

THE NATIONAL QUALITY FORUM

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MENTAL HEALTH OUTCOMES STEERING COMMITTEE

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MONDAY
NOVEMBER 16, 2009

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The Committee met in the Columbia A Room in the Hyatt Regency Washington D.C. Hotel, 400 New Jersey Avenue N.W., Washington, D.C., at 10:00 a.m., Tricia Leddy and Jeffrey Susman, Co-Chairs, presiding.

MEMBERS PRESENT:

TRICIA LEDDY, MS, Co-Chair
JEFFREY SUSMAN, M.D., Co-Chair
SHEILA R. BOTTS, PharmD, BCPP
RICHARD J. GOLDBERG, M.D., MS
WILLIAM E. GOLDEN, M.D. (via telephone)
ERIC D. GOPLERUD, M.D.
MAUREEN HENNESSEY, Ph.D., CPCC
DARCY JAFFE, ARNP
DANIEL I. KAUFER, M.D., FAAN (via telephone)
ANNE P. MANTON, Ph.D., APRN, FAAN
KATIE MASLOW, MSW
LUC R. PELLETIER, MSN, APRN, FAAN
HAROLD A. PINCUS, M.D.
ROBERT ROCA, M.D., MBA, MPH
JOEL E. STREIM, M.D.
GEORGE J. WAN, Ph.D., MPH
CAROL WILKINS, MPP (via telephone)

NQF STAFF PRESENT:

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HELEN BURSTIN
IAN CORBRIDGE
ASHLEY MORSELL
REVA WINKLER
BONNIE ZELL

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P R O C E E D I N G S

10:08 a.m.

Welcome, Introduction and Disclosures

CO-CHAIR LEDDY: My name's Tricia Leddy, and along with Jeff Susman, we are the co-chairs of this committee, and we'd like to welcome all of you, and we're going to start with introductions.

So in your introductions, if you could do two things. First of all, tell us a little bit about your background, and you know, what your background is related to this subject or not, and also tell us about your experience in looking at measures, performance measures or this type of measurement work in particular would be of interest. In addition, the most important thing in doing the introductions and for the rest of the day, is when you're speaking, to push the red button.

I should mention that this meeting is being recorded, and that the way that the people on the phone -- there are three people

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on the phone that will introduce themselves, and the way that they are hearing us is through the microphones. So let's start with Luc and with the staff.

MR. PELLETIER: Good morning. I'm Luc Pelletier. I'm a clinical nurse specialist at Sharpe Mesa Vista Hospital and core adjunct faculty with National University in San Diego, California. I'm the previous editor-in-chief of the Journal for Health Care Quality, and I've done a good amount of work.

I did some work with National Quality Forum on evidence-based treatments for substance use. It's great to be here.

MR. ROCA: Good morning. I'm Bob Roca. I am currently the Vice President and Medical Director at Sheppard-Pratt in Baltimore, which is a free-standing -- large free-standing psychiatric hospital. I'm also on the part-time faculty at Hopkins and the University of Maryland.

In my capacity as the chief medical

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officer, I'm in charge of the quality program and performance improvement programs for our health system. I've had an interest in developing physician practice profiles for our physicians and have worked on -- with a number of other people in creating that over the last couple of years, to give physicians doctor-specific feedback on performance in a variety of dimensions.

I've worked with some members of the Maryland Psychiatric Society and the APA to put a program together at which we arrived at our tentative set of performance measures, process-oriented performance measures for psychiatrists and would be interested in hearing what some other people might think about what we came up with offline later today.

I have a little bit of experience with the National Quality Forum as a member of a technical advisory panel on a group of measures for inpatient psychiatry that's

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recently been looked at, and it's great to be here.

MS. ZELL: Bonnie Zell, Senior Director for Population Health at the National Quality Forum.

DR. GOLDBERG: Good morning. I'm Rich Goldberg. I'm a psychiatrist from the state of Rhode Island. I'm the chief of Psychiatry at two of the general hospitals, Brown-affiliated general hospitals and a Professor of Psychiatry, Brown University, and the chairman of a Psychiatry Service Line over a network of hospitals in the state of Rhode Island, leading fairly recently a quality initiative that's state-wide, to develop and implement outcomes measures across our system.

We held recently an inaugural conference for the state in quality and safety in psychiatry and behavioral health, and although I'm personally kind of focused on policy and conceptual issues in quality, I have -- we have divisions which are measuring

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quality outcomes.

We have a web-based system of outcomes for our outpatient programs that we track, which again I'm looking forward to sharing ours and hearing from other people, and I'm pleased to be part of this initiative.

Hope I can contribute something and learn something from others as well.

MS. HENNESSEY: Good morning. My name is Maureen Hennessey, and I'm a psychologist. I'm also a certified coach with a special interest and expertise in patient engagement and coaching for patient engagement.

I'm on the clinical faculty for the Medical School at the University of Missouri in Kansas City, and I'm also president of Gardener Health Systems, which is a consulting firm that specializes in wellness and preventive health strategies, and I'm also on the board of directors for the Trauma Support Network, which is a national organization focusing on

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training and engagement in care of individuals who have experienced trauma, or who are first responders for people who've had trauma.

My background includes working on standards development and measures development for URAC with consumer, their consumer-directed health product, their care management and disease management products, and also working with NCQA on a number of different task forces, including preventive health. I also did some work with IOM on the community initiatives, particularly involving depression, which is one of my special interests. It's great to be here.

DR. PINCUS: I'm Harold Pincus. I have a number of different hats, but I'm Professor and Vice Chair of the Department of Psychiatry at Columbia, and also Director of Quality and Outcomes Research at New York Presbyterian Hospital. I'm also Director of Quality and Outcomes -- excuse me, I'm also a senior scientist at the Rand Corporation, and

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I've been involved with a number of different NQF committees and groups, and most recently, I guess, was one on sort of defining patient-centered episodes of treatment for alcoholism.

Before that, I co-chaired the Medication Management Measures Steering Committee. I'm also involved with a number of other sort of quality measurement initiatives.

I'm the principal investigator of the National Evaluation of the Veterans Administration's mental health system, among other things, and I'm glad to be here.

DR. STREIM: Joel Streim. I'm an internist and geriatric psychiatrist on the faculty at the University of Pennsylvania and also at the Philadelphia VA Medical Center. Most of my work is in the area of nursing home populations, with medical and psychiatric comorbidity and physical disability, and looking at clinical outcomes in that population, very specifically, both those with cognitive impairment and not.

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The projects I've been most involved with recently have to do with impairment activity staging, working with colleagues in rehabilitation medicine, looking at predictors of rehab and functional outcomes in elders using large data sets, and also recently was involved in working on revision of the behavior and mood items on the minimum data set that's used in all 16,000 nursing homes across the country, working with Deb Saliba's team, also at Rand. She was at Rand; I'm not.

But those are the sorts of things that I'm primarily involved in, related to this work.

DR. MANTON: Good morning. I'm Anne Manton and I'm a psychiatric mental health nurse practitioner at Cape Cod Hospital in psychiatric urgent care. That's a relatively new role for me. Most of my career, I have been clinically in the Emergency Department and my full time job for

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20 plus years was in academia, and it's from the academic experience that most of my performance measures or outcome criteria have been working at that, in terms of student achievement and curriculum appropriateness, etcetera. This is my first NQF experience, and I'm happy to be here.

MS. JAFFE: I'm Darcy Jaffe, from Harbor View Medical Center in Seattle. I am currently assistant administrator over Psychiatry and Behavioral Health Services. Harbor View is part of the University of Washington Medical Center System. Related to this, I have been on an UHC expert panel looking at outcomes for inpatient psychiatry. I helped out with the Institute for Behavioral Health Care Improvement, looking at outcomes for behavioral health in emergency departments.

At Harbor View, we've been working over the last 10 or 15 years. We have a pretty robust inpatient database for outcomes.

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I also work with the Mental Health Integration Project, which is aimed at improving behavioral health care and primary care, and has a web-based tool looked to be able to track outcomes on patient improvement, and I'm happy to be here too.

MS. MORSELL: My name is Ashley Morsell. I'm a research analyst at NQF, and I'll be supporting Reva and Ian with the project.

MS. WINKLER: You've probably received emails from Ashley, so you now have a face to go with the email. I'm Reva Winkler. I'm a project consultant for NQF. I've actually been at NQF for almost nine years now, overseeing many of the project we do. And as we'll talk about later, this particular effort around mental health is part of a larger outcomes project that I oversee with the rest of the staff. So welcome, and you'll be hearing a lot from me more later.

MR. CORBRIDGE: Good morning

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everyone. Thank you guys for all traveling down here. We greatly appreciate it.

My name's Ian Corbridge. I'm the project manager for the Mental Health Outcomes Project. I guess I have a background as an RN working in mental health, so it's obviously something that I'm close to and important to myself. So I'll be here working with you guys, and let me know if there's anything I can do to help facilitate the process for you.

Do you want to open it up to individuals on the phone at this time?

MS. WINKLER: Yes.

MR. CORBRIDGE: I guess Dr. Kaufer, would you like to start off introducing yourself?

DR. KAUFER: Sure. My name is Dan Kaufer. I'm a neurologist at UNC-Chapel Hill.

I'm certified in Behavioral Neurology and Neuropsychiatry as an integrated subspecialty.

I run the memory disorders program here. My experience related to this meeting has to do

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with being a technical -- being on the technical expert panel for a couple of reviews, one on drug treatment for Alzheimer's, another on prevention of Alzheimer's disease.

I've also been very involved with the Behavioral Neurology section of the American Academy of Neurology, and working on developing quality measures and standards for diagnosing and treating dementia, which is my primary interest in this context here.

DR. GOPLERUD: This is Eric Goplerud. I'm a research professor at George Washington University and direct the Center for Integrated Behavioral Health Policy here at G.W. My past experience with NQF has been to chair the Technical Advisory Panel for a project on substance abuse, evidence-based practices.

Also with Harold Pincus was on a recent panel on substance abuse, episodes of care. For, I don't know, 13-14 years I was on

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the NCQA Behaviors Measures Advisory Panel and have a long-standing interest and involvement in performance measurement.

DR. GOLDEN: I'm Bill Golden, and I am Professor of Medicine and Public Health at the University of Arkansas. I'm on the call today as the Medical Director for Health Policy at Arkansas Medicaid. I have been a former board member of NQF and have been developing performance measures for the last 17 years. Currently sit on the AMA PCPI and have co-chaired many of their committees.

I also co-chaired an independent committee that developed performance measures for bipolar disease, which actually several of which have been NQF-approved. Long ago and far away, I was actually on the original AHCPH guideline development panel for depression and primary care. I'm really interested. There's a desperate in Medicaid for mental health measures. It's a substantial comorbidity issue in that population.

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MS. WILKINS: Hi, this is Carol Wilkins. I'm currently an independent consultant, but I was until a few weeks ago the Director of Public Policy and Research for the Corporation for Supportive Housing.

This is my first experience with NQF, but I guess the experience that I bring that's most relevant is a lot of work looking at the relationship between homelessness and housing status, both the utilization and cost of health services, particularly among people who are frequent users of emergency health services, and more appropriate utilization of services that seem to reflect changes in quality outcomes.

I've been responsible for coordinating or gathering and synthesizing and sharing a lot of the evidence about the effectiveness of housing-based multi-disciplinary service models for people who are homeless or unstably housed, and often have co-occurring mental health, substance abuse

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and chronic health conditions.

I'll be traveling to join the group in person tomorrow.

CO-CHAIR SUSMAN: Is there anybody else on the line. Okay. Well, I'm Jeff Susman. I'm the Chair of Family Medicine at the University of Cincinnati. My research interest is in primary care and behavioral health, particularly developing grounded theory of depression care and interventions that are based on the real world of primary care.

From an NQF point of view, I've been our member representative to the National Quality Forum, and have worked on the behavioral health TAP in the past. I also have been involved with NCQA and a number of the other sort of measure-setting, measure-vetting fora.

My interest in quality measurement also extends to home, where the Robert Wood Johnson Foundation has funded a series of 15

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communities to improve care, and it's aligning forces for quality, and I had the Quality Measurement and Public Reporting Work Group and Physician Liaison Group, which makes for interesting conversations at eight o'clock in the morning.

Finally, I've been working recently with the PCPCC Behavioral Health Task Force, which is how do we integrate behavioral health into the patient-centered medical home? One of the challenges, I think, with the existing NCQA criteria is that there isn't really overt recognition of behavioral health's importance within the NCQA scoring criteria.

So hopefully we can bring some of that from our National Academy perspective. I'm on the Commission for Quality and Practice, and the editor for our, and medical director for our Metric project, which is a quality improvement project aimed at practicing clinicians throughout the U.S. and our membership. So it's a real pleasure to be

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here. I appreciate the expertise and diverse perspectives we have, and I think this is going to be real exciting couple of days. So thank you all for attending.

CO-CHAIR LEDDY: I'm Tricia Leddy.

I didn't follow my own instructions about pushing the red button. I'm Senior Health Policy Advisor for our Director of Health. I am right now in charge of reviewing requests for hospital mergers. So that's been my world for oh, the past almost a year.

Previous to that, when hospitals were not asking to merge, I was the Deputy Director of our Mental Health Department, so I've been in state service quite a few years.

So I did that only for two years, and before that, I ran, developed and ran our Medicaid managed care program called Rite Care.

So most of my experience is Medicaid, and while in Medicaid, developed performance-based contracts with health plans, and needed and did a lot of work with

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developing measures as part of that, that we could use for actual payment, and then health plans paying the physician practices for certain measures.

Mostly using HEDIS measures, of which there are only a couple of mental health measures we could use. But also in my role in Medicaid, I developed across the entire Medicaid program, a research and evaluation component in collaboration with Brown University, where we developed health outcome measures for each of our Medicaid populations, and then set up a measurement, a system of measuring those health outcome measures each year, and used them really to change the program. So in Medicaid I used outcomes not only for quality improvement on the health plan or provider level, but also for ourselves as a program in defining the contracts and what is in the contracts with health plans, or what is in the benefit package.

So that's where we could use

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measures that really looked at the entire Medicaid population and how they were doing, and develop program improvements to address anything that was not showing improvement or was a problem in accordance with baseline. So I would also like to welcome everybody. This is my first National Quality Forum task force.

A lot of people have been on National Quality Forum task forces before, and now we're going to have the introductions of -- we're going to -- Helen is going to introduce herself and provide an overview of the project.

DR. PINCUS: If I could ask one question? Is there a way to get on the Internet here?

CO-CHAIR LEDDY: I tried.

CO-CHAIR SUSMAN: The answer would be no.

DR. PINCUS: Is there a password?

CO-CHAIR LEDDY: No, I did the password thing, and I can't get on here. So it's not -- I think it's the basement.

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CO-CHAIR SUSMAN: If someone has an urgent need and is actually physically present here, I do have a satellite card and certainly can share that.

DR. BURSTIN: You'll spend a good portion of the day like rats seeking light up the escalators, as I just did at about five of 10:00, so apologies. This is always a difficult hotel.

DR. PINCUS: How do you get access to the materials?

MR. CORBRIDGE: We have some here, actually on a pen drive, or it would be in your emails. So if you'd like it on a pen drive, I have it right here.

DR. PINCUS: Thank you.

CO-CHAIR SUSMAN: So those of you who need the materials or only got gobbledygook when you tried to raise them up, just let Ian know.

Orientation to NQF

DR. BURSTIN: Good morning

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everybody, I'm Helen Burstin. I'm the Senior Vice President for Performance Measures at NQF and thanks for being with us, and thanks for those on the phone. I know it's always difficult to not have the visuals, but appreciate your input.

Reva will run through the larger vision of the specific part of the project. But I just want to at least add my welcome and emphasize how important this particular project is for us, really the chance to finally get to focus strongly on outcomes measurement is something we've said we wanted to do for a long time, trying to move the field more away and not as closely aligned to just process for the sake of process, but at least process measures that have a closer link to outcomes and ultimately health outcomes.

So we really, when we got the initial list of the top 20 conditions that Reva will go over with you, just really thought it made a lot of sense to pull this

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particular group out for some further discussions, because I think there are some really important unique issues around mental health outcomes.

We did include in here some of the memory disorders on Alzheimer's, for example, as being we wanted to think very broadly about the kind of mental health scope we're going to ask you to help us think through. But this project is also a little unusual in that we've staged it such that you're going to essentially help us write the call for measures, as Reva will go over for you.

We thought it was premature for us to do a call for measures and then get in some things that maybe would seem appropriate or not appropriate, not the right scope, too broad, too limited. So you're really going to have a chance over the next couple days to help us set that scope. We'll then do the call for measures and you'll have plenty of opportunity to engage in the usual NQF

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activities of reviewing and evaluating the measures for their strength in our four criteria, as Reva will go over for you, but I just want to add my thank you, and I'll be in and out over the next couple of days. But you're in great hands with this team.

MS. WINKLER: Thanks everybody and welcome to all of you. Certainly in hearing the introductions, what I hear is a wide variety of experience with NQF. So we really want to try and bring you all to the same place. So, what I'm going to try and do initially is give you an overview of NQF's operations organization and current activities, because everything we try and keep sight of all the various activities within any particular project, so that everything remains somewhat of an integrated whole.

So for those of you who are very familiar, and this is repetitive; I apologize in advance. But for those of you who haven't a great deal of experience with this, I think

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it will help provide the context of what NQF is as an organization, as well as then we'll get into the details of the project.

NQF is an organization that began ten years ago. We just celebrated our tenth year anniversary. There has been a lot of evolution in NQF. I've been here for nine of those ten years. We are a private, non-profit voluntary consensus standard-setting organization, and that mouthful actually has some very specific meaning, because the process, the formal process of the consensus development process does comport to federal law.

That gives it a certain amount of standing with the federal government, and it is why we adhere very closely to that formal process that we'll describe to you later. We are a membership organization. We have over 400 members. It's a very diverse stakeholder membership that's very deliberate. We really want to bring in all sorts of perspectives

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around the health care table.

Those members are organized into eight stakeholder councils that include, and I'm not going to try and hit all eight of them, but consumers and purchasers as well as health plan health professionals, community and public health agencies, provider groups. So you know, just about anybody you can think of fits in one of our stakeholder councils and that is very deliberate. And as we'll talk about, a steering committee is meant to be a proxy for that membership. So you'll find the same kind of diversity of membership around the steering committee.

NQF's structure is typical of a non-profit organization. We are overseen by the board of directors. They have organized a subcommittee of the board to actually assist them in the work of providing the final endorsement of the measures that we do endorse, as voluntary consensus standards. That is a fairly significant workload, so they

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created a subcommittee to help them do that.

We also very closely as a member of the National Priorities Partnership, which some of you may have heard about or been involved with, and we'll talk a little bit more about who they are. And then we also have our leadership network, which is comprised of the chairs and vice chairs of all of the stakeholder councils, to provide leadership among our membership and input and communication among all the various activities within NQF.

So we are a growing organization, and a fair amount of activity is ongoing. We'll just kind of touch on a few of them. One thing I'd like to draw your attention to is NQF's website at www.qualityform.org. This past summer, we have revised and upgraded our website. There is an awful lot of information here.

I would strongly recommend that all of you go to the website and actually enroll

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for an account. Absolutely anybody can; no membership requirements at all, because that will allow you to tailor your own dashboard, so that you can, once you log in, have the things of interest to you come up readily available such as this project, or some of the other activities that NQF is engaged in.

Another way to access information about this project is under the tab, measuring performance. If you drop down to consensus development projects, this is certainly one of them. You'll also see the wide variety of consensus development projects that NQF has got ongoing at this time. So there's an awful lot of activity, and I would strongly recommend that you do enroll and check in with the website. You will find most of the information around this project will be posted.

As Tricia mentioned, the recording and the transcript of this meeting will be posted on the project website, all of the

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documents, all this stuff. So it can be a very good reference source of where documents and information is located as the project progresses. NQF has a three-pronged mission.

One is improving the quality of American health care by setting national priorities and goals for performance improvement. The second one is endorsing national consensus standards for measuring and public reporting on performance.

And that's really the area that this particular effort is addressing, and that as well we have an educational arm to promote the attainment of those national goals in use of the performance measures.

