NATIONAL QUALITY FORUM

Moderator: Benita Kornegay-Henry
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OPERATOR: This is Conference #: Tara19.

(Tara): Yes. We'll be starting in just a minute. We have -- our slides are -- our fellow -- our colleagues from the web are not able to join us yet. So just a second. We're going to start screen sharing just so we can get started and then we'll have to pause in a little bit to flip back to the web platform. So we'll go ahead and get started in just one minute.

OK. All right. Good morning everybody. Welcome to Day Two of the Reducing Substance Use Disorders Technical Expert Panel Measure Evaluation.

We have a -- we're going to start with our agenda for today. The main objective is to continue reviewing the measures. We'll then reconvene around 2 o'clock with the rest of the TEPs. At which time the (chairs) will report out on the measures that we recommended. Then we will discuss the recommendations to the coordinating committee as a larger group and we'll have an opportunity for public comment and end out the day.

To start this morning, however, I have some updates on a few changes that we've made. So, if you will recall yesterday, we kind of found this hole in the decision logic where a measure that was NQF endorsed could be recommended as a measure of concept. We are -- we don't want to do. These are fully flushed out measures, fully specified and tested up to the (news).

So, we've changed our process just a little to remedy that and I'm going to pass around an updated handout. If you guys want to -- these has the changes that we'll be discussing.

So, do you want to go to the next slide? So the changes are mainly in these definitions of the ranking. The change in the ranking definitions for high, medium and low recognizes the variability of the Medicaid populations and acknowledges that the typical NQF measure will not apply to all the needs of the population.

It also addresses the issue that NQF measures were voted as concept. Clearly, a measure that has been evaluated against the rigor of the endorsement process is not a concept. This change allows for the important qualifier that the measure or concept is in the Medicaid population. If an NQF endorsed measure is not being used in the Medicaid population, it should move forward with the vote on the medium.

So, now you'll see that a high is a concept already in use in the Medicaid population or a measure that is fully specified and tested for the Medicaid population.

So, we'll continue with only measures that are specific to the Medicaid population will receive a high. The change comes in the medium and low, really. Previously, a medium was defined as a concept that had a numerator and denominator, didn't necessarily testing, there was nothing in between a Medicaid measure and a fully specified measure that was not used in Medicaid.

So those measures will not come in to the medium ranking. So, it will be NQF measures that are used in Medicare, other program not specific to Medicaid, they'll receive a medium.

And then the low-ranking is a measure that these are the kind of measure concepts, the way we understood them which is not used to Medicaid population and has -- does not have a numerator or denominator or had -- and has no evidence of testing -- excuse me -- has no evidence of testing.

So, the kind of larger change here is that now previously, we had these two buckets of measures and measure concepts. Now, we have these two buckets. One for the lows will be measure concepts is I think they're not tested, not ready to go. And then the high mediums will perform this other bucket that are measures and also measure concepts that are used in Medicaid.

So we have a couple instances among the types of measures that might not necessarily be considered fully developed measures based on NQF standards. They may not have been tested. They may not have gone through all of those steps that we see as part of the measurement development process but they are used in Medicaid. We came across a bit of that, across the program areas.

So those measures will now -- those measures will now -- those concepts, while concepts to us will be in this first bucket which is now going to be called not just measures but measures and promising concept. Please let me know if this is not making a lot a sense. I know it's kind of a last-minute change but we just wanted to address this.

So, if you want to go back one slide. You'll see now the change to the actual logic is previously the measure had to -- particularly the high-ranking commitments that first bucket. Now, it can receive a higher medium. And then now, only measures that are low will be included in that measure concept second bucket.

Is this making sense? Is it clear? OK. Thank you.

Sorry for the last minute change. It's -- yes, we just wanted to make sure that this is consistent because I think some of the tests we're doing, which is slightly differently, so we met this morning to make sure that we were all in the same page.

In order to -- for the sake of consistency, we will have to go back and review three measures that we previously decided on. These three measures are measures that are NQF endorsed measures that were -- that you all recommended but that received the measure concept designation. So we just need to -- it is up to you if you'd like to re-adjudicate the entire measure or if you'd like to simply look at this one criteria. We can absolutely do that. We'll

just need to take a revote on these buckets for those three measures that we know are problematic if we can't move NQF measures for this measure concept.

So just to -- are there any questions on this change? OK. The handout you have is update. I'd also like to point out that yesterday's handout had some inconsistent language with the slide but that moving forward -- this is the correct language that reflects the most up to date decision logic for -- ready for immediate use criteria.

Female: OK. I have a question, (Tara).

(Tara): Sure.

Female: Do we sum that if it's an NQF-endorsed measure is being used in the Medicaid population?

(Tara): No.

Female: OK. So, because -- it wasn't clear whether it was in the Medicaid …

(Crosstalk)

Female: So, can you -- are you going to be able to clarify stuff for us if we have questions?

(Tara): So, if you have questions, we're happy to do our best to find the answers to those questions. It's not always clear to us if it's -- it in need to the Medicaid population. We will do our best to find that information. But no, an NQF measure is not assumed to be in the Medicaid population. Now, if you -- if we have an NQF measure that comes through, no evidence that it's keeping used in Medicaid but it is a fully-pledged measure, that will receive the medium range …

(Off-Mic)

(Tara): And it won't be designated a measure concept.

Female: OK. Because I think there were some that we -- we struggle trying to understand if it really was in use in the Medicaid concept -- Medicaid population versus the general population.

(Tara): Yes.

Female: OK.

(Tara): Yes.

Female: The only way we know that it's used in the Medicaid population is if it's an on course that Medicaid course set. That sort of, like, the only sort of definite given any other measure if it's coming to the Medicare side, then (MAT) side or, you know, if it's PQRS, we know it's being used in a type of a program, we just don't know if it's …

(Tara): OK.

Female: All right.

(Tara): All right. Thank you.

Female: Well, I want to introduce John Shaw …

(Tara): Yes.

Female: … who's going to be attending the first part of our morning session. John, can you tell us a little bit about yourself?

(Off-Mic)

John Shaw: Hi. John Shaw from Next Wave and I'm on the coordinating committee and part of why I'm here is to get a little bit prepared for our June meeting and make sure that as much can be done before we have to deal with it the better.

One of the thoughts that came up and one of the other group yesterday, relative to Medicaid use versus some of the measures that were calibrated to Medicare fee-for-service is the risk adjustments on some of those measures

may or may not be applicable to Medicaid particularly because of the importance of substance use and mental health issues that may be weak in the Medicare fee-for-service population but much stronger predictors in the Medicaid population.

So that's an area where we're hoping that NQF can reach out to CMS and get better clarifications going forward. And that was a big area of struggle in the (BCN) group yesterday. And so, hopefully, we can get that result before we have to deal with it in June.

Female: OK. Thank you. I also want to thank everybody for their cooperation yesterday. I think we've got a lot accomplished and we're just going to move forward and …

(Off-Mic)

Female: And I also -- if we do finish early and we're still waiting to meet with the group, I think one of the things that I like to do is if we have time is we need to be thinking about some of the theme that our group -- so if we could -- I'd like to have some consensus on that from the group about some of the things that we've identified maybe as gaps, some of the things we see in additional measures we might need and things like that.

So, if you have time, that might be something we could use with some of the extra time that we might have.

(Tara): Absolutely. And just a thought, I know there were talk yesterday of prioritizing some of these measures. We can absolutely discuss that with some leftover time.

Great. Next slide? On to the next slide.

(Off-Mic)

(Tara): So, just a brief recap of yesterday, these are the measures that we recommended. We move number 92 from Care Coordination to Access, Initiation engage of alcohol and other drug treatment.

We only ended with one on the Care Coordination measure. The three that were recommended from this initial domain where two of them were removed to other domains. So, our final care coordination measure is primary care visit follow-up, number 97.

And we recommended several Clinical Care, number 96, you all remember, was initially a Care Coordination measure. We now moved that to Clinical Care. We've recommended Preventative Care and Screening tobacco use, screening and cessation. TOB2, tobacco use treatment provided or offered in the subset measure; TOB2A, tobacco use treatment. TOB3, tobacco use treatment provided or offered at discharge and the subset measure TOB3A, tobacco use treatment at discharge. Number 14, alcohol screening and follow-up for people with serious mental illness.

Number 69, tobacco use screening and follow-up for people with serious mental illness or alcohol or other drug dependent. Number 13, alcohol and other drug use disorder treatment provided or offered at discharge. Number 23, documentation of signed opioid treatment agreement. Number 25, evaluation or interview for risk of opioid misuse. Number 57, substance use disorder treatment penetration AOD. Number 50, screening for patient to our active injection drug users. And number 61, substance use screening and intervention composite.

(Off-Mic)

(Tara): Number 57, substance use treatment penetration AOD. We can pull those both …

Female: Is that -- is that the last one?

(Off-Mic)

Female: Yes.

(Tara): It was recommended as a concept.

Female: OK.

Male: OK.

(Tara): Yes.

Female: What are the ones that we have to review?

(Tara): So, the ones that we have to review are three NQF measures. It was number -- TOB2, TOB3, and one other that we can review once we finish our …

(Off-Mic)

(Tara): Thank you.

(Off-Mic)

Female: OK. Got you.

(Off-Mic)

(Tara): So, we'll do those …

(Off-Mic)

(Tara): And I believe there's one more -- no.

(Off-Mic)

(Tara): OK.

(Off-Mic)

Male: Can we do those first while they're a little fresh on our minds from yesterday?

(Tara): Sure. Do you have a minute to kind of …

(Off-Mic)

(Tara): And then we can move it. We've tracked down some of the supplemental SBIRT measure information as well so we can do those -- re-adjudicate those first three and then move in …

(Off-Mic)

Female: Do people want to vote just on the -- the last two, the last decision three or do you want to go to the whole measure again? What do people want to do because we can do the whole -- we can do the whole thing or we can just do it at the -- at the point where we decided it needed to be in a concept.

(Off-Mic)

Female: The last -- last part? Yes. OK. Because I might not remember what I said. We could be in a different decision point. OK.

(Tara): So, the three measures that we will -- we review are numbers 64, 65, and 13. Not 23, sorry about that. Thirteen.

So we can start with number 64 in the decision logic. I'll give everyone a second to navigate there. The measure is tobacco -- TOB2, tobacco use treatment provided or offered and the subset measure of TOB2A, tobacco use treatment.

OK. So, just as a reminder, the votes for this measure were five medium. For CMS domain key concept for opportunity for improvement, it was four high, one medium. For efficient use of resources, it was five medium. For ready for immediate use, five medium. And importance to stakeholders, five medium.

So we can begin at the ready for immediate use question using our new updated language.

Female: And what was our vote again for that?

(Tara): For these criteria specifically? It was five medium.

Male: And as I recall, we were not as friendly toward this measure because of this focus on (hospitalized patients). Those patients really should -- should and could be getting the services in a primary care setting.

Female: Right.

Female: Given our vote those, now it's -- now it's accepted because we all were in the medium, right? We were all in the medium? So the people …

(Off-Mic)

Female: Right. Yes. Yes. So, if we follow the way we follow the way we voted, it's …

(Off-Mic)

Female: Yes. Yes. It's a -- it's recommended.

(Tara): Yes. Correct. So, it does -- this -- at this question, nothing will be removed. It's just really the designation. So, given that it is an NQF measure, it would fall into the medium criteria. We just need …

(Off-Mic)

Female: Are people OK with just sorting on this? Do you want to reevaluate it from the top? You're OK? All right. So, let's vote. Who is voting high for this concept? Who's voting medium for this concept? We have five voting medium. So, it will move ahead. We're recommending this one.

(Tara): Yes. Measure 64 move forward with the measure designation.

The next measure for every review is 65. TOB3, tobacco use treatment provided or offered at discharge. And the subset measure, TOB3A, tobacco use treatment at discharge. This, again, is an NQF measure. Number (16 to T6). And the previous votes for that measure were for CMS domain's key concept, five medium; for opportunity for improvement, four high, one medium; for efficient use of resources, five medium; ready for immediate use, five medium; and importance to stakeholders, one high, four medium.

Female: So, I think this is similar to the other one. It's just a discharge, right, and then throughout the hospitalization? OK. So, how many are going to vote high for

this concept? Who's going to vote medium for this concept? We have five voting medium. So, it's recommended.

(Tara): Great. Measure 65 moves forward the measure designation. The next and last measure for your review is number 12. I'm sorry, 13. Thirteen, alcohol and other drug use disorder treatment provided or offered at discharge. Again, NQF measure 1664 and initially received for CMS domains, five medium.

(Off-Mic)

(Tara): Sorry. For opportunity for improvement, five medium. For efficient use of resources, five medium. For ready for immediate use, received four medium and one low; and for importance to stakeholders, we received …

(Off-Mic)

(Tara): … four medium and one low.

Female: OK.

Female: All right. So we're going to vote on its use for immediate use. All those voting high for this concept? All those voting medium for this concept? We have four voting medium. All those voting low? Did you -- did you …

(Off-Mic)

Female: OK. I'm sorry. I didn't see you. So we have -- we have five voting medium. I'm sorry. I was …

(Off-Mic)

(Tara): OK. Thank you all. So, measure 13 passes with the measure designation. I appreciate everyone's relooking at this.

Female: So, we can move in to these SBIRT measure that we discussed yesterday, yesterday evening, and went and tracked down some additional information that I think was pertinent to the conversation. This is the one you probably did not vote on. It is -- it refers to measure 12 on your discussion guide if

you'd like to pull it up. It is alcohol and drug use screening, brief intervention and referral to treatment as per OHA 001.

So, here we have some more specific information on the workflows. There are three different workflows for this that exist for this SBIRT measure. In adults, the process begins at the brief screening which is -- it takes place in both the primary care setting and the emergency department or the emergency department, I should say. And if positive, moved to a full screen.

The patient will receive the full screen. In the primary care setting, the full screen will be administered by the medical assistant and in the emergency department administered by the behavioral health professional. The full screen references to specific tools. The AUDIT is a full screen that assesses the severity of alcohol use and the DAST, D-A-S-T, is the full screen that assess the severity of non-medical drug use.

Following the full screen, a clinician or behavioral health specialist scores the full screen in the exam room in primary care and before discharge in the emergency department, the clinician then provides brief advice or education to patients with low risk substance use for those patients identified to have a mild to moderate substance use disorder, brief intervention employing principles of motivational interviewing and for those patients determined to be experiencing a moderate or severe substance use disorder, patients are referred to a specialized treatment.

Next slide. Next, we have the adolescent population. The adolescent population is a little different. In the case of adolescents, all patients aged 12 to 17 are automatically given a full screening once a year using the S2BI screening tool. The screening is administered via paper form, tablet or interview in the exam room for the primary care setting and in the emergency department service administered via an interview during triage when the patient is alone.

The screening aims to measure frequency of substance use in the past year. Following a positive screening, the clinician or behavioral health specialist delivers brief intervention employing principles of motivational interviewing

to explore patient's readiness to change and patient is determined to have a mild or moderate substance use disorder. In the case of patients determined to have a moderate or severe substance use disorder, patients are referred to specialized treatment.

And the third workflow refers to pregnant patients. In this case, pregnant patients are given a full screening, at least once during the pregnancy. Again, that screening is used to determine if there's a need for brief intervention. Brief interventions are delivered when indicated on the five-Ps screening tool. Positive results there indicated on the five-Ps screening tool. Referral to specialized treatment are delivered to patients when that indication is present.

So, here are the CPT codes that correspond to these workflows, these SBIRT measures. Anybody has any question?

Female: So, the question -- are they been already in the -- using -- and also sees the billing codes are not being used in Medicaid, so there -- not with these measures tracking -- so, questions like what is the measure measuring?

(Off-Mic)

Female: That's like, do we know which one of the measures …

(Off-Mic)

Female: … the measure looking for …

John Shaw: These are the CPT codes that OHA requires in order to count this is towards their incentive measures.

Female: For both screening and intervention.

John Shaw: Yes.

Female: So, the full screen would count or the full screen with brief intervention but not the brief intervention by itself?

Male: The actual …

(Off-Mic)

Male: And I'm not remembering the details but I think that only in the CPT codes account for billing purposes, what …

(Off-Mic)

Male: … reimburse by the coordinate care …

(Off-Mic)

Male: … this is what Medicaid attributes. But again, each of the coordinated care organizations, the screening (set) its own rates. So, my understanding is that you have to have -- you have to -- you have to have the brief intervention -- no, excuse me. You have to have the full screen and the brief intervention in order for it to count towards the (measure) that OHA …

(Off-Mic)

Female: Yes …

(Off-Mic)

Female: So, somebody who has a screening which is negative that provider doesn't give any credit for doing the screening in this measure.

Female: And I'm confused because what …

(Off-Mic)

Female: … describing seems to be different from what is written here in this measure so I don't know -- I would be more excited about a measure that was staging what it is that you're describing versus what I'm reading and I don't really know how to reconcile that.

(Off-Mic)

Female: Right.

(Off-Mic)

Female: I do, too. Yes, so where does that leave us?

John Shaw: And so, are the measures drawn from those two different rates? Are there actually two different measures?

(Off-Mic)

John Shaw: So, just one metric covering both …

(Off-Mic)

Male: Well, there's some variations. If it's a Medicare claim, it's a little different than the Medicaid claim and stuff like that.

John Shaw: Yes. I would propose that we have a separate little meeting on the phone after this is full clarified and we have the exact language …

(Off-Mic)

Male: I can get (SBIRT)ise …

Female: So, I mean, like -- so the denominators (go to retrieve the strong) and the numerators to receive the screen in a brief intervention, that would be …

(Crosstalk)

Female: That would be great because then it's assessing those who had a positive screen that they get intervention they're supposed to get which would be great.

(Crosstalk)

Female: If we just can't held it -- that's whether or not that's what it is. It sounds like it might be.

