is whether or not it's documented in the chart. And that's another – and whether or not it aligns.

Male: It's does, but these are not very strong tools.

(Off-Mic)

Male: Still I'm interested that they allow for a patient interview instead which for some clinicians maybe better and for many maybe worst.

Female: Demonstrates the strength of the tool. And the alignment, it does align.

Male: Yes.

Male: I was just part of the development of a prescription opioid risk as PROMIS based, risk assessment. So, there maybe a better tool out there. We still have to sort of authenticate it, validate it. So that's – it won't be easy to use because of the PROMIS measure.

Female: And this here says, a brief validated instrument for example.

Male: Right.

Female: So, you know, if there were something that were better, you could use it.

Male: Right.

Female: Yes.

Male: Now, I would feel better about this if it's specified that there had to be some kind of history taking around substance use and problems in the past and the treatment in the past and I'm not familiar with that so far.

(Cheryl): Is that – do any of these tools get to that?

(Off-Mic)

(Cheryl): It will be – OK.

Male: Oh here, I just found it. So, mood swings, need for higher doses of Meds. (Inaudible) patient with your doctors. That's standard.

Things to (inaudible), you can't handle them. Tension in the home, that's standard. Counted pain pills, concerned people will judge you for taking pain meds, often feel bored. Taking more medicine than you're supposed to, worried about being left alone with all the craving for meds, others expressed concern of your medication.

Close friends had a problem with alcohol and drugs, bad temper, both consumed by the need for pain meds but not early. Others – who else – and have others kept you from getting what you deserve.

(Off-Mic)

Male: Yes. How often are you – legal problems? Attended an AA or NA meeting and an argument that of course where there is violence, history of sexual abuse, how often others suggested you have a drug and alcohol problem? So at least that gets at ask treatment. Our pain medicines treated for an alcohol and drug problem. OK. Well this is – it's pretty reasonable.

(Off-Mic)

Female: No. That's the Opioid Risk Tool?

(Off-Mic)

Female: Oh OK.

(Off-Mic)

Female: Opioid risk tool is much frequent.

Female: I was going to say – there's quite a few questions.

Male: So, the limitation strikes me here is that this only applies to people in treatment for longer than six weeks. This should be at day one.

Female: Beginning, beginning.

Male: Yes.

Female: Yes.

Male: Well, sometimes you don't know that acute pain is going to become chronic pain, so I could see letting people off the hook.

Male: But if they have as positive history, you got to want to be more cautious.

(Crosstalk)

Male: Yes. I mean if somebody with a broken leg in the emergency room and there is, you know, 10 out of 10 pain, you're going to make sure that there …

Male: Right.

Male: … don't have alcohol and drug dependent …

Male: And you give them three days worth.

(Crosstalk)

Male: Tell them to go see their primary care physician.

Male: Yes.

(Off-Mic)

Female: … in six weeks.

Female: So, regardless of whether – like we definitely by the time they're on it for six weeks that we would – the CDC, I would agree that we should be checking to see if they were at risk for misusing the opiates before we continue at least (in this way). So, that would be – we should support the benefit of this and

certainly there are – the tools are not as good as there are tools out there for some other areas of medicines. But there are definitely more evidence-based (inaudible) most patient interview which could mean anything.

And I certainly, in Maryland, we're promoting the use of the Opioid Risk Tool. What we recommend providers doing as part of their evaluation and ongoing evaluation about the treatment which, you know, measuring whether or not patients are – providers are doing it.

The biggest concern I would have is how well will it be captured? So it does need to be captured through, like here is a data source of your registry but it would – it actually have to be a chart review, not a registry.

And I think that might – it's another chart review measure. Again, like the other one, there's benefit to it if you – if your state thinks that that's something they'd really want to assess. But it is another higher cost tool measurement because it's requires chart review to get that documented.

(Cheryl): No, it sounds like if we were looking for prevention, we'd want it at day one. But, you know, six weeks later, you, know, it's just asking – it's looking at something different.

Female: Right. So, what you're going to do …

(Off-Mic)

(Cheryl): Right.

Male: Well, on of the questions focus on how you've been doing with your pain medicine already?

(Cheryl): Right. Yes. Are you taking – needing more and taking it as not recommended?

OK. Any other discussion on it? OK. So, to what extent does it address critical quality objective of the CMS quality measurement domains? Those voting high? OK, five for high.

Does it address an opportunity for improvement, significant variations? Voting high, we got five high. OK.

Does it demonstrate efficient use of measurement resources such as data collection process, contribute to alignment, not duplicative? For those measuring high efficient use, OK, we got five for that.

And is it ready for immediate use? Already use in the Medicaid population, what?

Female: PQRS.

(Cheryl): PQRS, OK. And it's also said it's used in Medicare.

So, those voting high? And we've got four. Medium?