As I mentioned, NQF is now ten years old. Some of you have been with us and involved with some of our activities through a lot of that time frame. There has been a lot of evolution, both in the quality measurement enterprise, all of the organizations that contribute to that work, all of our members,

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the actual work that we do, the criteria we use to evaluate measures.

We have certainly seen performance improvement and evolution in the work that NQF does. Certainly there is -- over time been a drive towards higher performance, both expectations of the measures and the quality of the measures and the robustness of the measures, to raise the bar, if you will, to help drive further and higher performance.

Shifting towards composite measures, the idea of composite measures that bring together different aspects of performance in a summary is very useful for a lot of our stakeholders, as well as it's just a different way to look at performance, whether all things have been accomplished in the care of a patient, rather than piecemeal one at a time.

Another one of the focus areas that we really want all of our projects to attend to is looking at disparities. How can we

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measure disparities? How might measurement of disparities be appropriate for whatever the topic of an individual project is? So keeping an awareness of disparities in everything we do is certainly a priority. Over the course of the last ten years, NQF has endorsed over 500 measures, and certainly we have evaluated many, many, many more. Certainly over that time we've looked at many measures that are very similar. Measures are developed by a variety of folks for their own purposes, and get brought to NQF.

So we see measures that are either addressing the same focus of care, the same outcome of care. They all seem to be slightly different. A little bit different in the coding, a little bit different in the specification. Not a lot, but a little bit. And Certainly the end users have told us over and over again that having measures addressing the same thing, being a little bit different, is not helpful out there. It makes it very

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difficult to implement and to not have them aligned in a way that facilitates implementation means they aren't as likely to get implemented.

So harmonization has become a real significant priority, looking at the specifications of measures for things like age inclusions; looking at what does it mean to, you know, measure diabetics. Well, how do you define it so that they all capture the same thing. There are times when the specification of the measure, it's appropriate to be different. But if not to try and get them as aligned as possible.

As we're evolving and asking more and more of measurement and quality improvement, we want to try to promote shared accountability in measurement, and particularly across patient-focused episodes of care. Get us out of the silos, follow the real patients.

For a patient, their experience is not just

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within the hospital, not just within long-term care, not just at home. They often, you know, spend time in all of those arenas. And so patient-focused episodes of care is a place we need to evolve to.

And in doing so, greater focus on outcome measures, which is what this project is doing, is really looking at outcome measures, because all of the elements that contribute to patient outcomes in all the different settings and all of the different caregivers, are important to capture. We also want to start looking at appropriateness measures. Not only did it -- was the care efficacious, but was it appropriate, even if well-done. And then cost and resource measures coupled with quality to look at efficiency

NQF will be embarking on a project that will stage somewhat behind this project, looking at cost of resource use measures, that once these two projects are finished hopefully

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we'll start to have the building blocks to build some of these quality aligned with cost resource measures to measure efficiency. So there's just an awful lot of activity going on, that everything is interrelated. It's our job on the staff to try and keep you aware of all the things and keep ourselves aware of where we do interact with all of the other staff members within NQF's organization.

NQF's strategic goals, as any organization has them with their mission and goals. We essentially, our goal is to be the principle body that endorses national health care performance measures and quality indicators. By doing so, increase demand for high quality health care and be recognized as a major driving force and facilitator for quality improvement within the health care arena.

So as I mentioned over the tenure of NQF's existence, we've certainly seen a growth of NQF-endorsed measures, and I

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mentioned that 500 is going to be 600 very soon. We certainly have an expanded set of measures, and there have been several drivers for that large set. As adoption of measures for different types of incentive programs, such as the pay for reporting or pay for performance programs, there have been great needs for either the federal government or various payors.

Measures at the individual physician level. This has been the area I've worked on primarily over the last several years, particularly around physician level measurement in ambulatory and in-patient care.

Measures that are -- we've mentioned disparity-sensitive. We try and identify those measures that are particularly important and sensitive to disparities, such that with the appropriate stratification we can have a better -- more information, better understanding about disparities in certain topic areas.

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Measuring patient experience or surrogate experiences of the care that's given in a variety of settings, an important thing.

Cross-cutting areas, that regardless of the topic, are conditioned illness or reason for interacting with the health care system. There are just certain things that are relatively cross-cutting. Patient safety issues, medication issues, those sorts of things.

So right now, and rather all the time, there are several key issues for the NQF portfolio of measures, you know. We constantly have to ask do we have too many, too few or do we have the right measures. I think that the NQF portfolio is not something that's static. It's an evolutionary thing. The measures, for the most part, that are endorsed are the plan is to have a three-year maintenance review, and some measures just will have outlived their usefulness, have been superceded by better and more robust measures

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over time.

As we move to having more outcome measures, perhaps we need fewer process measures or perhaps we need composite process measures rather than individual ones. So this evolution is something that's ongoing, and I'm not sure the answer is too many or too few, but the answer is what are the right measures.

And again, over time that will change. So it is not a static portfolio.

One of the benefits of going to the NQF website that I showed you earlier is that you can search for the NQF-endorsed measures, and you can search by a variety of criteria and find out what may be available in your area of interest. Another key issue within the NQF-endorsed measures is the availability of data sources. And data sources is certainly one of the challenging aspects of measures. What we are seeing, however, are new data sources or more mature or more methodologically-challenging answers to data

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management, that are allowing us to combine data sources, to create measures that didn't - - that weren't available before.

This will also include transitions to EHRs, and pulling in data from multiple sources using health information exchanges. So a lot of sort of evolution is occurring on the data front as well, and becoming more sophisticated in the methodologies, being able to address some of the data challenges that were not available to us previously. So all of these things are the context within which we'll be working, as we try and identify appropriate outcome measures for this topic area.

Just mentioning quality measurement and disparities again, a focus, NQF prefers to identify measures that are sensitive to disparities and be able to stratify them out, to break out the different populations, so we can get information on disparities. Again, the challenges of collecting the appropriate

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information to be able to do that are well-known. But continuing to push for that data capability is something we don't want to overlook.

We mentioned episodes of care, and I'd like to share with you another bit of work that NQF is doing around the episode of care framework. This is a series of work that NQF has done over the last two years, starting with a framework for what is an episode of care. And some of you perhaps have seen our bubble diagrams, as they are often called. I certainly have been in the audience at other meetings and seen our bubble diagrams being used.

This is an example of the episode framework as applied to coronary artery disease and acute MI, where you look at the population at risk, you look at acute phase treatments, post-acute rehab and then secondary prevention, with several different trajectories for a patient's course of care,

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with different outcomes. As you can see, on the right-hand side, the kinds of outcomes of interest, including functional status, quality of life, secondary prevention, rehab and then advanced care planning.

So those are the kind of outcomes.

The steering committee or the -- I forget what we call the committee that helped pull this together for acute MI. But you can see that the episode of care begins with the onset of acute symptoms, extends for a year post the acute MI, and there are two different trajectories.

So we are going through a series of different topics and applying the framework. Some of you mentioned last week having been involved in the one for substance use. We've also done episode frameworks on diabetes and cancer, and I'm trying to remember what else - oh, low back pain. That's it, low back pain.

So this is something that's

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continuing and as we are hoping to do a little bit more of this work in another part of the outcomes project with some of our technical advisory panels, as we're trying to ask the question what are the appropriate outcomes of interest for the various conditions that have been identified for this big project. But this is an example of what we mean by an episode of care.

As you can see, it crosses care settings, and really is focused in on what the patient experiences. We mentioned that one of NQF's missions is to establish national priorities and goals, and certainly there is a need for some prioritization. There is a lot of activity around performance measurement, lots of organizations involved. And trying to prioritize those efforts to collectively get a greater push out of the results than everyone going their own way, aligning those efforts, and hoping to accelerate them is a goal for which the National Priorities Partnership was

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constituted two years ago, I think I was.

Thirty-two leadership organizations, and you could probably come up with a list. But you could take a look at the list on the NQF website, as well as I'll show you the website for the National Priorities Partnership. This organization is co-chaired by Don Berwick from IHI and Peggy O'Kane from NCQA. This is an effort around these organizations to focus in on six identified priorities, which I'll go over with you in a minute, to align the efforts of all of these organizations around some common priorities and goals.

Those -- selecting the priorities and goals were around trying to get the biggest bang for the buck. They tried to find the overlapping around effectiveness, patient safety, disparities and wastefulness and found the high impact areas.

The National Priorities and goals are six, and just briefly, care coordination

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is one, you know, looking at medication reconciliation, looking at preventable hospital readmissions and ED visits. The second one is improving the health of the population, population health, and you're going to hear later from Dr. Bonnie Zell, who's just recently joined NQF staff as our -- to lead our population health work and focus around preventive services, healthy lifestyle behaviors and ultimately to find a way of developing a population community health index.

So Bonnie's going to tell you a little bit more about how we might be approaching that, particularly with an eye towards the contributions of mental health. The third priority is patient safety. This has certainly been sort of one of the main focuses of NQF's activities over the last ten years. Improving safety and reliability, looking at hospital level mortality rates, looking at serious adverse events.

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You're probably familiar with the work NQF has done over the years in serious reportable events, and the safe practices, looking at health care associated infections.

So these are important priorities and goals.

The last three are, and then these are in no particular order, engaging patients and families in managing care. So, informed decision-making, patient experience with care, and patient self-management. These are important areas that I think we may be touching on in this particular topic area.

Another priority is around appropriate and compassionate care for life-limiting illnesses, end of life care, palliative care around both symptom and psychosocial and spiritual needs, as well as communication and support for families.

Then the last one is really the appropriate use of health care services, to eliminate waste while ensuring the delivery of appropriate care. Just this one always seems

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to be a hot topic. So the potential areas of overuse that the National Priorities Partnership has identified are around medication use, lab testing, diagnostic procedures, maternity care, consultations, U.S. Preventive Services Task Force D list, preventive services, as well as preventable hospitalizations, ED visits and non-palliative end of life care.

So lots of potential areas, and this is a focus, I think, of a lot of work in all aspects of what NQF is doing. While NQF is very much involving in convening and one of the 32 National Priorities Partners, it is a separate organization, if you will, and has its own website. So feel free to check out www.nationalprioritiespartnership.org, and you'll get a great deal more information about who the Priority Partners are, their meetings, the issues around each of the priorities and goals, and just the work that's going on with this group.

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We keep an eye on what's going on with the National Priorities Partnership, because all of NQF's activities as a good partner within that organization is focused in on aligning and adding our work and aligning our work with the rest of the partners. So as we try and align the various activities, this is the episode of care framework with the National Priorities Partnership goals and priorities. So we keep trying to align and build on things. So just keep in mind we don't want to ignore all these various activities that are important to NQF.

Another aspect, we're on Slide 19 for those of you on the phone, is the health IT landscape. Health information technology and the evolution, the stimulus to more use of EHRs, is something that NQF is very much involved in. We have a department, a growing, small department that is working on quite a few projects around some of the challenges of adopting of EHR, particularly as a useful tool

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for performance measures, as well as to support the incentives for more use and uptake of EHRs out by clinicians.

So the work that NQF is doing is working around accelerating those efforts, helping work with others on the challenges of getting the right information within the EHR, and characterize the data fields appropriately so it can be used for performance measurement, as well as working with the, all of the stimulus activities around the ARRA, particularly around meaningful use and some of the other issues around EHR development.

The challenges around data we've already touched on, I think a bit. But again, the health information technology capabilities need to be integrated, need to be brought together. There's just a lot going on out there. So NQF is very much involved in all of these spheres, and it's challenging to keep up with what's happening over on that side of house actually. So but we do our best and we

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use Helen to keep us honest and be a messenger between all those activities.

One of the more important activities for performance measure lately is the most recent NQF Health IT expert panel has created what's known as the quality data set.

What NQF staff did last spring and summer was look through all the endorsed NQF measures and identify the actual data elements that it would take to construct those measures, and created a data set called the quality data set, that describes what those data elements are and what the type of data needed to support the quality measurement and the flow.

The IT folks are continuing to work with the quality data set, to look how that would be integrated within an EHR environment, and to incorporate it with actually the work flow within a practice. From this, which is ever-growing as we keep endorsing measures, the idea, the next step is to develop a major authoring tool, such that we can standardize

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the data types and the data elements needed.

So that the definition for a measure about patients with diabetes will have a common denominator. There will be a standard way of specifying it and defining it and identifying the data elements needed. You don't have to keep doing that, each group doing their own thing, and being slightly different.

So this promotes standardization, harmonization, as well as incorporating it into the EHR, kind of all in one activity. So this is something that is rapidly growing, and I believe we just released the quality data set for comment? Oh, it's done. So we've released it as the final report. You can get more information on that on our website.

So there's just a lot of different activities that all interrelate around what NQF is doing, and it's a busy place. Right now I think I'd like to stop and just entertain any questions you might have about

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what NQF is doing in general, around any of the things I've mentioned, or anything else that you'd like to ask

CO-CHAIR SUSMAN: Maybe at the break here, we could introduce our two new members of the group who have walked in, and that will give you all a chance to absorb the 350 slides and tour of NQF that we've had. Maybe Sheila, would you like to start?

CO-CHAIR LEDDY: In your introduction, in addition to introducing yourself, especially talk about your experience with measurement.

CO-CHAIR SUSMAN: And you have to use the microphone, the dreaded red light here.

DR. BOTTS: How's that? I passed the first test. I apologize for being late in my travel. I come from Kentucky. I traveled up from Lexington today and we don't have a Metro in Kentucky, so it took me a little longer than the 30 minutes I planned.

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So anyway, it's a pleasure to be here. I'm from, I have an academic appointment in the College of Pharmacy at the University of Kentucky, and I specialize in mental health. So as a part of my job, I practice in the VA setting in mental health, providing direct patient care and medication management.

I do research in that setting as well, largely focused on adherence and specifically on PTSD at this moment. Another portion of my job as the faculty member is working with our policy and outcomes research group. We have sort of a core group within our college, largely working with Kentucky Medicaid.

So we have done work in schizophrenia and depression, and have a real interest in outcome measures for both of those, and particularly as they affect rural health populations in those specific cultures in the Appalachian region.

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DR. WAN: Hi, good morning. My name is George Wan and I'm from Johnson & Johnson. I'm an epidemiologist and health services researcher by training. I'm currently the outcomes research leader for the CNS franchises as well as immunology at J&J North America Pharmaceuticals.

Our focus in the clinical development area are focused on three primary areas of research in the neurosciences, which includes mood disorders, psychoses and cognition, and prior to joining industry, I worked as a research analyst at the Medicare Peer Review organization for the state of Virginia, which are now the quality improvement organizations, and as well as working as a consultant at the BJC Health Systems Center for Quality Management.

And just to tie that into some of the industry support that we provided, at McNeil, which is a Johnson & Johnson company, we provided grant funding for the development

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of the ADHD quality management or quality of care indicator for HEDIS.

CO-CHAIR SUSMAN: Thank you very much. Now, for your questions about anything you wanted to know about NQF but were afraid to ask.

DR. STREIM: You mentioned that data sources are a main concern, and I see them as one of the big obstacles to the whole NQF enterprise. As health systems are developing their electronic health records, and as payors are developing their databases for measurement and payment, what kind of coordination, if any, is there?

You know, I see all these things evolving sort of in parallel. But how much cross-talk is there? How much do they look to NQF's recently-released sort of definitions and guidelines?

DR. BURSTIN: That's an excellent question, Joel. I'll take that one. When Reva gives me that look, I know this one's

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mine.

The world has evolved so quickly with the release of ARRA. I mean that whole focus on \$40 billion going out the door I think has changed the universe, in a way that I think most of us thought would take at least another five years.

So there is now a great deal of attention. NQF works very closely with the Office of the National Coordinator, with CNS and others. We're in the process right now, for example, of retooling, as we're calling it, the taking a measure that's currently constructed using a variety of other data sources and retooling it for electronic health records, based on the data elements within the quality data set, working closely with health systems and others to say okay, if you're going to make an investment in an EHR coming up, you're going to want to have an EHR that is going to be certified.

Again, so much of this is an

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evolution. We'll find out about the certification requirements to follow, but to achieve meaningful use. One of the requirements is that you have to have the capacity to transmit quality data, you know, quality results.

So a lot of our work has been trying to intersect all those various players.

As they come up with these certification requirements, the health IT standards panel and the Office of the National Coordinator has looked to this quality data set of seeing if one the requirements is you have to be able to transmit quality measures.

You have to make sure you have an EHR that can incorporate these data elements.

So there's a lot of sort knitting together that's happening very, very rapidly. But we're expecting to see this first set of measures that may be used to assess meaningful use being retooled and approved within the next six months.

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Most of those are currently NQF-endorsed measures, and in fact the measures that are going forward beyond that, for 2013 and 2015, align very closely the national priorities and goals that Reva went over with you.

So there's a strong focus on care coordination, for example. So we're going to continue to try to align our work, to make sure that what we're putting out is actually what people need to be able to achieve those goals. That's a great question.

CO-CHAIR SUSMAN: Richard.

DR. GOLDBERG: Just maybe following up on that, that, you know, as important as it is to align people around the EHR, I think in the short run, the next couple of years, we really need to have realignment of what the payors are paying for, to change anything.

I think that's one of our biggest obstacles, is that we have some ideas of how do we evolve this, and we're frustrated

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because they're paying for other things.

So by way of education, starting out with NQF here, what's the involvement of the major payors in this? I don't think one is around the table right now.

So maybe you can explain to me how we're interacting with some of the national payors, and how this will help them be more aware of the need to realign some of the payment mechanisms. Not just Medicaid and Medicare. There's other payors we're dealing with too.

DR. BURSTIN: I'll just mention that most of the major health plans and large purchasers are members of NQF and are very engaged. In fact, the board is consumer purchaser majority, quite intentionally, as is the consumer standards approval committee, the Consensus Standards Approval Committee, excuse me.

Back and forth to San Francisco in a day this week, and I'm still sort of

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recovering, the CSAC. And so we do spend a lot of time doing that. We are not directly involved, obviously, in what things get paid for.

But it's not a surprise if there's a specific measure on a quality of something.

You might think it might have, you know, an expected impact on them.

So I think that, you know, this work should have an impact there, and I think if there are specific elements that are currently not paid for, where a performance measure would be very useful, that might be an important indicator.

DR. ROCA: Reva, you made the comment that NQF is moving towards composite measures. Could you say a little bit more about what that means?

MS. WINKLER: As we're raising the bar, there was a great deal of interest that we hear from all points within the NQF membership, and certainly as we go through the

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process of needing to have more robust measures.

Certainly composite measures, there's a variety of types. We actually over the last two years have had some steering committees look at measure evaluation criteria for composite measures, acknowledging that individual measures could be combined in any number of ways.

You can add them up, you can weight them, you can do any number of combination. Certainly, we hear a great deal from our members and it was a discussion at last week's CSAC meeting, about measures of perfect care, if you will, sort of the all or none measure, you know.

If there are five processes that should be done, rather than an individual measure of each of those processes, ask the question what percentage of your patients got all five?

That takes, that becomes a very

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different question, and for measures that may seem to be doing pretty well and hovering in the high, suddenly asking the question differently realized hmmm, maybe we're not doing as well as we thought we were.

So there is a great deal of interest in those, and I think there is more development of those types of measures happening. Certainly, the feedback from more recent steering committees and CSAC to measure developers has really, you know, made that clear, that those are the type of measures, as well as others, but would be very desirable, rather than having just series of process measures and having, you know, just lots of measures, have them combined concepts around more holistic patient care.

So all of our calls for measures now are open to not only just individual measures but composite measures, and a good composite measure is highly desirable, as we move forward into more robust measures. So

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did that answer your question?

CO-CHAIR SUSMAN: Just to give an example, in Cincinnati, we're looking at diabetes improvement and have a D5, which includes LDO, A1c, blood pressure, smoking and aspirin use.

You know, on the individual measures it might be 70-80 percent. But the D5 composite, in the typical practice, is around 15 percent.

So really striving for that level of perfection, if you will, is challenging. Even in Minnesota, where this has been rolled out for about three years, they're around 19 percent or so.

DR. PINCUS: I guess two questions.

One is coming back to the issues around IT, and actually both Helen and I testified just a couple of weeks ago at the National Coordinators, I guess, yes, sort of coordinating committee, sort of coordinating twice, or policy committee.