Male: And I think we've covered …

(Off-Mic)

Male: … already. Haven't we?

Female: Probably for adults, we have -- we haven't done it, so there's children …

(Crosstalk)

Female: Yes. This could be one of our best measures. So I think it takes us a little more time to get it ready, it might be worth …

(Off-Mic)

Female: OK.

Female: So I'm reading here more detail than over there and it says here hospitals are held accountable for either the brief of full screening rate. So that's the first part. Then for the second part, it says hospitals must report but are not held accountable for the brief intervention rate. So I don't know if that counts and sort of, you know, your intensive accountability for doing both versus doing the screen and then the intervention.

(Off-Mic)

Female: So, if they did the brief screen but they didn't do an intervention, then they're in the denominator. Yes, they're not -- they're not somebody who's accomplished the full measure.

Female: No. One caveat I'm going to throw out there for all of us, if you remember, everything came out this is Medicaid. This is not totally generalizable. These are not standard codes across the Medicaid. Each state makes up their own code for this which means it won't -- whatever codes they're using won't work in Maryland or South Carolina or wherever because each state making up their own code so there's not yet standardized codes that are out there.

Male: But it would still be useful for Medicaid programs around the country that see these metrics …

(Off-Mic)

Female: So we might be able to adapt the standard code if there was a metric with it. I mean, but that's, like, I know Maryland already has codes in place for building for -- as per -- for all the different levels so we wouldn't be changing ours which are -- if they're not that same one then …

Male: Will the various Medicaid programs could slightly modify the metric and still find it very useful?

Female: The S2BI is validated. That's one of the newest measures about. It's a single question which is shown to be pretty good -- have good reliability for teenagers. So there -- it's good that they're making a distinction between what they're doing for adults and what they're doing for adolescents.

Male: Yes, I have sent e-mails to my …

(Off-Mic)

Female: OK.

Male: So, if they call, we can …

Female: OK.

(Off-Mic)

Female: All right.

(Tara): OK. So we will continue to table 12. And go back to …

(Crosstalk)

(Tara): OK. Excellent. So, now, I believe we can just jump back in to where we left off yesterday. And by my notes, we left off at Measure 51 in the discussion guide. And that measure is (SUB1), Alcohol Use Screening.

Female: OK.

(Tara): So we will open up measure (SUB1), Alcohol Use Screening for discussion. OK.

Male: So, this is one of the joint commission measures just like …

(Off-Mic)

Female: Yes. For hospitalized -- hospitalized adults. I'm looking for -- it says that was just alcohol. OK. Because in the description -- all right. So, it's provided, offered and refused and then those who received the brief intervention. Right?

All right. Any -- any discussion of this? We have our denominator on health records and then we've got two different numerators. Those who received or refused and those who received. What? Am I looking at different …

(Off-Mic)

Female: Fifty one or fifty two? I'm sorry. I thought you said 52. I'm sorry. OK. That's the next one.

(Off-Mic)

Female: Yes. OK.

(Off-Mic)

Female: Right.

(Off-Mic)

Female: Discharged. Yes.

(Off-Mic)

Female: Right.

Female: Right. You've got this …

(Off-Mic)

Female: But we do all the ones with tobacco …

(Off-Mic)

Female: Great. OK. So, this is …

(Off-Mic)

Female: So this is the first three days of admission. OK. Any discussion of this? How do we feel about this? This is joint commission.

Male: Kind of similar to the tobacco ones …

Female: Yes.

Male: … measures but it should be going on in primary care …

Female: Right. Right.

Male: … less important, that is also those on hospital but …

(Off-Mic)

Female: I would say this might be a couple of that lower priority …

(Off-Mic)

Female: … tobacco for the Medicaid population has alcoholic …

(Off-Mic)

Female: … tobacco is for …

(Off-Mic)

Female: … and the hospital population is certainly not the main …

(Off-Mic)

Female: … of most Medicaid programs for alcohol (risk) screening.

Male: So, but to add to that, the patients going into the alcohol withdrawal are going to be much more difficult to manage in the hospital than patients craving nicotine. So we can't give them the alcohol patch.

Male: And also, yes, even though alcohol is less of a cost driver, the intervention is, actually, generates proportionately much greater cost reduction within the first year -- cost reductions for tobacco cessation or there's some in the first year but they're largely delayed.

Male: Yes. I think the issue here is the complications that the alcohol use disorder gives to the care team and the cost to the hospital is readmissions.

Female: OK. Any more discussion? OK. So let's go ahead.

To what extent because this measure address critical quality objectives to CMS quality measurement domains, all those voting high? Here we have five voting high. OK. To what extent, does it provide an opportunity for improvement for significant variation in care? All those voting high? Four voting high. Medium? One voting medium.

To what extent, we demonstrate efficient use of resources or contribute to alignment across programs. All those voting high? You have four voting high. All those voting medium? One voting medium. OK.

To what extent is it ready for immediate use? Already in use in the Medicaid population. OK. Can we -- can we assume that it is -- right? We can't?

(Off-Mic)

Female: Hospital population. OK.

(Off-Mic)

Female: Right. Right. So they're in -- no, what I'm saying they're included, so we can't -- we can take it to mean that -- that it's used in the …

(Off-Mic)

Female: We talked about this before. If it's broad …

(Crosstalk)

Female: … it doesn't exclude them.

(Off-Mic)

Female: So, if you, like, if you said, like, it's not …

(Off-Mic)

Female: … average to the Medicare patient …

(Off-Mic)

Female: … they have now from the hospital population for the Medicaid patient. But again, here's the catch. Medicaid patients who are older are Medicare patients …

(Off-Mic)

Female: … 64-year-olds that were …

(Off-Mic)

Female: And so that say, like, can that already be ruled out and we've got …

(Off-Mic)

Female: … current overall hospital population result rate …

(Off-Mic)

Female: OK. So, we don't have that?

Male: I never heard of Medicaid programs tracking this …

(Off-Mic)

Female: Right. OK. All right. Any more discussion? OK. So to what extent is it ready for immediate use? All those voting high? All those voting medium? We have five voting medium.

To what extent do you think it's important to Medicaid -- state Medicaid agencies? The key stakeholders? All those voting high? All those voting medium? We have four voting medium. All those voting low? One voting low.

So, we are recommending that one.

(Tara): Yes. So the measurement for that …

(Off-Mic)

Female: OK.

Female: And the next one is kind of just the …

(Off-Mic)

Female: That's the one that's …

(Tara): Yes. So our next Measure is 52. Let me …

(Off-Mic)

(Tara): Yes. Measure 52, (SUB2), alcohol use brief intervention provided were offered, and (SUB2A), alcohol use brief intervention. This measure is NQF-endorsed.

Female: OK. Do we need to discuss it? We go straight to voting? OK. So …

(Off-Mic)

(Tara): Please use your microphone.

Male: Sorry. The description says those who refuse the brief intervention are not included. The numerator says the number of patients who received or refused the brief intervention. That seems to be conflicting.

Male: I think there's actually two separate measures …

(Off-Mic)

Male: In the single item?

Male: Yes.

Male: OK.

(Tara): Yes.

Female: Yes. It's confusing. It's numerator stays the same but, you know, then there's two separate numerators.

Male: I don't know how you decide whether somebody refuse the brief intervention or just decided not to be changed. That aspect of the measure is really not very useful. I don't think.

Female: So, this takes the numerator from the previous group. Those who was screened?

(Off-Mic)

Female: And then it looks to see who received or refused which still includes the 2A, right?

Female: Right. But to be clear, our brief intervention is generally, like, a brief advise …

(Off-Mic)

Female: … so I'm not sure how you refuse your doctor talking …

(Crosstalk)

Female: Yes.

Female: Because they may …

(Off-Mic)

Female: I mean, like …

(Crosstalk)

Female: Can we talk briefly or can we talk extendedly?

(Crosstalk)

Female: … a brief intervention is like two to three minutes of talking …

(Crosstalk)

Female: … interviewing, talking, if you're doing it well. But it -- it's still …

Male: But within CMS codes, you have to talk for at least 15 minutes.

(Crosstalk)

Female: Using the motivational …

(Off-Mic)

Female: So, I guess I'm a little confused. The patients who received or refused? I mean, it's …

(Crosstalk)

Female: Again, it's like offered.

Female: OK.

(Crosstalk)

Female: OK. You tried. OK. OK.

(Crosstalk)

Female: I know.

(Off-Mic)

Female: Yes. OK.

(Off-Mic)

Male: What it does raise …

(Off-Mic)

Female: Right. Right. Because …

(Off-Mic)

Male: Well, this raise the question whether we want to vote separately on these …

Female: Yes.

Male: … measures. I don't think …

Female: We can't. Yes …

(Off-Mic)

Female: It's one measure because that's how it was approved so we have to move forward and, you know, as one measure, unfortunately. I'm not sure how useful (SUB2) would be ultimately -- it's really, you know, (SUB2A) was going to be relevant just the population. OK.

Male: Maybe there can be an annotation about that.

Female: Yes.

Female: OK. Are we ready for -- all right. So, to what extent this is addressed cortical quality objectives? All those voting high? We've got three. All those voting medium? We have two voting medium. OK.

Next. To what extent will it address an opportunity for improvement or variation care? All those voting high? OK. We've got two voting high. All those voting medium? We have three voting medium. OK.

To what extent does it demonstrate efficiency use of measurement resources? All those voting high? One. We have one voting high. All those voting medium? We have four voting medium.

OK. To what extent is it ready for immediate use? All those voting high? All those voting medium? You have five voting medium.

And to what extent is it important to state Medicaid agencies and other key stakeholders? Voting high? You have one voting high. Medium? All voting medium? We have three voting medium. All voting low? We have one voting low.

(Tara): OK. So the measure passed. It is recommended -- excuse me -- with the definition measure.

Female: And I'd like to ask you before but what's your perception of the importance of these from a Michigan perspective?

(Off-Mic)

Female: … can you summarize this one?

(Off-Mic)

Female: The importance of alcohol screen brief interventions with an inpatient setting?

Female: So, from the state perspective, the more important piece is the primary care.

Female: That's too narrow.

Female: Yes. Yes.

Female: And I think, maybe, that will be reflected when they go to that prioritization process?

Female: Yes.

Female: Sorry. It's budget season …

Female: Believe me. I understand. I'm sorry to put you on the spot.

(Crosstalk)

Female: Very few states track inpatient quality measures about almost anything. Like, very few state Medicaid look at much inpatient quality other than the readmission type of stuff and it's like -- it's like not these specific -- like that joint commission type stuff, most state level agencies aren't looking at that other than …

(Off-Mic)

Female: … your hospital passed joint commission review.

Male: I do wonder whether they would want to take a look at that because these are their higher utilizers and this -- if this includes emergency room patients, then the Washington State Expert Economic Analysis is really striking with patients who got (SBIRT) in emergency rooms alcohol and drugs manifested more than $4,000 per patient deduction and cost over the next year. So, that would be interesting to Medicaid.

(Off-Mic)

Male: That's too bad.

Female: Yes.

Female: So, I agree completely with (Tiffany). The only additional piece I would put in there is that the -- if you're a managed care state and the Medicaid managed

care entities do quite a deep dive on their provider network. So, that's where this kind of thing gets picked up a lot in Michigan and kind of ranking the hospitals against each other. So, that is our consideration.

Female: And you would think too if they're trying to understand root causes of readmission, this would be -- this would be something that could help them with that.

Female: Yes. The coordination of care is usually a higher problem.

Female: Yes. Yes. There's lots of problem.

Female: Yes.

(Off-Mic)

Female: Yes.

Female: OK. Our next one, (Tara)?

(Tara): OK. Our next measure is number 56, substance use disorder treatment penetration.

Male: Didn’t we do a measure just like this? Just …

(Crosstalk)

Female: Yes, I think …

Female: Same name.

Female: What number again?

(Off-Mic)

(Tara): Yes. It's similar.

Female: It's exactly the same thing, I think.

Female: Right.

(Off-Mic)

Female: Yes, we don't have …

Female: Do we have a numerator or denominator or more description? I like the concept but how is it -- what is this measure? What's measuring …

(Off-Mic)

Male: … denominator is members who needed a substance use disorder service and the numerator is how many patients got …

(Crosstalk)

Male: The problem is we don't know how many patients need the service.

(Off-Mic)

Male: Yes.

(Off-Mic)

Female: Well, and it's a measure concept. So the -- I mean, you have questions too is who -- who you talk -- who's our -- who's the population here?

Female: No, I think this is also pretty redundant and it's the prior measure and doesn't provide any additional detail.

Female: Yes.

Female: I'm not sure …

(Off-Mic)

Female: Yes. So, (Lia), I think it's a …

(Off-Mic)

(Tara): … numerator and denominator that was said. Because I was able to pull that. This is the measure we found from Washington state and the numerator is -- include in the numerator all individuals with (CD) at least one substance use disorder treatment service meeting, at least one of the following criteria in the 12-month measurement year. One inpatient or residential substance use disorder treatment services. Two, outpatient substance use disorder …

(Off-Mic)

(Tara): OK.

(Off-Mic)

Male: This is maybe what Washington State is doing based on their …

(Off-Mic)

Male: … and identify patient need on the …

(Off-Mic)

(Tara): So, the rest of the numerator number three, methadone opiates substitution treatment services. Number four, other medication-assisted treatment using medications indicated in (STDTX pen values set to the Excel text with referencing) the specific list.

Classification of BHS services is based on procedure codes and modified field values to finding the applicable servicing counter reporting instruction. The denominator for the measure is included in the denominator all individuals in the eligible population with the substance use disorder treatment need.

Female: There you go. There you go. That was clear.

(Crosstalk)

Female: So close.

(Off-Mic)

(Tara): So, it gives a …

(Off-Mic)

(Tara): Sorry to disappoint. It does give more information on its substance use disorder treatment is identified by the occurrence of any of the following in the identification window.

(Off-Mic)

(Tara): Yes.

(Off-Mic)

(Tara): Diagnosis of a drug or alcohol use disorder in any health service event receive a substance use disorder treatment service meeting numerator criteria A procedure (DRG) revenue and related codes. B, (NDC) codes. Three, receive a brief intervention as per services. Four, receive a medically-managed detox services.

Female: So, a brief intervention is qualifying them for substance use disorder? Because …

(Off-Mic)

Female: Yes.

Female: Yes. Like what …

(Off-Mic)

Female: But if that -- but a brief intervention could not -- could be used for many patients who don't have an actual use disorder. So who might just be trying cigarettes and we're telling them to stop trying cigarettes.

Female: No, you smoked one. Great. Let me give you a brief intervention about why you should not ever smoke again. That's a big difference between a self-induced disorder need and actually giving a brief intervention.

(Crosstalk)

Female: I think what we were hoping for is that they would typically give us the folks that had been screened and had a need for actual treatments.

(Off-Mic)

Female: Right.

Female: Well, the fact -- the fact that it's a measure concept, does that mean we, you know, it's like we can recommend how they might -- moving forward is a concept to recommend how it might be improved to be …

Male: It sounds to me like an important gap.

Female: Yes.

(Tara): So, the trick there is that it has to be -- you have to recommend the measure as it exists now. The measure or measuring concept that is that we can note recommendations in general or specific to a measure but we cannot -- you have -- you can't move on the measure that we wish it was.

Female: OK.

(Crosstalk)

(Tara): Yes. Sorry.

(Crosstalk)

(Tara): And oftentimes, we designated this measure concept. A lot of the state measures that we found -- we just could not find evidence of testing and if that was the case, it got the concept designation but this isn't new to the state -- in the state program. So, based on the updated criteria for the ready for immediate use, it would receive a high designation because although -- yes, it will receive the high because although it is a concept, it is currently in use in the Medicaid program. So that is where that we have that new change where that first bucket, the highs and mediums, are not just measures that they're

measured and what we're calling in the previous project they call them promising measure concept.

These are these -- we're not -- they're not fully tested. They're not really up to NQF snuff, but they are in use in the population that we provide.

Female: You know, the other thing is that -- this also is how concept looks like more like access than actual. It's an aspect of clinical care but I think it's also access which is trying to get people into …

(Crosstalk)

Female: … into services. So, we don't have very many access measures and …

(Crosstalk)

Male: … clinical care coordination and access.

Female: And access, yes.

Female: This would just (gather up the HEDIS measure), you know, it's the only two accurate measures.

Female: Right.

Female: yes.

Female: Right.

Female: However -- OK. So we -- any -- go ahead. Go ahead, ((Tiffany)).

(Tiffany): I would say, you know -- sorry. Receiving a brief intervention, is the (rolling downfall) to it, like the rest of the measure, the denominator is really good. The caveat there is how many are you overputting into the denominator than we did (deserve to be in) the denominator because of they receive a brief intervention, particularly in the adolescent population where you're going to do a lot of brief interventions or …

(Off-Mic)

(Tiffany): But you do a lot of brief intervention but who don't need substance use disorder treatment. You're just trying to move them in a longer path for readiness to change …

(Off-Mic)

(Tiffany): … ready to stop smoking.

Female: And that's the prevention aspect.

(Tiffany): And that …

(Crosstalk)

Female: Yes.

(Tiffany): It's great but that's -- like, but it's going to make this denominator substantially larger than it should be because that's a lot of patient to get a brief intervention specially for things like tobacco, right?

Female: I think that's one of the challenges that we've come up against a few times with this decision logic is when we -- we see all that there is issue related to the validity of the measure, there's no way to kick it out, you know, so we end up trying to formulate another strategy to move that measure out or make, sort of, express their concerns, but it's kind of a -- it's a little bit of a challenge. It might be worth kind of noting for the future.

(Tara): Yes. We'll definitely note that. Thank you.

Female: Yes. What point do you say?

Female: Do we vote it out because it's a bad measure? Right?

(Off-Mic)

Female: Yes. Right.