Female: One.

(Cheryl): OK. And to what extent do you think it's important to state agencies and other key stakeholders? Those voting high? OK, five for high. OK.

Female: We are recommending that measure.

(Tara): Yes. Measure 25, evaluation and review service because opioids misuse is recommended.

Our next measure is measure 28, HBIPS-1, admission screening for violence risk substance use, psychological trauma history and patient strengths completed.

(Cheryl): OK. So this is admission screening to psychiatric inpatients. So the denominator discharges psych inpatient discharges and the numerator are in admission screening within the first three days for violence, substance use, psychological trauma, and patient strength.

Female: This thing looked at by the psych site? This is looking at psych more than …

(Tara): I think, maybe, but I confirm.

(Cheryl): Yes, it's more just identifying the substance use in a psychiatric population.

Female: Right. But it's not (inaudible) used in isolation?

(Cheryl): Right. No.

Female: If any behavior problem that we need to be addressed or actually even trauma history, it's all sort of things.

(Cheryl): It's not clear.

(Off-Mic)

(Cheryl): Yes. Yes. So probably just asking are you using drugs and alcohol.

Male: Like a mixed mental health substance use measure.

(Cheryl): Right. Right.

Female: Yes.

(Cheryl): Yes.

Male: And it seems like the substance use part duplicates a joint commission measure, screening measures sub one. I forget if we did that one yet?

Female: No.

(Off-Mic)

(Cheryl): Does anybody familiar with the NQF behavioral health P3, because that maybe was where the substance use questions are embedded in that. I mean I don't know how valid that screening tool is to evaluate substance use.

Male: What is P3?

(Tara): It's phase three. It's just phase three of the behavioral health project. The PDP for the (Keep your Health) portfolio. And we can pull up these reports

actually which has detailed information on measures that the committee discussions.

Debjani, do you have it?

Debjani Mukherji: So HBIPS-1 is not being looked at them. They are looking at number five. HBIPS-5 number five, they're looking at that one, not this one.

Female: Not – yes, OK. From a state Medicaid perspective this is looking a small subset of population -- did they get a risk screening? It's not likely to be of high interest to a lot of the state Medicaid out there in my opinion.

Female: Yes.

Female: It's just not measuring something that is likely to be of high importance to the Medicaid level because it's just – well, assessing risk for inpatient, psychiatric patient is important as part of that inpatient treatment. And that psychiatric treatment is – it's not likely be applied value to the most Medicaid agencies. I'm not sure what we would – what most Medicaid agencies would do with this.

Female: Or what the provider will do if they identified, you know, high risk …

(Crosstalk)

Female: There's things we can do to help us address risk …

Female: Right.

(Crosstalk)

Female: … patient, the inpatient psychiatric patient.

Male: (Narrow) population.

Female: Yes.

Female: But it's a – it's not – I just can't picture where it applies to the larger – to the Medicaid population management. I don't know how this measures. It would be of much benefit.

Male: Oh, it's a narrow population but it's also an expensive population. So …

Female: Right.

Male: And I guess even if people have – and we do have a metric for outpatient screening, and even if that's been accomplished, it's possible that we have substance abuse precipitated (distribution). So, I think it has some importance actually, the substance abuse part.

Female: But if doesn't look at it, that (inaudible) any risk factor. So the numerator would be anybody with any of these risk factors which on an inpatient psychiatric setting would be a high percentage of patient might have a history of risk of violence (inaudible) for other substance (use) psychological trauma and given that they're psych patients possibly.

The inpatient strength …

(Crosstalk)

Female: I'm not sure what this inpatient strength means.

Male: Well, I wonder if we can comment on the substance use part of this and refer the rest of this to the mental health group.

Female: That's right. (But I feel) …

Female: Yes.

Female: That would be a great mental health measure.

Female: Right.

(Crosstalk)

Female: … like in substance use, like how is this defined.

Female: It …

Female: I mean if you …

Female: Right. Yes.

Female: … use the substance once ever, you know, it's really underdeveloped.

Female: Yes, I think it does speak to comorbidity that you can see between psychiatric and substance use, and they're often – they're often expensive, high usage of services. But I'm not sure how you're going to pull that out. And it says screening and brief intervention. It doesn't really speak to that here about what they're going to do.

Female: Right. This is a process measure for when your patient got admitted, did you assess risk that might affect their admission and their (strength) that might affect their admission or affect their psychiatric treatment? This is a process measure for the hospital and did you do the assessment. It's like – you know, it's part of their – you know, past medical history taking. This is their social history …

Female: Right.

Female: … and past medical history. And some of is social, some that's medical related history, but this is really the – like did you get their strength? Did you get their risk?

Female: Do you know their risk behaviors?

Female: And not – but it's just process. Did you get it?

(Crosstalk)

Female: Did you do anything about it? Where did you get it?