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They're clearly, and it relates to sort of our task, because there are clearly some ways by which the mental health field is well behind, in terms of the capacity to utilize some of the information technology in a widespread basis, and also the ways in which the ARRA stuff also is more limiting for mental health.

So one question is as NQF is sort of thinking about, you know, dealing with some of the changes brought on by this influx of resources, and applying sort of more thinking about health information technology, how does mental health fit into it?

And I have a second question, which goes back to the episode-based care thing, that may be relevant as we get further into our task.

But I still have a hard time, even though I was at the meeting that was focusing on episode-based care for alcohol use disorders, of how it actually would get used,

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and particularly how it actually would get used in the context of some of the outcome measurement stuff that we're going to be talking about?

DR. BURSTIN: Well, on the first piece, it's important to note that when the quality data set was assembled of what are those key data elements that should be part of all electronic health records for quality measurement, it was built on the basis of the 500 some-odd quality measures NQF has endorsed.

So there's a bit of, you know, self-fulfilling prophecy here. There's not a whole lot of data elements for mental health.

But the good news is it's supposed to be an iterative quality data set. So we're also hoping as these measures come through, some of those key data elements will get added.

But again, some of the concepts are still there: active medication use, active diagnoses. Some of those should be

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translatable, but if there are specific and unique issues that you think won't get captured, and one of my personal concerns is somebody who still sees patients a half day a week, is that a lot of that mental health stuff sometimes isn't in the EHR.

So the question is how does it even, how do some of those privacy concerns come through and how do we get that connectivity, to ensure we have that information in an environment that people are comfortable, in terms of ensuring privacy.

But from that point of view, I think you guys will help build the quality data set for the mental health field that we don't necessarily have those right elements.

In terms of how you actually ultimately use this episode-based framework, I think we're just beginning to see that. I think if you look towards some of the proposals that are being looked at currently around health reform, for example, there are

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some discussion of doing bundled payments for the acute illness for plus 30 days, for example.

Thinking about the quality measures you would use to assess that acute phase may be different than the ones you might use to assess the in-hospital care.

So I think that, you know, some of that will evolve. But if you look at some of the resource use specialists, for example a lot of those on the chronic illness side look at care across one year. Is that the right approach for mental health? Should there be other potential approaches? What would episodes look like differently?

So that if you wanted to understand outcomes, again I'm a general internist and not a psychiatrist, but certainly you could think about how perhaps, you know, how often somebody gets readmitted in the course of a one-year period, depending on somebody's underlying -- if they had a serious mental

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illness versus low grade depression.

Those may be very different kind of episodes than they would be certainly for somebody who I would tend to see with diabetes.

But it's just being worked out. But I think the idea is to begin to understand how you could have measures that get us out of our silos. So many of our measures are this happened in the end. Like you just looked at those in-patient psych measures.

This happens inside an inpatient psych hospital, but very little connection to what we could have done on the outpatient side to prevent that in the first place, or improve adherence and the work Sheila does, trying to think about different approaches.

Without being able to connect the dots between those different silos of measures, it's hard to get that comprehensive picture that allows us to really improve care.

DR. PINCUS: I guess coming back to

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our task, I mean when the slide that shows it, it laid out sort of one set of outcome measures, you know, if you look at the AMI one.

The question I have is is there an expectation that there would be different outcome measures at different phases that would be tied to it?

So as part of our task, also, to think about the outcome measures that might be appropriate sort of at the acute phase or at the initial post-hospital phase, as compared to the more maintenance phase.

DR. BURSTIN: Again, I think you're the clinical experts. I think it should be driven by what makes sense clinically.

CO-CHAIR SUSMAN: Okay. So I think what we're going to find, as we discuss this with our instructions for the meeting, is that there's a relative paucity of outcome measures currently, and it's one of our tasks to sort of think big about what should this look like

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in a more idealized world.

Where would be the outcome measures be utilized, how would they be utilized, and you know, we'll have to at some point get down to the fact that there's a gap between the reality of today.

But we should be thinking about what would be ideal. We should really be pushing ourselves to move care forward rather than well, we can't do that because we don't capture that data today.

DR. GOLDEN: May I make a brief comment or question?

CO-CHAIR SUSMAN: Please do.

DR. GOLDEN: Yes. This is Bill Golden. Two areas that I have interest in or maybe we could get into the outcomes of outpatient management of children with mental illness. That's a huge need for Medicaid programs, to begin to measure what they're purchasing.

The other thing to think about,

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that goes beyond the episode of the mental illness per se, is the impact of better management of mental illness on the management of comorbid diseases.

So I have looked at the data in our state and we have a large number of hospitalizations inpatient who have comorbid psychiatric disease, and it's a good chance that the comorbid diseases could be better managed if the mental illness is also managed.

CO-CHAIR SUSMAN: I'll just say that we raised those issues as well, and one of the challenges here is to really connect the dots.

First of all with populations, we have a lot of crossover with the childhood origins of mental health issues, particularly serious mental illnesses.

Then on the connection between mental health and quote, you know, "the medical side" if you will, there's really an arbitrary distinction there that I think this

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group should really be working to take down those walls, because we all know how important and bidirectional those influences are. Any other questions?

DR. WAN: I just want to -- George Wan. I just wanted to get NQF's, at least, perspective on certain measures that may not necessarily be, you know, clearly defined patient health outcomes measures. They may be more to the process structure types of parameters.

For instance, medication adherence would be one. The other one would be frequency of followup care or re-hospitalization. So these are known indicators of quality. But would these be parameters within our kind of peer review for discussion?

MS. WINKLER: One of the topics we're going to hopefully spend a fair amount of time on later is we've got a proposed list of the types of outcome measures, and you're

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going to help decide if indeed you would include them as outcome measures or not, or refine them and be more specific for the mental health world.

So we found with our -- and we'll tell you more about the fact that this big outcomes project has several other components to it, and the other steering committees are finding they like it big. So the opportunity to include, you know, other outcomes, intermediate outcomes, functional outcomes, you know.

Medication adherence actually is one that is typically included. You'll have that opportunity to help us. That's what we call setting the scope. So you'll set the boundaries around it for us, and we'll work together to do that this afternoon.

CO-CHAIR SUSMAN: Maybe that's a good transition to the second part of our orientation of the outcomes project. Ian, are you going to take that?

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MR. CORBRIDGE: Yes. I don't know. We're a little bit ahead of schedule. I don't know if people want to get up to stretch or grab a coffee, or if you guys are ready to go. It looks like we'll move forward then.

CO-CHAIR SUSMAN: Two minutes.

MR. CORBRIDGE: There's time enough for that.

CO-CHAIR SUSMAN: Thanks. Those of you online can catch up on your email.

(Whereupon, the above-entitled matter went off the record at 11:18 a.m. and resumed at 11:32 a.m.)

CO-CHAIR LEDDY: Okay. It sounds like -- I thought that was Bill Golden's voice. We're going to resume on Slide No. 23 on your slide set, and tell you a little bit more about this particular project.

As I alluded to earlier, the outcomes project is a rather large project. The mental health component is only one part of it. The entire project is funded by the

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Department of Health and Human Services. They have an interest in pushing outcome measures, identifying outcome measures, particularly around the top 20 Medicare conditions. So that was their focus.

They were amenable to including, for us adding child health, but the 20 top Medicare conditions include depression and other serious mental illnesses, and Alzheimer's and related conditions.

So in organizing this project, it seemed that the child health and the mental health components had special characteristics that suited having separate steering committees to look at the special issues around those topic areas.

Now this is the third steering committee meeting for this outcomes project. The main steering committee and the child health steering committee have already met. We're certainly seeing overlap. The boundaries are not hard and fast.

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It will very much depend on the measures that come forward. If we've got, you know, measures that both are child and mental health, we may have to figure out how to put you guys together and work that through. If we don't have any, then that's not an issue we have to grapple with.

So we are very much aware of the crossover and the fuzzy edges between these, but it does allow child health and mental health to have kind of focuses of their own. This whole project is meant to be big, expansive. We want both cross-cutting types of measures, either for your entire population or your entire population with X condition, as well as condition-specific outcomes. But we are focused in on outcomes.

Within the NQF portfolio of over 500 measures, roughly about 200 of them are outcome measures. We are looking to expand that side of the portfolio to outcome measures.

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So it's not like we've got nothing. But in the area of mental health, we don't have a whole lot, and I think we counted three or something like that.

So there is certainly a need for more, and I'm not aware that we have any measures that really address Alzheimer's as specifically, and certainly not outcome measures. So this is part of a bigger effort.

Anne will be the project manager for the mental health portion of it. I oversee the entire project.

So just keep in mind that there are other aspects, and we'll be sharing things we're learning in all of the different committees, so that we have the benefit of the minds of three groups of folks, as we're trying to think through the challenges of outcome measurement.

Just to kind of show you how it goes, we phased the project strictly as a project management tool. But you can see the

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types of conditions the main steering committee is looking at.

The typical medical conditions, asthma, COPD, coronary artery disease, AMI, heart failure, a-fib, stroke, diabetes, CKD, arthritis, you know, osteoporosis, the different types of cancers, you know, the GI, the cholecystitis, GERD ulcer thing, UTI, pneumonia and eye care and glaucoma and cataract.

Then Phase 3 is where mental health and child health fall in, and the phases have no more meaning than we had to call them something. We could have called them red, green and blue too.

But you will, if you go to our website, you will outcome, patient outcomes Phase 3, and that's where mental health will fall into, just as a way of describing it. So that's the big picture of the outcomes project.

Now I'm going to let Ian sort of

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focus in on the task at hand for mental health.

Project Overview

MR. CORBRIDGE: I guess I just want to make sure that you guys know this is a discussion. So any time you have questions and comments, please feel free to just bring those forward as we're going through, so instead of letting them wait until the end.

So just kind of diving deeper into the actual mental health outcomes project, we're specifically really looking at obviously trying to improve quality within the industry here, but also looking at issues specifically within outcomes in mental health, looking at cross-cutting, non-condition-specific outcomes, as well as obviously condition-specific outcomes, looking at depression and Alzheimer's, as well as related disorders to that.

Another key aspect, I guess, of this outcomes project is looking and

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identifying gaps. So what is there currently within the outcomes field that's targeting mental health?

What would the steering committee like to see? What do we need to see, and then starting to ask the questions where do we need to go to really get those questions?

I think right now, as we don't really have any measures put forward right now, this is an opportunity for us to really start having those discussions, and really engaging those questions, kind of functioning at the higher level at this point.

Then we'll move forward when we actually do get measures, but this is the opportunity for you guys to actually kind of direct and show where we really feel like we are lacking measures currently in mental health.

So moving forward, as I guess has been noted, really there's only currently 16 endorsed measures through NQF that's actually

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targeting mental health, and only three of those 16 are actually outcomes measures.

So a key part of this project is really trying to increase the measures that we have specifically targeting the mental health field. There's a list provided in the background document. I believe it's on page 12, that goes over some of the current, I guess, process as well as outcome measures that are currently targeting mental health within NQF.

So moving forward, this is just kind of a little breakdown of what the current, or I guess both outcome and process measures look at. Some of them are, I guess, disease-specific, looking at bipolar as well as depression. Those are kind of the two primary ones.

Then we have moving down, there's also some process measures, looking at assessment as well as adherence. So just to kind of give you guys a background of what we

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currently have, and to start thinking about what we really feel like we need to have.

All right. And so I guess probably you guys are well aware of some of the challenges that we face, while looking at I guess outcome as well as process measures within the mental health field.

Traditionally, I guess, things have focused on looking at looking at older adults within the acute health care setting, and sometimes our patient population doesn't always fit that bill. They may end up at that point at some point, but they're not always there. So that's a challenge.

Then, I guess, mental health is encompassing. When you look at individuals from a disease standpoint, disease process. We have issues with substance abuse and comorbidities, and we have varying, I guess, points of service utilization from within the community as well as the health care sector.

So when looking at issues of mental

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health, I think the challenges that we're going to face is that it's very broad, and part of our role will be kind of specifically creating a framework of what do we need to look at, and how can we target that.

So that will be part of your role later on this afternoon as we start to look at some of these outcomes. What do you guys feel like we need here?

And just kind of moving down, just kind of inconsistent use, as it's been identified. Individuals with comorbidity sometimes the treatment plans aren't always coinciding.

We're missing either the co-occurring diseases, the chronic diseases, and we're treating the mental illness. So there's a lapse there.

And also sometimes the source of information from the patient population are caregivers. Sometimes it's very inconsistent. We have poor historians of patients, or

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whatever it may be. So that's another key aspect that we're working with.

As has kind of been noted, looking over kind of NQF's plans for the increased measures, we're looking at really increasing the value of the measures that we have. I think starting off with an NQF portfolio, there's a lot of measures put forward.

So now I think we're starting to go back and we're specifically looking at outcome measures. We're really trying to increase the value of those and hold, I guess have some accountability with that.

So moving away from just a process measure, where we check off a box and we completed that stage of whatever process that may be, to actually having targeted outcomes that not only improve quality but also I guess the health and well-being of the patient population or the community.

So as been noted, I guess we talked about kind of retooling measures to make them

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more appropriate to the mental health population. Also kind of looking at enveloping the work of NQF into different activities.

We noted, I guess, the National Priorities Partnership, and that's kind of -- should serve maybe as kind of a framework for us to start looking at.

I didn't provide you guys with the document. I didn't want to burden you guys with a whole bunch of paperwork all at one time and have you not read anything. So I can send that to you later on, and you guys can kind of look at that and see where things may touch with this focus on mental health, or may not be applicable, depending on what you guys see.

But I think it provides a strong guidance for our work here at NQF, and it will probably be very helpful within this steering committee as well, focusing on mental health.

I guess so looking over some issues

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of within NQF, how do we work and how do we function.

There is, I guess, a formal consensus development process that we go through, different stages, and we'll kind of go over -- the next slide we'll go over a breakdown of kind of how we function here, what our role is, what you guys' role is as a steering committee and how that fits into the larger picture.

So I guess kind of as has been noted, we are a multi-stakeholder membership organization. We have consumers, purchasers, different plans, professional organizations, providers, quality researchers as well as community and public health, as well as suppliers within all of that.

Function both, I guess, within the private and public sectors, having representation from both. I guess really the focus is on, I guess, the continuum of health care, and also I guess for this project, it

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may at some point expand beyond that.

I know the patient population with the mental health sector receives health care and health services from a wide variety of different sectors, whether that actually be within a health care facility or within the community.

So I think part of the steering committee's role here will be to actually determine what is the bridge between the different sectors, how do we leverage our resources as a health care industry, and do we have other areas of accountability or do we have other areas that we need to influence. So that will be part of our focus here on the steering committee.

Then I guess at the end, I mean there is the formal endorsement, a voluntary consensus standard. NQF doesn't actually have teeth, in terms of enforcing the standards that we put forward, so they are voluntary. Individuals, hospital entities or whoever has

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the opportunity to actually adopt these.

There is a major steward that should be behind each endorsed measure. But it moves forward from there. There's no actual kind of teeth within that. Oh yes, please.

DR. GOLDBERG: Talking about interaction with the other stakeholders. As usual in these meetings, most of the mental health is in the medical sector. Harold has written about that for decades now.

So whatever we do, we need to think about, you know, the feasibility, utilization by the medical sector, of these things, which is a somewhat different issue but an extremely important issue from its use in the specialized mental health sector.

So again, it's not that linkage, that liaison between this group and I guess what you're calling the main group, is going to be very important, to think how we do that.

So it's not sort of dropped on them

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as news from the outside. When this is seen from the outside, we have a problem.

CO-CHAIR SUSMAN: Well, we're actually the main group.

MR. CORBRIDGE: Correct, and I think that's very important, and there will be a lot of issues, I think specifically as you've noted within this population, that will cross other areas.

So I think part of my role as a project manager is just making sure that you guys are informed of what's going on in other avenues, in other projects within the outcomes project, making sure you guys are informed, and if need be, we can have conference calls between or have some facilitation between those groups.

MS. WINKLER: Do you want me to do the next one?

MR. CORBRIDGE: Sure, yes.

MS. WINKLER: Just here's the schematic of the formal consensus development

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process, and it is formal because in order to comport with federal law, as I mentioned, we have to have very specific characteristics of this -- whoops, of this process.

The consensus development process begins with an identification of specific project topics, and outcomes is where it's at for us. So a key component of this consensus development process or, as we call it, the CDP, is the steering committee. The steering committee acts as the guiding body, the decision-making body that is really the proxy for our multi-stakeholder membership. So you are representing them. In this particular case, you're bringing a particular focus of expertise along with your multi-stakeholder roles.

The project steering committee reviews the candidate measures that have been submitted for evaluation for possible endorsement.

You may -- some projects have

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technical advisors or technical advisory panels to assist them in those evaluations. Each project tends to have a little bit different characteristic, depending on the needs and the expectations within it.

We do have standardized measure evaluation criteria, which we're going to go over with you in some detail. I think that's tomorrow, and ultimately at the end of that evaluation process, your role is to make recommendations to the NQF membership, the public at large if you will, on which measures should go forward for NQF endorsement.

After that, those draft recommendations are then subjected to a 30-day member review and public comment period. The comments that we do get in, we do pay very close attention to, and we will be looking at each individual comment, proposing a response to each individual comment, and we will be back with you to help us do that.

Certainly, comments may cause you

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to reconsider some of your recommendations or revise them or adapt them or whatever. It's meant to be an iterative process with this additional input, because you are representing the members.

That revised draft report is then sent to the NQF members for voting, and they cast votes individually for each of the measures that you recommend. The results of the voting and any comments that come in during voting are then taken to the consensus standards approval committee.

They meet monthly by conference call or in person by meeting, and they review the process, they review the results of the voting, they review some of the major issues that occurred during the project to, sort of as a check on behalf of the board that that process was carried out, that everybody's voices were heard, and that consensus is obtained.

They then make their

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recommendations for the board, and the board basically ratifies the actions of the CSAC. That's not a rubber stamp, because occasionally the board will, you know, decide to go into further discussion or deliberation over something that's been through the entire process. But for the most part, they do rest that responsibility with the CSAC.

Once the board has acted and granted endorsement, they are then known as voluntary consensus standards. They get assigned an NQF number, they go into the database in our library.

There is also a 30 day appeals process after the announcement of the board endorsement. Those appeals are then heard by the CSAC, to determine if any changes in the endorsement decision should be made.

All of the measures that are endorsed by NQF go into an automatic maintenance cycle, so that they're all reviewed in three years for, you know, are

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they still pertinent, are they used, are they still useful? Perhaps they need revision, perhaps they, you know, there are better measures out there. So there are a lot of reasons.

I mentioned the evolution has been relatively rapid over the last few years. So the revision, updating and identifying better measures is just an ongoing effort. So maintenance is a very critical part of the work that we do.

So this is when we talk about the CDP. You all, as a steering committee, are the sort of guiding decision-making body that works very closely with us as the NQF staff. We'll make sure you follow the process. You'll tell us what's going to happen and make those recommendations.

CO-CHAIR SUSMAN: A couple of questions. First Harold?

DR. PINCUS: One thing that's not on the chart is probably among the most

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important things, is the input to the steering committee, the results of the call for measures.

The experience I've had, and actually I've talked about this a little bit with Helen and with Janet, is that you know, we're stuck with dealing with what's out there, what people submit, and in the mental health area in particular there's no entity out there that's sort of a steward for the quality measure development. There's nobody that's really seriously funding this stuff, so it's very spotty.

What role do we have in suggesting, coming up with, measures?

MS. WINKLER: Actually a fairly big one for this particular project. This project for mental health and actually similarly for child health, the reason we're having this meeting with you all up front, before we actually do the call for measures, is we're going to ask you to help us write it, and that

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has two roles.

One is we need to characterize what we're looking for as explicitly, as clearly, as detailed, whatever, so that we can at least, if there's something out there, we can identify it. We also have enlisted your assistance in getting the word out.

That actual call for measures will go out right after the first of the year. So you will also be part of our communications conduit to the mental health community out there, and we will be asking you to, you know, forward the message hither and yon, help us identify who it is we need to really target this message, so that if there are measures out there, they can get submitted to the project.