Male: It's not NQF-endorsed so we've got some …

Female: We got some wiggle room here. OK. Right. All right.

OK. So, let's start here. To what extent does it address clinical quality objectives, that quality measurement domains? Those voting high? We have three voting high. Medium? We have one voting medium. Low? We have one voting low. OK.

To what extent does it address an opportunity for improvement or significant variation in care for each program area? Those voting high? Those voting medium? OK. We have five people voting medium. OK.

To what extent does it demonstrate efficient use of measurement resources? Continue alignment of measures are not duplicative of existing measure within the measure set captures a broad population? OK. Those voting high? OK. We have one voting high. Those voting medium? You have one voting medium or two voting medium. OK. And those voting low? You have two voting low.

OK. So, we're continuing forward, right, as we've got three at the high medium.

(Off-Mic)

Female: The what?

(Tara): The measure of …

(Off-Mic)

Female: Right.

Male: I think it's a real problem if this measure moves forward …

(Crosstalk)

Female: The measure moves forward. Yes. We're still …

(Off-Mic)

Female: Yes. We haven't.

(Tara): Sorry. Sorry.

Female: Right.

Male: OK.

(Off-Mic)

(Tara): Yes, we can …

(Crosstalk)

(Tara): Yes.

(Off-Mic)

Female: Yes, I know. It has a -- it has a denominator but it's …

(Off-Mic)

Female: … the denominator is not about …

(Off-Mic)

(Tara): OK.

Female: But that's -- again, that's just …

(Off-Mic)

Female: Yes. Out …

(Off-Mic)

Female: It has a denominator. It has a numerator but we have probably …

(Off-Mic)

Female: Do we have …

(Off-Mic)

Female: … is this a problem with homegrown measure, right?

Female: Yes.

(Off-Mic)

Female: … and we all occasionally figure out our …

(Off-Mic)

Female: Well, is there evidence of testing that, I mean, that's where we could get the low.

Male: We don't know …

(Off-Mic)

Female: OK. OK.

(Tiffany): Do we want to revote on efficient use of resources? I heard someone …

(Off-Mic)

Female: That we're ready to go. To what extent is it ready for immediate use? Those voting high? Those voting medium? Those voting low. We have five voting low. All right.

(Tara): OK. So the measure -- so the measure will continue to move forward on this question because just because it receives a low, this is the question where it will just move in to the measure concept designation in order for the measure to not be recommended to the coordinating committee unless …

(Off-Mic)

Female: OK.

(Tara): So, our final question is around the stakeholders and whether or not this is important to key stakeholders.

Female: OK. All right. Good. Who's voting high on it's important to state Medicaid agencies and (consume with) family? Who's voting medium on this? Who's voting low on this?

(Off-Mic)

Female: OK. We have five -- five versus low.

(Off-Mic)

Female: Yes. Yes. I know.

(Crosstalk)

Female: Yes.

(Off-Mic)

Female: Yes.

Male: Well, it's not important to anybody if it's an invalid measure.

(Tara): Yes. And if it were measure -- if it were a measure concept that could be further refined, that would be -- that would be something that you could resign that denominator …

Female: And check out the part that's making it money …

(Off-Mic)

(Tara): Yes.

(Off-Mic)

Male: … problem is that unless there's systematic screening and assessment, well, you have a vast under …

(Off-Mic)

Female: OK.

(Off-Mic)

Female: There's a different …

(Off-Mic)

Female: Yes.

Female: … the measure of …

Female: Right.

Female: At least it was then very measure, not a true need but a recognized need …

(Off-Mic)

Male: … to gaining just like recurring …

(Off-Mic)

Female: Yes.

(Crosstalk)

Female: But it’s still -- it's still a start. Because right now we don’t -- we can't hold -- we can't hold you accountable for how did you get patients into treatment when we don’t even measure how did we get you into treatment.

Female: Right.

(Off-Mic)

Female: We need to get you into treatment but we're not measuring …

(Off-Mic)

Female: Right.

(Crosstalk)

Female: And we know there's a lot of folks that gets screened or ID'ed that don't ever end up in treatment.

(Off-Mic)

Female: And if we can -- if we can start measuring that and figuring out how to do a better job by getting those folks in the care, I think that would be a significant contribution.

Female: Yes.

Female: And that -- I mean, that's recently we want to pick out more but it doesn't matter if we pick them up if we don't move them for you. At least if we picked you, because we're moving forward down the treatment line. And if we (start to) (inaudible) to hold people accountable. It's hard to -- it's harder to hold you accountable. Did you screen everybody positive …

(Off-Mic)

Female: … screened positive but at least if you move people who are positive down the line and that's -- say, like, this is the first step and we -- we should be screening everybody but getting the true positives can be challenging. Because, again, patients also -- it's some of -- the art in asking the question on -- if you get a fill answer or not. It's amazing how often that can get a …

(Off-Mic)

Male: Well, maybe, this is for the gap discussion but, like, what we need is that cascade of measures, so …

(Off-Mic)

Female: And this one also, if it were a good measure, you could stratify those certain population. Who's getting care and who's not getting care. I mean, this could really be could help a lot of information.

(Off-Mic)

Female: Yes.

(Off-Mic)

Female: Right.

(Off-Mic)

Female: All right.

(Off-Mic)

Female: What's our next one, (Tara)?

(Tara): All right. Our next one is Measure 63. Percentage of adolescence, 12 to 20 years of age at the primary care visit during the measurement year whom tobacco use status is documented and received help with quitting if identified as a tobacco user.

(Off-Mic)

Female: Why is it just tobacco? There's so -- I mean, so few kids are using tobacco now. So many more are using marijuana and everything else. I know this is such a focus on tobacco. I understand but …

(Off-Mic)

Female: Yes. These are older measures. We just need to be adding other drug use …

Male: Continues to be the leading preventable cause …

(Off-Mic)

Female: Right. Right. If they continue to -- you're right.

(Off-Mic)

Female: But if they start -- if they start -- they're more likely to start in adolescence, you know. If you don't start before you're 18, unlikely to start but I understand there's a greater universe of things too that we should be looking out.

OK. So, primary care visit through the measurement year document and received help with quitting if identified. OK. So we got all these CPT codes.

Female: Can I ask a clarifying a question about this? So, is the denominator just all patients 12-20 who had a primary care visit so it's not the percent of adolescents 12-20 who had a primary care visit and were screened for tobacco use?

Female: You're supposed to screen at every visit if they want …

(Off-Mic)

Female: … asking every patient. So, it's …

(Off-Mic)

Female: If they walk through your doors, are they assuming them that this is happening?

Female: Yes. You're held accountable for whether or not you did it.

(Crosstalk)

Female: … screening and intervention.

(Off-Mic)

Female: I'm just wondering how you saw this numerator is, you know, say, 5 percent, you know, it's -- if we don't know -- I mean, how -- what percent -- you know, it's sort of lumped into things together, you know, we don't know what

percent is screened and then what percent received. It's kind of different for just the useful number.

Female: But I -- but I think we also got, with early ones, it's saying, well, what do we need -- you know, if we don't do anything about the screening, you know, what -- what good is it?

Female: So this is screening -- or screening with intervention? So the numerator -- if you screen every patient who walks through your door, you get a 100 percent.

Male: No?

Female: If you gave them an intervention if they were positive.

Male: Right.

Female: But, so, if you've seen them all and they were all -- they all screen negative, then you would get a 100 percent. If you screen them in some were positive and you get an intervention. So, this is -- it is actual -- it's measuring how many of the patients who walked through your door got screened and the appropriate care.

Female: Right. I just -- I don't know how useful that is.

Male: I think the reason people do this is -- is that healthcare organizations and clinicians are screening, they were too many metrics so this is a way to combine these clinical processes into one …

(Off-Mic)

Male: So, I agree it's not ideal but I think it's still pretty good and kind of meets the overall conceptual needs.

Female: It does help -- hold accountable for are you actually doing what you're supposed to be doing. Because, well, tobacco is not the focus of most, like, major public (helpings at the moment) and opiates are a much bigger focus at the moment for most states. Providers are supposed to be targeting this population and this is only the key time that people start and they're supposed

to be asking every time and are you actually doing it and they account every -- basically every single outpatient visits.

(Off-Mic)

Female: It's counted in the denominator which means did your patient one day came in at -- if they came in, did they get it? Were there any measures where you're held accountable and the patient didn't show up? Because you're supposed to make them show up. And so, I think, this is actually a pretty good metric, holding providers accountable.

Female: Right. You're saying, are we assuming that everybody is getting screened in the denominator or not?

Female: No. The denominator's anybody who showed up.

Female: OK. Well, in that case …

Female: And the numerator is did you get screened and or did you get screened in intervention if needed?

Female: OK. But it says and in the numerator.

Female: Who were screened and if identified …

Female: If identified as a user.

Female: OK. That's why I was like -- I don't understand …

Female: Yes. OK. Yes.

Female: Yes. Tying the screening with the intervention rather than just screening them but is anybody -- is anybody -- is anybody doing anything, do we know something …

(Off-Mic)

Female: It's OK.

(Off-Mic)

Female: But we're clarifying it.

(Off-Mic)

Female: OK. Any other discussions? Questions? OK.

All right. Let's vote. To what extent is it just critical quality objective? All those voting high? We have five. OK. To what extent is it addressed an opportunity for improvement for variation in care? All voting high? We have five for that.

To what extent does it demonstrate efficient use of measurement resources? It says registry but this is really -- this is going to be a …

(Crosstalk)

Female: Yes. Yes. All those voting high? You have five. Four. OK. All those voting medium? We have one.

Next. Is it ready for immediate use? Already in the Medicaid population. All those voting high? Medium? OK. We have five voting medium.

And then do you think this measure is important to state Medicaid agencies and other stakeholders? All those voting high? We have five voting high. So we're …

(Tara): … measure to move forward. This is recommended to the coordinating committee with the measure definition.

So, our next measure is 73. Use of opioids at high dosage and for multiple providers in persons without cancer.

Female: OK.

(Off-Mic)

Female: OK. So, just for -- for those who aren't having been living in the CDC guideline, it recommends avoiding going above 90, not 120. It recommends staying below 50 and avoiding going above 90 …

(Off-Mic)

Female: So, if you're at 120, that's definitely too high for a normal clinical practice. There are reason for people …

(Off-Mic)

Female: … from that but …

Female: Did they make a distinction, just maybe between they've got consecutive days versus a total of 120?

Female: No. That's daily. The 120 is your daily calculated dose.

Female: OK. OK.

Female: So, like we're 90 and it's …

(Crosstalk)

Female: OK.

(Crosstalk)

Female: … equivalent are you getting per day. And the risk of addiction goes up dramatically if you're at any dose for more than 90 days and the rest of addiction and overdosed are up significantly higher when you get above 90 to 100 MMEs per day. So you got the double combination here being at a high risk for addiction and a high risk overdose because you're on it for a long time and not a really high dose which is science behind the CDC recommendation.

Four or more prescribers are -- and four or more pharmacies, both of those are used by different payers as drug shopping, you know, your patient is not getting good care but they should be having an opiate prescriber agreement in

place where they're getting their care from just one provider or that provider is like a fill-in person if they're not in the office, so that you might have two but four is certainly too many.

And going to multiple pharmacies is also a flag. States usually use some number depending on how to catch their bad patient and/or are used by various states. This one is interesting numerator because it's got end-to-end …

Female: End-to-end, yes. It's getting -- drilling down …

Female: Because it's got -- it's gotten their numerator to be quite small and it's looking at -- I'm not sure what it's trying to identify. The drug -- the bad drug seekers or the high dose patient? Like I'm not sure what the point of the -- of the measure is.

Female: It sounds like what you're saying, you could just take the first part 120 MME and greater than 90 consecutive days and that -- that would be -- that's enough.

Female: We have that in Maryland except for we set it at 90. We created one in Maryland for 90.

Female: Right.

Female: Yes.

Male: I have a bit of a problem with that, though, because there are pain specialists, I think, who end up seeing the most complicated patients and for those folks, that's probably reasonable for them to have a sort of proportion of patient from that higher …

Female: So the expectation shouldn't be that it's (at zero). So that's -- I mean, that's where you -- like, where you -- what percentage of your population you expect to be at that. Not zero when it's not a never event. It's an uncertain circumstance of event. But if you have providers who aren't pain specialists and they're providing a lot for patient for this, it's concerning. But if you have a lot of your patients at a high dose in the population …

Female: Right.

Female: That's concerning.

Female: Well, I think that's what they're to do here is they're saying, you know, among those group -- that group that's at a 120 MME, who are those that we think are actually using this in inappropriate ways. They're trying to narrow down among that group. I'm kind of …

(Off-Mic)

Female: … concerned about the denominator. I mean, why are they limiting it at all? I don't necessarily see, you know, what -- what necessarily the point of narrowing it down to people with opioid …

(Crosstalk)

Male: … is just so weak. Don't include in this metric. People who got one prescription for acute pain.

Female: One provider and it happens to be a high and low.

Female: Right. So who -- who is the population now?

Female: The numerator has 90 days …

(Off-Mic)

Female: … 15 days. I'm confused.

Female: Yes.

Female: Greater than 15 …

Female: So the numerate -- in order to be in the numerator, you have to been on the opiates for 90 days but (already) being the denominator you could have been, like, been on it for 16.

Female: Right. And that's OK …

(Crosstalk)

Female: … make a lot of sense.

Female: I mean, and that's like -- it's more than 15. So, it captures everybody about 15.

Female: Which is eliminating people who are -- who are in a short-term.

Female: It's not -- it should be in the numerator but they're still capture in the denominator.

Female: So why -- why do you want patients who got a two-week prescription and who got 16 days of opioid after surgery to being the denominator, who makes the numerator look better? Because it's going to make the numerator look better because -- but who is the population that -- I mean, what -- do you understand what I'm saying?

Female: Yes.

Female: Post-op patient.

Female: Who do -- who do you want the denominator be?

Female: Well, the -- the denominator should be all patients getting 90 days of consecutive -- it should -- it should have patients who are getting at least -- numerators and -- and it should be getting at least 90 consecutive days, maybe, any opiate or of 120 or …

Female: I think that's fine but that would answer a different question. The other thing, I said, in the title, this talks about cancer and then there's no reference for that and the denominator or enumerator -- I mean, that's …

(Off-Mic)

Female: … an issue that would need to be addressed to move forward.

Female: It also doesn't make …

(Off-Mic)

Female: I can't tell where there's measures …

(Off-Mic)

Female: Like, what are we -- I'm not sure what the number in the …

(Off-Mic)

Female: You're trying to get the -- this combining high dose of multiple providers but it's very confusing.

(Off-Mic)

Male: I wouldn't like to see something labeled as bad quality care if pain specialists are doing this appropriately. I think it's a sort of a red flag. We better look into this but to (say that quality of care) is really going to put a lot of pressure on pain specialists to under treat …

(Off-Mic)

Female: Right. We have a pain specialist who have patient who are receiving for pain prescriptions for four or more prescribers at four or more pharmacies.

Female: So have we …

(Off-Mic)

Female: So, just to be clear, every payer that I'm aware of that tracks a flat-out number, not a rate but a flat- out number of the number of patients who would meet the numerators. Here are some variations. It might be that they set their numbers at three and three or a hundred or any opiates for 90 days and to -- but every payer that I'm aware of tracks problems with patient for opiates in some form or fashion.

And some do it by pharmacies, some do it by prescribers, some do it by the combination. Most have some sort of lock-in type of program or care

management type of program that those patients get flagged for if they -- if they go into it. It's not a rate. It's a flat-out number.

Anybody who goes on it. And it's the OK if -- and it's, you know, every state and every payers got their own (slight) version but it's the which way. As a rate, I don't know what -- I don't know what this numerator or denominator means together. I can say what the numerator means and what the denominator means, I can't figure how they go together …

(Off-Mic)

Female: Are you saying also that given what you know states are doing, is this duplicative? Do we even need something like this? Because that's -- it doesn't do what …

(Off-Mic)

Female: It's not -- if it was a rate, so I could compare how many bad apples do I have in my state compared to the bad apples than someone off the state, I don't know how hopeful that would be but maybe that would be duplicative but with this numerator/denominator, I'm not sure that's what it even does.

Male: I think a better metric would be more of a structural metric is our payers or managed care organizations doing some kind of quality assessment and improvement on this issue and then it would involve maybe gathering this kind of information, contacting docs that there was a concern but allowing there to be exceptions for docs who are pain specialists and doesn't know what they're doing, et cetera.

(Off-Mic)

Female: The multiple prescribers -- the multiple pharmacy's problems is I get that every -- every payer I'm aware of. When I've met with my -- some of my state partners, everybody had a version …

(Off-Mic)

Female: … not of this measure but of the numerator.

Female: So, I pulled the report and sort of the discussion of the committee, the patient safety committee that has looked at this and as far as why they talk -- they recommended this measure for endorsement, they said that the committee express that the measure could be highly useful for identifying patients and their prescribers who's actions lead to taking high doses of medications for prolonged periods for multiple prescribers. And they thought that the reliability, validity, and feasibility of all the data that was provided was very high. So, just to sort of give you the thinking of the -- the committee that had looked at this measure for endorsement.

Female: OK.

Male: I agree to it's useful to identify those patients and see if they're getting good quality care but I don't think it's useful as an actual quality metric.

Female: Right. Well, the denominator (falsely) lowers the numerator. And it doesn't make a good metric when you're not going to have a true, like, the denominator account everybody with 16 days of opiates. That doesn't work with the numerator that only counts 90.

(Off-Mic)

Female: Yes. Exactly.

Female: OK. So, let's -- any other questions? Comments? OK. Here we are again.

OK. So, to what extent does it address critical quality objectives of the CNS quality measurements domains? Who feels it -- votes high on this? Voters medium? And votes low? I think we're all …

(Off-Mic)

Female: OK. All right. We have four -- five people voting low on that.