Female: Thanks.

Male: As far as the substance use goes, screening is just the first step. I agree you'd like to see some intervention there and referral treatment. What I wonder first of all is it just doesn't pass this question here, can we just focus on the substance use part and refer the rest to the mental health group?

(Tara): So, no, we have to evaluate the measure …

(Crosstalk)

(Tara): I've e-mailed my colleague in PNHCC if they've discussed this measure yet. And if they have not, I can send over (the sub-type docs).

Female: Yes, it just seems like this is built as a clinical tool for providers, and it may be very useful and, you know, endorsement-worthy in those settings, but in terms of trying to inform policy level decision-making. But they – I think …

(Off-Mic)

Female: … it lacks the detail that we need to look at population …

(Crosstalk)

Female: Yes.

(Crosstalk)

Female: So in pulling of the measure information, the way that they calculate the substance use is documentation in the medical record, then they get admission screening for substance use and alcohol use which occurred over the past 12 months, which (performed) within three days of admission. This grading must include the type, amount, frequency of use, and any problems due to past use.

Female: But they're not telling us if it's validated, too, which is could be anybody.

(Off-Mic)

Female: Right, yes.

Female: This is a good hospital quality measure for psychiatric patients.

Female: Yes.

Female: I don't know what the Medicaid population outside of a hospital. Like, I don't know what the goal or what the use would be. I'm not picturing what's the use of this would be at the payer level for (many reasons).

(Off-Mic)

Male: … how much on your radar screen are Medicaid patients do end up with psychiatric inpatient admissions? Are they focused to try and improved outcomes or reduce cost or they're just (inaudible) compared to everything else?

Female: So psychiatric …

(Off-Mic)

Male: Well, we're trying like get a sense of how big of an issue it is to try and make sure that Medicaid patients who are admitted to inpatients psych units are getting high quality care. Is that something Medicaid is highly interested in or not?

Female: Yes, highly interested in. But follow-up after emergency department and follow-up after inpatient, or measures we already know we measured through several other types of measure. I can't remember if there are – if that's HEDIS or is that something else, because I can't HEDIS at this point.

Female: So this is just asking if it's important to do a set of a general screen on violence assessing other substance use, psychological trauma history, strengths that sort of done at admission. Is that, you know – is that you think – has that been relevant to your Medicaid population admitted for inpatient psychiatric issues to also identify, you know, substance use as part of this whole bunch of risk behaviors?

So, yes, that's a good idea. You know, it's always a good idea and you can always do better at trauma-informed stuff in particular. But it's not occurring – I wouldn't call it critical right for us, and I see you shaking your head …

(Off-Mic)

Female: Yes. Great. Wonderful. It's a great …

(Off-Mic)

Female: I mean if you're …

(Off-Mic)

Female: If it was …

(Off-Mic)

Female: … measurement.

Female: Yes. If this was linked to outcome and intervention, that's a different thing. This measure is – like I just don't see how this is a hospital process.

Female: Yes.

(Off-Mic)

Female: Yes.

Female: Did you ask about abuse? Did you ask about drugs?

Female: Yes, we did. They don't really care how you did it. And if you did anything about it as long as you do it. Yes, yes, that's a good job.

(Off-Mic)

Female: Then you're accredited.

Female: Yes.

(Cheryl): OK. Any other comments? OK. So let's go ahead. To what extent does this measure address critical quality objectives of the quality measurement domain? Those voting high? Those voting medium?

(Off-Mic)

(Cheryl): OK. We've got two voting medium. Those voting low? We have three. OK?

Male: It's rejected.

(Tara): Yes, the measure is rejected on the first decision-logic question. So we will move to the next measure. We'll move.

Our next measure is number 31, medical assistance of smoking and tobacco use.

(Cheryl): Medical – 31, medical assistance …

Male: What is this CAHPS survey?

Debjani Mukherji: It's the CAHPS trademark which gets to patient for their outcomes and sort of get to patient experience, not necessarily patient-reported outcome. And right before we go into sort of the CAHPS, I just want to make a quick subdistinction that was made this morning. So you'll see a lot of instruments and surveys and tools? They're sort of things you can use to ask how do you feel to get the patient experience. They are not measured. What you'll have to do or the developer will have to do is take elements from this survey instrument tool and create performance measured, let's say, this percentage of patients who answered yes, you know, this is their outcome or intermediate or whatever that is. So a tool itself or an instrument is not necessarily a measure versus actually having a PROPM, which is a patient-reported outcome performance measure.

Male: And this is in the public domain and very commonly used, right?

Debjani Mukherji: Yes, CAHPS are very commonly used. They're also trademarked so you'll probably see the CAHPS trademark.