The second aspect of this project, which we've alluded to, is the second goal, and that is what are the measures that need to be identified, that need to be developed? What is that agenda that's specific to mental

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health, because I think most of us realize that what's available to us not what we need.

So the question will be, as we'll talk some this afternoon as we try and characterize what we would like to have and hope might come in with a call for measures.

But if they don't come in, that's going to be the beginning of identifying the kinds of measures we would like to see developed in the very near future, so that the next time we do this, we won't end up with the very few measures that are probably out there at this point in time. So those are both important aspects.

DR. PINCUS: Okay. Is it my imagination that NQF has developed some resources to be able actually to commission measures so to speak?

DR. BURSTIN: Yes and no. Let me just loop back one second to the measure development side. So we are actually now instituting a part of our process, which is

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about identifying measures for development. So we're trying to at least kind of stay ahead of the curve and identifying where there are measure gaps.

Actually, this is funded under an HHS contract. A fairly large amount of work being done on a condition-specific basis, at least initially, and some cross-cutting work, to see where there are measures, where there are measures that are needed, and really identifying an agenda going forward for measure development.

You will be one of those feeders into that list, for the measures that need to be developed. The thought is that we want to specifically be able to in the future be less about saying whatever measures come across the transom, but say in fact these are the identified measures that need to be developed.

There is also a significant amount of money, again who knows what's happening with health reform, but there's a significant

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amount of money in the current health reform bills to go to AHRQ to support measure development.

So it's been a big hole. There's not a lot of dollars that go out there to support the development of measures. So we're hoping that will go forward as well.

The other thing that I think we all recognize that, especially in the outcomes field, there just aren't that many there. And I think it would be helpful to conceive of this as really sort of Phase 1 of this work. I think our expectation fully is likely in a year or 18 months, we'll reopen the outcomes project and say okay, based on what we said was needed, what's now out there that we can bring through?

So it's very much a period of time where we're going to try to support some of that development. You know, measure development can be -- de novo measurement development can be very, very expensive, and I

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think you really need to be able to have, especially for the outcome side with risk adjustment and things like that, you know, the real resources available to make that work.

To date, there hasn't been a whole lot of availability to do that.

CO-CHAIR SUSMAN: I think Joel, you were next?

DR. STREIM: Yes, a corollary of Harold's first question. I realize people who are sitting on this steering committee were selected for expertise in different areas related to the project.

But I'm also aware that our names were put forward by, and we were nominated. I'm wondering is this group selected actually to represent specific stakeholder organizations or groups of stakeholders, and to what extent are we as individuals here as individual experts versus representatives of -- there were three organizations, I think, that put my name forward?

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Do I have some accountability in getting back to them, besides polling them for input?

DR. BURSTIN: It's an excellent question. The list, the way these committees are constructed specifically is to be multi-stakeholder. So we very carefully went and made sure we tried to get, you know, a bit of a Noah's Ark, of trying to get most of the major stakeholders represented.

We can't always get all of them. we try to, as much as possible. You are really here as an expert, based on your CV and what you bring to the table. But we are also expecting that you bring that stakeholder perspective, which you bring to the table.

Not a lot of people are nominated by three organizations, Joel, so you'll have to work through how you want to split your personality --

DR. STREIM: I was just getting nervous about that.

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DR. BURSTIN: Yes.

CO-CHAIR SUSMAN: Maureen, did you have a comment?

MS. HENNESSEY: Yes. There had been a little bit of reference earlier to the notion that we'd be involved in looking at patient engagement, perhaps in some ways. So one of the things that I was wondering is what is the scope of this group or some others related to it, with looking at measures to promote healthy behavior?

So rather than looking at it from a behavioral health perspective, a healthy behavior perspective which really cuts across many different kinds of disorders.

DR. BURSTIN: So as was mentioned, population health is one of the National Priorities Partnership areas. Specifically one of the goals under population health is trying to think through how you promote healthy behaviors.

You know, there's no reason why if

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that comes up as part of the steering committee, that would fine, if there are some as related to mental health.

But the broader perspective and actually Bonnie will go through a broader discussion with you later, trying to make the connections between population health and mental health in particular.

MS. HENNESSEY: Okay very good.
Thank you.

CO-CHAIR SUSMAN: Okay. Any further comments or comments from our call-ins?

(No response.)

CO-CHAIR SUSMAN: Let's proceed.

DR. GOLDEN: Really, we might need some deep background on how, are there any objective or relatively well-accepted measurements in general of products. I think one of the products of mental health is it's not like you have a glucose level or a lab test.

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That may be our first conceptual challenge, is to figure out, you know, what measurement in general, if we've got standards and performance measurements, just the measurement of the product itself. Will there be a little session on that at some point in the future?

MS. WINKLER: Well, this is Reva. This afternoon, what we want to talk about is the types of outcome measures that might be applicable to this particular patient population, and I think it would be perfectly reasonable for you all to broach some of that, is what is an outcome? You know, what would be a desirable outcome?

What is important information on the outcome around, you know, mental health, around Alzheimer's disease, you know? What do those look like? I think it's not necessarily clear. And so your question is quite pertinent. But that's certainly something open for this group to discuss.

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DR. GOLDEN: Well, I guess my follow-up question is, you know, sometimes we have a unit of measurement like if it's physician care or hospital care or a system. Do you have any preconceived notions about if you're looking for an accountable party for these measures, what that might be, or is that a pretty broad statement at this time?

MS. WINKLER: I think for this first go-round of looking at outcomes measures, I think we're going to be limited by what measures are identified and how they're constructed. Those usually will have an applicability for whatever level of measurement.

I think when we put together the analysis of measures we want to have, we could certainly be a little bit more prescriptive about we would like to see measures at this level or measures of this type, measuring this population or this practice or this organization or this practitioner, whatever it

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is. But I think for the measures that will be evaluated, we'll kind of have to deal with whatever we get. The scope of this project for all of the outcomes is not to limit to any particular setting, and not to limit to any particular level of analysis.

So these are not just hospital or just outpatient measures. They're not just, you know, plan level or system level or facility level. It's whatever would be appropriate. So we really are trying to be as open as possible, and I think it remains to be seen what measures are currently available for us to look at.

MR. CORBRIDGE: All right. If there's no more questions, I guess we'll proceed. It sounds like this afternoon will actually be very productive.

I mean it's the line of questions that you guys and direction that we're going so far, I think will be very good, as we kind of work through some of these issues.

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So just kind further defining some of the roles of the steering committee. I know we've probably touched on a lot of these already. I guess just kind of highlight some of them. Obviously to evaluate candidate measures, that go against a formal measure evaluation criteria, which we'll review later on.

So this is something NQF kind of revised in 2008, so we'll go over some of the old criteria in addition to the new criteria that have been added. So you guys have an understanding of how these measures that come forward, how they'll actually be judged.

So another role of the steering committee will obviously be to make recommendations put forward to, I guess, NQF membership for endorsement.

And those, I guess, the actual measures that you guys look forward to putting up for endorsement will go to, I guess, the CSAC, for which they will review, and the co-

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chairs, I guess, will be there to represent the entire steering committee, if they're able to make that for that process.

So and then I guess you guys, as the measures come forward and if there's any questions or if there's public comments that come up, we will definitely let you guys know what those are, push those forward to you for you guys to review, and move on those.

Then I know that, I guess, for all the steering committees to act on any direction or advice provided by the CSAC.

So obviously, I guess, as has been kind of mentioned, the role for the steering committees is obviously to bring you guys expertise in whatever field that may be or subfield.

So we're really looking to you guys to actually elicit not only the questions that need to be asked, but also help provide the direction of where we need to go.

I guess we all don't have a

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background in mental health, and so we're looking for you guys to provide that. So I guess just some other advice for the steering committee, I guess, to consider.

Information submitted by the measure stewards. There's going to be a lot of different information that comes forward. You guys will have the opportunity to review the information and attachments they provide, and then act accordingly.

I guess at this point, we're looking at drafting measure evaluation for subcriteria. I'm sorry, the criteria. And then another, I guess, role for the steering committee would be to respond obviously to an questions that are put forward to you guys.

And then to provide comments to the committees on measures strength and weakness, obviously after reviewing the measures. You guys will be able to talk amongst yourselves and see how these measures stand up to the criteria for NQF and move accordingly.

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The role of NQF staff, so I guess those of us sitting over here as well as Helen, and others who are working on the outcome project. So we're here basically to assist you guys and helping you formulate the process to evaluate the measures that are put forward, and at this point to come up with a framework to actually solicit what we would like to see as measures, and the direction that we'd like to go.

I guess as myself as the project manager, I'm here to assist you guys if you have any questions, if there needs to be any collaboration between different steering committees, whether it be working with the child health steering committee or whether it be working with the main outcomes steering committee that is dealing with the kind of top 20 conditions.

I guess that will be my role, to help facilitate that process and engage in any communication as necessary.

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Kind of further looking at some of the roles of NQF staff members here, we'll be working on the process of actually putting forward the request for measures. We'll be collecting the measures, we'll be categorizing it, putting it into a format that's simple for you guys to read and disseminate.

I guess just maintaining all the documentation of the entire project, as has been noted. This meeting right here is obviously being recorded for public view, and so individuals from the public as well as members of NQF are able to review and look at the information that we're putting forward, and I guess the topics that we're discussing.

I guess NQF staff also works directly with the measure developers, trying to solicit specific things that you guys elicit that we need to have with the measures for mental health, as well as working with them to try to provide further clarity on if any of the measures, if there's questions, or

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we have trouble kind of understanding the direction of the measure.

Then I guess, as has been noted, just providing communication, dialogue between different steering committees, as well as you guys setting up that framework. So we're hoping that this initial steering committee will allow you guys to not only be able to meet one another, but also provide us with a framework to move forward, but also allow for you guys to engage each other at other times, whether it be via email or for conference calls that we need to have at another time.

So just kind of looking further into NQF endorsement criteria, as I indicated, in 2008, the board of directors kind of reevaluated the major criteria for NQF to use. We'll go over that here shortly.

I guess the main point to kind of reviewing and revisiting this major criteria was to provide clarity within those major criteria and strengthen the recommendations

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and changes for endorsement criteria, in order to really achieve these kind of four goals here, one of those being providing a stronger link to national priorities and higher level performance measures.

So I guess as we're drawing back to that National Priorities document, is really trying to make sure that our measures, our outcomes here are targeting that document, and are following somewhat of that framework to the degree that we feel is applicable for this project, as well as to provide, kind of as indicated here, high level performance measures.

So we're trying to move beyond maybe just checking the box, to actually having strong significant outcome measures that improve quality within the field. I guess greater measure harmonization here. We're really trying to bring in, either whether it be current measures that we do have, or measures that are submitted to us.

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If they're applicable, make sure that they're going together, instead of having multiple measures that target essentially the same thing but may have one slightly different aspect. But make sure we bring those together for greater harmonization and greater emphasis obviously on outcome measures.

As indicated, this is really the focus of this project, and where we're trying to move to within the field. For process measures, we're really trying to tighten them to outcomes and process links. So making sure that the individual process measures within NQF or some that come later on are actually tying into outcomes.

MS. WINKLER: As Ian mentioned, these were the criteria we revised a little over a year ago for -- to raise the bar essentially. This was led by the Consensus Standards Approval Committee, and every time they meet, they really are focusing in on the criteria.

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So we will try and keep you focused in on the criteria and your rationale for either rejecting or recommending a measure should be based on the criteria. There's no scorecard, so you know, that we can use to add it up and a certain number needed to pass. However, we do want to be -- your recommendations to be based in the criteria.

To just show you how that has evolved, because it is important to understand the thinking of certainly the folks on the CSAC and on the board, the prior criteria were the same four, but importance has been more focused on important to measure and report.

This has become a must-pass criteria. It really has to do with the balance between the burden and cost of measurement. Data collection, data crunching and reporting is not -- it's not a minimal resource activity.

So the work should have a reasonably good punch, be important enough to

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be worth the cost of doing the measures. So important measurement reporting has several subcriteria that have to do with things like does it address the National Priorities Partnership; is there a quality problem around this process of care or this outcome; and particularly around the process measures, is there good solid evidence that the process will relate to improved patient outcomes.

So those are the kinds of measures that are likely to provide us the greatest bang for our buck, in both raising the bar of measurement and driving improvement in quality. Scientific acceptability is more focused now on the measure of properties.

It's not the evidence of the measure -- I'm sorry.

DR. PINCUS: Importance for whom?

MS. WINKLER: Right. Well, the issue is around -- that's why those subcriteria are very clearly laid out, and it's the importance as determined by those

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subcriteria.

So if it meets one of the NPP priorities and goals, that's important certainly to NQF and the National Priorities Partnership, as our role in helping support that.

The other option would be high impact. Is it -- does it have high value, high cost, high severity? So you know, high impact. And again, I will agree with you that it is in the eye of the beholder, and certainly when you have different topic areas and more narrowly focused, what's important to this group may not be exactly the same as what's important to another.

But again, there are no absolute thresholds. It doesn't have to have a certain number of patients affected, it doesn't have to have a certain number of dollars cost per year. But again, realize that you're weighing it against the burden of measurement, which is not insignificant. It needs to be very well-

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grounded in the evidence.

So those are the evaluation criteria. Some of it is definitely subjective.

DR. PINCUS: But just as an example, because something, at least, that I've grappled with. On the one hand let's say you're looking at sort of measures for electroconvulsive therapy, which is a relatively rarely used treatment in this country, versus measures for psychotherapy.

Should we care about measures for ECT, given the fact that it's used, you know, maybe on you know, 20 to 30 thousand patients?

As compared to psychotherapy, used on, you know, tens of millions?

MS. WINKLER: That essentially will be the kind of decision the steering committee's here to deal with. The question is will it be useful, valuable and worth the cost of collecting and crunching and reporting the data for both populations?

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DR. BURSTIN: And just to add to that, it's not just the prevalence of a condition. It's also the impact of it. So there may be a small number of patients affected, but with a very significant impact on morbidity or mortality, in which case --

DR. PINCUS: For those patients.

DR. BURSTIN: For those patients, exactly. So as an example, we're doing a project right now on pediatric heart surgery.

Not exactly something you would think off the top of your head boy, now that's the, you know. No question about it. That's going to affect huge numbers of people.

But it's very high impact for kids who have congenital heart disease. So you know, I think that's the balancing act we have to go through. So again, from your perspective where you said you know this area really well.

I mean just as an example, when we initially went through this project focus,

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focusing from with HHS, they were just interested in the top 20 conditions for better care, and we tried to expand it out, saying the universe is bigger than patients over 65.

So for example, we added in serious mental illness. It wasn't on the list. It doesn't apply as a top 20 condition for Medicare, and yet obviously a huge number of people, not for Medicare; Medicaid, yes, but not Medicare. This is one of those strange splits -- I saw your face Richard.

So yes, this is one of those issues that you have to think very broadly from a different perspective. So who's perspective?

We've tried to, at least for the sake of the outcomes project, think big and you guys will help us focus.

DR. WAN: I just have a question about the conditions for consideration. I know that the focus would be mental illness, and you also threw in Alzheimer's. Are there opportunities to identify neurologic

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conditions that have high morbidity as well a low prevalence rates, such as epilepsy?

MS. WINKLER: At this point, we've expanded the topics that were kind of given to us in our agreement with HHS, to expand the mental health beyond depression and wrapped in the dementia. We probably don't have the people we would need to have if we wanted to really go into the other neurologic areas.

So I think we're going to want to stay relatively focused within those parameters, just so we can -- and do the right kind of work.

CO-CHAIR SUSMAN: I would encourage us, though, to think broadly about the interaction with other medical and mental health conditions. So one of the areas that I know will come up is substance abuse and addictions.

Clearly, there's an important bidirectional role there, and we need to consider it, although not get fixated in one

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single area.

DR. ROCA: And along these lines, what about something like delirium?

DR. KAUFER: This is Dan from home or from the office. Yes, I agree with the comment about for right now, leaving Alzheimer's. I think Alzheimer's disease is a very important beachhead to establish, and I think it's probably -- because I've thought about this, and I think it's probably better to focus on that for right now.

Clearly, there are a variety of other neurological conditions that deserve attention in this format. But I think to focus on Alzheimer's disease in the context of mental health, I think, would be a good starting point for further work in that area.

CO-CHAIR SUSMAN: But for example, I would think with Alzheimer's disease and other associated dementias, delirium is a very common concern or outcome that is meaningful to patients.

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So that we might, you know, focus in the connection between treatment, for example, side effects and delirium, as a meaningful outcome. But probably not the condition of delirium itself and all its manifestations in the hospital-outpatient arena and so on.

DR. BURSTIN: This is actually an interesting one. I think that's one of those ones that falls between the cracks to a certain extent, because it isn't a classic condition you would list out on a top 20 conditions.

I actually think delirium, given the importance everybody has put on it in terms of even considering it as a hospital-acquired condition, at least for the initial rounds.

I think it would actually be something I'd put on the table, because I see it as highly linked, that it's not a condition per se, but it's something that will influence

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that whole 20 list on the medical side, as well as a lot of the stuff on this side.

So I would think this is exactly the sort of scope-setting we want you to do. But if you can make a good case why delirium outcome measures are appropriate, I would say bring them in.

DR. KAUFER: This is Dan again. Actually, I agree. I would maybe perhaps change my mind. I agree that delirium and dementia, I think, really do go hand in hand, and to talk about one without the other I think would be, you know, would not give a complete picture.

Because there clearly is very complex interaction between those two disorders. And I think, you know, it may just be a way to see how this evolved in terms of the scope or the relative treatment. This is a question that I have about how Alzheimer's itself fits into all these other disorders.

So maybe putting -- I know within

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DSM, delirium and dementia are kind of go together. So from that point of view, it does kind of make sense to address both of them.

DR. STREIM: I think you've already said you want to put on the table all those cross-cutting issues. I think that's an apt term for neurodegenerative diseases, even beyond Alzheimer's. I mean if you think about Parkinson's, there are the motor manifestations, there are the cognitive manifestations, there are the mood and behavioral manifestations.

I think that's actually a good model for thinking about how to do mental health measures that are relevant to a whole host of comorbid conditions.

DR. BURSTIN: Although explicitly, you know again this top 20 list does explicitly include Alzheimer's and other dementias as conditions, regardless of the mental, you know, whether there's an associated mental condition. So that in and

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of itself.

But I do think there are cross-cutting issues like delirium that I think fit really well, and that will get address. My fear would be otherwise they will fall through the cracks, and not get addressed anywhere.

DR. KAUFER: You know, I think what we -- if this is the scope of this meeting here, I think delirium can be addressed within the context of dementia as a risk factor for it and a comorbidity of it, and maybe not -- I would agree that it probably deserves equal emphasis as Alzheimer's disease, that maybe in this context it might play more of a secondary role, at least for the time being.

CO-CHAIR SUSMAN: Yes.

DR. GOLDEN: A question for a group if I could interrupt that. This topic could also start to potentially use data from non-traditional sources, for things like foster child placements, you know, incarceration, alternative schooling, those kinds of data.

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I was just curious if there's any thought about looking at some of the social data in some of the other governmental agencies, to look at outcomes.

DR. BURSTIN: This afternoon, Bonnie Zell, our population health director, will go over with you sort of intended to be a very wide view of population health and all those potential other sources and places to help you set scope, and decide what you're comfortable with.

But I think, you know, the reality is a lot of data doesn't reside in health care. So we're comfortable pulling data in. I guess the issue is how much do you want to focus attention on? You know, I think at least on the child health committee, there was an interesting, I think, distinction made between yes, we wanted to focus on the broader population health perspective, but at the same time, wanted to have some level of accountability back to health care for the

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measures you want to put forward.

So something that was completely within the context of schools only wouldn't fit. There are somehow schools related to health care would be, assuming I got that right at the end of the meeting, yes. Okay.

MS. HENNESSEY: Could you clarify? Schools would or would not?

DR. BURSTIN: Schools would, as long as there is some connectivity back to an accountable health care system, yes.

MS. WINKLER: Measures that would focus just outside and just reside in the school or, you know, some other non-health care area, you know, that measures that bridge and would have maybe joint accountability, or joint interaction, or how health care should be or needs to be interacting with some of these other entities and organizations, they felt, was definitely included.