(Tara): OK. Measure 73 does not move forward for recommendation.

Female: OK.

(Tara): OK. The next measure is very similar. Use of opioids at high dosage in persons without cancer.

Female: OK. Is it any clear …

(Off-Mic)

Female: No, it's just saying denominator.

Male: If we move the best part of the measure.

Female: Right.

Female: Yes.

Female: Right.

Male: We move the least problematic parts of …

Female: Yes.

(Off-Mic)

Female: Yes, it's the same problem. OK. So, to what extent does this measure address critical quality objectives of our domain? Those voting high? Those voting medium? Those voting low. OK.

(Off-Mic)

Female: Five are voting low. So, please make a note that states would be extremely interested in measures like this that were valid and measuring what the intent of these works measure. The problem with these is they're not actually measuring what their intent is. The numerators and denominators don't work together. But you can't look at something for 16 -- any patients who are getting opiates for 16 days in the denominator, that doesn't work.

We have been trying to measure how many of them we're on high dose for more than 90 days. The other thing is we really -- I think most states would

prefer to see something where there's alignment across (federal or national guidelines and the CDC's guideline is 90. There's nobody's guideline at 120 right now so I'm not sure why we would pick 120.

John Shaw: One-twenty was yesterday's …

Female: Right. It was -- right. It was -- but it's -- if we're going to create a new measure, it would be great to have it in alignment and certainly CDC's guidelines is not every patient is supposed to be below that. It's a -- I think just that it's recommendation that you should use extreme caution before going above and make sure that it's appropriate for that patient.

But it shouldn't be a zero number, patient on 120 but having a national standard for -- having a national knowledge of what that number is would be really helpful, how many patients around the country are on 120 for more than 90 days would be a really helpful thing to know for most state so they know or there are patients actually getting higher doses of opiates in other state as we know there's a lot of variation in prescribing practices around the country but we don't know what this looks like and that would be really helpful. But that's not what this measure does.

(Crosstalk)

Female: So, you'd have that -- the denominator of everybody …

(Crosstalk)

Female: … everybody getting 90 consecutive days of opiates.

Female: That's not necessarily a fatal flaw. It depends what your question is. If you want to just narrow the denominator so it just narrows the population. So, if you're saying among people who had it for more than 15 days, this is the percent that was on it for 90, that's OK depending on what the question is that that made a point he's answering.

And that's why my first question was what the heck is this denominator. What is the subpopulation that we're defining here? I mean, it's not worth nitpicking

because, you know, the reality is there are other problems with it but it's just -- it pains me to refuse these measures because of the clinical and the policy importance of them and I hope that something else is coming down the line that's starting the course of the day …

(Off-Mic)

Female: This would be, like, very top …

(Off-Mic)

Female: … (ever) state Medicaid agency …

(Off-Mic)

Female: But these numerators and denominators -- I don't know what they're trying to do when they're together. I'm just not sure.

Male: Yes. There is one other problem in this -- Oregon have said the coordinating care organizations in Oregon have said they want every patient to be below a 120. And so they're tapering people above that. What happens when you do that? They switch to heroin or other illicit sources. So you've got -- it's a messy situation. And this could create more mess than itself.

(Off-Mic)

Female: It's important to -- with these to set a current is at so that we know what the national average is and not expect -- it should not be zero. Not every patient should be really low and trying to tell everybody to go low is going to cause more harm.

(Off-Mic)

Male: … that I take is -- is a concern about the whole concept of having a quality metric is we know that the quality metric should not be zero, yet, the way this will get implemented is that practitioners with lots of these patients will automatically be singled out for delivering bad quality care.

Female: Yes. The other question here is who else, like, they're only excluding cancer and they didn't identify how cancer's excluded, like is it only active cancer treatment or is it patients who ever had a diagnosis of cancer which is quite a different thing. They also didn't include sickle cell. They also didn't exclude palliative care patients or hospice in the (private care) patient.

Female: And that -- those are all populations who have really well …

(Off-Mic)

Female: … for being on higher dose that probably don't need to be tracked with the rest of the population. But cancer, in particular is active cancer, (wherever) had this cancer, so very different saying and you can get yourself in trouble depending on which way you define it if you don't understand which one you're defining because (included image of that cancer well -- those) it can have (cumulous) trials and they are still excluded throughout their lives …

(Off-Mic)

Female: So, we actually do have some more information on the exclusions, specifically, and those states as any member with the diagnosis of cancer or prescription drug hierarchical condition category, 8, 9, 10, or 11 for the payment year of (03/16) or a hospice indicator.

Female: So, is that cancer -- is that active 8, 9, or 10 …

(Off-Mic)

Female: I'm not …

(Crosstalk)

Female: So, you're not excluding that from the denominator?

Female: Yes.

Female: Yes.

Female: But I have that …

(Off-Mic)

Female: You know, do you -- you think to the 15 days is just to avoid acute?

(Off-Mic)

Female: Acute. You know?

(Off-Mic)

Female: I mean, I think it's a -- I think what it is is somebody saying, you know, we should worry about that 15-day thing. We just want to look at -- the rest of the universe is getting more than …

(Crosstalk)

Male: … just giving out five days …

(Crosstalk)

Female: But in the clinical world, if somebody got it for 16 days, you want to say they belong with looking at the same group of people that for 90 days, like, most people would have gotten that (line of 30). I don't get this -- but I don't -- I just don't get why there's a difference in the length of time from the numerator and the denominator, like, if you're looking at -- are you trying to (look at the) patients who got it for a long time and that's, like, maybe you're looking at the rate of patients got (full encounters, why the) numerator, you want the -- the denominator low.

(Off-Mic)

Female: Which is -- which has value too, is just knowing how the patient get it for a long time.

(Crosstalk)

Female: I think there's -- there's value in it.

(Off-Mic)

Female: Yes. You mean, it depends upon the -- like …

(Crosstalk)

Female: Right. Right.

Female: … for a long time.

Female: Right.

(Off-Mic)

(Tara): OK. So, would (you) like to revote on this measure. Just as a reminder, it went down five lows, four -- to what extent that this measure address …

(Off-Mic)

Female: I think we're more discussion the gap.

Male: Yes.

Female: Yes.

(Tara): OK. Yes, great. So that …

(Crosstalk)

Female: What we would like to see given this, I think that's -- yes. OK.

(Tara): Yes. Definitely. Noted.

OK. For the right next one -- would anybody like to take a break or would that …

(Crosstalk)

Female: OK.

(Off-Mic)

Female: We get 75.

(Crosstalk)

Female: We'll resume at 75 …

(Tara): Fifteen minutes?

(Crosstalk)

Female: You can pick one of them.

Female: Well, I like this one better than the provider one.

(Off-Mic)

Female: Yes.

Female: We could actually …

(Off-Mic)

Female: To which one?

Female: To 74. So, if you're counting any patient who get some opiates for more than a couple of weeks …

(Off-Mic)

Female: The number of patients who are kept on a high dose …

(Off-Mic)

Female: For more than 90 days are …

(Off-Mic)

Female: … like starting times what it is that you're …

(Off-Mic)

Female: And they include two or more …

(Crosstalk)

Female: … they include two or more prescriptions too.

Female: Well, no, no. This isn't two more …

(Crosstalk)

Female: OK. Right. OK.

(Off-Mic)

Female: … quality indicator is that …

(Off-Mic)

Female: Well, I'm not sure …

(Crosstalk)

Female: But, I mean, like we -- we have …

(Off-Mic)

Female: And that's where, like, having a national -- like, there's benefit of having the national measures that …

(Off-Mic)

Female: … the patients that we are making out of. But a substantial number of these patients is like …

(Crosstalk)

Female: … started from the one before.

Female: Right. And then there's one after, too, coming up.

(Crosstalk)

Female: … but the 75 is the -- yes, is the one looking at the …

(Crosstalk)

Female: You know what? There are a lot of yellow people coming up that I don't know just because I'm not -- I'm not working program in the program in (the fellowship). So when I was fellowship director up in upstate New York, I knew a lot of this. So, you know …

(Crosstalk)

Male: … point, you make it a ring or a voice or something.

Female: Then we'll just stop.

(Off-Mic)

Female: … it's not on the radar screen of a lot of training programs …

(Off-Mic)

Female: … traditionally it hasn't been and we're just -- we're trying to -- -we're trying to get it into fellowship training and, you know, it's -- it's a challenge.

(Off-Mic)

Female: … I'm going to pass around my rationale for saying why I think …

(Off-Mic)

Female: So, everybody can take a look at my -- at the graph and you can -- you can see the reference from this one but, actually …

(Off-Mic)

Female: … like that's one of the general articles. But here's -- that's the rationale. So what's …

(Off-Mic)

Female: Which is why it would be if you think …

(Off-Mic)

Female: I can see why they're kind of the 120 …

(Crosstalk)

Female: … I don't think we really should do this one …

(Off-Mic)

Female: And that's like reducing substance use disorder, really -- we really probably should do this.

Female: Yes. If you can …

(Crosstalk)

Female: It's not getting the whole population …

(Off-Mic)

Female: Is that one of the tiered -- was that one of the exclusions?

Female: No. So you can't exclude -- so here's the thing. If you can't …

(Off-Mic)

Female: No, but I was thinking the clinical -- the clinical solutions.

(Off-Mic)

Female: Not sickle cell? And not …

(Off-Mic)

Female: And not -- not neuropathy.

Female: But, I mean, it is the -- that's certainly the reason why it won't ever go to zero. I mean, there -- they will never go to zero nor should this ever go to zero because there are patients …

(Off-Mic)

Male: Well, that's why we need to have people …

(Off-Mic)

Female: Right.

(Off-Mic)

Female: Yes.

Female: But and that will -- but not every quality measure has a standard of …

(Off-Mic)

Female: … you really think the pain management …

(Off-Mic)

Female: … or do you think it's …

(Off-Mic)

Male: Well, let's take the payer that's telling the clinic that they will get more money if all of their patients are below -- are below …

(Off-Mic)

Female: Their pain management clinic or …

(Off-Mic)

Female: … I'm not sure most -- most are saying not -- like if you're in the …

(Off-Mic)

Female: I mean, I don't see why -- it's …

(Off-Mic)

Female: But how do you take that …

(Off-Mic)

Female: How do you do auditing …

(Off-Mic)

Female: Well, Medicaid programs are …

(Off-Mic)

Female: … patients who are five more or four more …

(Off-Mic)

Female: They are -- some are starting to get prescribers …

(Off-Mic)

Female: What do you think about this?

Female: I -- it is a circle and it feels like it's such an important issue that we should take -- it feels like you need to take a step forward. I share some of your concerns about unintended consequences and it happens -- you know, I -- sometimes, these measures, once they start getting used doing the …

(Off-Mic)

Female: … of what we were trying to see. So I think this is …

(Off-Mic)

Female: Yes. Well, so that's it. Like it's one of the …

(Off-Mic)

Female: But we certainly don't make that none of them should belong to this or that, you know, provider …

(Off-Mic)

Female: So we're also not requiring what state to choose to do with the measure.

Female: Yes. That's not our chart.

Female: Right. So a state could choose to use it as an audit, a way to identify high risk people recognizing that there are -- I mean, I don't know, maybe that's being optimistic.

Male: Whether we approved this, we're saying a quality metric is needed or going beyond saying that's some kind of assessment and improvement program as needed.

Female: But here's the thing, I mean, there's a -- this could be a quality metric but the measure of success isn't necessarily zero percent, you know, because look at epidemiological problem today that say, you know, that's 12 percent of your people in the population typically means it should be above 120. If you double or triple that, you probably have a problem here.

Male: Unless you're a pain management doctor who really knows what they're doing and …

(Off-Mic)

Female: Right. That's it for the -- if somebody chooses to adapt it that -- then it's for them to figure out what level is theirs and I think that they get -- the benefit of

measure like this if it was adapted will be that we might be able to get a national or regional kind of average or comparison so that way when I'm looking at my rate, well, I might know that some of my patients should be on it.

But what if I have 40 percent of all my patients who are meeting this and that my neighbor also has 15. Well, that told me, I probably don't have that much more pain than they do in my state. So maybe I have prescriber who's prescribing at higher doses for some reasons.

Male: And what if you're a neurologist and you have lots of neuropathy patients as opposed to a neurologist that has …

Female: Well, that it will be -- if it's at the Medicaid level and not the proprietary level. Remember, this is not -- this measure -- we are looking at measure at a Medicaid population level. We're not looking at a prescriber level.

So this would be a measure that you would be looking at. Probably at the lowest level it would be used with like MCO, CCO type of -- but it really would be it's a population measure. It's not looking at (any other) prescriber or practice. This is not a practice measure. This is a population measure.

(Off-Mic)

Female: It's not a provider performance measure or provider …

(Off-Mic)

Female: It looks at the population level.

Male: In the prescription, it says level of analysis is unsure. Care setting is unsure.

Female: But we are looking at it as a Medicaid measure which is the Medicaid …

Male: I don't -- I think it would automatically get used of provider measure.

Female: Not by a Medicaid agency. Medicaid agencies don't usually go to the provider.

Male: You're always being held accountable for that and they're going to pull the provider …

(Crosstalk)

Female: Which is up to the state to decide if they want to then change the measure down to that level. But that's …

(Off-Mic)

Female: That's not the comparison group would be then. Because then you would have to come up with your own comparison within your state at the provider level.

Female: So those safety committee who endorsed this measure is endorsed as a health plan or population regional or state level of analysis and it can be stratified by negative commercial Medicare.

Female: I appreciate the rest involved, you know, and endorsing it but I also think that there are risks involved in putting forth..

(Off-Mic)

Female: … academic and not something to look at prescription drug …

(Off-Mic)

Female: So if I could weigh in so after hearing these discussions, I would be comfortable with this measure being an option for state for a couple of reasons, an option for state and the state is the one that's going to set the target benchmark, right?

And you're only going to set that target benchmark for your MCOs based on what you know about the percent of the prescribers that are going to need to receive this, right?

Female: Essentially.

Female: So you're not going to set -- during the set of benchmark that is logical within the MCO business that you have. If you -- a lot of this may not even have that population that's going to need that within their own fields, right?

And so for that particular state, it might be pretty easy to adapt a very strict and a very high benchmark. So after hearing the debate, I would be comfortable as a state choosing this measure.

Female: For example, like in Maryland, we've created such …

(Off-Mic)

Female: ..opioid measures we created like six of our own and they're looking at different aspects of this. But really very clearly defined for the MCOs which ones are simply for our knowledge as you -- if the number going up or down, not an expectation because we -- there is no clinical basis for what percentage should be at 90 or less and what percentage shouldn't be and if you're high already, should you go down.

But then we -- others were expecting someone to go down. So like we're hoping that the number of patients on opioid and benzo combination will go down if those are not being (used) together and that our providers hopefully (exhaust) that FDA black box warning with that and look, you're awesome.

Male: Well, I think that's an example of where quality metric could really make a difference where it's so clear that people should not be on high dose of opioids and benzos. I mean, that's where blunt quality metric can work.

But to use a blunt quality metric to force people, you know, (taking) all care that has so many nuances and subtleties and to say, you're over 120, bad quality, I just think that's the wrong way to go.

Female: All right. OK. Are we -- is there any …

(Off-Mic)

Female: Revote -- we want to -- yes. We want to revote on 74.

(Off-Mic)

Female: This discussion is to revote on -- yes, yes.

(Crosstalk)

Female: Yes. OK. OK. So to what extent this measure address critical quality objectives of CMS quality measurement domain? All those voting high? Four voting high. All those voting medium? Voting low? We have one voting low.

OK. Next, to what extent this addresses an opportunity for improvement in the significant variation of care for each program area? All those voting high? Voting -- we have one voting high. All voting medium? There's three voting medium. And all voting low? We have one voting low.

OK. Next. To what extent does this measure demonstrate efficient use of measurement resources, data collection, you know, not duplicative of existing measures within the measure steps? OK. All those voting high? OK. We have five voting high.

OK. To what extent is it ready for immediate use?

Female: I should remind that the measure is NQF endorsement.

(Off-Mic)

Female: OK. All right. All those voting high? We have four. All those voting medium? We have one.

To what extent this measure is important to state Medicaid agency and other stakeholders? All those voting high? We have four voting high? All those voting medium? We have one voting medium.

(Tara): OK.

Female: We have recommendation.

(Tara): The measure is recommended to the coordinating committee.

Female: OK. I'm glad you change up for this.

Female: Thanks for helping.

(Crosstalk)

Female: But it also raises the question of unintended consequences and what could that measure be used for and …

(Off-Mic)

Female: Yes.

(Off-Mic)

Female: How many providers will …

(Off-Mic)

Female: Yes. And identified providers who are legitimate …

(Off-Mic)

Female: Yes.

Female: And I think that point that (Richard) really bring here during the report I think that we should take every opportunity to make sure that is reflective …

(Off-Mic)

Female: Yes. And it's a population measure, not a provider …

Female: It is a population measure …

(Off-Mic)

Female: Not a provider.

Female: Not a provider measure. That is a good way to say that.

Female: Yes. It should. It's a population …

(Off-Mic)

Female: It's critical.

Female: Yes. It is.

(Off-Mic)

Female: Yes. Well, that's -- it's important. Yes.

(Off-Mic)

Female: This is not …

(Off-Mic)

Female: And could you even use the word dangerous that it would be …

(Crosstalk)

Female: … potentially dangerous or unintended consequences.

Female: Yes.

(Off-Mic)

Female: That's specialty?

(Off-Mic)

Female: … general population …

(Off-Mic)

Female: … hospital care should be effective …

(Off-Mic)

Female: You know, we have big problem.

(Off-Mic)

Female: OK. I'll send on requirements.

(Crosstalk)

(Tara): Is this for the transcript purposes, we're doing our best to take this down but we rely on the transcript to get some of these nuances.