(Cheryl): And this is probably medication-assisted treatment with smoking and tobacco use. I'm not sure if it's medical assistance, because the keyword is a medication-assisted treatment. So I think that's what we're working with here. I just don't think that's correct.

(Crosstalk)

(Tara): Yes. I just looked at the measure in (NQCS), and it should read medical, medical assistance. And it is – I wouldn't rely heavily on that keyword for this one. I don't believe that is a medication-assisted treatment measure.

(Crosstalk)

(Off-Mic)

Female: Oh, great.

(Off-Mic)

Female: No, but that's medication-assisted treatment though, right?

Female: No, but she's saying it's not.

(Tara): I'm saying, yes, the – I – so looking at the measure specifications and I could be looking at this one. It doesn't look as though it is specific to Medicaid assistance.

Female: But it says the numerator …

(Crosstalk)

Female: … they have to have all three components or is it either any of the above?

Female: It's not clear to me.

Male: There's three different measures.

Female: There's three different measures. Thanks.

Female: It's like …

(Off-Mic)

Female: So just to – so compared to the HEDIS measure which is claims-based, this one is patient-reported.

(Tara): So Debjani …

Debjani Mukherji: Yes?

(Tara): … can you (explain) on how this measure is constructed a little bit? The numerator has three components.

(Crosstalk)

(Tara): And, yes, so actually the – I'll take back what I said before. The comment that – the keyword for medication-assisted treatment does apply because one of the components requires medication-assisted treatment? But I'm going to try to get together.

I'm sorry, 00027. It's (in QCS). I'm on the page right now.

(Off-Mic)

(Cheryl): So this is from the CAHPS. So this is reported versus – there is one that is looking at the claim version, right?

(Off-Mic)

(Cheryl): Right. Like – I mean this is really looking at – do you remember doing these things with your provider versus not – did your provider do these things? Because if we don't – you know, that's not – I mean this is all – it's asking for the patient side. But we already have the one that was at the other side. So I'm not sure why this would be beneficial.

Male: Yes, that's a good point. We're already getting it from the medical record.

Female: Right. We already have it from claims, which is more reliable than (memories).

(Cheryl): Well, this – and this is also – you're talking (recalls) during the measurement year. Within the past year, do you recall your – that you're talking about this? Do you talk – do you remember recommending cessation? You know, it's not like we didn't, you know …

Female: And it's looking at all three components.

(Cheryl): … (two) weeks after. But it's asking them to recall this anytime having occurred within the previous year. Well, I think, you know, their recall time is really a problem, too. They said, you know, a week ago you saw your physicians that you get, you know, you might …

(Crosstalk)

Female: And it's also under review by the committee currently with new specs.

(Cheryl): OK.

(Off-Mic)

Male: … we say yes …

(Crosstalk)

(Cheryl): Well, I think so. I can't remember what they said …

(Crosstalk)

(Cheryl): … but I think …

Male: But I don’t think that …

(Crosstalk)

Male: … they should know that.

(Cheryl): Yes.

(Off-Mic)

(Cheryl): I don't remember what that help was but I got help. OK, so how about we – any other discussion? I think we can move along.

All right. So to what extent does this measure address critical quality objectives? Those who's voting high? Medium? Who's got three for that? Low? We have two voting low. OK. All right. Next?

I should know this by heart. I'm sorry about that. To what extent (that it's) an opportunity for improvement and a significant variation in care evidenced by quality challenges? Voting high? Medium? Is that four medium? Low? We have one for low.

OK. To what extent does it demonstrate efficient use of measurement resources? Performance improvement and alignment measures across other health plans and programs? OK, voting high? Voting medium? Voting low? OK, we have five low.

(Tara): OK. Five votes for low on efficient use of resources, the measure does not move forward.

Move on to the next measure.

(Cheryl): OK.

(Tara): Next measure, discussion guide measure number 57, substance use disorder treatment penetration.

Female: You said 57?

(Tara): Yes, number 57 in the discussion guide.

(Cheryl): All right. So this is the number of percent of members with substance use to sort of treatment need who received treatment in the measurement year. So our denominator, so it's all individuals in an eligible population with need. And then the numerator is we've got several potential numerators here.

(Off-Mic)

Female: Yes, at least one of these, inpatient or residential treatment, outpatient. So if you use the sort of treatment, methadone, other MAT, OK.

Male: So just measures intended for payer population of patients, right? And I guess what I don't – I mean I like the concept of this but what I don't understand is how the denominator would be calculated.

(Cheryl): How do they define numerator …

Male: I mean how do they who needs substance use disorder treatment especially since we know that these disorders are so under-recognized?

Female: That is – well, the question would be – is it measured by going to have the diagnosis? Is that how they're measuring it?

Male: (Lynda) has an answer.