DR. GOLDEN: Yes. Let me give you an example. There was a program in Seattle or

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Washington state of treatments, drug treatments for mothers to be, and one of their outcome measures was, you know, reduction in foster child placements. So you kind of mixed those two together.

DR. PINCUS: I guess this discussion also, when you think about another issue related to this. When we talk about conditions, are we talking about measures for the conditions, or measures related to the populations that have those conditions?

So for example, might there be some adjustment to diabetes-related measures for people with serious mental illness that are on antipsychotics?

DR. BURSTIN: I think the interplay is very appropriate.

DR. PINCUS: Good.

CO-CHAIR SUSMAN: So as I understand the agenda, we're going to have a lot of time to really grapple with these questions of scope and vision for this

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project, beginning this afternoon. So great discussion, and do you have a few more slides to give us?

MS. WINKLER: I don't think we need to do -- I just want to finish this slide and then I think we're pretty much ready for lunch. But I'll just mention that feasibility is also one of the criteria, and I know some of you have brought that topic up in terms of, you know, can we even do it?

Although at the same time, I think with all of the evolution that's going on around data, better data management, more sophisticated data systems, whether it's health information exchanges, EHRs, blending, data streams, claims with other electronic data, we're seeing an evolution in what's possible.

And so keeping that forward look in terms of feasibility, and particularly with the emphasis on using health IT, is part of the criteria there. The other is usability.

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This where harmonization becomes important. Can people use these measures? If they're not harmonized, and you have a handful of measures on asthma and they're all characterized slightly differently, that's not useful for people.

So for those that are going to implement measures, can they use them, can they implement them? As well as once you get the information from the measure, result doesn't mean anything to anybody. Is it actionable on the part of participants in the health care system? Is it useful information for patients' families or consumers, purchasers? Does it help? Is the information garnered important? Is it meaningful? Can anybody do anything with it? Is it really a good assessment of quality and actionable.

So those are the criteria. It's important for you to maintain this context. Tomorrow, we're going to go over the actual subcriteria a little bit more in detail, to

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help you understand the criteria which are going to assess the measures.

It will help, I think, us understand the kinds of measures we will be looking for in the call for measures, because all of them will need to be evaluated against these criteria.

But right now, for this afternoon we're going to be talking about the, you know, how do we characterize outcome measures as it applies to this topic, and how do we ask for what possibly might be out there? So with that, I think --

DR. GOLDBERG: Over the last, I don't know, six or eight months, I've attempted to be a user of the NQF site and looking at the measures, and I know part of our job is to look at and think about high level performance measures.

But I wonder what kept NQF from creating some simple categories within this long laundry list of measures? I mean some of

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them are like side effect measures. Some of them are a basic database, did you get the data? Some of them are, you know, sort of treatment evidence and other simple categories that you could think about.

Why is it listed in a kind of laundry list that has no simple categories that could facilitate thinking about what do we have, and can you comment on that?

DR. BURSTIN: Yes, and I'll just say that that was database version 1.0. We've never had that before, so actually getting to this point was a big leap for us. It is only at this point searchable by key word. We are now in the process of trying to figure out, through some work -- we actually have a consultant now, the web team actually now has an external group helping them think that through.

What would be helpful from this group for building that is what are the appropriate filters you'd want to see. We're

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at least putting in, for example, just so you know, what site of care -- what level of analysis the measure is appropriate for. For example, if you want to only pull up measures appropriate for hospitals, it will at least allow you to do that.

We're trying to consider the conditions. Should we link it to the UMLS? I mean there's so many levels of complexity here that I think we're just trying to -- you know, advice is most welcome. We're at the point now of doing that. I suspect the new one will be available within six months.

So they're actively doing it right now, but we wanted to get something out there at least people could begin to search on. I agree, it's definitely clunky.

MS. WINKLER: Actually, I don't think we really have anyone here for public comment. We've got several NQF staffers, but I know. Katie, you're hiding. Come on down and introduce yourself to the rest of the

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committee.

Is anybody else on the phone that joined us who hasn't introduced themselves? Did they open it up? Operator, do you need to open up any of the other lines? Hello? All lines are open. Okay.

CO-CHAIR SUSMAN: So you've been lurking.

DR. GOLDEN: Are we on lunch break?

MS. WINKLER: We're waiting for Katie to introduce herself, and then we'll go to lunch.

DR. GOLDEN: Okay.

NQF Member/Public Comment

MS. MASLOW: I'm sorry for being late, and I didn't want to be rude and come in and just interrupt.

So I'm Katie Maslow. I work for the Alzheimer's Association here in D.C., and I've been on a couple of NQF panels looking at quality indicators, and I'm very excited about this one.

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CO-CHAIR SUSMAN: That's great.
Anyone else have any further comments before
lunch? That would be extremely risky, but --

If not, then we have what is it, a
half hour for lunch? All right. So you know,
just don't be late.

VOICE: When do we reconvene?

MS. WINKLER: Reconvene at one
o'clock.

(Whereupon, the above-entitled
matter went off the record at 12:26 p.m. and
resumed at 1:17 p.m.)

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A F T E R N O O N S E S S I O N

1:17 p.m.

CO-CHAIR LEDDY: Okay. So we'll start the afternoon agenda. A couple more people will be joining us.

So what we're going to do this afternoon starting at 1:15 is we've sort of already done the orientation to the project of the steering committee, because we were so efficient in the morning, and so we're going to continue with the moving into the framework for the mental health outcomes.

MR. CORBRIDGE: All right, and do we have individuals that are on the phone still?

DR. GOLDEN: Yes. Bill Golden's back. How are you?

MR. CORBRIDGE: I'm doing well, thanks.

DR. KAUFER: Dan.

CO-CHAIR LEDDY: Dan Kaufer is there.

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MS. WILKINS: Hi, it's Carol Wilkins.

CO-CHAIR LEDDY: Carol. One thing I would ask the people on the phone, just from being in the room's point of view, is especially for those of you who don't know you and recognize your voices, if before you make comments, because you've made some very interesting comments, if you could just say who you are, that would help us, I think.

DR. GOLDEN: Sure.

Orientation to Project

MR. CORBRIDGE: Wonderful, okay. Well, I guess we'll start then, for the afternoon session, and for those on the phone, we are going to be just kind of starting off on Slide 39, which we didn't finish up before we went to lunch, and it's just kind of providing a brief project time line for what we're going to be working on, in terms of dates.

So obviously, we had the selection

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of the steering committee and we're having our first meeting right now, and as we've indicated, we're hopefully looking to have our first call for measures in mid-January, and then hopefully have our second steering committee once we have those measures, actually packaged and ready for you guys to see and have viewed them. So in April we'll come together and actually talk over those measures again.

Determining an Appropriate Framework

MR. CORBRIDGE: As we go through the afternoon, if you guys please, it's a discussion. So if you have any questions, comments, please just engage. So just kind of looking at the scope of the outcomes project, just Donabedian's kind of definition of what outcomes refer to.

So outcomes refer to changes, desirable or undesirable in individuals and populations that are attributed to health care. Now this is just, I guess, one

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perspective that we're going with, and I guess at this point I wanted to open it up to you guys, to see if this is something that was agreeable to the steering committee, and if so, we'll make comments and go from there.

MS. WINKLER: This is a fairly classic construct for measuring performance. But I think the issues around the definition that are important is desirable or undesirable, individuals or populations, and attributed to health care. So this kind of sets a certain parameter for when we talk about outcome measures. All of that is part of outcome measures.

DR. STREIM: And that's health care broadly defined to include health behaviors, as well as -- or is it just health behaviors within the context of the health care system, as opposed to somebody going to the gym on their own to exercise?

MS. WINKLER: Well, I think that from a realistic perspective, if we're going

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to use these measures for things like public reporting and accountability of some entity, NQF's focus is the health care world is sort of where we're at.

Certainly, some of the times those boundaries may -- can be pushed a little bit, with sort of joint interaction between health care entities and maybe those outside, and leveraging sort of joint responsibility.

DR. STREIM: Sure. Well, the reason I asked is because I'm aware that some payors are now actually paying for gym memberships and providers are encouraging their use, as part of a treatment plan. And so that's health care.

MR. CORBRIDGE: Again, I think part of what you guys' role here will be to do is to really kind of decide that framework of what are we going to include and exclude within this.

DR. PINCUS: Actually, let me just focus on a couple of other words in there.

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Number one, "changes," and number two, "in," and number three, "individuals." So that, you know, there's many things can change. So if change in what, you know, so earlier we talked a little bit about adherence potentially being in there. I mean that's a change, you know, to whether people are more or less adherent, based upon some intervention or another.

But that's usually considered a process measure. Does the sense "in individuals," meaning something internal, i.e., physiological? And thinking about individuals, which individuals?

So if you're looking at, for example, an outcome related to the treatment of depression in moms and one of the outcomes is the proportion of moms whose kids are fully immunized, is that an outcome measure, even though the individuals are one step removed?

MS. WINKLER: I think those are all, you know, really good questions and they do speak to the scope that we're asking you to

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really consider. I think that to look at the first question you asked about changes, I think that in general, outcomes are felt to be some kind of result.

So perhaps changes or results of impact of or something like that is the implication. I don't know if there's a better word than "changes." This is the traditional construct.

In terms of individuals and populations, I mean I think individuals are patients as one, and it's issues around the outcomes for that individual patient. Within a population of, say, a practice, it would be the aggregate experience of those patients, each patient, attributed to that practice.

Populations also can be looked at in bigger areas. Practice population, geographic population, population of patients with a certain condition. So I don't think it's tightly defined. It's a little bit more loosely defined.

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DR. GOLDBERG: Yes. I just want to make a point. If we're going to be talking about accountability of people, that we'd be careful in the scope not to hold people accountable for things that are beyond their control, that when we cross from individuals to populations, a lot of patient behaviors, for example, are not in the control of the provider.

I think you have to watch for that, when we're asking providers to be accountable for certain changes.

MS. WINKLER: I'm wondering --

DR. GOLDEN: Well, in some ways, also because of the, what is the word, vagueness or the lack of distinct borders probably seclusion of an episode pair, you know, a cost parameter could actually be in some ways a philosophy here, you know, the question of can you duration and intensity of services versus outcomes is actually very applicable to mental health, because of the

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length of time or number of sessions per week.

It's a bit uncertain in many systems, just what is an appropriate mix of intensity versus outcome?

DR. MANTON: I'm also wondering if there should be a word after "health care," like "intervention" or "action" or something. It seems unfinished. You know, health care seems too broad. It could just -- yes.

I'm also thinking that "changes" isn't maybe always what we want. Maybe we want to maintain certain behaviors. So --

CO-CHAIR SUSMAN: There's also this issue of accountability and the tension between what a consumer, a health plan or employer might see as accountability, versus what we as clinicians sort of view as the limits of our accountability.

And certainly I think we have to wrestle with that, in a way that not only is true to the three or four stakeholders we represent, but also looking at, you know,

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what's best for the health of populations, and perhaps becoming more willing to assume accountability as providers of care for things that aren't directly under our control.

Whether it's smoking cessation. I mean after all, I don't stop the smoking cessation. I can counsel and you know, is that a legitimate expectation of providers.

I would argue yes, it probably is, whether you're smoking or not, because you can counsel in a way that's either more or less effective, to just take a very particular example, but the one that could be used, I think, as we move forward to consider similar issues.

MS. HENNESSEY: And one of the ways that is helpful for me is to think about the fact that as a clinician, I am not responsible for a patient's smoking cessation, but I am responsible for influencing his or her decision to stop smoking.

DR. WAN: When we talked about

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attributed to health care, another approach to look at it would be based on some type of treatment option or treatment strategy, and it could be non-pharmacologic or pharmacologic in nature, as an example.

MS. WILKINS: This is Carol Wilkins. I have another question about that "attributable to health care" dimension, and particularly in the realm of mental health. There are also consequences or outcomes that are attributable to barriers or limitations on access to care.

Those can be capacity limitations; those can be the failure to assess and identify the mental health condition. That is part of what may bring someone to come to emergency rooms, you know, 20 times a year, for medical concerns.

Or it may have to do with policies and practices in the health care delivery system that for example, in some settings might require sobriety as a pre-condition for

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treatment.

So when a person suffering with substance abuse doesn't get access to or gets kicked out of a treatment intervention or health care service. So I guess I'm wondering, this presumes that people actually get care, and that that's where we're looking at quality outcomes.

But I would presume we also want to look at outcomes that are attributable to avoidable or changeable, modifiable barriers to access.

CO-CHAIR SUSMAN: I mean I think the whole structural barriers to health care are part and parcel of what we should be dealing with here, particularly in the mental health arena and in individuals with cognitive impairment. It seems like that's often one of the most important things we can do, is to tear down those barriers.

MR. CORBRIDGE: And I guess just to kind of follow up with some, I guess, comments

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or views that were expressed, Bonnie Zell will be talking, I guess later on today, really about issues of maybe dual accountability. So maybe it's something that the health care sector can also work with or leverage with other resources, whether it be in the community or everywhere that may be, where there's dual accountability within a system.

So the health care system leverages resources in combination with another entity.

So that will be something that she'll bring up and something that for you guys to discuss later on this afternoon.

So if we can move forward on this, just kind of looking at some different domains within a framework that we'd be looking at within the mental health field, I guess traditionally, or things that we've looked at.

At NQF, predominantly our measures have been by disease type. That's one I guess domain or way that it can be stratified. Also by health status, whether one's healthy,

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chronic illness or special needs would also be another way.

Also it can be, I guess, broken down by the setting of care, whether that be in the hospital, outpatient within the community or whatever that living environment may be for that individual.

So these are different avenues that we've looked at, and I guess as a steering committee if you guys have any insight, if we need to be looking at any additional, if you'd like to I guess restructure, organize, or is this something that's agreeable?

DR. STREIM: Well, under the rubric of health status, I would probably separate out chronic illness from disability. I'm making a distinction about functional status.

I don't know whether you meant that to be included under the rubric of special needs. Maybe you can clarify what you meant by "special needs."

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MR. CORBRIDGE: I guess special needs are depending on, I guess, upon the situation you'd be looking at. Does the individual need assistance with any special area, from a carryover standpoint? Is there any assistance that's needed from the health care system in providing care for this individual?

DR. STREIM: So maybe saying "functional status" would capture that more explicitly. It's more descriptive.

MR. CORBRIDGE: I mean I think the whole concept or model of recovery is something that we should try to embody here, and it's probably equally important in care for elders, as it is for those with serious mental illnesses, depression.

DR. PINCUS: Yes. I think typically when people think about it, and I guess I'm not sure how you're using the term "domains" here, whether you're talking about sort of the categories in which we're going to

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be measuring people like disease type, or whether you're talking about a domain of outcomes like symptoms, and the symptoms might be by disease type.

Because I think that symptomatic status versus functional status, you know, are typically conceptualized as, you know, related, and then within functional size, the different domains within that of functional status, you know, whether we're talking about social or occupational or other kinds of fact features.

The other thing is with regard to settings of care. Why specifically settings of care as being a domain of measurement, as compared to sort of the category in which you may have different measures, but it's not so much a domain of measurement in and of itself.

But I can imagine that there might be domains of measurement that have to do with an individual's sort of relationship in one way or another with their environment, both

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psychosocially and also more instrumentally. So that, you know, so that there might be certain psychosocial problems that would be important to look at, for example, homelessness or sort of interaction with the justice system, you know, that might be relevant for different categories.

I would think of those things as being more domains rather than settings of care.

MS. WINKLER: Yes. Just in response, when we're talking about a framework, in its most simplistic form we're looking at being able to look at the various characteristics of measurement, say on a two by two table, and say okay, we have these three measures, and they fit into these slots.

Then measures that may come may fill in a couple of other slots, and we're going to have some empty slots.

Those were really the important -- and look at those for important gaps in care.

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So the question is what are the titles of the rows and columns, if you will, on our grid. These are domains that are very, very typical in traditional measurement, I mean, by disease states.

It's the main steering committee, you know. It's diabetes, CKD, coronary artery disease, blah blah blah. It's disease states. Health status is another one, because healthy is usually preventive care. Chronic illness is the same illnesses.

Special needs are, can include disability or some other thing that may be particularly pertinent for certain disease states, particularly children and others. Settings of care is the most traditional way to measure things, because you know, we've got hospital measures, we've got outpatient measures, we've got nursing home measures, we've got home health measures.

So that's the most traditional way to slice and dice, and look at measures for a

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group. But these may very well not be the appropriate ones for mental health, and that's the question. That's what we need your help, is what would those be for this particular group of patients.

CO-CHAIR SUSMAN: I think Richard and Robert, and then Luc.

DR. GOLDBERG: Yes, I see this slide as starting to raise the issue of stratification and risk adjustment, that you know, at one end of the continuum, we all know that outcomes are multi-dimensionally determined.

At one end of the continuum in our field, I mean some people start to argue with it's almost individual-based, which leads us to a big problem if it is.

At the other end, you've got outcomes that are so global that people are going to argue forever around the risk adjustment and stratification of the problem.

So one of our challenges is how to get into

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meaningful categorization, where there's not an infinite number of categories that are based on individuals, nor is it so large that the usefulness of it is lost in a risk adjustment dilemma.

So creating those kind of categories is one of our challenges, I think.

DR. ROCA: I just wanted to underscore the importance, I think, of distinguishing between measures of symptoms and measures of function.

I mean when people come to us for care, they're usually wanting to feel better and do better, and that really speaks to both things that we might measure as symptoms that are in the subjective realm, and things that we might measure as function that are in the realm of things that might be observed by an outside observer. I think that it's important to preserve that distinction.

MS. HENNESSEY: I agree, and I would even take it another step, which is to

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say I think we need to be looking at not only the consumer satisfaction, but also the caregiver satisfaction, particularly when we get into areas, for example, like dementia, Alzheimer's and so on.

MR. PELLETIER: I just wonder if the settings of care are just too limiting and foster actually the silos that we don't want to talk about, that we don't want to focus on, and I think care coordination is probably more of the glue that keeps us paying attention to the needs of the patient as they move through all of the settings.

So I hope that our model is fresh in that respect, and that we really identify or acknowledge the uniqueness of mental health, which is a multi-disciplinary form of treatment.

CO-CHAIR SUSMAN: I mean this whole concept of providing the right care at the right location at the right time is really where we should be heading, and while I might

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be able to provide care in a hospital setting, if I can provide either preventive care to avoid hospitalization, or perhaps provide the care in the context of the home or an outpatient setting that's more attuned to a patient and family's needs, that's really where I think the field should be heading.

If we have this sort of overarching goal, we should be trying to get care more attuned and surrounded by the patient's needs and desires, rather than this artificial nature of well, here's the hospital but we've missed the whole point, that we could have avoided hospitalization in the first place.

MR. PELLETIER: But the pieces that get missed are the hand-offs from all those settings, and I think that hopefully we'll be able to talk about what are accountabilities.

I work in inpatient. What's my accountability to the next level of care? I have to have accountability to them.

DR. GOLDBERG: You know, I'd like

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to echo that. It's sort of a little too provocative, but to have at the end of our work, if people say where are the hospital outcome measures? We don't have any. We're talking about episodic care. Stop thinking about the hospital outcome. Start thinking about what happens to this person over nine months of treatment.

That may be a little stark; I know we're not going to go that far, but I mean I think your point is very good, that if you create these settings, it kind of slots people into thinking in silos again. Too much.

MR. PELLETIER: Right, and it also, I think, gives the message to a developer that oh, they're just interested in acute measures, which we're not. We're interested in, and we have to find a word, care continuum or care coordination, where there is --

MS. HENNESSEY: Transitions of care.

MR. PELLETIER: Transition, right.

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Transitional care.

MS. HENNESSEY: I think the other thing that I think about is even going back to the component of empowerment for self-care, so that care is not something that we as caregivers or clinical professionals are providing. It's also that which we provide for ourselves.

MS. JAFFE: I also think that if we can somehow weed the recovery model into these domains, that that's really, as we're trying to bring in other stakeholders in mental health, the conversation that is happening in other areas, along with the persons that are in a medical home as a setting of care.

If we're looking into the future and thinking about the future, that's really probably the conversation that we want to also make sure we include.