Female: No but I think, you know, it's making sure -- I think the discussion was worrying about unintended consequences and making sure really it does not get used for -- to assess quality of what providers are doing.

(Tara): Yes.

Female: At an individual provider level.

Female: Just to -- and on that note, you know, we're going to make a recommendation and it's going to go forward for that. Ultimately, at the end of the day, it's the date, it's …

Female: What they want to do.

Female: What they want to do. So variation is a big issue. So unfortunately it might be but it's just not something this committee asked this group.

(Off-Mic)

Female: Right. You hope that they're reasonable about it. OK. So 25 is looking for the …

(Off-Mic)

Female: 75, yes, these are the guys who are getting formal subscribers, formal quality.

(Tara): And I just wanted to add something quickly. I'm sorry that there's seems to be a gap in the information here but this is an interactive measure so we have all these basic data points including the data source or I'm sorry, including the level of announcement in care setting which are marked unsure.

The level of announcement for this measure is the health plan and other -- and population region and state and the care setting is pharmacy or other.

Female: OK. So this is -- looking at the multiple subscriber.

Female: This is really looking as to how your providers are using the (TD1P) and not prescribing if they're saying …

(Off-Mic)

Female: I'm sorry. Right. This is really looking for products who are drug-seeking -- who are (either) drug-seeking behaviors. So as a quality measure, all it really tell you is are your providers providing the patients words on drug-seeking behaviors, which if they're using the PDMP, they should have seen this for themselves, but it doesn't directly assess for they not really use the PDMP. It's just looking in and to see how many patients are (showing) drug-seeking behaviors.

Male: I'm totally comfortable with this. I mean, I think this is pretty clear that this is bad care.

Female: Yes. And that's why I do -- you're …

(Off-Mic)

Female: … drug-seeking behavior whey they got distributed.

Male: Is that care a bad pitch?

Female: It's a bad patient who didn't get identified because you didn't look and identify them.

Male: And you're still prescribing …

Female: And somebody still -- somebody was that board prescriber and that …

(Off-Mic)

Female: And why did the patient get it now. The question is …

Female: And maybe bad picture.

Female: Now, I do have a question, how -- what prescribers in formal conversation and what timeframe? In a year? In a 30 days? In a 90? What's the timeframe here? So that makes a big difference.

Because if you went to four pharmacies in a year, I'm not really worried about you. If you went to four pharmacies in a month, that's whole different story.

(Off-Mic)

Female: Four prescribers in a year versus four prescribers and that say -- that's a big difference and I can't help him this.

Female: Yes. The denominator …

Female: There was a numerator. Like the timeframe -- OK. It's -- I'm sure they have this. They have to define in order to make -- get a number but I don't what was to find out.

Female: Yes.

Female: But we can profile the report to see if it would discuss this …

(Off-Mic)

Female: … process.

Female: Yes.

(Off-Mic)

(Tara): So for the numerator, it's the measurement year.

Female: The measurement year?

(Tara): Yes.

Female: In a year.

(Tara): Yes.

Female: So year? OK.

(Off-Mic)

Female: Yes.

Male: Yes. I agree.

(Off-Mic)

Female: It would be really clear.

(Crosstalk)

Female: Any. Any.

(Off-Mic)

Female: Yes. This is just a surprise more than 16 days.

(Off-Mic)

Male: Well, I'm more comfortably using this on a per provider basis. I mean, provider is just -- they have very few patients like this than many. The exception is maybe if somebody's move a lot but otherwise they shouldn't have patients like this.

Female: Yes. Sure. We should …

(Off-Mic)

Female: … possible if that is happening. Yes.

(Off-Mic)

Female: No. Not a good level. It's impossible to know how long is this.

Female: Or many people are …

(Off-Mic)

Female: How many of your prescribers are likely doing their appropriate PDMP check to identify these patients.

Male: And if the patient is moving a lot, it is so that they can get …

(Off-Mic)

Female: Right. Again, four pharmacies in a year is horrible but it is being able to explain for (prescriber) and for pharmacies should be (upon the location where it's a legitimate -- both). It's certainly possible to have both. But with -- for legitimate reasons but it shouldn't be a large number.

Female: Are we ready? OK. So to what extent is it just critical quality objectives? All those voting high? We have four out of five. All those voting medium? One.

OK. To what extent it is just an opportunity for improvement and it's significant variation care? All those voting high? Three. All of those voting medium? We have two for the meeting.

To what extent does it measure efficient use of measurement resources or contribute to alignment of measures across the program plan and (safety)? All those voting high? We have five voting high.

Excuse me, to what extent it is ready for immediate use? All those voting high? Yes. Five out of five. And to what extent it is important to Medicaid agencies and other key stakeholders? All those voting high? We have five out of five.

(Tara): OK. Measure 75 is recommended to the questioning committee.

Female: Next.

(Tara): Next stop, we have Measure 60, Substance Use Screening and Intervention Composite.

Female: Just a comment. Could -- any of the two that we just voted on, could those also be safety? Because we don't have anything in the patient safety domain either so that might be something …

(Off-Mic)

Female: Safety. Yes.

Male: Yes.

Female: Yes. You know, we're trying to make sure we're covering all of our six domains so this could also getting to this patient safety domain.

Female: That's really interesting.

Female: Part 1, isn't it?

Female: Yes.

Female: Awesome.

(Tara): And so I would like to move this measure patient safety.

Female: Yes, 75.

(Tara): Number 75. Thank you.

Male: Did we do item 60 yesterday? It sounds look familiar.

(Crosstalk)

(Tara): Yes.

Male: So what was the issue in measure like this yesterday? I'm curious what the difference be.

(Off-Mic)

Female: So that was the one yesterday, outpatient? Let's go to outpatient.

Female: I thought we gave one that was outpatient.

Female: Yes. I know. I thought it's screening and intervention. Maybe this has everything. This has alcohol, prescription drug.

(Off-Mic)

Female: Right.

(Off-Mic)

Female: Yes. This is full (SBIRT).

(Off-Mic)

Female: Right.

Female: Did we approve the screening only?

(Off-Mic)

Female: Yes.

(Crosstalk)

Female: And this should include under 18 …

(Off-Mic)

Female: We have the one before that.

Female: Right. So that's again …

(Off-Mic)

(Tara): So actually, looking into this, I think this is an error. We're just checking the NQF numbers are the same. So we're pretty sure this is the same measure that we did review.

(Off-Mic)

(Tara): Because it is a standard.

Female: And we recommended it.

Female: Yes.

(Tara): Yes.

(Crosstalk)

Female: This is really familiar. OK.

(Tara): Yes.

Female: But we still like it.

(Off-Mic)

Female: I guess a couple of people …

(Off-Mic)

Female: … a couple of times.

Female: Five across, five times across.

Female: OK.

(Crosstalk)

(Tara): OK. OK. Moving on. That was (an easy one).

(Off-Mic)

(Tara): Yes. OK. Number 55 is the next measure, Substance Abuse Education and Primary Care.

Female: This is 55?

(Tara): Yes, number 55, substance abuse education and primary care.

Female: This is on survey. What's not surveyed?

(Off-Mic)

Female: So this is done on separate survey.

Female: Who responded to a survey?

Male: This is not …

(Off-Mic)

Male: … for quite a while so this is the concept. Nobody can actually …

(Off-Mic)

Male: And I don't think we would expect primary care clinicians to educate all patients about alcohol and drug issues if patients don't have those issues.

Female: So have you given a survey if you're …

(Off-Mic)

Female: And we don't know the time period either.

Female: You don't know the time period?

(Off-Mic)

Female: Yes. Yes. This is promising.

(Off-Mic)

Female: And your constant keyword is prevention activities for opioid prescribing processes which -- now that does fit either.

(Off-Mic)

Female: OK. So …

(Off-Mic)

Female: So do we want to -- we can vote. OK. Are we ready to vote? OK. To what extent this does address critical quality objectives of the CMS quality measurement domain? All those voting high? All those voting medium? All those voting low? We weren't clear of this one. OK.

(Tara): OK. So Measure 55 does not move forward. It's not recommended to the coordinating committee.

Next, number 58, Substance Abuse Disorders: Percentage of Patients Aged 18 Years and Older with the Diagnosis of Current Alcohol Dependence who are Counseled Regarding Psychosocial and Pharmacological Treatment Options for Alcohol Dependence within the 12-month Reporting Period.

Female: OK. This is …

Female: How is this captured? Just clinic record like EHR only I guess.

(Crosstalk)

Male: Yes. EHR records.

Female: What it does mean with this NQF staff note alternative measure identifier? Is that say -- does that indicate that it's …

Female: There must have been …

Female: … endorsed first to the source set this is found out. It's not -- it did not refer to an NQF number I think.

Female: OK.

Female: But this is the number that was given at (certain levels).

Female: OK. One -- how would this get captured if the patient is going into things like alcohol, you know, for their psychosocial?

Male: Well, it doesn't require -- describing but it requires to be educating patients which I think is really important …

Female: Right.

Male: … in the documentation with addiction for alcohol dependence or so under prescribed and never even offered to most patients.

(Off-Mic)

Male: Which measure you say?

Male: This exam has a measure about the use of FDA approved medications for alcohol use disorder …

(Off-Mic)

Female: That's the one that …

(Off-Mic)

Female: ..to measure more substance.

Male: OK. Got it.

Female: Yes.

Female: Well, definitely, that one is -- isn't that one -- it's the (pulls that) medication, right?

Male: Yes.

Female: So -- but not everybody …

(Crosstalk)

Female: Psychosocial.

Female: So this is -- this around patients who don't want medication but just want psychosocial activity who receives at least education -- I guess …

(Off-Mic)

Female: … you can't capture the psychosocial intervention based on what often happens in the community. So you can only capture the fact that you refer them to it.

Female: Right. Right.

Female: This has a lot of medication. You're going to get from a …

Male: No. But you could from your Medicaid encounter data.

Female: Only if it was done through Medicaid. So like …

Male: Why we're talking about Medicaid?

Female: No. I mean, only if the patient got a psychosocial …

Male: That's correct.

Female: Through a Medicaid therapy. They might very well go to a treatment center that's not Medicaid -- that doesn't bill. There's not a lot of …

(Crosstalk)

Male: … how well they cover treatment for alcohol abuse disorders.

Female: Right. This is, you know, the providers, we tell them a lot of different options which is …

(Off-Mic)

Female: Yes. I don't have …

(Off-Mic)

Female: Right. There's different -- it's different.

(Off-Mic)

Female: I mean, whether they are counseled about it, it's not helpful but I've seen …

(Off-Mic)

Female: It sounds unclear. Where -- how they're determining that denominator? Where they're getting this? It's just assuming that …

(Off-Mic)

Female: Right. Right. But …

(Off-Mic)

Female: Yes. How they're making that diagnosis?

Male: Well, that's the depth discussion but it needs to be systematic reading the assessment.

Female: Yes. Yes.

Male: So that the denominator is sound.

Female: OK. So excluding that you've identified extensive …

(Off-Mic)

Female: Right. Right.

(Off-Mic)

Female: Then counseled, right.

(Off-Mic)

Female: Right. Right.

(Off-Mic)

Female: It's going to be out of memo. If you would like to address this you should have done that.

Female: Hopefully at the same time not 12 months later.

(Crosstalk)

Female: We're still within the 12-month period though.

Female: Does anybody have any trouble with that denominator identifying it or you feel like why should I identify it, that's really what we're looking at. OK.

Male: I don't see what other denominator there could be really.

Female: No. I mean, in stores, I, you know, what do they -- how are they saying we would identify them.

Female: OK. OK.

(John Munch): And good morning. Just to let you know. This is (John Munch) calling in at (Dennis McCarthy's) invitation.

Male: OK. Thank you, (John).

Female: OK.

Female: All right. So let's …

(Off-Mic)

(Rick Brown): Hi, (John). (Rick Brown) here. How are you doing?

(John Munch): Fairly fine. Good morning.

(Rick Brown): So, (John), the -- we're looking at measures. One of the measures we're looking at is how are we going to calculate screening and brief intervention rates and I have not been able to articulate clearly because it's complicated.

(John Munch): Yes.

(Rick Brown): Do you have a better understanding?

(John Munch): Well, I probably have a better understanding in you. I -- it is -- it's a long winding road and it is complicated. I think it probably -- I'm going to guess to meet some of the staff certainly around, you know, our SBIRT since the projects began about 2009.

I think around '12, '13, the Oregon Health Authority began investigating SBIRT as one of the incentive metrics and instituted a metric I'm going to guess in '13 that included SBIRT, alcohol and drug screening as -- for adults that included -- it was measured by the billing codes.

And the billing codes were 99420 for having a screening then done and then 99408 for 15 and up brief intervention, 99409 for a 30-minute and up brief intervention. And that's a fairly arbitrary cutoff as I think 13 percent for someone having then screened as the metric and then a -- and it got very complicated because we had to decide what it meant to be screened.

And what that eventually meant was they use as a main process, a two-step SBIRT screen which was a brief screen, one or three-question alcohol screen, one question drug screen and those would lead into the audit or the desk and that was kind of the accepted method as a clinic workflow.

If she completed -- if a patient completed the audit or the desk or both, they're all given credit for having been screened and to be able to use a 99420, it's a somewhat vague CPT code.

Once that was -- is that CPT code or ICD-9, I'm forgetting now. That's a CPT code and it needed to be tied to alcohol screen or drug screen as an ICD-9

code. So that was instituted in -- what -- the result of that was it was -- that most of the clinics that were all involved in Medicaid in Oregon started doing screening and brief intervention.

How faithful to the process that was -- it's really -- it's not completely clear but that was the -- so the numerator for those were anyone who dropped any of those three codes. But almost always that was in 99420 screening code, the denominator was all adults who came to the clinic in that calendar year..

(Crosstalk)

(Rick Brown): This metric had nothing to do with intervention then. Is that correct?

(John Munch): Intervention was not included because it was too complicated to figure out what that meant. Yes.

(Rick Brown): (John), I believe you're wrong.

(John Munch): Well, now let me clarify it. You also get credit if you did a brief intervention. But as far as the metric goes, you weren't counting specifically brief intervention. They were …

(Rick Brown): Correct.

(John Munch): They were counting whether or not. But if you did a brief intervention, you essentially did the screening. So I know with the …

(Crosstalk)

(Rick Brown): And, (John), I think that the metrics, the 13 percent is based on screened and received the brief intervention.

(John Munch): I disagree with it. There would -- they would -- not nearly that many people would get brief intervention. I mean, it's 13 percent of all people who are screened and we're having a hard time meeting them and screen with an audit or desk.

And we -- you assumed that around 20 percent to 25 percent of primary care patients should probably be positive on a brief screen, should, you know, that's a very ballpark figure and so they're all going to held the authority to say that you have that number and just started at 13 percent for getting an audit or a desk as part of a brief screen.

But I'm pretty sure that brief intervention wasn't specifically counted in that metric and I can send you the -- I have to sign it but counting document has, well …

Male: I've -- we'd look at the SBIRT or on web pages.

(Rick Brown): OK, (John). I think we reinforced the fact that this is complicated. It's poorly articulated and before we move this measure forward, it needs a little bit more …

(John Munch): Yes. I'm going to throw in there real quick because this is probably -- the most important is that they -- the biggest downfall with this was using billing codes as the metric and they realized that now.

They've dropped SBIRT as a metric in 2017 and are going to revamp that are in discussion right now to change the metric to be based on EHR counting as opposed to billing counting for 2018. And so if there's any lesson that we learned from all this, you don't use billing codes.

(Rick Brown): Yes. I'd suggest that we should not move this metric forward.

(John Munch): OK.

(Rick Brown): OK. Thanks, (John). I appreciate the help.

Female: Thank you.

(John Munch): You bet. Bye-bye.

Female: Yes. Great plan. I don't know if we finished our discussion on this but then we can go back to that.

Female: Yes.

(Tara): Just to remind everyone, we're on Measure 58.

Female: OK. Are people ready to vote? OK. So to what extent this has addressed critical quality objectives measurement domains? Those voting high? Those -- we have one voting high. Those voting medium? We have four voting medium.

OK. To what extent this addressed an opportunity for improvement or significant variation care? Those voting high? Those voting medium? We have one voting high, four voting medium.

Male: One low.

Female: I'm sorry. And one voting low. OK. Three high -- one high, three medium, one low. OK.

To what extent does this demonstrate efficient use of measurement resources to contribute to alignment of measures across programs and not duplicative of exiting measures? OK. Those voting high? Those voting medium? I think we have four voting -- five voting medium.

Male: Five.

Female: And to what extent this is measure ready for immediate use? OK. Those voting high? Those voting medium? We have two we got here.

Male: So people know …

(Off-Mic)

Male: … to measure a content.

Female: Right. OK.

(Off-Mic)

Female: OK. So it's going to be low, there's no evidence of testing. OK. OK. So who's voting high on that? Who's voting medium on this? And who's voting low? We have five people voting low. OK.

To what extent do you think it's important to Medicaid agencies and other key stakeholders? Those voting high? We have two voting high. Those voting medium? We have three voting medium.

(Tara): OK. Measure 58 is recommended. We can now jump over to ..

(Off-Mic)

(Tara): … as initial concept. Yes.

Female: Yes.

(Tara): OK.

(Off-Mic)

Female: So we're going to jump back to the …

(Tara): We can jump back to SBIRT measure which I believe is number 12. Would it be helpful to bring up this slide we discussed earlier for everybody?

Female: That would be helpful.

(Tara): Yes. Sure. Let's see on the deck.

Female: OK. All right. So, (Dennis), is your sense that …

(Dennis McCarthy): I think we have one store that struggled with it. We've watched providers struggled with it. We've watched the Oregon Health Authority struggled with it. We saw that (John) and I have different interpretations of it I think and the order we are changing it …

(Off-Mic)

Female: Yes. It's also measure constitute point, right?

Female: Yes.

Female: OK. Had we -- where were we with our voting?