Female: No, no, that's a …

Lynda Zeller: I'm not sure if it's an answer, but I'll tell you what I would do if we're having to do this measure. I would take an existing prevalence statistic, like (SAMSA), you know. I would take one of those and use those. I realized then you're making very large denominator because it's going to be more than just your Medicaid population or – but one of the things we know about SUD is how undertreated we are, right? So it just seems like you have to find a denominator that's not – I mean I don't know otherwise how you determine people with need because we know we're under-reaching people.

(Off-Mic)

Female: … because the eligible population isn't the prevalent. It's – sorry. The eligible population isn't the prevalence for the area. It's the prevalence in your eligible population, which is the only way – I mean realistically, the only way to do is patients who actually have the diagnosis. And certainly we all recognize the fact that diagnosis is not made enough.

Lynda Zeller: But I know at my percentage prevalence is in the overall. We have sample data that have in fact in prevalence expectations right down to expansion date population. So I mean there really is information that you can use and you can very easily extract like that, and we're actually doing that as state commissioners, a lot of us, to try to identify just how big that untreated population is.

It's really important work. And this is one of them that I pointed to and I said it's very squishy. I even said the denominator is very squishy. But there's no more important work if you can't. If you can figure out a way to do this one, it's going to put – it's going jettison us forward very quickly. So I get it. It's a squishy denominator for that. I kind of wanted to put it on my slide anyways because of that, because it's desperately needed.

Male: I love the concept. And the only way I guess I could feel more comfortable with the denominator is that these metrics were part of the set of metrics where we're making sure that there's systematic screening and assessment, and then we would really know for the clinical population what the portion of people got the screening and assessment, and of those who did, how many of them actually (have) been treated.

Male: Well …

(Crosstalk)

Male: … probably little problematic to go tell a clinic, "Here's your expectation because this is the prevalence in your state." So …

(Off-Mic)

Male: But my clinic has a bigger need than your clinic does.

(Off-Mic)

(Dennis): OK. I've gotten distracted here, excuse me. Here, let's see your screening is excellent and you're identifying people with use disorder; some of them are mild, some of them are moderate, some of them are severe. Which treatment goes to which patient population? Because you don't want to be setting your mild to residential care, you don't want to – you know, so you've got some gradations and intensity of care that also complicate this calculation.

I think on accrued level, the states are doing exactly what you say. We estimate that our Medicaid population is at 10 percent rate. Therefore we expect 10 percent of our patients to be in care. We know it's only 5 percent. We're under-diagnosing. We're under treating. But how do you move beyond that?

(Cheryl): You know, this sort of gets back to – and I mean I recognized the problem with the denominator. But the denominator is pretty vague, but it gets at what we were finding problems with the other one which said they were referred, but did they go? So let's say for example, if you're defying your eligible population, let's say – I don't know, let's say your eligible population is all the people in hospitalization who report having, you know, with screen report have – you've identified them with the need. You want to know not just did they get a referral, did they just get – but this says, did they get there?

So I like the numerator because the numerator talks about obtaining services, given an eligible population that you've identified the need, so you've identified the need in this population, it's vague, but you can identify it however you want. I mean (it's suppose) it's your – if you're screening – you know – and so that's why I think it's a little bit different.

Female: Well, but as – to look at it as a measure, the denominator has to be defined. We can't have a vague denominator as a measure. We have to – so I can ask the question if – what is this denominator that we're trying to decide on right now? Like is this – we're able to define it? Or is it already defined?

(Dennis): Well, I think the clue here is it says the keywords are hospitalization and ED use.

Female: OK.

(Dennis): Well, Washington State had a very aggressive screening brief intervention referral to treatment initiative that was focused on EDs and hospitals because that's probably where they're getting the denominator.

(Cheryl): So (the steps) are eligible.

(Dennis): Yes.

(Cheryl): So this is saying – so this is taking it one step further than did they get referred? That's why I do like this because it says not only did they get referred, but did they get the services whether it's – I think that's what they said. Outpatient substance use treatment services, methadone, MAT. So in that sense, it is taking it – it is taking it to something that's concrete.

Female: I agree. It reminds me so much of that very first measure that we looked at. That I think kind of answered what we would be able to get out with this. I think that the way that the this whole item we're looking at out now, this frame suggests that we could somehow, you know, measure the prevalence, you know, that treatment, you know, received versus treatment need, which I just think is beyond our capacity with the administrative data that we have unless we start to extrapolate, you know.

But you know, if we have information about people who were ending up in the ER or an acute care setting and they get that diagnosis code, you know, I mean if we're not at 100 percent of those folks entering treatment within a 30-day period, (they're) not the place where we have some room for improvement. Hard enough to find all those folks who are out there who have a need, but we have an (I.D.) that these are people we know have a problem with this and if they're not in treatment that, that's a place where we can move things forward.