MR. PELLETIER: And that's in alignment with other national standards and reports, mental health reports, etcetera.

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DR. PINCUS: I think one way I think that may be confusing us a little bit is that a framework is not the same as domains, and you know, so when I think of a framework, like the rows and columns, it's a way of categorizing different measures that may have, that are measuring different domains.

So I could see one dimension being, you know, disease type, including a category that cross-cutting across diseases. I could see another dimension of the framework being sort of somewhere along the continuum of care, something might be most commonly measured, also one that -- you know, and also having a category that's sort of not specified in terms of that.

Then a third dimension being one around specific outcome domains that might include symptomatic functioning, you know, symptomatic status, functioning in different domains, subdomains of functioning, and also incorporating other kinds of issues that might

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have to do with health care utilization and cost and things like that.

DR. GOLDEN: Well, mental health also lends itself to access issues. I don't know if that's a part of your continuity of coordination.

But there's some interesting data out there that says that, you know, if you can't get a psychiatric consult in an ER, you're more likely to be admitted to a hospital, and especially in rural areas, the availability of specialty care.

So I don't know if that's part of the domain there or whether that's separate category.

CO-CHAIR SUSMAN: Joel, did you have a question?

DR. STREIM: Well, I think Harold addressed my main concern, which was that this slide was hard for me to wrap my brain around, and I think the way he described it helps. So I would endorse the idea of sort of rethinking

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how to describe a framework.

That said, I was wondering if it would also be useful to go back to your first principle, Reva, I think, about you know, importance of the measure as being the first cut in determining what's a valuable outcome measure.

I think in terms of outcomes, you know, what really matters? It's health status in that it causes -- you know, if you're talking about diseases, it's that the signs and symptoms of disease under that first bullet are causing distress, disability, you know, social dysfunction, whatever, and affecting quality of life.

I think those are the sorts of -- I'm not sure. I wouldn't call those domains per se. Those are just sort of categories of outcomes to be measured that are of importance.

The other one, you know, I'm talking about some examples that apply to

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individuals. But we also do need to think about examples that apply to the health of the community or the health of the nation.

And you know, if you're talking about controlling infectious diseases that are transmissible in communities, you know, your outcome measure may have to do with something like staying on your INH, you know, that adherence affects communities.

So I think that's what I would include under the rubric of health status, both the health of individuals and the health of communities. And sort of as clinicians, we think of in terms of what makes a symptom or an outcome clinically significant?

When we talk about the concept of clinical significance, it's again what causes distress and interferes with function?

CO-CHAIR LEDDY: Any other comments on the potential domains? It seems like we need more of a definition for what a domain is. Like if it's a grid, is it just one

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section of the grid?

MS. WINKLER: What these next several slides are doing is offering you ways you might slice and dice it. So this is just Slide 1 of 4. So let's see --

CO-CHAIR LEDDY: Do we have other options Reva?

CO-CHAIR SUSMAN: We're hoping the next three are more to our liking.

(Laughter.)

MS. WINKLER: Good.

MR. CORBRIDGE: So just kind of moving on in the continuing discussion that we're having here, in trying to really decide what an appropriate framework would be as looking at different areas where information can come from, I guess information in terms of outcomes can come from the patient or caregiver within the mental health population, as reported by either that patient or caregiver.

We have clinician-observed

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outcomes. What did I as a clinician observe within this setting, or we can have physiological outcomes, going along with vital signs or lab results.

So this just kind of, as Reva indicated, further just trying to figure out how we would slice and dice what we're ultimately trying to determine and create here. Yes.

DR. PINCUS: We had a category, inferred outcomes from secondary data, that would be relevant. For example, you know, again looking to domains that move a little bit outside health care, but might be relevant, again for kids, sort of school absences.

MR. CORBRIDGE: I think very much so. I mean that's where hopefully the discussion will come later on this afternoon. Were there any other questions? Yes.

MR. PELLETIER: Was there any consideration of having a consumer group at

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the table?

MS. WINKLER: We have consumer groups at the table.

MR. PELLETIER: Oh today? Great.

MR. CORBRIDGE: Yes.

MR. PELLETIER: Okay, great.

MS. WINKLER: Consumers, raise your hands. Katie, Maureen. Great. We do try. That's a real important stakeholder to have at the table.

Identifying/Evaluating Outcome Measures

MR. CORBRIDGE: Okay. So just kind of moving on further here. So this would be kind of looking at some outcomes that we have put forward for you guys to really hash out and look and see if these are applicable to what you feel is pertinent to the mental health population, and to move forward.

So we're just going to kind of go through the list and please feel free to comment. We'll try to write down, and I guess this is the point where we're really going to

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try write down.

I guess this is the point where we're really going to try to take your comments and insights, and try to really develop the framework so we can give you guys tomorrow. This is what you gave to us; how can we further work it out and to get what you guys are ultimately going for?

So just looking at one type of outcomes, you can have patient function, as we've discussed; systems health, related quality of life, physical, mental and social.

So we have some examples along with that, activities of daily living, continence, cognition, pain, depression.

So I don't know. We can go through these or if you guys have any questions at any time as we go through them, please bring those up and we'll try to --

DR. PINCUS: In mental health we really want to separate out symptoms and functioning.

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MR. CORBRIDGE: Okay.

DR. PINCUS: Because really, they're conceptualized really quite differently, and there are different ways by which it's measured. And so I think that's critical.

You know, whether one wants to put health-related quality of life as a subset of functioning or as a separate category, you know, that's I think more of a matter of taste.

DR. STREIM: I would argue for separate. Most of my colleagues who do rehab medicine would say that you can have somebody who's quite disabled and functioning at a low level who has -- would appraise themselves as having a very good quality of life and vice-versa, high functioning people who have think they have terrible quality of life.

So I think there's such different constructs in how they're measured and what you get.

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MR. CORBRIDGE: Okay.

MS. MASLOW: I think that the cognition in the examples is a problem for people with dementia. This is a measure that's very common.

It's in HEDIS and so on. It assumes that you can improve cognition, and so if it's going to be there, it needs to be phrased differently.

So maximizing or some word that recognizes that you can have -- you are going to have worsening cognition in these conditions, but a goal is the best possible cognitive functioning, I guess. So maybe that's sort of subsumed in the function symptoms.

CO-CHAIR SUSMAN: You've said --

DR. PINCUS: I think of cognition as being one of the subdomains of symptoms.

MS. MASLOW: But what if you can't make it better?

DR. PINCUS: I mean still, that's

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where it goes. I mean --

DR. STREIM: Well, I think that's true for a lot of chronic illnesses that are -- particularly for all the degenerative disorders.

Arthritis, you can control the symptom, you can prevent it from getting worse, you can perhaps reduce the rate of decline or severity. But it may get worse over time, no matter what you do, given current available health care.

So I think measuring symptoms, you're right, it doesn't have to be about improving symptoms. It could be ameliorating the rate of decline.

MS. MASLOW: But in Alzheimer's and most dementias, you can't do that either. You can affect the person's functioning --

DR. PINCUS: Right, right. I mean that's precisely the reason to separate it out, symptoms from functioning.

MS. MASLOW: Yes, yes.

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DR. PINCUS: So that one might say again, if you're looking at the matrix within Alzheimer's, you know, clearly you can measure symptoms, cognitive symptoms related to Alzheimer's.

But we may not recommend that that be a measure. We may recommend instead that the cell that has functioning should be endorsed for Alzheimer's, not the cell that has symptoms.

CO-CHAIR SUSMAN: I hear more agreement than disagreement in the end on this one.

DR. KAUFER: This is Dan. I'd like to comment on that. I think the issue with cognition is very important and very complex, especially because within a natural history of dementia, Alzheimer's and other dementias, cognition plays a variable role at different stages in the disease.

Early on, it's the primary factor. But later on in the course of the disease,

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functional disability and behavioral symptoms often become what is the most prominent manifestation, at least, with respect to care and management.

The standard, though, is to really just do cognitive assessments at all levels of the disease in standard clinical practice settings.

And what's disappointing to me is that there has really been a relative lack of development of appropriate measures for behavior and function that are widely used in clinical practice settings, although these really, I think, could be very useful and should be part, should be at least considered as part of what we would recommend.

CO-CHAIR SUSMAN: Rich.

DR. GOLDBERG: When I saw this chart in the handout that you mailed out, I kind of scratched my head and said what are these categories? I wasn't sure they all hung together.

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I mean if the top one is kind of patient observable behaviors, and the second one is measurable physiologic things and the third one is experiences, and the fourth is utilization, why isn't the third one health behaviors? Why isn't that up in the top line?

So when I asked myself that, then I wondered well what is the underlying basis for these four rows? I couldn't quite tell, because it seemed to be sort of observable experience, tests, subjective experiences that are measured in some way and then utilization.

Is that it? If so, they're not -- they don't all fit in right.

DR. PINCUS: I think the purpose of this discussion is for us to sort of pick it apart.

DR. GOLDBERG: Okay.

DR. PINCUS: It seems to me that a separate category ought to be, as you said, health-related behaviors. It should be, you know, should be a separate and distinct

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category.

MS. WINKLER: Just in response to your question, how did we get there? Actually, we were drafting a proposal to go to HHS. We wanted to describe that our interest was in being broad. So we created these bullets.

We've taken these set of bullets to each of the three steering committees, and it's amazing, the end result. You're all having fun with sort of fixing them for where we are.

So that yes, I think Richard, that was the intent. We didn't quite hit it in terms of you're right. Perhaps behaviors belong in the first one, and most of the committees have broken them more apart, to be specific.

DR. GOLDBERG: It's not meant to be critical of your preparation for this. I know that's what we're here for.

MS. WINKLER: But this is what

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we're exactly asking you to do is make it right and applicable to mental health.

MS. HENNESSEY: You know, I think in the examples case I would hit on the issue of caregiver and consumer satisfaction. Not just knowledge and understanding, but also satisfaction, whatever your experiences are.

DR. WAN: I just want to tie this into the patient function piece, which is very important as well, is the impact on those who are actually working. So who presently is in more work productivity, just calling that out as a separate, or at least alongside patient function.

CO-CHAIR SUSMAN: I mean the whole idea of meaningful work, I think, particularly for people with serious mental illness, is very important for us to consider in here.

MR. CORBRIDGE: Any additional insight or is that -- should we try to proceed down to the next one?

DR. PINCUS: Well, I mean are we

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supposed to now -- the question is whether our task is to, whether our task is to actually come up with a different set of categories, or is this just opening, or are we going to do that later?

MS. WINKLER: Essentially what we're going to do is take the discussion you're having and rewrite it, and then tomorrow, you're going to get a chance to look at it again and we write some more.

DR. STREIM: So this isn't just to give us the gist of the kind of thing. You want us to actually crystalize the categories that we think should be used right now?

MR. CORBRIDGE: Correct.

MS. WINKLER: Yes, because what we're going to do is list these out in our call for measures, describing what we mean by outcome measures, the outcomes we're really looking for, so that we can be explicit, so that people know.

Because I think if you say we want

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mental health outcome measures, you know, you get all sorts of different assumptions and what we mean by that.

So we're trying to be very descriptive and explicit about what it is we're looking for, and that's really your task, is to help us crystallize it. I think that was a good term.

DR. PINCUS: Okay. I would put up eight categories, of symptoms, functioning, health-related quality of life, health-related behaviors, secondary impacts, which would include things like presenteeism and absenteeism, things like, parental care as indicated by things like, you know, kids getting vaccinated or school absences and other kind of things. So that would be in that category.

(Simultaneous discussion.)

DR. PINCUS: No. I said I was going to symptoms, functioning, health-related quality of life, health-related behaviors,

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secondary impacts of health care, service utilization, which is sort of the thing that's at the bottom and then direct physiological measurement.

Oh yes, I didn't see the second one. I was just looking at that one.

MS. WINKLER: Oh yes. There's more.

CO-CHAIR LEDDY: I'm the worst at that. What about the patient satisfaction --

DR. PINCUS: Yes. I would put that under patient and caregiver perceptions of care.

MS. JAFFE: I also think we need something in there related to patient participation in care.

(Simultaneous discussion.)

DR. PINCUS: The whole issue -- you know, the question of, you know, the whole concept of recovery is about whether there needs to be something that captures that explicitly.

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MS. MASLOW: How about safety?

DR. PINCUS: Yes. Well, I guess I didn't get to that.

DR. GOLDBERG: Let's get the list out and we can always write it down. It's a good time to --

(Simultaneous discussion.)

CO-CHAIR SUSMAN: I mean I can read back what I've heard, and let me know if I miss one. There's symptoms and then maybe Reva can -- we'll wait a moment for the technical to catch up to the cognitive here.

DR. GOLDBERG: So while we're working on that, I would actually propose to separate symptoms and signs of disease or illness.

Whereas symptoms are subjective, self-reported signs or the observable, and that would capture, Harold was saying, physiologic measures, but also other observable things that can result in illness measurement.

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But I think those are --

DR. PINCUS: What other than physio were you thinking about? Because the problem is when you look at the actual measures that people use, it's usually some kind -- it's rare that there is, other than direct physiological measurement, it's rare that there's an actual instrument that doesn't combine symptoms and signs.

DR. GOLDBERG: Well, I guess when you talk about health behaviors, that may be one of the observable categories. That's something we can see and you can rate it --

DR. PINCUS: Right, but usually it's some kind of -- you know, usually the rating is based not just upon observations; it's based upon hearing some verbal reports from the patient too.

CO-CHAIR SUSMAN: Okay. We've got the technical. So we have symptoms, perhaps signs, depending on how we -- function, health-related quality of life, health-related

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behaviors. We had service utilization, direct physiologic, caregiver, perception of care, satisfaction, safety.

MS. MASLOW: Physiologic measures.

CO-CHAIR SUSMAN: And the last, safety?

CO-CHAIR LEDDY: I'm just wondering under secondary impacts or physiologic measures, is that where we would look at, for example, hemoglobin A1C in a patient?

CO-CHAIR SUSMAN: I can do that.

DR. PINCUS: I would separate it. I was thinking initially about looking at the first thing, secondary impacts of, you know, in the psychosocial environment, so to speak, as compared to secondary impacts.

CO-CHAIR LEDDY: But I think that --

DR. PINCUS: --in non-mental health domains.

CO-CHAIR LEDDY: But What about that cross-cutting of the medical and the mental health, I mean because there's such a huge

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impact. I think that there needs to be some place that we're capturing that.

DR. GOLDBERG: Maybe under physiologic, looking at --

CO-CHAIR LEDDY: I don't know that it's necessarily always physiologic. I mean it's -- that's why I was asking is it physiologic or is it secondary --

DR. PINCUS: Well no, but you're also talking about its impacts, intended versus its unintended impacts too, is really what you're thinking of as well.

So that, you know, like you're not intending to cause obesity when you're treating somebody with an atypical anti-psychotic. It's a side effect, but it's something that then indicates that, you know, given that --

But there are also situations where even though your treatment may not be causing or necessarily even affecting their health status, that you know, people with a mental

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illness may have a high risk for having a health problem, and part of again, your sort of mutual responsibility kind of thing and accountability is that it's your responsibility to make sure that the person gets good general health care and gets good preventive care.

CO-CHAIR SUSMAN: So perhaps what we could do, just so we're all on the same page --, is to go down the list and make sure we all understand what each one of these categories is, because I'm having a hard time personally at least making sure I know what's in the buckets. If we can do that, I think it will be helpful for all of us.

DR. PINCUS: Probably we will have to make the list, and then see what gets combined and what needs to be separated. So maybe you have a category again, maybe overlapping with what we said before, of sort of general medical outcomes.

CO-CHAIR SUSMAN: So we can always

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combine these categories together. But we should probably at least take a stretch down here to make sure that they're somewhat defined. So if we put in secondary medical impacts or outcomes --

DR. PINCUS: I wouldn't say secondary. I'd say general medical. They may not be secondary.

DR. ROCA: And in the interest of inclusiveness, I think it might be worth including something like what was on the second slide, in terms of health care, acquired adverse event or complications, because I think that's captured in some of those perhaps, and it may be the safety category. But I think it merits emphasis.

CO-CHAIR SUSMAN: So the symptoms. Ahh, I can now. Thank you. So the symptoms. Do we all have a clear idea of what a symptom is, where symptom ends, when it's assigned, at least in traditional medical categorization. Anybody have questions about symptoms?

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DR. PINCUS: We didn't put mortality.

CO-CHAIR SUSMAN: We didn't put mortality in.

So from a process point of view, let me give you an A or B. We can either brainstorm more categories, or B we can go down and refine the list. What would be the preference, because I think trying to do both at once is, from a meeting management perspective, difficult?

CO-CHAIR LEDDY: We need to finish the list probably, right?

CO-CHAIR SUSMAN: Sounds good.

CO-CHAIR LEDDY: Anybody else have anything else to add to the list?

MS. HENNESSEY: For clarification, the items that were on the slide already like safe and healthy living environment, are we looking at environment? Is that already included in there, or should we add that? Because we've got --

(Simultaneous discussion.)

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MS. HENNESSEY: I see it there. I'm just wondering to ensure that this new group will also include that.

CO-CHAIR LEDDY: Safe and healthy living environment.

(Off mic comments.)

MS. WINKLER: The question is under safety, are we talking about two types of safety? One is more, safety around living and the environment, versus safety and more traditional patient safety, adverse events kinds of things? I see it as two fairly separate things.

DR. PINCUS: So in the DSM-IV, we added -- we changed Axis 4 to be a psychosocial problem list, and one could conceptualize either, you know, that this was secondary impact, or what we just suggested about safe and --

CO-CHAIR LEDDY: Safe and healthy.

DR. PINCUS: Safe and healthy environment as being sort of improvement in or

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reduction of psychosocial problems that would be related to that list, and that list included things like, you know, family marital problems, included things like problems in homelessness, included things like problems within the vessel system, things like that.

MS. WINKLER: Would you consider those a type of functioning, subcategories under function?

DR. PINCUS: No, because it's not a question of whether you're functioning better; it's a question of whether the problems in your environment have improved or worsened.

DR. GOLDBERG: Are we going to include anything about the capabilities of systems to deliver these things, or is that outside the domain of what we're looking at?

CO-CHAIR SUSMAN: Say more.

DR. GOLDBERG: Systems have cultures or capabilities of being able to address these problems. Some systems can't do it because the way they're organized or the values they

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have.

DR. STREIM: Well, that's a risk adjustment issue.

DR. GOLDBERG: Is that an outcome? Is that a --

DR. PINCUS: I think that's more of a process kind of thing. Or actually maybe a structural kind of thing, if you're thinking about it from that point of view, the culture. It enables --

DR. GOLDBERG: I have a feeling it doesn't belong here, but I'm asking whether that's sort of outside the scope of what we're looking at, because --

DR. STREIM: It's one of the factors that affects outcomes, but it's not an outcome in itself.

DR. GOLDBERG: It may be the most important factor.

DR. STREIM: But it's not an outcome.

DR. GOLDBERG: Maybe it is the outcome that we want is the systems capability

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of addressing outcomes.

(Off mic comment.)

CO-CHAIR LEDDY: We'll keep the outcome and see if it has to be changed. So I'm thinking that it may be that we can't accomplish what we're saying. But then they need to take a look at themselves and say you're consistently not meeting this outcome. What do we need to do?

CO-CHAIR SUSMAN: So are we clear about that one?

DR. PINCUS: Looking -- just for the time being, to put sort of recovery measures on here also as a separate category. You may want to revisit that, but just to put it on there.

CO-CHAIR LEDDY: Can we also add incidence of disease, like diagnosed disease? That's one of the measures that I would think we would use a lot, like you would say the diagnosis of depression in a population goes down by a certain percentage, and we have

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nothing here that would allow for that.

The other thing we don't have anything about is the population, but I think that would be the same issue as what Rich brought up, about that's not really the outcome. That's the input, right?

CO-CHAIR SUSMAN: Use your mic please.

MS. HENNESSEY: Oh, I'm sorry. Incidence and prevalence might even go up. So for example, if we do more screening for trauma, it may go up.

CO-CHAIR LEDDY: Yes, could change.

CO-CHAIR SUSMAN: And is it simply health-related quality of life, or is it quality of life overall, and is that in a separate or is that included --

CO-CHAIR LEDDY: I think this goes back to that definition of outcomes that we had.