(Tara): We never took any …

(Crosstalk)

Female: OK. All right. OK. So are people ready to vote? OK. OK. So to what extent this does address critical quality objectives of CMS quality measurement domain? Those voting high? We have four voting high. Those voting medium? Those voting low. We have one person voting low.

Female: Not clear that the measure itself is (graded).

(Off-Mic)

Female: OK. Yes.

(Crosstalk)

Female: OK. So to what extent does this address an opportunity for improvement and/or significant variation? So those voting high? We've got one vote for high. Those voting medium? We have four voting medium.

(Off-Mic)

Female: Yes. Sure.

(Off-Mic)

Female: Yes. Number one.

Female: Yes.

(Off-Mic)

Female: To what extent does it demonstrate efficient use of measurement resources and contribute to alignment of measures across program health plan, not duplicative? OK. Those voting high? Those voting medium? And those voting low? Yes, which we don't have measures of it. OK. So that means it's out, is that right? OK.

(Tara): So the measures failed on its use of resources. We can now move to our next measure which is …

(Off-Mic)

(Tara): It's 59, right? Number 59.

Female: 59?

(Tara): Yes. Substance Use Disorders: Percentage of Patients Aged 18 years and older with the Diagnosis of Current Substance Abuse or Dependence who are Screened for Depression within 12 month Reporting Period -- within the 12-month Reporting Period.

Male: So it's like, this is (Mendes), a general outpatient measure. It's too bad it's not also meant for alcohol and drug treatment.

(Off-Mic)

Female: Just any substance abuse dependent screened in clinician office clinic, physician practice.

Female: It doesn't include the …

(Off-Mic)

Male: I think overall, this is important. There's under recognition of dual diagnosis. I mean, this is really going to be standard practice.

Female: Yes. You hope that they're doing one and they're doing the other.

Female: Right.

Female: Right. Right. OK.

Female: It's also a key that patient who has a dual diagnosis …

(Off-Mic)

Female: … that often they're often self-medicated …

(Off-Mic)

Female: … problem for that.

Female: Now we see them in teenagers, too. So it would be nice if this were …

Male: Where alcohol and drug abuse (related) to depression.

Female: Right. Yes.

Female: OK. Any discussion, further discussion? OK.

Male: I guess just when we get down the list of depressions a little bit, I'm trying to figure out how -- where …

(Off-Mic)

Female: Yes. We're going to see it's the APA, NCQA Physician Consortium for Performance Improvement.

Male: Well, I guess this -- so it's -- there's a steward assigned so does that mean it was submitted to NQF but NQF is not …

(Crosstalk)

Male: So if NCQA was the steward, does that mean they have done validity testing?

Female: Yes. We have …

(Off-Mic)

Male: So it's a (mystery).

Female: The fact that it's in the current health, I don't think it's clear to me. I don't -- I mean, it could be something that they funded that we don't …

Female: Yes. Things going to the (IPLAN) has to -- not necessarily tested and valid.

Female: So it's just not clear.

Female: So we don't know if there's many testing on this as well so we have to examine …

(Off-Mic)

Female: There isn't. Right.

Female: OK. So to what extent this has addressed critical quality objectives of our measurement domain? Those voting high? OK. We have five voting high.

All right. To what extent this has addressed an opportunity for improvement? Those voting high? OK. We have five voting high.

To what extent this does demonstrate efficient use of measurement resources or contribute to alignment about -- of measures across program? So this is great for aligning across primary care training and substance use disorder treatment and all that -- resource slide depending on how our state reimburses or allow selling toward depression screening.

It will require chart review for most places unless you pay independently for your depression screening when you can tell it was depression screening. So if you're OK for a combination screening like SBIRT and depression as one, you will really use it, you (talk to the chart).

Female: Yes.

(Crosstalk)

Female: PHQ-9.

Female: Right.

Female: Unless PHQ-9, you pick up at least four which …

(Off-Mic)

Female: … but not everybody does when -- so it will require chart and you list it. They listed all sources and then straight claiming paper records so it's -- OK.

Female: So who votes high on this one? Demonstrating efficient use. We have two. OK. Who votes medium on this? We have three voting medium. OK.

To what extent is it ready for immediate use? OK. Those voting high? Those voting medium? Those voting low which is don't know. We have five voting low on that one. OK.

So to what extent you think it's important to state Medicaid agencies? Those voting high? I think we have five voting high. So that's because the measurement concepts.

(Tara): Correct. Yes. The measure is recommended to move forward as a measurement concept.

Female: OK.

(Tara): OK. Our next measure is number 36, Percentage of Patients Prescribed a Medication for Opioid Use Disorder.

(Crosstalk)

(Tara): Thank you for reminding me.

(Crosstalk)

Female: OK. OK.

(Tara): Yes. We'll need a rationale with everyone to kind of speak to why …

(Off-Mic)

Male: Yes.

(Off-Mic)

Female: OK.

Male: So it measures an important piece of evidence-based practice. It's been tested with both DA data and tested with Medicaid data and folks with (brands I) have tested with commercial data. So I think it's a much stronger item than you scored it, that NQF scored it as and I think it's essential for 21st century medical care.

(Off-Mic)

Male: Yes.

Female: Analytic (SBIRT) here …

(Off-Mic)

Female: Would you think because it's a low -- because some of this stuff was unsure?

Female: Yes. It's deemed -- if we were not able to find regions.

Female: OK. All right.

Female: This would be one of the highest and important for most Medicaid agencies.

Female: Would be the highest and …

Female: And important for most Medicaid agencies. If someone be able to review, this would be the one that my secretary of health would want to protect above all others we looked at.

Male: If they're really paying for it.

(Crosstalk)

Female: But of all, this is -- because of the abuses causing so many problems and getting patients into treatment, it's such a priority of all the things we've

looked at with -- around substance use disorder. This should be the one that if we needed to chart reviews, we would pay for for the chart review. We want paper for some of them but this we would.

Female: Yes and 50 -- 100 percent of state Medicaid agencies are not covering …

(Off-Mic)

Female: Yes.

(Off-Mic)

Female: True.

Female: That's why we're going through all 250 plus managed care plans.

Female: Yes.

Female: So it is a max …

(Off-Mic)

Female: A big part of this is figuring out how are we getting this patient for treatment.

Female: Right.

Female: And this is the first measure that really looked at …

(Off-Mic)

Female: So this is access as well as plan of care.

Female: Right.

Female: Yes.

(Off-Mic)

Female: Yes. And actually it maybe better suited there.

Female: Yes.

Female: For clinical care because you can't -- you have to …

(Crosstalk)

Female: Yes.

(Tara): OK. So we will move this measure at the accept domain.

Female: Yes.

(Tara): OK.

Female: All right.

(Off-Mic)

Female: Yes. Yes. I think we can have a vote.

Female: Yes.

Female: OK. So to what extent does this address critical quality objectives? Those voting high? We have five voting high.

To what extent does it measure an opportunity for improvement it? Those voting high? We have five voting high.

To what extent does it measure -- demonstrate efficient use of measurement resources? Those voting high? We have five voting high.

(Off-Mic)

Female: Yes.

Female: High five.

(Off-Mic)

Female: To what extent is it ready for immediate use? Those voting -- we've got five.

(Crosstalk)

Female: We've got five voting high. OK. All right. How do you think -- how important you think it is to state Medicaid agencies? OK. Those voting high?

(Off-Mic)

Female: Yes. We've got -- I think this is a sweep. Enthusiastic high. OK.

(Off-Mic)

Female: All right. Good. OK. We move that one forward. OK. Our next one.

(Tara): Next we have Measure 42, Presence of Screening for Psychiatric Disorder. (Sheryl), this is one that you opted to attain.

(Sheryl): Yes.

(Tara): By rationale.

(Sheryl): I just thought this was important because we have so many issues related to another one that we talked about. The depression, we have so many people -- co-morbidity is so important that patients need to be in addition treatment.

They need to also have some diagnosis to make sure there isn't a co-morbid psychiatric condition because I think just in my world, you know, with young people it really increases difficulties with (childhood) treatment, with adherence to treatment, you know, other medical problems. So that's where we're coming from with this.

Male: Can I ask you about the numerator? What does formally assessed mean that they have to see a mental health professional or could they fill out mental health diagnostic questionnaires?

(Sheryl): That's -- I didn't know what the numerator on this, how …

(Crosstalk)

Male: Do you have more information on this?

(Sheryl): OK.

(Off-Mic)

(Sheryl): Yes. I mean, I have my ideas what it should be but we're -- it's not all clear so.

(Off-Mic)

Male: … if that's the language the NQF laid out, it does not -- in summary, it does not articulate how they are stuffed.

Female: OK.

Female: Yes. Yes. So it could be a problem. It could be …

Male: It seems like it's a good measurement concept for further discussion.

Female: Right. Right. Yes. And I think …

Female: And it's like if someone that actually measures just, I mean …

(Off-Mic)

Male: We don't have that …

(Off-Mic)

Male: … measures but not to my knowledge that it's going to publish. So I think we don't know how they …

(Off-Mic)

Female: OK.

Male: That's why we're going …

(Off-Mic)

Male: … the technical stuff of how …

(Off-Mic)

Female: OK. So level of analysis and care setting is also not -- I mean, you're assuming it's -- somebody in addiction treatment centers …

(Off-Mic)

Female: … the setting, right, as using addiction treatment.

Male: So mostly primary care also because …

Female: Right. It could also -- yes, they could also …

(Crosstalk)

Male: Yes. There is not measures for the …

(Off-Mic)

Male: … and specialty practitioner.

Female: Right. Right.

Male: But there's no reason to have much broader application that they were looking at that you are members and people could …

(Off-Mic)

Female: Sure. OK.

Male: By the practitioner.

Female: OK.

Female: OK. Are we ready to vote? All right. So to what extent does this address critical quality objectives of quality measurement domains? OK. I think we have five saying high.

To what extent it address an opportunity to improvement? All voting high? I think we have four voting high. Medium? One voting medium.

To what extent does it demonstrate efficient use of measurement resources? What was that?

(Off-Mic)

Female: Yes. Yes.

Male: Including how it's measured.

Female: Right.

Female: Right. So those voting high? Those voting medium?

(Off-Mic)

Female: Yes.

(Off-Mic)

Female: OK. I'm going to vote medium. OK. OK. We've got five people with medium.

(Crosstalk)

Female: OK. So to what extent is it ready for immediate use? We -- OK. Anybody voting high on this one? Anybody voting medium? Who's voting low? We're all voting low on this one, five for low.

OK. So to what extent do you think it's important to state Medicaid agencies and other key stakeholders? Those voting high? Those -- we have four for high. Those voting medium
?

(Crosstalk)

Female: OK. We got five voting high. OK. So we move to concept.

(Tara): So the measure will be recommended as a concept that is -- now I can say that we have changed any of the specification I know initially it was labeled as a measure but I think the TEP feels that the testing information is not sufficient to label as a useful measure.

Female: Yes.

(Tara): So we'll recommend it as a measure concept and change that designation.

Female: And, I mean, we need more clarity on how you're assessing that for ...

Female: That's psychiatric diagnosis.

Female: OK.

(Off-Mic)

Female: Yes. I think -- yes.

Female: OK. It should be done.

Female: Yes. Next.

(Tara): The next measure -- that is our -- no. We have one more in this domain and then we move to our final measure of efficient caregiver experience.

So our next measure is Measure 37, Percentage of Patients Prescribed a Medication for Alcohol Use Disorder. (Christina) and (Dennis) both acted to retain this measure so we need a rationale.

(Off-Mic)

(Dennis McCarthy): This is important. These patients are not getting this medication. That's the big issue here. Patients are not getting the medication. Their applications, they should be routinely offered. They're not being routinely offered and it's important to highlight that …

(Off-Mic)

Female: Yes. There's a significant opportunity for improvement here.

Male: And I guess like the other ones we don't know if they missed measures and tested them.

(Off-Mic)

Female: Do you have a sense of the numerator and denominator? Is that listed because that's not here.

(Dennis McCarthy): OK.

Female: It's the same for the one for opioid use.

Female: OK.

(Dennis McCarthy): The numerators included all FDA approved medications as well as off-label medication but there's not med analysis for off-label medications.

(Medical) providers would capture the number of prescriptions written for Medicaid to dispense and payers will capture the number of prescriptions filled that day.

Female: That's the numerator?

Female: Yes.

(Dennis McCarthy): They way I've been asking is population of people with alcohol use disorder diagnosis is the denominator.

Female: Denominator.

(Dennis McCarthy): And then the percent or the number with a medication dispense which we only get to (dispense information) is …

(Off-Mic)

Female: This is a little bit similar to the one we had with the psychosocial and the medication.

(Dennis McCarthy): Correct. Yes. But this -- that was patient …

(Off-Mic)

Female: For the Medicaid, for what's prescribed.

(Dennis McCarthy): Yes.

Female: Again, with this summary, we want to make sure it was …

(Off-Mic)

Female: … that it should be at the population provider as well because not every patient with alcohol use disorder will want a medication. Some percentage will (want) and they should be offered. But what percentage would say yes, we don't know.

(Crosstalk)

Female: We should be very clear …

(Off-Mic)

Female: … like the level with the population, not provider.

Male: I wish you're comfortable with this measure at the provider level because I think house providers educate patients, have a lot to do with whether patient should get the medication. And we know we would not expect the result can be 100 percent but it ought to be better for each provider whatever …

Male: This is a scenario where we need the development shared decision making aide because the practitioners often don't know what the options are. The patients don't know what the options are. The patients' family doesn't know what the options are. So there's quite a bit of work that needs to be done to be able to get this routinely used.

Male: I'm just concerned that patients with mild disorder I believe shouldn't really be on these medications.

Male: Why not get naltrexone just to reduce their drinking?

Male: I guess I'll replace that -- I don't think the effectiveness of these medications has been established as well for people with mild disorder and brief interventions won't be effective for any of those patients.

Male: Well, that's your opportunity as a clinician to see how it works with your patients.

Female: But that one thing when you made very clear that there should be a population concept, not a provider, why don't you have more patients who are …

(Off-Mic)

Female: … clearly not have people and when -- in the diagnosis about how disorder -- I don't know that ICD-10 has the levels of severity of, you know, severe alcohol use disorder, moderate alcohol use disorder, like how is that -- would that be defined.

And so that's not -- that's a subjective, not a call and that's the -- I don't think -- I think this is good but I think we want to make sure that it's population concept, not us like the other -- so just like the opioid use disorder treatment.

Female: Yes.

Female: It's a population concept.

Male: But for the moment, I'm comfortable with that that if I were looking at specialty drug and alcohol treatment program …

Female: Well, that's a different thing.

Male: Yes. I would want …

Female: Right. So that's a different …

(Crosstalk)

Male: And then you find with your care provider that scores between, you know, the score is zero, I mean, that would be a problem and that unfortunately most would.

(Off-Mic)

Male: The vast majority of primary care providers don't go near these medications.

Female: Right.

Male: And that's a big problem.

Female: Yes.

Female: Most they don't have the …

Female: But that's also important population information, I mean.

Female: Right.

Female: We found in a study that since 2000 there's actually been specific really significant draw in some of these medications. Yes. I mean, it was shocking.

(Off-Mic)

Female: So we looked at every which way and checked the coding and stratified it every possible way. So this is the problem.

Female: We don't think they're -- and we don't think they're …

(Crosstalk)

Female: But that's right, this is a significant problem and a very important concept measure. I don't know if …

Male: But, (Dennis), are you saying it has been tested and validated?

(Dennis McCarthy): This has been tested in the VA. They find variation, you know, from VA clinic to VA clinic. They're not -- they're looking at clinic level. It's been tested in the commercial health plans. I haven't seen that particular report and I'm testing it within the Oregon's data.
I'm not sure we're all articulating the measure the same way because there's technical specs, if not, it's been poorly articulated. But in my data I see that the use of medication among patients with an alcohol use disorder has increased from 3 percent since 2010 to 5 percent in 2015. So it's a long way to go.

Female: Yes. That's right.

Female: Is there …

(Off-Mic)

Female: … as a measure to offset the counseling and offering of it like the other measures we looked that that's the concept or do they get offered which would …

(Off-Mic)

Female: That one should get 100 percent.

(Off-Mic)

Female: With data, I'm talking about specialty substance abuse treatment. So there could be trend, you know, they have to pick up in, you know, broader enrollee data, you know, for other settings so …

(Off-Mic)

(Rick Brown): You know, the other comparison point we have is about -- across that time period, 20 percent of the patients received medication for tobacco cessation. So, you know, I would think that it should be similar.

Female: Right, (Rick). Yes. Yes.

Female: OK. Are we ready to vote on this? All right. So to what extent does this address critical quality objectives of our measurement domains? Those voting high? We have five voting high.

Does it address an opportunity for improvement? Those voting high? We hope so.

(Off-Mic)

Female: OK. To what extent does it demonstrate efficient use of measurement resources or contribute to alignment and the measure not being duplicative of existing measures?

(Off-Mic)

Female: Yes. I'm looking -- yes.

Female: I mean, I've done it with the max data but I …

(Off-Mic)

Female: Yes. Yes.

Female: Yes. So those voting high if it is efficient resources? OK. We have five voting high on that.

OK. To what extent is it ready for immediate use? Those voting high? OK. We've got one voting high. Those voting medium? We have four voting medium.

And to what extent do you think it's important to Medicaid agencies and other key stakeholders? Important, high? We've got five voting high.

(Tara): Great. Measure 37 move forward in the chart …

(Off-Mic)

(Tara): So before we move on to our next and final measure …

(Rick Brown): Can I interrupt you?

(Tara): Yes. Of course.

(Rick Brown): One point, the opioid measure, the opioid medication measure, it's also a safety measure because patients that don't get the medication are much more likely to die.

(Tara): So we have two -- you have two there. One of them was …

(Off-Mic)

Female: No. No. We added one that's safety already.