So I think there would be some value in it, but I think that the measurement is really unspecified as it currently stands. So that certainly needs to work. I'm also not sure how much more we would get from this measure than we would from the Washington circle measure that we started with.

(Cheryl): Yes. Because I think, too, everybody is – I mean I agree with what you're saying with prevalence, but people's populations are going to be – are going to have different prevalences. But, you know, we're talking about stratifying, you know, different populations really may not – may have very different needs than others. So, determining how much certain treatment, certain populations are able to get, I think also can look at someone's disparity issue.

Female: (Tara), is there a defined denominator that we're supposed to be using for those?

(Tara): I can – this was – this measure came from a state program which can have a lot …

(Crosstalk)

Female: It's really hard to vote without a defined denominator.

(Off-Mic)

Male: … if the measure is a good concept, it's not operationalized, we can't have enough.

(Tara): Great. Yes.

Male: Well, it might be operationalized because we have the PQRS measure number.

Female: That's right …

(Off-Mic)

Debjani Mukherji: And do we want to say, as a group, something about these measures that were developed by states for their own particular (use space) and sort of their

programs there? And now, we're bringing it up here for sort of looking at Medicaid across the board and that it doesn't always translate because we don't know, as you said, the specifics of the state's population.

In Medicaid, there's variations. So, do we want to say something globally about how a lot of these measures are now – we're looking as a concept because not that they're not good measures, they are just very specific to the state's needs and they just don't translate to sort of the national Medicaid populations.

Female: But another state might find them useful.

Female: Yes.

Male: I actually think this is less of a state issue and more of an issue that we do not have systematic screening and assessment. And that's why we don't know what the level of need for treatment is in clinical settings. So if this kind of measure were attached to other measures that ensured that we were getting systematic screening and for those (between positive) reassessment. And then for those who are supposed to get brief interventions, they get interventions, for those who get referrals, they get referrals. For that whole sort of cascading set of measures, we're going to make sure everybody is getting the appropriate service at the appropriate step, this would be a wonderful part of that. But in isolation …

Female: Yes.

Male: … it's hard to support it.

(Cheryl): Yes, it's like the numerator was what we wanted and some of the other ones that we had a good denominator with. Yes. Does that mean it should be a concept? Should we – or is it just – really does not recommend? I guess I'm asking.

Male: Well …

(Crosstalk)

Debjani Mukherji: FYI, PQRS is hep C measure, PQRS 387. So I don't know if that information translated. So this is not a PQRS measure. It's – the one that it's referring to is actually a hep C.

Male: That makes more sense.

(Off-Mic)

(Cheryl): OK. All right. Any other comments?

OK. So to what extent does this measure address critical quality objectives of the CMS quality measurement domain? Those voting high? We have five, OK. It's a good concept. All right. Next question is …

(Off-Mic)

(Cheryl): Yes, I'm also tired. That should tell us something, right? To what extent does it address an opportunity for improvement and a significant variation in care evidenced by quality challenges? Those voting high? OK, we have four for high. Those voting medium? We have one medium.

OK. Does this measure demonstrate efficient use of measurement resources? Data collection have contributed to alignment of measures across programs?

Male: I'm sorry because now I'm going to vote on this side, I need a reminder of what the questions are.

(Tara): The next questions are around – ready for immediate use and stakeholders.

Male: OK, thank you.

(Cheryl): OK. And it doesn't have an NQF number.

OK. Well, I can – if you want, I can read that. OK, so this one is to what extent does it demonstrate efficient use of measurement resources? Those voting high? Medium? We've got five there. OK. To what extent is it ready for immediate use? High, already in the Medicaid population? Voting high? Voting medium? Voting low?

Male: I should say lower than low because it doesn't (have a good) denominator.

(Cheryl): Yes.

(Crosstalk)

(Cheryl): Yes. So that's – so does that mean it's – does that mean it goes over to concept?

(Tara): Yes, it will have a concept designation but it does mean we move forward to the next question.

(Cheryl): Oh, we don't have to say – do we all have to say whether it – I thought we had to say …

(Crosstalk)

(Tara): We do.

(Crosstalk)

(Cheryl): … to what extent do we think it's important.

(Tara): We do, yes.

(Cheryl): Oh, OK. I'm sorry.

(Crosstalk)

(Cheryl): OK. So to what extent you think it's important to state Medicaid agency and other key stakeholders? So those who are voting high? OK. So it's going to move as a measure concept.

(Tara): Yes, measure 57 substance use disorder treatment penetration will continue as – we recommend it as a measure concept.

(Cheryl): Good.

(Tara): With the note that the denominator needs to be more clearly defined.

(Cheryl): Yes. And how were they measuring it?

(Off-Mic)

(Cheryl): Yes, maybe that will happen, right?

Male: And would it be possible to add a note there that this measure in concert with measures that ensure systematic screening and assessment would be more rigorous because there would be well-defined denominator.