CO-CHAIR SUSMAN: I mean it seems to me one of the things we should be striving for

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is global well-being, particularly with patients who are at risk in multiple dimensions here, whether with serious mental illnesses or with severe cognitive impairment.

MS. JAFFE: I actually agree with that, and one of the -- when we were looking at quality of life, general quality of life was one of the best indicators of not returning to the hospital. So I agree with that.

CO-CHAIR SUSMAN: Harold?

DR. PINCUS: Well, on the other hand, going in terms of like, what is the health care system accountable for, it would be hard to argue that, you know, things beyond health-related quality of life, they should be accountable for.

CO-CHAIR SUSMAN: But if our health-related quality of life is going up, but the total overall well-being is going down, maybe we should be relooking at the things that we're doing to people.

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DR. PINCUS: Well but then, I guess the argument, then you're saying that if you're holding the health system accountable for it, then it's health-related quality of life.

CO-CHAIR SUSMAN: Then it's a tautology, isn't it?

(Laughter.)

DR. PINCUS: You know, if it's justifiable to hold the health system accountable for it, then it's health-related. It's not justifiable.

CO-CHAIR LEDDY: How about if we say outcomes are health care outcomes? Wouldn't that address that issue?

DR. PINCUS: I think one of the things you're talking about, you know, if you're talking about school absences, that's not a health care outcome. You know, you wouldn't think of it -- it is a health-related outcome, but it's not a health care outcome, at least as I think about it.

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CO-CHAIR LEDDY: Yes. In general we'd kind of characterize this as patient outcomes which are attributable to health care, in which health care plays a very significant role. But the outcome is for the patient.

CO-CHAIR SUSMAN: So we're trying a meaningful way --

DR. STREIM: Just a point of clarification. Even when you're talking about patient outcomes, but they can be measured at the patient level, the population level, the facility level, the health system level, okay.

CO-CHAIR SUSMAN: Maybe we should -- did you have an opportunity to introduce yourself? I know we heard you on the phone.

DR. GOPLERUD: Hi. This is Eric Goplerud. I just walked in.

CO-CHAIR SUSMAN: In the flesh. Should we go through the list that NQF nicely provided, and see if there are other things that we missed?

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CO-CHAIR LEDDY: Can I just say before we add more things? In terms of outcomes, it seems to me that for them to be useful, they need to be things, outcomes, that the providers or the health care system can influence.

Some of these things are sort of so far -- they're wonderful, but I'm not sure that we as a group could influence them. Well, I think like global well-being. I'm not sure. I mean I could maybe influence it in my own little sphere, but I don't think I can influence the global well-being.

I don't know how I would do that, and I wouldn't want to be held accountable for it, you know. So I want to look at things that the system or the patient or whomever would have every right to hold me accountable for.

DR. STREIM: I was hearing though that we're also charged with identifying gaps and measures and there may be lots of gaps in health care too. So I think creating the

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categories, even if we can't fill them in with existing measures at this point, it still a useful framework to have.

CO-CHAIR SUSMAN: It seems like a second process that we're going to have to go through is to make sure that each of these categories has coherence, and that there isn't a bunch of overlap with other categories.

Then refine them to say well okay, let's really look at this. It's nice to have it up there, but is this something that the health care system, at one level or another, should really be accountable for.

So does anybody see something up here that we haven't included?

DR. STREIM: Well, under the rubric of the general medical outcomes, I take it that would include various comorbidities, where it's not just secondary outcomes. I mean there are reciprocal interactions and all that stuff gets subsumed under that.

CO-CHAIR SUSMAN: That's my

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understanding of that category. Does that square with everybody else?

DR. STREIM: Yes.

CO-CHAIR SUSMAN: Now let's go to the next page.

CO-CHAIR LEDDY: Is the health care acquired adverse events or complications also subsumed under that?

CO-CHAIR SUSMAN: I think we have one.

CO-CHAIR LEDDY: Yes, under safety of patient, right.

CO-CHAIR SUSMAN: It seems to me most of these are on there.

DR. WAN: Where would we put the impact on the criminal justice or, you know, interventions, police and --

(Off mic comment.)

CO-CHAIR SUSMAN: So let's see if we can get these original -- our list up --

DR. PINCUS: Yes. I was going to say secondary impacts on this, you know, on the

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psychosocial environment. You know, that might be a way to --

CO-CHAIR SUSMAN: So do people understand what that means now?

DR. PINCUS: Yes, you know, slash reduction in psychosocial problems.

CO-CHAIR SUSMAN: This might be incarceration, it might be homelessness, it might potentially something like family violence.

DR. STREIM: Like I said, not just environment. The situation is the internal environment, I mean the patient's situation as well as the external environment. So maybe that's considered the same.

DR. GOLDBERG: Categories will influence thinking --

CO-CHAIR SUSMAN: Absolutely.

DR. GOLDBERG: So just as we made this comment before that, you know, if we have categories that are, you know, inpatient, outpatient, partial resident, you know, it

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influences people to think in silos. Another analogy of that is, you know, you mentioned incarceration.

We all know that the impact of a lot of mental health disorders cut across mental health agencies and Department of Corrections and social service and vocational and residential, etcetera. If we compartmentalize those, it channels thinking in a way and biases thinking towards maintaining those separations.

I don't know if there's any way in the example columns, when we give columns, that encourages people to bring them together, rather than encourages people to make more, you know silo-ized lists in each of those, some kind of note that says you're encouraged to look across the full impact of these, you know, you're calling secondary disorders.

Otherwise, people are going to waste a lot of thinking going down a road that's too compartmentalized.

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CO-CHAIR SUSMAN: I see a lot of nodding around the table about that comment, and how we would operationalize then, the call for measures should probably very clearly say that yes, we're interested in all these individual silos, but we're also interested in the cross-cutting sort of concepts that might bring these together. Is that a reasonable restatement?

MS. MASLOW: I think also that the issue of transition, transitional accountability fits in there. So it's impact between agencies or sectors, but also as the person moves from one place to another, some kind of accountability or responsibility.

So I would see all of these things as possible outcomes in settings or silos, but we would be looking for measures that can go across settings or silos.

CO-CHAIR SUSMAN: So the idea of seamless transitions of care, coordination of care should probably be up here, at least as a

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placeholder and reminder that that's one of the important factors for outcomes? Is that

--

DR. STREIM: Does that go on a process list rather than an outcome list though? I mean it's important to question --

MS. MASLOW: It seems like it goes like this. It's another column, in a sense.

DR. STREIM: Yes, I think -- I mean we talk about sort of, you know, sort of the different diseases being sort of another column, and so another sort of dimension, not a column, would be sort of where along the continuum of care this would be most relevant to measure, and one category, always an integral tool, would be at transition.

MR. PELLETIER: Does it become an organizational outcome then?

DR. STREIM: Yes, that's on the --

MR. PELLETIER: Where the process is we want you to talk to the next level of care.

Did you talk to the next level of care, yes

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or no? Here's the outcome. That informs treatment hopefully.

DR. GOLDBERG: I think those are steps towards the outcome.

DR. PINCUS: I think that's stretching out outcomes beyond --

DR. STREIM: Yes. I think that goes to how we define the whole framework that we were talking about before. We want to be able to measure these outcomes across settings, where people are likely to get care.

But that's the -- I think that's when we were talking before about doing the two by two or the three by three. That's a different part of the framework. This is just the list of the outcome categories.

CO-CHAIR SUSMAN: One might expect that if you have more seamless transitions in care, that that would have an effect on the patient's experience of care, caregivers' experience of care, medical outcomes and so on that we already have up here, that this is one

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of those processes.

CO-CHAIR LEDDY: So am I correct that all of the outcomes that we're talking about are patient outcomes, and we're not looking at system or provider outcomes; is that correct?

CO-CHAIR SUSMAN: Well, I think we talked about being fairly inclusive, of not just simply centering on the individual patient, but also looking at their caregiver, family, populations as variously defined. So where does that lead us?

CO-CHAIR LEDDY: Except for the satisfaction one, they're all patient-related, right? They're all looking at what is happening with the patient.

MS. WINKLER: Right. What would be an alternative? I guess I'm having trouble understanding what you're saying it isn't.

CO-CHAIR LEDDY: I think the last one is an example of a system outcome. I don't see it necessarily only as process. I see it as a system outcome in terms of being able to

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assess how well the system is working or not.

MS. HENNESSEY: Another example of what it isn't, and this may be beyond the scope of what we can reasonably do, is that it is not a measure of the well-being of a patient or consumer's network.

It's not just the most immediate caregivers, but it's those people who are in turn impacted by the caregiver, other than the patient.

CO-CHAIR SUSMAN: So it's like dropping the stone or the pebble and the ripple effect out there?

MS. HENNESSEY: It's really looking at some of the social connectedness, social networking.

MS. JAFFE: So do you think there are, it's possible that if we had good outcomes on all these measures, that it's a proxy for saying there's probably good outcomes in the support network. If all of this is good, the support network may be good

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as well.

But as Jeffrey said, if we have good care coordination, good transitions, if you have good access, then that will impact the outcomes that we have listed.

CO-CHAIR LEDDY: So I think that we're missing the other dimensions, and that's what's confusing. I think people are confusing that. Like to me, I would suggest three dimensions where we would define each dimension. One would be the population dimension. Who are we talking about and how many people?

Then the next dimension is the health care dimension, and the health care dimension would include setting, who the provider is, what service is provided such as care coordination or care transitions? What is being done? That's where we would talk about, say with our next speaker, about well in the population --

If we're talking about population-

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based health, our public health functions that are for a population, is that going to be part of that second dimension, which is a health care input. So the inputs we're talking about toward outcomes are all of those things.

Then the outcomes, what happens as a result? So that is what we're trying to define here, and so I think that part of what I'm hearing is that because we don't have those categorization of inputs in here that are so important, we don't see them, that we're trying to fit them into outcomes.

DR. PINCUS: We've got to be careful about reinventing the Donabedian model here. You know, that's sort of where we're heading towards.

I mean the way I would think about it is, I mean you know, we thought of it in terms of, you know, the structure really being -- is there the capacity to provide effective care?

Number two, is effect, you know, process being is, you know, what is currently

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determined to be effective for evidence-based care being provided with acceptable fidelity.

Number three are, you know, is it making a difference in the outcomes stuff?

I think the way to incorporate things like care coordination and transitions in an outcomes model is to maybe put it as a subset of service utilization, and maybe to explain that service utilization really is looking at, and here's where the episode-based framework comes into play, is that the process measures at a later stage, at a later stage in care, are actually outcomes for the earlier stage, and to think of it from that perspective.

So that if you're providing effective, you know, care transition at the inpatient to the next level of care, it's going to result in better outcomes, better process outcomes, for example, less rehospitalizations, you know, at the next level of care, as a result of the next level of care.

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So maybe to move that under the service utilization piece, and when we describe what we mean by service utilization, we're really talking about sort of impacts, service utilization impacts on subsequent care. I don't know if that makes sense to people.

MS. MASLOW: I would rather -- I think that what you are saying is again it's another dimension. It's not one of the outcomes.

So I don't think it's an outcome. I think that it's an input, and that we need to think of these outcomes as being affected in part by whether there is coordination of care.

So they need to be measured across settings and look at the effective continuity of care on the outcomes.

CO-CHAIR SUSMAN: Robert?

DR. ROCA: I thought on an earlier slide that there was some hint that we may have permission to include some process

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measures in our discussion, that especially if we had reason to believe they were very closely tied to outcomes.

Because I think what we're hearing is that everybody thinks coordination of care is absolutely vital. We can't leave it off the list.

We're hardly there yet, in terms of achieving that or even measuring it in a regular way. So maybe we should just acknowledge that this is one process measure that needs to be there, even though our focus is really on outcomes.

MS. WINKLER: We do want to be careful that we don't really push into the process arena. When we talked about process closely tied to outcomes, that was sort of NQF's measure evaluation criteria. So that if you're evaluating a process measure, that relationship should be very crisp and strong.

So we don't really want to push the process, because the focus here is truly on

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outcomes. It's possible -- I've sort of heard someone describe the care coordination or aspects of care coordination as possible intermediate outcomes.

If you -- and perhaps if that's the way you're thinking, then it might be appropriate to include. But if you're talking about particular processes, I'd be kind of careful about expanding outside our outcomes charge.

CO-CHAIR SUSMAN: If we can put this on the parking lot and maybe figure out the 95 percent that's pretty clear here, and recognize that look, this is an important mediating set of variables or processes that we really want to make sure get included.

As we write these up for their call for measures, that we want people to be aware that this group is really cognizant that crossing boundaries physically and otherwise is really common for this set of patients, and that's really important that there be some

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attention paid to that, and the ultimate effect on outcomes. Rich?

DR. GOLDBERG: I think there will be a tendency -- I really want to echo what you say, that I think a lot of people are going to respond with a lot of very highly-focused process indicators once again.

If we're trying to push towards higher performance outcome measures, it's really going to require discipline to help people see that those are -- if you call them intermediate outcomes, isn't that a bad way of looking at it?

But we've got to push people past that, or else we're going to get lost in that forest of process measures again.

CO-CHAIR LEDDY: So can't we do -- I think if we recognize the three dimensions of the Donabedian model, it really will help, and that is, if you look back to it, it's population. The input is the health care service that's provided, which is what

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everybody is very anxious to have in there and descriptive with all of the different components like care coordination, and then as a result, what is the outcome?

So if we go back to that model, I think we're only focusing on one-third of it.

So, all three dimensions, who we're talking about, what services are being provided and whether it's a clinical service, a public health service, an integrating service and what the outcome is as a result B- if we look at it in those three dimensions, then when we get the comments from the outside world, I agree, it's going to be everywhere. People will say that a certain service is very important to measure; a certain population, the whole disparity issue is going to come up.

So if you think of it, when those come up, if you have all those three dimensions, they go in the right box and you'll still have the outcome box, and it won't be the process box.

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MS. MASLOW: I agree with that. I agree with that way of thinking about it.

DR. GOPLERUD: I'm not sure that cost efficiency or cost effectiveness is an -- fits in here, but in the world of trying to talk to business, if you don't talk about cost-effectiveness, you really miss an important outcome.

I think that's in some way going the way that you were going, is are we efficiently using the resources to produce an outcome?

I'm just thinking about the IOM 6 criteria, and we've got most of them, but we don't have efficiency up there.

MS. WINKLER: Eric, you may have missed some of the discussion we had this morning. Certainly, I think that most people would agree that cost and resource utilization is the type of outcome.

However, in this particular project, NQF actually has a companion project that's going to follow a little bit behind, actually

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focusing in on resource utilization. And at the end of both projects tying the two together to provide a quality measure, particularly when it comes with the cost measures together, to create those efficiency concepts.

So while yes, it's an outcome measure, it's not one for this group because we're paying attention to it in another task.

DR. GOPLERUD: Just so long as it then gets applied back into the Pedia ProHealth world, given how important and how often we get left out.

CO-CHAIR SUSMAN: Do we have the whole issue of patient self-efficacy, self-management in this?

DR. STREIM: I assume those came under health-related behaviors. We may want to specify subgroups of some kind.

CO-CHAIR SUSMAN: Yes. I just wasn't sure that we had captured that yet or not, or whether it was under the recovery sort of

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model idea.

CO-CHAIR LEDDY: So one thing we didn't do is go back and actually describe or give examples of these. Do we want to do that, or because it's 2:30, do we want to go into the population-based?

Okay. Let's start from the beginning and start. Ian's going to take notes and people are going to talk about what the definitions of each of these words are, right?

Okay. Symptoms.

MS. WINKLER: Particularly talk about the type of outcome, and what may be an example of what an outcome measure for that type would be, so that we're all pretty clear we know what we're talking about, as an example.

CO-CHAIR LEDDY: I think it was Harold before or that said symptoms is the patient complaint, versus -- or somebody said that. The symptom was the patient complaint versus the sign is the B or the signs and

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physiological issues are more of what a provider would see.

DR. PINCUS: Yes, I did say that.

CO-CHAIR LEDDY: Somebody said that.

DR. PINCUS: Yes. I had suggested that we might want to separate out signs and symptoms, and Harold commented that that's an important distinction when you're teaching medical students about the subjective versus objective measures.

But if we're talking about measurement, and you start to think about what is it we can measure, we often use the word symptoms to apply to both.

So it may just add a layer of confusion to separate them. I think the issue here is you want to talk about, in terms of measurement, frequency and severity of the signs and symptoms of illness.

CO-CHAIR SUSMAN: So it would be things like pain, depressive symptoms, various manifestations of bipolar disorder.

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DR. PINCUS: Or more synthetic. I mean if you have a brief depression rating scale, would that be --

CO-CHAIR SUSMAN: Right. Yes, I mean it could be PHQ-9 or it could be a NDQ or it could be a whole bunch of the cognitive rating scales. But I assume that's what the symptoms and signs are.

CO-CHAIR LEDDY: Is that enough about symptoms?

MS. WINKLER: Just in terms of symptoms, in terms of what those would be as outcomes, would it be symptom improvement or would it be symptom change as a result of treatment and make it worse, or something, or not work, or have no change or maintenance?

So that's essentially what the outcome measure would be. Is there something else particular to mental health that I wouldn't be thinking of when I think of symptoms like pain improvement? Okay.

CO-CHAIR SUSMAN: Eric?

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DR. GOPLERUD: Looking at some examples of symptoms might be no longer tobacco-dependent, or non risky use of alcohol. I'm kind of pushing on what are we including under mental illness or mental health. I would say are those health behaviors?

CO-CHAIR SUSMAN: Health-related behaviors, I'd say, not symptoms.

DR. GOPLERUD: Well, no. I would say that tobacco dependence is a -- or the absence of tobacco dependence in somebody who's a smoker would be a symptom, sign and symptom.

CO-CHAIR SUSMAN: I guess I would push back and say that's more a health-related behavior. But the question's for the group.

DR. GOPLERUD: It has a DSM diagnosis.

DR. STREIM: Yes. I thought by health-related behaviors, we were really talking more about engagement in treatment, self-management and I agree with you, Eric,

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that the example of substance abuse is a symptom of an illness.

So under symptoms, we may want to be very explicit and say they're both the subjectively reported by patients as well as objectively observed by others, whether it be health care providers or family members or community members, who see someone who says I don't have a drinking problem, but the spouse says "But boy, does he get irritable and beats me up."

CO-CHAIR SUSMAN: I think this is going to be really hard though. Somebody from the outside, where we have a category that says "symptoms," and then we start including things like substance use or tobacco use.

I mean I understand conceptually, but just from face validity, face meaning perspective, I think it could be confusing. I wonder if we had a category of patient behaviors that would -- behavior change, symptom-related behaviors. I don't know how

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to frame it, but just -- it's going to go out to the rest of the world, we have to think about how they're going to see that.

MR. PELLETIER: But isn't the outcome reduction, alleviation, maintenance -- I mean that's the outcome. It's not that we really want to focus on the symptom.

DR. GOLDBERG: Well, sometimes we do. Let's not forget a simple thing like asking the patient, are you better?

CO-CHAIR LEDDY: Yes.

DR. GOLDBERG: You know, if people are going to read this, let's not deviate from something real simple as --

CO-CHAIR SUSMAN: I don't know. What do we have to measure? We have frequency measures, we have severity measures? I think that's what we probably need to have.

DR. GOLDBERG: Under those characteristics, I would say that for addiction, they meet both intensity and frequency.

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CO-CHAIR SUSMAN: Yes. So I think as we go through these examples, it is helpful to think in terms of what can we measure, what do we measure in each of these categories, and that will generate our list of examples.

DR. BOTTS: There's also the issue, I think, of coordinating care across disciplines. So if you look at the effect of some of these behavioral disturbances on diabetes, for example, and engagement in care.

Whether it gets couched in terms of symptoms or whether there's -- it seems to me health-related behaviors are sort of two things. They're health risk behaviors, and that may fall in some of the addictive disorders.

But then there also -- and whether you call them outcomes or not. But they're what keep people coming and being engaged in care, which almost falls in what Harold was describing earlier as their measurement of what you've done before.