Male: OK.

Female: Right. That was the second one.

(Tara): Yes. We noted …

Female: So we've got two of them.

Female: Yes.

Female: Yes.

(Tara): Yes.

Female: Yes.

(Tara): We noted number 36 should be moved to access and (it's possibly) designated with both access in clinical care and …

(Off-Mic)

Female: We also had another one that was safety.

Female: Yes.

(Crosstalk)

Female: … additional one for safety.

(Off-Mic)

Female: Are you saying there's another one that should be safety then?

(Off-Mic)

Female: Right.

(Off-Mic)

Female: OK. OK.

(Off-Mic)

(Tara): OK. So Measure 74 will be marked as patient safety.

(Off-Mic)

(Tara): Yes. OK. Before we move on to our final measure, I just received word that all the other texts are very near in conclusion as well and we proposed moving up to general section to after lunch.

So rather than starting at 2:30, we'll start at 1:30. So what we finished now, that will be about -- lunch is at 1 o'clock so we've got 40 minutes to discuss the prioritization and gaps that I made a line specifically, is that sufficient?

Female: Yes.

(Tara): OK. Great. So I will let them know we will most likely be …

(Off-Mic)

Female: We just have that one in the next domain then?

(Tara): Yes. We have one measure left and then the rest of the time we can use this for more general conversation.

Female: Great. Let me just assume that we'll be getting that your own. What number is that last one, Tara?

(Tara): 104.

Female: 104?

(Tara): Yes. So our next and final measure is Measure 104. This is -- I'm sorry. So now that we have closed out the clinical care domain, we need to open it up for public comment.

So if anybody on the line would like to make a public comment at this time with regard to any of the measures and the clinical care domains, please speak now or enter your messages into the chat.

OK. No public comments. We can move on. So now we move in to our last domain which is patient and caregiver experience domain. We have one measure to review, Measure 104, Follow-up after Discharge in the Emergency Department from Mental Health for Alcohol or Other Drug Dependence.

Female: I'm not quite sure what this is patient experience.

Male: Yes. This is more care coordination.

(Tara): Yes. Yes.

Female: It didn't seem like it belongs to this domain.

(Tara): OK. We can definitely …

Female: Anybody else has a sense that we're saying where you think it's more care coordination to you?

Male: Yes.

Female: Yes.

Female: Yes,

Female: Yes.

Female: OK. So this is our denominator. So it's a treated discharge with the primary diagnosis of mental health or alcohol dependence. We've got 11 months for some reasons.

Male: So that there's time to protest for 30 days follow-up.

Female: OK. Got it. OK. Let me set it. And then the numerator is the percent of those who received follow-up in seven days or follow-up within the 30 days and the follow-up is with any provider.

Male: The denominator includes people with primary mental health diagnosis but the numerator doesn't mention mental health. I wonder if that's just an error or is there a problem with the metrics.

(Off-Mic)

Female: Yes.

Female: And there's also an exclusion that says if discharge is followed by readmission or direct transfer to an emergency department for principal diagnosis of mental health or alcohol or other drug dependence that in the 30-day follow-up period, it counts only their readmission discharge or discharge from the emergency department to which the patient was transferred.

And then these discharges, they're excluded from the measure of hospitalization or transfer may prevent an outpatient follow-up that this won't be taking place. And also discharges followed by admission or direct transfers in acute or non-acute facility within the 30-day follow-up period regardless of the primary diagnosis for the admission are also excluded.

Female: Those people who haven't been readmitted anywhere.

Female: Or patient has the different numerator than the …

(Off-Mic)

Female: Right.

Male: Yes. So this has an NQF number. So would it be possible just to check the numerator and see if the numerator includes follow-up for mental health disorders.

Female: Well, in the …

Male: The numerator shouldn't be a percentage. It should be a number.

Female: Right.

Female: And there's -- certainly, there's two different ranges for it?

Female: Yes. Seven days, within seven days and within 30 days.

(Off-Mic)

Female: There's -- I mean, you know, there's not -- that's really a clinical …

(Off-Mic)

Female: Any provider. Any provider.

Female: Any provider counts. Right. Would those actually reduce your -- does it reduce your readmission rate if you see any provider that …

(Off-Mic)

Female: … being seen after a discharge (with the issuance) of readmission rate which is where this is helpful, right?

Male: And it also stretches this is also an access issue.

Female: Right. An access to your primary care.

Female: Yes. Yes.

Female: With the information which is …

Female: Important.

Female: Important.

Male: Well, assuming …

Female: So it's just the percent who had a follow-up for …

Male: You know, assuming the numerator here includes mental health follow-up so people with mental health disorders, I think this is really important.

Female: Right.

Male: So people don't keep bouncing around in the systems and not getting care for their problem.

(Off-Mic)

Female: And it says that provide -- it's (submitted) with the provider with a corresponding primary diagnosis of mental health or alcohol. So you're going to see your provider for that -- with that diagnosis as opposed to something else.

Female: Right.

Female: OK. Right.

(Off-Mic)

Female: Right. Right.

Female: And hopefully that's what they're going for. OK.

Female: But we have to …

(Off-Mic)

Female: So for the numerator statement, there are two tests. And so for the mental health, rate one is an outpatient visit, intensive outpatient encounter or partial

hospitalization with any provider with a primary diagnosis of mental health within seven days after emergency department discharge.

And then rate two for mental health is, again, the same thing but for 30 days. An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 30 days after emergency department discharge.

And then the second part of the numerator is the alcohol or drug dependence which is again broken in two rates. Rate one is an outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within seven days after emergency department discharge.

Wave two, an outpatient visit, intensive outpatient encounter, or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependents within 30 days after emergency department discharge. So those are the official …

(Off-Mic)

(Tara): … numerator.

(Off-Mic)

Female: So this is -- we've reviewed one earlier that was (more referral for these), and this is like an actual visit using claims …

(Crosstalk)

Female: … yes, using claims there.

Female: When these go the coordinating committees, do they -- (Tara), when these go to the coordinating committee, like, will they get the more detailed version -- OK, so they'll know what we've approved?

(Off-Mic)

Female: And do we want to talk about whether we want to move the domain …

(Crosstalk)

Female: Yes, we think it's care coordination …

(Crosstalk)

Female: … and access …

(Crosstalk)

Female: There's a hand-off from ER …

(Crosstalk)

Female: But this is not access to outpatient inter-coordination from the ER to the outpatient.

(Off-Mic)

Female: This is great for health plans to -- they're the ones who should help the case managers making sure the …

(Off-Mic)

Female: This is actually an awesome measure to health plans to kind of go for.

OK, so ready to vote?

OK. You're not going to expect me to do this from memory …

(Off-Mic)

Female: The first criteria …

(Off-Mic)

Female: It goes live. Who goes high on the first one?

OK, all right.

Does it address critical quality objectives? All voting -- represent five for high. OK.

And just an opportunity for improvement? We've got five voting high.

Sufficient use of resources? OK, we've got five voting high.

Is it ready for immediate use? Yes. It sounds like it's got NQF. Voting high? We've got five, OK.

And …

(Off-Mic)

Female: Yes, and how important it is to state Medicaid agencies and other key stakeholders. Voting high? OK.

And that is it.

(Tara): OK. Measure one moved for recommended for the coordinating committee and we will update the …

(Crosstalk)

(Tara): … likely to (generate) that out.

Good job. I have to say, NQF team did not think we would be able to get through all of these. This is a nice surprise.

And that also means that we will most likely not need our call?

Female: What's their final tally of those three -- you do have that …

(Crosstalk)

(Tara): I have not tallied up the one from today. Let's do that really quickly.

(Off-Mic)

Female: Prioritizing them?

(Off-Mic)

Female: Well, you might say that you've got two that is similar, but this one is more …

(Off-Mic)

Female: Yes.

(Tara): Right. We won't be able to do like kind of formal rankings. But just so we can kind of consolidate our talking points, I have notes for (what we hand over) to the coordinating committee. You can kind of look at the measures grouped together, how you like …

(Off-Mic)

(Tara): Well, we might find that there are two or three, they're very similar, that we like to then looking at the three -- looking to them together to say, you know, this one is better than, you know …

Female: And you'll be there as well just so …

(Off-Mic)

(Tara): Yes. So getting some consensus from the group of people are helpful …

(Crosstalk)

(Off-Mic)

(Tara): So the final tally of measures is that 25 were recommended, and 21 …

(Off-Mic)

(Tara): There's nothing we know -- we've never done a project like this before with this kind of search. So I'm not sure how typical it is. Are you familiar with any kind of review like this?

Female: So we've eliminated 22?

(Tara): We've eliminated 20.

Male: But remember how many measures were there in our initial whole list, I mean, well over 100.

(Tara): 114.

(Crosstalk)

(Off-Mic)

Female: And with our redistribution, we've gotten into I think four, or probably four or six domains. We don't have anything in population.

Female: Maybe we do.

(Off-Mic)

Female: Yes, but maybe some of the ones that we say should be a population-based measure …

(Off-Mic)

(Tara): So one more formality, we need to open this up to public comment. If there are any members of the public on the phone who would like to make a comment, please speak now. You can also submit comments via the chat function on the web platform.

OK, no public comment. Well, continue.

(Crosstalk)

Female: Anonymous public comment …

(Off-Mic)

(Tara): So like I've said, we've recommended 25 measures. I think it would be helpful if I pulled all those titles together for us to review really quickly. So give me about three minutes to do that and then we can throw those slides up and continue …

(Crosstalk)

Female: … we can take a quick five-minute break …

(Tara): Exactly.

(Crosstalk)

(Tara): I don't know what the rules are, when it's not supposed to be until 1:00 o'clock, but we're in the room with the food, so I don't know what that means for the rule.

(BREAK)

(Off-Mic)

(Tara): Well?

(Off-Mic)

(Tara): I know, right?

(Off-Mic)

Female: Wow.

(Off-Mic)

Female: And they said it's going to take months?

(Off-Mic)

Female: And I think they said it's going to take months to fix that …

(Off-Mic)

Female: Well, then they found that more of it was damaged and just that section …

(Off-Mic)

Female: They've got problems, like last year, they had that snow storm …

(Crosstalk)

(Off-Mic)

Female: We closed for three days because of that because it's literally so little snow so we should see little people sticking up the ground like, the street, there was just no …

(Off-Mic)

Female: People were like, everything slows down. My daughter had a section in her eyelid, we couldn't go to the doctor or like …

(Crosstalk)

(Off-Mic)

Female: It's sideways down (I-95).

(Crosstalk)

Female: … but they stopped everything because it's kind of …

(Off-Mic)

Female: I can remember when I've moved in Maryland, my whole car would be in (Case 9). It's filled out there with water. And we're like, you can't do that. I'm like, I've got a half an inch of ice. If you think like two kettles of boiling

water is going to fracture my windshield? It's just going to make it down to like, a quarter of an inch of snow.

(Off-Mic)

(Crosstalk)

Female: Yes, it's funny building.

(Off-Mic)

Female: So I was like, they're everywhere. I went up there and they're just like, stored strategically …

(Off-Mic)

Female: So they're like at the edge of …

(Off-Mic)

Female: So (Road 33) through this, we have the equipment, and you just wait for it to actually dump …

(Off-Mic)

Female: So there were a couple of times when we first moved to Connecticut. I would drive to school and I get there with my son, and the school will be closed. And I'm like, did we miss something. It was maybe the boiler broke or something. And I'm like, what's the problem? And they looked at me, it's going to snow. And we come from Rochester where you know, 47 inches in 48 hours. We missed one school day. I was like, what do you mean it's going to snow. It's like, the ground was completely bare. And I think the snow, it's going to be a problem getting to home. And it took us a while to get used to. No forecast was …

(Crosstalk)

(Off-Mic)

Female: Oh, yes, in Rochester. If it was below zero.

(Off-Mic)

Female: No, because they're waiting at school bus …

(Off-Mic)

Female: Not freezing, zero.

Female: Well, it would be not wind chill, it would be negative …

(Off-Mic)

Female: Yes, and you're out there …

(Off-Mic)

Female: Yes, you know, keep their battery, their engine block, and move on.

(Off-Mic)

Female: … they're laughing and like, I hope you're ready for the cold.

Female: You've got summer down there.

Female: You got -- you just came from the summer. She just got in here. She just came from the summer in New Zealand and has like, not a lot of cold weather, and I was like, you're going to one of the coldest parts of the country …

(Off-Mic)

Female: Interestingly strategic though, isn't it?

(Off-Mic)

Female: It's called reengineering.

(Off-Mic)

Female: Yes.

(Off-Mic)

Female: In the hospital.

Female: Yes.

(Off-Mic)

Female: Wow, that's a big family medicine. OK.

(Off-Mic)

Female: Wow. That's really big. We don't even have it at Yale.

(Off-Mic)

Female: Our university state government relations going into …

(Off-Mic)

Female: That's right. Take that, (Yale), you know …

(Off-Mic)

Female: I think that's one of the reasons that (Pat) moved to retire. She had an option and I think it was -- that was involved because she was at the Dean's Office and there's not much support.

(Crosstalk)

(Off-Mic)

Female: Can you run it down?

Female: Yes, yes.

(Crosstalk)

(Off-Mic)

Female: Yes, I was embarrassed to say …

(Off-Mic)

(Crosstalk)

(Tara): OK, I think we're ready.

(Off-Mic)

(Crosstalk)

(Off-Mic)

Female: We can definitely bring that up.

(Off-Mic)

(Tara): Yes, you're right. What number was that?

(Off-Mic)

Female: Well, just document the patient.

(Off-Mic)

Female: … just to do all of the three …

(Off-Mic)

Female: They keep adding more stuff in it.

(Off-Mic)

Female: Right, right.

(Off-Mic)

Female: And the person is not going to see if any tags finished that record except at night.

Female: Right …

(Off-Mic)

(Tara): I'll go back on the mic.

So (Christina) brought up a good point, which is that we've moved measure 36, presented patient's prescribed and medication for opioid use to (sorters) to both access in clinical care. But the similar measure that looks at alcohol dependence have not given that same designation. So with that consensus, we can treat that measure similarly.

(Off-Mic)

Female: So I have to run everyone …

(Crosstalk)

Female: Nice meeting you and working with you …

(Crosstalk)

Female: … thank you for your presentation and …

(Crosstalk)

Female: Bye.

Female: Thank you.

(Off-Mic)

(Tara): Yes, I know. I could eat them all.

(Off-Mic)

(Crosstalk)

(Tara): Yes, exactly.

(Off-Mic)

Female: Yes, let's put them together and look at what really said about …

(Crosstalk)

Female: We really need our (escort).

(Crosstalk)

(Off-Mic)

Female: Yes, everything is pretty much processed.

(Off-Mic)

Female: Yes, that's where we want to really -- we want to talk about -- what are the things here that kept coming up.

(Off-Mic)

Male: There's an important announcement (today). (ASAM) was announcing that next week will be addiction treatment gap week.

Female: Not treatment measure?

Male: … treatment gap awareness.

Female: Yes.

Male: Recognizing the gap in treatment for those clinical diseases of addiction.

(Off-Mic)

Female: For those of you who live it daily.

(Off-Mic)

(Tara): So we're going to -- what time are we going to reconvene?

(Off-Mic)

Female: … at 1:30.

(Tara): 1:30, OK. So we've got a half an hour here. OK.

OK, microphone back.

So we list down all the measures that have been recommended based on the CMS domains and hopefully representing the new domains. Please call it out if you feel like something was not captured, but we've assigned them in the areas that we've discussed.

We have flexibility to move around the signs if there's a different order that you'd like to review them in. But we can …

(Off-Mic)

(Tara): OK.

These are our two access.

Female: I think I'm making to suggest from that if we have the percent of patients prescribed the medication of opioid use supporters under the access domain, that we might consider also adding percent of patient prescribed in medication for alcohol use disorders under access domain as well.

(Tara): Yes.

(Off-Mic)

(Tara): I believe that measure number 37. So we will move that …

Female: … measure number 37 access.

Female: OK.

(Tara): Yes, these were the only two that ended with the care coordination as I mentioned.

Female: And we've moved it from somewhere else, too, I think.

Female: Yes.

Female: They've (sorted) out.

(Tara): They were in clinical care and the last one of four was our patient care (experience).

(Off-Mic)

Female: I think follow up discharge from the hospital are ED or somewhere.

(Crosstalk)

(Off-Mic)

(Tara): This was the measure identified to reports of individuals that have primary care that's after an STD treatment encounter and except with the event which clinicians measure comprehensive patient care.

(Off-Mic)

Female: Well, it wasn't clear that it's after the administration of (we can see it was) in six months where they go see …

(Off-Mic)

Female: … provider and felt like it should have been like three months …

(Crosstalk)

Female: … three months or something sooner.

(Crosstalk)

(Tara): Because this is after detox, yes.

Female: It doesn't say detox. It's just …

(Off-Mic)

(Crosstalk)

(Tara): Even though the denominator …

(Crosstalk)

(Tara): No, it doesn't, you're right. It's the keyword -- right …

(Crosstalk)

(Off-Mic)

(Tara): OK.

Do you remember total scores for these?

Female: Both, the final …

(Crosstalk)

(Tara): Yes.

Female: We do.

Female: Because that might be helpful to show which ones we really (trip) for each group.

(Tara): Yes, so what -- can you go back to access and see like, for 92, 36, and 37, what were our …

Female: For 92, which is initiation engagement of alcohol and other drug-dependent treatment, we had all five.

Female: OK.

Female: For 36 -- all five, all five high, that it's said, pardon me, for both measures of access.

For 37, we had five for high and CMS domains key concepts. Five in high for opportunity for improvement. Five in high for efficient use of resources. And ready for immediate use, we have one high, four medium. And importance of stakeholders, we have five high.

Female: OK. So we mostly got high. OK.