(Cheryl): You mean well-defined numerator?

Male: No, the denominator …

(Cheryl): Oh, the denominator …

Male: … that would need treatment.

(Cheryl): Oh, OK.

Male: If everybody gets screening and assessment, then we would know exactly in each clinical setting how many people need treat.

(Cheryl): But I also think, too. In fact, this is a little bit – this is more defined numerator, too, because it talks about obtaining care rather than just getting …

(Crosstalk)

Male: … care coordination element …

(Cheryl): Right, yes.

Male: … as well, yes.

(Cheryl): OK, next. What number are we next?

Male: Fifty.

(Cheryl): Fifty?

(Tara): Next is measure 50, screening for patients who are active injection drug users. (Tiffany), are you – if you're having – are you having …

(Off-Mic)

(Tara): Oh OK.

(Cheryl): (Inaudible) the next, there are a whole bunch more coming up in the opioid. So I would like to involve …

(Off-Mic)

(Cheryl): No, no, no. So we might want to just – since, you have to leave a little early, you might just want to end because I'd – those are going be …

(Off-Mic)

Female: Yes, we have …

(Off-Mic)

(Cheryl): We can save them until tomorrow.

Female: Yes.

(Tara): All right. So we're ending here, we'd like to – we would like to finish this measure 50.

We'll do this one.

(Tara): OK. Active injection …

(Cheryl): This will be our last one.

(Crosstalk)

(Tara): OK.

(Cheryl): OK. Number 50, screening for who are active injection drug users. So you don't have a numerator or denominator in this one, but it's a percentage of patients regardless of age, who are active injection users, drug users who receives screening for HCV infection within the last – within 20 – 12 months reporting period.

(Off-Mic)

Male: It doesn't say what care setting. So I mean if these were in an alcohol-drug treatment program we'd clearly know who the injection drug users are, I'm worried in general healthcare setting as if we're not systematically seeing and assessing this kind of the same issue, we don't know who's the injection drug users are, we don't know what the treatment need is. I like the concept. It's just the denominator may be squishy in general healthcare setting.

(Cheryl): Right. The denominator here requires (inaudible). They're saying their data sources are registry unless you're diagnosing them with injection of drug use. That's probably an ICD-10. There's probably is one on injection drug user.

(Off-Mic)

Male: Well …

(Cheryl): I don't know. I don't know …

(Dennis): Well …

(Crosstalk)

(Off-Mic)

(Dennis): And as part of our review of the Oregon data, we looked at screening for HIV and screening for HCV and separated alcohol, and opioid users from the rest of the Medicaid patient population and the adult patient population.

Now, the good news is this, those with HI – those who are drug users or alcohol users were twice to three times as likely it's screened. The bad news is that got up to 7 percent.

(Off-Mic)

(Dennis): Yes.

Male: So, you're saying even if we're under-recognizing people need the servers, it's still huge quality issue and maybe we should recommend this measure anyway?

(Cheryl): How …

(Off-Mic)

(Cheryl): … Google to see if …

(Off-Mic)

Female: … (annual XPC) for people who are drug users, and there's …

(Off-Mic)

Female: … for that. I'm not finding something that's …

(Off-Mic)

(Dennis): When we talked to the coordinated care organizations about what they were doing with HCV, they said nothing because most patients don't become active. We'll address it when it's a serious problem. And they don't want to pay for the – for the virus – for the anti-viral medication.

(Cheryl): Other states are doing a lot of treatments. Well, Maryland is doing a lot of screening and treatment on HCV. But my guess it's really the, like how is the denominator captured here?

(Off-Mic)

(Crosstalk)

Female: … I know.

(Crosstalk)

(Cheryl): … and the numerator is great. And I think actually it's better than the HIV because there's a lot of free HIV testing, and that happens outside the system where you won't see the claim. And it's – and there is some of that HCV as well but the HIV as well (is that) more common. You can go to like health fairs and things like that and get your HIV oral swab done right there, whereas HCV is a blood test …

(Off-Mic)

(Cheryl): … claim comparatively.

Male: So here's the U.S. Preventive Services Task Force recommendation for hepatitis C screening, recommended for persons that are high risk for infection, and also one time for adults for between 45 and 65. So it implies that we should be asking all patients a bunch of questions to figure out if they're at high risk for infection and so screen them. And that's what's really missing from this metric that's causing the proportion of denominator is there's no requirement can be asking patients about their judges. It's found at the same issue with before about referring people to treatment (and) what's the treatment here. Well, we don't know because there is no systematic screening …

(Off-Mic)

(Cheryl): And certainly if you identify somebody at risk, it would be a good idea but who – how you're defining somebody at risk and how you going to measure that.

Female: Right.

Female: Yes.

Female: What is the actual denominator …

(Off-Mic)

(Crosstalk)

Female: Yes.