Female: In care coordination, number 97 …

(Off-Mic)

Female: … we had for CMS domains key concepts, no votes high, four votes medium, one vote low. Opportunity for improvement, three votes high, two votes medium. For efficient use of resources, five high. Ready for immediate use, five low. And importance of stakeholders, five high.

Female: This is the measure that you've obtained, (Sheryl), that we've discussed yesterday. It was -- the rationale was that it's important to have care team accountability. We had -- yes, there was -- it should have been -- it should be a 30-day follow up (not) six months following the treatment. And need the recommendation that they should use claims.

(Off-Mic)

(Crosstalk)

Female: Will that -- those notes that you have, will those be available to me when I have to ask for the care coordination committee, what do you think?

(Tara): For the coordinating …

(Crosstalk)

Female: The coordinating committee meeting?

(Tara): So I'm not exactly sure how -- what it will look like. But we will definitely provide you with all of our account of the celebration.

Female: OK.

(Crosstalk)

Female: … to take some of those notes now.

(Tara): Yes. So just as an FYI for the meeting, the report out, we'll have a general report out on the list of measures with a very brief, very high level rationale for what's the committee (lifestyle), only on measures that were recommended, and just generally what was the …

(Off-Mic)

Female: But you don't have to give all the scores. That will take too much time. I thought we have like an overall, like, summary score for them. So that's the right …

(Off-Mic)

Female: Unless people find it helpful.

Female: OK.

(Off-Mic)

Female: So we've got preventive are. And now we've got those two …

(Off-Mic)

Female: So just from hospitalization, right?

(Off-Mic)

(Tara): Yes, 96, it looks like this was the one that looks at over a period of 24 months that says problematic, because it's not realistic for the Medicaid population that they say either on Medicaid …

(Off-Mic)

(Tara): Inpatients, right, hospitalized …

(Off-Mic)

(Tara): So rather than kind of like just looking at these and briefly recapping, is there any other way that you would like to discuss these measures for the purpose of finding the themes and prioritizing? I mean, I'm happy to continue on this, so we didn't really have a structure for this conversation planned. But whatever you think would be …

(Off-Mic)

(Tara): No. So clinical care had many. They're split over several slides, yes.

(Off-Mic)

Female: Yes, like we're meeting screening. So screening for tobacco and alcohol and drug use separately versus other combinations that I think most -- I would think that …

(Off-Mic)

Female: But we've put screening and then we put screening with treatment …

(Off-Mic)

Female: So like there's 60 (SBIRTs). So we're looking at -- like, if they are seeing combination screening where you will screening for alcohol, tobacco and drugs. And there's the alcohol screen and tobacco screen, drug screen separately.

Female: Right.

(Off-Mic)

Female: We want to put all the screening measures together?

(Off-Mic)

Female: … two-step process for us to just get all these screening together and then …

(Off-Mic)

Female: So by combined, what do you mean, do you mean as like, that sort of measure is specified, or do you mean in some kind of measure set …

(Crosstalk)

Male: I think it should be in the measure set when there's -- they're making sure that they're systematic screening and assessment. So we have the denominator …

(Off-Mic)

Male: … systematic, population-based screening assessment not just for …

(Off-Mic)

Female: OK.

Male: So we're getting to that notion of a cascaded measure, and that's really important to make sure that they're all the same. And as I've heard many …

(Off-Mic)

Male: … these measures are referral or they don't have the most dependence, then we won't have to refer …

(Off-Mic)

Female: Yes.

(Off-Mic)

Female: Yes, you know, it is difficult to try to identify folks that have substance abuse disorder. Any have been with the very best efforts, so you're not going to get close to anywhere near where we would need to be in terms of finding everyone.

That said, you know, there has been some very large time-intensive efforts particularly with people who work on the financing side of the field to try to codify what drug treatment looks like and what the diagnoses are using claims data. There's been efforts by you know, both (SAMS) as well as (PAMI Mark) and her group, and where they have actually, you know, sit out all the codes with efforts, strategies for each state. And I don't know if that's somewhere that you guys want to go down the road, and you know, the codes and the environment are always shifting. But if we're talking about a standard set and you know, the squishy denominator is important to try to mail down, it may be necessary to do it. But I realize it's really complicated.

Male: But to remind me maybe that -- at one time see if that was funding state-needs assessments where they were asking each state to make those estimates for their state. Now, the quality of those assessments vary substantially and that was more than a decade ago.

So are we grouping our screen measures with what we're doing -- we're grouping our screen measures and then we also have screening and any intervention. We've got single substance versus composite substances, right?

So we have …

Female: You know, then we also have screening for general population and screening for specific populations, whether it's psychiatric or -- so there's any number of ways we can cluster these.

And then you've got something that's really focused on opioid division of care assessment.

(Off-Mic)

Female: Just to be clear, if someone sadly are probably not getting it …

(Off-Mic)

(Crosstalk)

Female: … that gives you your Phenergan, your (supporting posture) from two liters a month.

(Off-Mic)

Female: I need that, Phenergan with Codeine. And I'm like, well, we can …

(Off-Mic)

(Tara): So in the interest of time -- in the interest of time, I think we should move on to the conversation around kind of broader themes for now.

We get -- I mean, I just think having to exercise the prioritizing these, the logistics of it are challenging, and it won't be an ideal, later review those. So I think we should kind of recap these broader themes that (Sheryl) can bring forth to the larger group. I know some of the ones that we've noted are just needs for a cascading measure through the process of screening and intervention and treatment …

(Off-Mic)

(Crosstalk)

Female: Let's talk about some of the general themes.

(Tara): Let's talk about general themes.

(Off-Mic)

Female: Combining them in a …

(Off-Mic)

Female: And is it -- I'll speak in recap some of these themes we have taken over these past two days and then maybe you guys can add to it if that's easier. We can do that.

Female: OK.

Female: So the one that we heard the most was this cascade of measures that (started) screening and go all the way to assessment and intervention. And with that, the other one was not looking a referral. And then the other one was …

(Off-Mic)

Female: And the other one was that not looking at just tobacco, or looking at the whole continuum; drugs, tobacco, other substances, so looking at more of a composite. Outcomes measures were the ones.

And then we had some measures that were -- or separate measures together that looked at substance abuse, assessment and treatment, and we'll have assessment and treatment and for those measures to be broken out into multiple measures, that was one.

And then for the opioid where it was the 90-day, post 90-day prescription follow-up that's sort of the timing, the guidelines, global screening measures, opioid measures in general, and then the other was denominators for these measures. Anything else?

(Off-Mic)

Female: One of the big gaps that we haven't discussed all and have nothing that even touching on all is like …

(Off-Mic)

Female: … a huge problem and a huge gap in this area. We don't have a single measure that looks anything whether we're screening, assessing, intervening, doing anything, for pregnant lady if she went up with substance abuse disorder, or identifying that. I know it's a huge problem.

(Off-Mic)

Male: Say again?

Female: I thought there was one -- with (A10) that one of the populations included pregnant women.

(Off-Mic)

Female: The pregnancy press that I remember was around the (SBIRTs) information. There was one of the work was with the …

(Crosstalk)

Female: That's right, the work from Oregon.

(Crosstalk)

Female: You can do (SBIRTs) for pregnant women, but we don't have any measures that look at that population. And that's the (the absent) syndrome and substance abuse disorder pregnancy. It's like, it is taking everywhere else in the population and picking in pregnant women. You have two people with complications …

(Off-Mic)

Female: Yes, we don't have any measures that look at …

(Crosstalk)

Female: … like in obstetrical care.

Female: Right. There wasn't a single measure. And that a big part of it is a lot of the women are not getting screened even by their OBs for substance abuse syndrome, or whether it's opioid or others.

Female: We know that the guidelines say universal …

(Crosstalk)

Female: … on screening, even if we didn't have one with intervention, but at least some screening …

(Crosstalk)

Female: That's a huge gap. And that's a big priority for (states). Medicaid particularly, because Medicaid is the one that have (results) of pregnant women and the babies who …

(Off-Mic)

Female: Do you know of any measures that are in use that address …

(Crosstalk)

(Off-Mic)

Male: It would be relatively easy to develop is for neonatal abstinence syndrome which means babies in opioid withdrawal.

Female: It's a (promise) that is opioid used treatment doesn't reduce opioid, you know, abstinence syndrome because they then treat -- they still treat pregnant women with …

(Off-Mic)

Female: … methadone …

(Off-Mic)

Male: Correct. And (bufinarcin) has less of it than methadone does.

(Off-Mic)

Female: And it's the -- you can still get them in the …

(Off-Mic)

(Crosstalk)

Female: … it should be the (SBIRT) for the pregnant women.

Male: Well, and some of the measures we've agreed should be used could easily be tailored to pregnant women.

Female: You an easily have that in one of the ways that they're broken. It could be the general Medicaid population in pregnant women as a separate demographics.

(Tara): And I'm looking at our maternal prenatal, we don't have anything related to substance abuse. And I used to work at ACOG and I know they're dealing with NAS but not what you're looking for. Because the evidence is not there to create a guideline to cure the measure, you need the sort of evidence …

(Off-Mic)

Female: Yes. And that's for like -- the evidence is there for screening. They should all be getting screened.

And the recommendations are vague. Just do universal screening of women for alcohol, tobacco, all of these, all of the drugs at your first prenatal visit and periodically throughout the pregnancy. But they don't -- they just say that, you know, what do you use, that there's no recommendation for specific …

(Crosstalk)

Male: I just want to go back to the missing outcome metrics for a second and underscore the importance. We have some metrics that involve delivering, I guess, your interventions are delivered to patients. And it is so easy to check a box that I told a patient to quit smoking, or I told the patient to cut down on their drinking. And that is not a robust evidence-based motivational intervention that actually gets the reductions in substance abuse and the cost reductions that research shows are possible.

So I mean, those process measures are such a low bar. And without outcome measures, it's possible for people to do well on those process measures but not help patients at all.

(Off-Mic)

Female: Are you aware of any?

Male: No.

(Off-Mic)

Male: … and I think where we have to start at least is a metric involving substance abuse. And I know that's not the end all and be all, but at least that's something that could be looked at across every single setting, whether it's (SBIRT) or whether it's treatment, and to look at -- I mean, the metric I think that would be best for the measure that the variables for those metrics would be number of risky drinking base in the past month. And by that, I mean, base in which a man drinks more than four standard drinks, or drinks more than three standard drinks. Because it's that kind of drinking that tends to result in negative health and social consequences.

And for drug use, it's really hard to quantify how much people are taking, but we can certainly get data on how many days from the past month people have used one or more drugs. So I know there's lots of, you know -- they're not perfect, but they would be a starting point to be able to look at outcomes.

Male: Ultimately what we need are changes in the electronic health records, so those items are standardized. And we get consistent responses. Neither is making investments in recommending data sets for electric health records, question sets. It's long ways to go to get Epic to adopt it.

Female: The other thing with (onset) I think that I would be interested in even more than just how much are they reporting using its -- you know, how well do they actually go through treatment, like how long were they retained in treatment for substance abuse disorder. And that they go to -- when they went to treatment, did they go for two visits or six months, or 12 months. Like, were they consistently getting buprenorphine for -- or methadone for all 12 months after -- or for one month. And I think -- and I don't know what the ideal --

what the measure links we would want to measure. I don't know if we want to do it in 12 months, or six months of treatment. But that would be an outcome with measure.

Neonatal abstinence syndrome could be not (cumulated) measures as well.

(Off-Mic)

Female: Using one to add to this by the way, so (John), your list was wonderful. Thanks so much for summarizing that -- was the under 18 population. And so how many times we have that same conversation about why we're cutting these folks out. I think that Oregon was one of the examples where that wasn't the case, and that's a real issue.

Another was just sort of I think a thing that struck me was just sort of the state of the field regarding measurement, and how lacking and specificity and sophistication, you know, many of these measures are. And makes me wonder, or you know, with the epidemic to substance abuse treatment, you know, there's so many ways in which this field had kind of lagged behind others and is working to, you know, kind of fill that up. But more work needs to be done there. There were so many promising concepts and ideas that we saw that we didn't move forward and it was really hard to deal with problems with the design of the measure that was the issue at hand.

And then, you know, getting back to outcomes, I'm not sure how -- I'm thinking something related to -- I'm looking at addiction use of the emergency room for addiction-related convictions, you know, whether it be you know, things like over their third detox, or other kinds of conditions that maybe we've baited to -- or other kinds of, you know, these that may result from sustained addiction. You know, if you're trying to look at you know, OK, here it is sort of process-focused indicators like, or people getting screening or getting people on their treatment, or what does that look like downstream and they were actually seeing reduction and people coming in, so (system) in crisis.

Female: OK.

(Off-Mic)

Male: … it would be so helpful if the proceedings have this process could be published in the substance abuse journal, rather than just distributed as a list of measures to Medicaid directors. Is that possible?

(Off-Mic)

Male: It's not within the scope of your work.

The five people here could take that on.

Female: Is there any conflict of us going to that or problem? I mean …

(Off-Mic)

Female: I think it's more like one the passcode is completed, it's something to take up with probably (Karen Iana) because like, as long as -- I think -- I don't think it's the group wanted to work on something publishing that separates based on this work as a foundation. I don't think that would be a conflict (corrected), right?

Female: So we just -- we have to see there are limitations. But it's something that we can definitely put on the …

(Off-Mic)

Male: … anybody in the public could have recorded this and disseminated the information, so why can …

(Off-Mic)

Male: The tricky parts here are that they're government contractors, they can't do anything without their project officer, their contract officer approving it. Now, you can have a quiet conversation saying would this be a problem this week if the committee did this, and they might say, don't tell me, and then it would proceed quietly.

Female: So back to the outcomes for a second. I'm going to piggyback on (Christina's) suggestion of you know, (ED business). I would actually say that one of the outcome measures that we really should be looking at is our patients who get treatment for substance abuse disorder, having (reach) all cost (ED) on inpatient, because we know that there's a lot of crossover and how it affects medical problems as well on and that they have a higher utilization rate from medical indications, as well as with related to substance abuse disorder and how it affects their ability to do take care of themselves medically.

So it's actually, we would take one of the outcomes with you we'd expect is the reduction in all costs hospital utilizations, not just direct substance abuse related.

(Crosstalk)

Female: No, I agree. But it was the greatest (feed) both in the -- the nice thing about looking at the all cost is it then provides a financial incentive for states to be able to put more money into substance abuse disorder treatment, because by reducing all cost you then take money. And it helps tell you your true ROI on substance abuse disorder treatment.

Female: Right. And this is going to be my last comment with you know -- we really don't look at costs or meet -- we didn't see measures that allow us to make a case related to cost effectiveness or be able to think or make a policy decision. And I think that it seems to me like it would be something state Medicaid would be very interested in.

Female: I mean, that's the reason we're doing this, because it's one of the top drivers of costs. So that's why -- lest we forget this is why we're one of the topics. So being able to look at outcomes that you know are driving the costs …

(Crosstalk)

Female: So saying that my patients all got their screenings on doesn't want me argue to Governor (Loki) Hogan that we are going to save money by getting more patients with substance abuse disorder treatment. And you should spend even

more money getting people with substance abuse disorder treatment you're already spending. But saying we're reducing ED visits, we're improving …

(Crosstalk)

Female: … hospitalizations regardless of the cost for patients who got the treatment, say now I can justify expanding -- I can justify our waiver that we just got for inpatients with ED.

Female: Or the psychiatric care as well, this comorbidity that's even higher use.

Female: Well, and related to the acute care utilization, you know, there are measures out there that researchers abuse. I don't know that they're out there and publicly available. I don't think …

(Crosstalk)

Female: That have been used (in studies) you know, but particularly you're doing the Medicaid analytic extract data. So I doubt they've been published. I'm not surprised that it's (final) in research. But they may be available. And I think that getting that is that impact, you know, piece I think is really important gap.

Male: There are three economic analyses of (SBIRT) programs I know of that have just documented the (fines) and hospitalizations and emergency room visits. So if there's simple variables that you can get from a claims database.

Female: You know, I think you know, talking about the under 18 year olds, you know, the outcomes for many of them is prevention, not ever starting, not ever initiating use. So we don't have anything that says, you know, go to our screens and got preventive, you know, measures. You know, there's education about preventing use, you know. Are we looking at lower rates of initiation of other substances, and that's an outcome as well. So you know, it seems like we're missing that upfront piece, the prevention, early intervention …

(Off-Mic)

Female: Right.

Male: … the metric there would be of all of the teams of a certain age who are abstinent this year, how many are still abstinent next year.

Female: Right. And you know, we know …

(Off-Mic)

Female: Right. And we have rights, you know, national rights of initiation across age groups, you know, the National Survey of Drug Use and Health, you know, looks at that. So you can take a national benchmark and you can look to see. But those are -- seems like what we're capturing are people who already have just dependence or disorders, not that those are big drivers, but you know, we've also got this other piece that we need to get at if we're going to sort of reduce the burden layer downstream.

(Tara): OK, thank you. So we are out of time. I just want to kind of end on a disclaimer that we've captured your conversations and your suggestions. But that it is beyond the scope of this project to put forth measure concepts or to suggest new measures. We tend -- you know, we've taken all of your comments down, but I don't want to write any checks I can't cash and promising that some of these, you know, proposed measure concepts because that is beyond the scope of this project unfortunately.

But thank you all very, very much.

Female: Could I ask one clarification? You mentioned that the theme was related to opioids. I wanted to clarify what that was.

(Tara): More on measures, specific measures related to opioid, opioid use measurements, more assessment and …

Female: OK, thank you.

(Tara): OK. Thank you, everyone. We are now reconvening in the large conference room next door.

(Off-Mic)

Female: Oh yes, thank you.

(Tara): OK, thank you, everybody.

Female: Thank you.

Female: Great group.

Female: Excellent facilitator.

(Crosstalk)

(Off-Mic)

END