(Crosstalk)

(Cheryl): So what is Medicare using as their denominator?

(Tara): We were not able to find that information.

(Off-Mic)

Female: I mean …

Female: Yes.

Female: … how's that defined? And it makes a big difference because I mean (inaudible) data sources of registry, which again …

Female: Yes.

(Off-Mic)

(Crosstalk)

Male: … I wonder – because I think about this – I could see this would be a totally appropriate metric for alcohol and drug treatment programs.

(Off-Mic)

(Crosstalk)

Male: But it's squishier for primary care if they're not doing systematic screening …

(Crosstalk)

(Off-Mic)

Male: Yes.

Female: But, you know, at risk for STD is …

(Off-Mic)

Female: … you know, at risk for sexually transmitted infections are …

(Off-Mic)

Male: So I wonder, should we review this for different settings?

(Crosstalk)

(Cheryl): Yes.

(Off-Mic)

Female: Right.

(Cheryl): Right. Yes.

Male: Well, is it ready for use in alcohol and drug treatment programs?

(Off-Mic)

(Cheryl): … because it says active injection drug users. So, I mean, you hope that somebody use some treatment but it doesn't say, you know.

(Off-Mic)

(Cheryl): I mean it would be nice if …

(Crosstalk)

Male: Correct. And alcohol or drug treatment program should be routinely screening their rapid test. Again, they most – many of them do not have positions involvement, many that don't have nursing involvement. And they don't have any access to the antiretroviral. So you can tell somebody if they're HCV positive, you can't do it …

(Off-Mic)

(Cheryl): Yes. But it also sounds like, you know, given that there's such low rates of screening right now, there's a huge opportunity for improvement there, potential provision of care.

Female: Yes.

(Off-Mic)

(Cheryl): Right. Well, we could go the concept route.

(Off-Mic)

(Crosstalk)

(Cheryl): OK, folks, let's go. To what extent does it address critical quality objectives of the CMS quality measurement domain. OK. Those voting high? Is that true? Those voting medium? We have three. OK?

Next, to what extent does it address an opportunity for improvement? Those voting high? Four. Medium? One. OK, does it demonstrate efficient use of measurement resources and/or contribute to alignment of measurement across programs, health plans, or state? Voting high.

(Off-Mic)

(Cheryl): Yes, it's like, yes, maybe it's like …

(Crosstalk)

(Off-Mic)

(Cheryl): I know.

(Off-Mic)

(Cheryl): I know that's the problem. OK, nobody is voting high on that one. OK, voting medium. It's not duplicative. It is not – it does address some areas of

alignment, doesn’t encompass broad populations but it doesn't, all right, I'm going to vote medium.

(Off-Mic)

(Cheryl): Four with medium. Low, one was low.

Female: We could end there.

(Cheryl): To what extent is that ready for immediate use? High, no? Medium? Low? We’ve got five voting for low. OK, so do you think it's important to state Medicaid agencies and other key state holders? High, voting high? Four for high. Medium, one for medium. OK. And then – OK.

(Tara): OK. So the measure …

(Crosstalk)

(Cheryl): All right, OK.

(Tara): … as a measure concept. And I think that is where we will end today, does it sound right?

(Cheryl): Yes, I think so. I think we're …

(Off-Mic)

(Tara): Yes.

(Cheryl): So what are we going to do with our …

(Crosstalk)

(Tara): Well, one comment …

(Crosstalk)

(Off-Mic)

Debjani Mukherji: So, we will have SBIRT come back. And I just have some a quick question. In the SBIRT website there's an adult one and adolescent one and a pregnant. Do we want to look at all three? OK, that's all I need to know. We'll we have time.

(Cheryl): Yes, we will. Yes.

(Off-Mic)

(Cheryl): And then we can identify gaps. We can really, really define the gaps.

(Crosstalk)

(Off-Mic)

(Cheryl): I have to have some rationale for those.

(Off-Mic)

(Cheryl): That's right, that's right.

(Off-Mic)

(Cheryl): We'll have time for reflection on the gap.

(Tara): So, just as an update …

Female: So we've reviewed how many?

(Off-Mic)

(Tara): OK. This is a quick update, how many did I say before, we reviewed 30 measures …

Male: Wow.

(Tara): … and have recommended 13, I believe.

Female: Oh, wow.

(Tara): I'll have a check …

(Off-Mic)

(Tara): Is there anybody on the line would like to make a public comment?

Is anybody – would anybody like to make public comment at this time?

(Off-Mic)

Female: OK.

(Tara): There are no questions in the chat and nobody – any questions or public comments? OK. Thank you.

(Off-Mic)

Female: So, as a correction. We've reviewed 29 measures. We have 14 recommended, 15 not recommended.

Female: Thank you for that clarification.

(Off-Mic)

END