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The outcome is a measure of are people satisfied with the level of care, if what you're offering is not only accessible but acceptable, so that people continue to come. Specifically, I focus on medication adherence.

So this is something that you can look at as a process piece or an outcome piece, depending on where you slice your pie.

So I think those are -- that integration of care, particularly overlap with medical illness and the self-management of those, and all kinds of evidence to support that, particularly just with diabetes, that that needs to be integrated as an outcome measure. I don't really care whether it's symptoms or behaviors.

CO-CHAIR LEDDY: I mean yes. I see symptoms as the symptoms that we find in DSM-IV, you know. Anhedonia, insomnia, etcetera, and looking at frequency and intensity and moderation of that.

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I mean I guess that's what I was thinking about in terms of that symptom category was symptoms. I mean the kinds of things that we hear that we make a diagnosis based on, and then is it better or worse.

CO-CHAIR SUSMAN: So we have two alternatives that have been proposed here that I'm hearing. Eric's talked about this sort of being a symptom like not smoking or continuing to smoke, related to an underlying depressive disorder, serious mental illness, versus the sense that now the symptoms should be pretty pure. It's just sort of the things that we count in assessing the criteria for DSM-IV. So we have anhedonia; there's sleep disturbance, there's X, Y and Z. What is your pleasure?

DR. WAN: I just had a, going back to symptoms around absence of symptoms or the achievement of symptom resolution or the remission of symptoms, would that be under recovery or symptoms?

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CO-CHAIR SUSMAN: To me they'd be symptoms, but it's an outcome of reduction of symptoms of those B- Richard, you had a thought.

DR. GOLDBERG: We should probably ask Harold, because he was the one who suggested recovery as a category, and he stepped out for a moment. But I mean you could take the concept of recovery and say that's captured or it overlaps with symptoms, function, quality of life, etcetera, health-related behaviors. All those things that could improve with treatment are part of a recovery process.

I think he was probably thinking more of serious mental illness and recovery of psychosocial functioning, as well as symptoms.

But I'll let him speak for himself.

DR. GOPLERUD: There's been quite a bit of work in the addiction side as well as in the mental health side about positive recovery. So that has been defined a little differently in terms of self-determination and

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self-management.

DR. STREIM: Yes, I think it's important. I wasn't suggesting that overlap was bad here. I think it's important to leave it in because there's a separate set of measures that fit in there.

Which reminds me of another concept, and this may have to do perhaps with the framework grid that goes out in the call for measures. We're talking a lot in this discussion about cross-sectional measurement, and some of this could also be not just frequency and severity of symptoms at one point in time, but recovery trajectories, how quickly are people getting better; how completely are people getting better.

I think we want to make sure that when we call for measures, we're getting people to think about not just cross-sectional but longitudinal measurement.

CO-CHAIR SUSMAN: So the idea of response, remission and, you know, ongoing

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well-being. Have we exhausted this one?

CO-CHAIR LEDDY: In function, does this include both the patient's telling you I can do this or I can't do this now or change or whatever they can do, as well as observed by clinicians or caregivers, whatever? So two different perspectives, you should say.

CO-CHAIR SUSMAN: Yes. I think that there are -- if we look at again, available measures that we use in clinical work and in research, we measure things that are self-report and things that are observer-rated. So we would want all measures to be candidates for purposes of calling for input.

DR. GOLDBERG: So are we going to get eventually to multi-axial outcomes, because you mentioned before, you looked at on a much narrower scale, diabetes or some medical illness. You look at one measure, it's too limited. Then you realize well, you need five measures to really get at what you're trying to get in terms of outcomes.

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So it may be that symptoms alone is not going to be enough, that there's sort of a higher order synthesis. We at least now mentioned that you need symptoms and functions together in some kind of coordinated outcomes measure, and it may be that by the time we get done, there will be packages of these that fits into three, four, five coordinated to push people, push them in their thinking. That it's not just enough symptom recovery if we're not thinking about functional, you know, outcomes.

So again, the categories really are going to drive concepts, and we have to be careful of the unintended consequences of separated outcome categories. Now whether we want to explicitly ask people to bundle across these categories, I'm not sure.

CO-CHAIR SUSMAN: I would think it would be legitimate to ask for measures that indeed address multiple categories, and we'll see what we get.

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MS. HENNESSEY: Well yes, and interestingly enough we were talking earlier about school absenteeism. We were also talking about workplace absenteeism, workplace presenteeism, and also disabilities.

DR. GOPLERUD: Yes, I thought that was in secondary impact, right? Isn't that -- I thought that's what we had -- well, it's what Harold had originally described. But did you have another idea for where it fits in the existing list?

MS. HENNESSEY: Yes, it came to me from a function perspective. But candidly, I could go with it either way.

DR. GOPLERUD: Oh, well let me suggest for function very specifically, that we include basic activities of daily living, referring specifically to personal care, bathing, dressing, feeding, grooming, hygiene; instrumental activities of daily living, more household management, shopping, cooking, laundry, transportation, and social role

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functioning, which I think gets at job, family, all those roles, friendships.

DR. GOLDBERG: Then there's a question of how much of those are cross-cutting across everything we'll look at, and how much of them are going to be in specific bundles, when you might not look at IADLs and adolescent ADHD. I don't know if that's the best example, but they don't belong bundled with every disorder we may be looking at for outcomes, but they're absolutely critical to some disorders.

DR. STREIM: Yes. I think this is a list that we weren't intending to be necessarily a requirement for all. But you know, it's sort of a call for measures in any of these.

(Off mic comment.)

CO-CHAIR LEDDY: We're mixing, defining what the word meant to us in examples, going back to some of the pages previously, right. So --

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DR. STREIM: Okay. So by way of definition, function relates to level of disability?

CO-CHAIR SUSMAN: Or ability.

DR. STREIM: Or ability, yes. Level of capacity versus disability.

DR. GOPLERUD: Okay. So as we're thinking about these measures or shaping this for a call for measures, we should be I think particularly looking for what are generalizable measures that we can import that are already out there, like there are functional measures that are out there that have not been explicitly tuned to ADHD, but certainly are a lot more usable if they're the same measures that are used for various physical disabilities, etcetera.

I think each time we look at these, we ought to also be looking at, or in our call, asking for generalizable measures that can be imported from general medicine. So general health status, general functioning,

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ADLs, all of those things.

Really, we don't have to have had the double blind crossover studies for each one of our diagnoses for them to be useful. So I think that's an important prospect concept, because we're not going to have measures that fit every one of these things, nor should we.

DR. GOLDBERG: Let me just say there's a lot of measures out there. Most of them aren't being used for a number of reasons. One of the reasons is they're not practical.

Now I know this comes down to feasibility, I guess, or utilization that we're going to get to. Do we want to mention anything in the call for measures about highlighting this issue of not just asking people to send in a scale?

If we get a bunch of scales, they're going to take clinicians, you know, 15 minutes each to do and now we're -- there's an expectation to do six of those, it's never

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going to happen.

This is a creative new enterprise for people, I think, to find things that can be clinically incorporated and useful in ways that haven't been done.

MS. WINKLER: Given that that's one of the evaluation criteria, I think it would be difficult to incorporate it in the call, though I think stating that the measures will be evaluated against NQF standard evaluation criteria of, you know, the four things and you know, please check on these before you submit your measures so you don't waste your time.

CO-CHAIR LEDDY: So if we put -- if we highlight the evaluation criteria in the request for measures, that would -- I think that would do what you're talking about, Rich, which is important.

CO-CHAIR LEDDY: Are we done with function? Anybody want to add anything to function, either part of the definition or an example?

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DR. KAUFER: Yes, this is Dan. I'm sorry, I may have missed this, but in terms of instrumental activities of daily living, I think one of the very important aspects in adults is financial capacity, which is taking on a larger and larger role. That's it.

CO-CHAIR LEDDY: Okay. We got that. Anything else before we move on to the next -
-

CO-CHAIR SUSMAN: Yes. Just one other thing about the concept of functional status. You can think of it at the organ level, the system level, the organism level. Most of what we have up there is at the organismic level, you know, what can a human being do when they're sick.

But you know, one of the outcome measures, and I have to think about this for mental health, is you know, when you have a symptom of a brain disorder, there are also functional impairments in central nervous system and brain functioning.

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You know, one example is cognition. Another example is behavior broadly defined, and some of those would perhaps fall under function. We have to maybe think about what kinds of measures, in a call for measures, how do we want to prompt people in the field to be thinking about that aspect of function, or is it captured enough in symptoms?

MS. HENNESSEY: So you're thinking, for example, affect management?

DR. STREIM: Hmmm. See, I think of affect as a symptom or a sign, but that's --

DR. PINCUS: No. I think affect management, it's psychosocial, you know, sort of outcomes from psychosocial rehabilitation and those kind of things. I would agree with you, that's -- and in some ways, what's not in there is vocational outcomes and interpersonal -- and vocational functioning and interpersonal functioning.

DR. STREIM: The kind of social roles there.

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DR. PINCUS: Yes.

(Simultaneous discussion.)

CO-CHAIR SUSMAN: So certainly someone with autism being able to modify and sort of self-monitor is a real important functional skill. Is that --

DR. STREIM: Yes, and you know, I realize it's easy if you're dealing with heart failure to say, you know, there's the New York state classification system. So if you've got ventricular function and cardiac output and then, you know, how far can you walk, then you can begin to tease apart symptoms and function.

For mental health, I think you can look at those same distinctions. It's just we don't do that routinely, except DSM axes really do get at -- well, the GAF combines the two and makes it very difficult to measure.

(Simultaneous discussion.)

DR. STREIM: It does a very bad -- you see, I think we do a very bad job of

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separating symptoms and function.

GAF is a very good example of where it gets lumped, and people have a hard time scoring those kinds of measures. So we want to get away from that maybe try to separate them.

DR. PINCUS: Part of the problem may be that the term "social roles" is so expansive, and maybe what's missing is some of the more elemental examples that might be informative to people that are responding.

DR. STREIM: Employability?

CO-CHAIR LEDDY: How about work, school, play, social interaction, something like that.

DR. STREIM: Yes, exactly.

MS. HENNESSEY: Family.

CO-CHAIR LEDDY: Family.

DR. STREIM: Yes, family and social interaction. Those could be -- I think that would be if we were to put that as a parent after social roles or something like that.

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CO-CHAIR SUSMAN: Are we happy with this?

CO-CHAIR LEDDY: Okay. The next is health-related quality of life and global well-being.

DR. WAN: I think there are a lot of overlaps between what we're listing out as function as well as the traditional domains for health-related quality of life, which could be emotional, social, physical well-being and so forth.

DR. GOLDBERG: Do they cover end of life issues as well?

MS. JAFFE: Well, I think some of the difference is that the function is asking your ability to do it in your quality of life questions, ask you how you feel about it.

So it's a lot more about the perception of how you're doing as opposed to a little bit more objective ability to do it. So you're asking a lot of the same questions, but it's more asking about a person, you know,

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how they feel their quality of life is in relation to this.

MS. HENNESSEY: That's an interesting question, because I'm not sure of the whole issue of end of life is even up here. Is it?

CO-CHAIR SUSMAN: Yes, it's here.

MS. HENNESSEY: Oh, I'm not sure end of life is even up here on our outcomes, is it? Any kind of end of life measures.

CO-CHAIR LEDDY: Do we want to add it?

CO-CHAIR SUSMAN: We have patient-caregiver experience, satisfaction; we have patient safety, adverse events; we have general medical outcomes. What specifically? Give me an example of an end of life measure or outcome?

MS. HENNESSEY: Well, one would be just presence or absence of advance directives.

CO-CHAIR SUSMAN: Is that an outcome?

MS. HENNESSEY: More an intermediate

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outcome.

(Off mic comment.)

MS. HENNESSEY: Oh sure, absolutely.

DR. MANTON: I mean I see end of life directives as being --

CO-CHAIR SUSMAN: Your microphone, if you're going to --

DR. MANTON: I'm seeing, I'm thinking of advance directives. So for example, I have behavioral health patients who have behavioral health advance directives. So that would be an example that I'm thinking of.

DR. PINCUS: It's not really end of life --

DR. MANTON: Yes, yes. But then I think about dementia patients with some of the Alzheimer's patients end of life.

CO-CHAIR SUSMAN: So would patient safety include things like overuse, appropriate use in this rubric we have, where -- or is that something that we should have separate?

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DR. GOLDBERG: You may as well just fill it. You could put it under service utilization.

DR. MANTON: Or you could put it under patient self-management.

CO-CHAIR SUSMAN: Or should we include it separately so your lumper is better here?

DR. STREIM: I think the goal, again, should be to have categories that would capture a wide range of potential measures. As long as there's a place to put the measure, it's okay if there's two categories that might subsume it, because we'll sort that out later, right?

We just want to open this up to the field, so that there's nothing excluded that might be of value. So I think overlap is okay for this particular list.

CO-CHAIR SUSMAN: So it wouldn't be necessarily then, as I'm hearing -- and correct me if I'm wrong Maureen -- the fact

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that one has an advance directive. It would be the appropriate use of interventions that the patient and family have chosen.

MS. HENNESSEY: I think that was part of what came to my mind from what Richard was saying. But also what came to my mind was whether or not in behavior health, we're informing consumers about not just end of life or palliative care, but also advance directives.

For example, some of my patients who have bipolar disorder have some advance directives about what they want to have occur when they begin to have a psychotic event.

DR. STREIM: Isn't an advance directive an example of a health-related behavior, if somebody --

MS. HENNESSEY: That could easily fall under that, yes. I'm just not sure that if we put this out as a call, whether people are going to see it that way.

DR. STREIM: Well, it could be listed

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as an example.

MS. HENNESSEY: Yes. I think if we listed it as an example, I think that would be fine, yes.

CO-CHAIR LEDDY: So we didn't put anything under health-related quality of life, global well-being.

MS. WINKLER: I have a question. Do you see the health-related quality of life well-being measures, those being patient reported?

As opposed to function, which actually could be observed by another, and that might be a bit of a distinction between the two? I mean it could be patient report also, but --

CO-CHAIR LEDDY: Didn't someone say something like emotional, physical, for the health-related quality of life?

CO-CHAIR SUSMAN: It's SF-12 or whatever you want to use.

DR. STREIM: What about self-report,

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measures of self-reported health in general? Do we want to -- I think we -- that's a little dicier, but I think that's another measure.

DR. PINCUS: And I'd put that under general medical outcomes, I think.

DR. KAUFER: This is Dan. I think that can be problematic in terms of people who both have cognitive disorders and mood disorders, which would lead to, you know, unreliable self-appraisals. I would say the concept of quality of life in this, in this area of medicine and mental health is problematic.

DR. STREIM: Well, but don't we want to get good measures for that, and if we can't get them from usual self-report as it currently exists, then the field needs to develop something. I mean I think again, this is a call for input from the field. So if we get bad measures suggested to us, we'll throw them out.

CO-CHAIR SUSMAN: Well, and plus the

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fact, I mean this does seem like it's, you know, sort of different points on a quality compass, that no one directional will be sufficient, that we want multiple paths because there's different types of patients who we're considering in all this.

DR. KAUFER: Dan again. From a point of view, I don't know if safety factors into the health-related quality of life. But in my perspective, that safety-related is a fundamental aspect of quality of life, and you know, I don't -- you could argue where it's most appropriate to fit in.

But you know, in my way of thinking, I think, you know, a fundamental aspect of quality of life is having a sense of safety.

MS. WINKLER: Am I hearing that you see the safe environment as a subset of quality of life, related?

DR. KAUFER: More as a -- I mean it's really if you're not safe, I mean, it's almost a prerequisite.

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DR. STREIM: I agree that there is some relationship, but I think when you think about how we measure that, I think it's important to have two separate categories, because we want to prompt people out there in the field to be thinking broadly about different kinds of available measures.

I think if we lump too much of these together, it won't stimulate them to think about all those things that are out there.

DR. KAUFER: I'm not sure -- this is Dan again. I'm not sure exactly where it fits in, but the main point of contention I have is that I think safety needs to be addressed more explicitly than it is. It's something that's often taken for granted, at least from what I see, and it's something that I think really deserves --

It's something that I deal with a lot, but there aren't good formal -- as you point out, there aren't good formal ways to do that. So I think that is something that needs

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to be addressed more formally.

CO-CHAIR SUSMAN: So we do have a category, patient safety and adverse events, and you're at a distinct disadvantage not being able to see the full list perhaps.

DR. KAUFER: Sorry.

CO-CHAIR SUSMAN: No, that's okay. It's one of the challenges of dealing with this remotely. There's also the safe living and safe living environment category. So hopefully that will come through as we put these out to call.

MS. HENNESSEY: It's such a subjective concept, quality of life. I think that's part of what we're grappling with. Is quality of life happiness, for example? Is that patient happiness?

DR. GOLDBERG: I think we're using -- safety is a word that can be used for lots of things. That's part of our problem. People who don't have a safe place to live is different from people who are being treated

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with restraints and seclusion in safe ways, are being treated with medication safely.

I see people all the time in our emergency room who we have to admit, because they don't have a safe place to live. So safety is an important part of their mental health presentation and disposition, and we've got to think about that, because it's affecting a lot of resource utilization.

So maybe when we're talking about safety, we need a second word with it, I mean something about physical environmental safety.

We have it, we have it. No, I'm serious. We already have it and that's --

CO-CHAIR LEDDY: Do we need more words to define safe living environment?

VOICE: Where are we?

CO-CHAIR LEDDY: Okay. If we stay with where we are, we're at health-related quality of life. Have we finished with that?

So we can go on to health-related behaviors.

We sort of skipped down to health-related

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behaviors and then we went back.

DR. MANTON: I'm not sure that we've defined global well-being.

CO-CHAIR LEDDY: Okay.

CO-CHAIR SUSMAN: Well, I mean there's multiple measures of either self-report or scales for well-being, and I think that that's a pretty typical health services sort of measure.

DR. GOPLERUD: And this would be one of those places where you'd particularly look for other conditions or more generalized measures of well-being or health-related quality of life, and wouldn't necessarily be as specific to --

DR. PINCUS: Yes. I think there's a huge literature on health-related quality of life, and I think the NQF staff can go and synthesize, you know, just the focus of that.

MS. WINKLER: Actually, in the largest part of the outcomes project, these cross-cutting, we are seeing some of these

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kind of health status measures come through.

So the issue, I think, may be are they applicable or should they be or could they be applied to the mental health population or who and that sort of thing. So that may be how it comes to you.

CO-CHAIR LEDDY: So do we have enough on health-related quality of life? Do we want to move on to at least a few more measures, or do people feel like you want to take a break now, since we are scheduled to take one at three? A short break?

Now we'll come back, finish these measures, and then we'll hear about population health, right?

CO-CHAIR SUSMAN: I've got about five after three. Would 15 after three be ten minutes or so?

DR. KAUFER: Sounds good.

(Whereupon, at 3:07 p.m., the above-entitled matter went off the record and resumed at 3:29 p.m.)

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CO-CHAIR LEDDY: So we have -- oh Katie, did you want to say something?

MS. MASLOW: I did. I've been thinking about this and I'm biased because I think that a very important measure is something to identify people with Alzheimer's or other dementias. But so that's my bias.

But if you look at this list that we've got, there were a few things on there that are specific to mental illness. But most of these things are the same indicators that you would use for anyone.

I think that that's a problem for us.

So to me, my issue, which is the need for identification of dementia, is not just my issue but perhaps something for the committee as a whole to think about.

We're talking about these changes or outcomes in certain people. We're not talking about mortality in general; we're talking about mortality for people with mental illness

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or cognitive impairment.

It seems to me that we need to figure out how to put this, how to frame it, and in a sense, what we're talking about. Because if we're using these kinds of measures, they're the same as for everyone, almost all of them are.

There are a few that suggest mental health issues: recovery, a couple of others.

But basically these aren't specific at all.

CO-CHAIR SUSMAN: You know in some ways, I'm going to put my bias on the table too, as a primary care doc, I'm sort of reassured that there's a lot of harmony of measurement across multiple different dimensions of care, and that actually is a potential strength of this effort, that we certainly need to be attuned to concepts like recovery or concepts of minimizing harm to the whole patient, that we might not give as much credence, although we should, in other aspects of health care.

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But to me, actually it's sort of reassuring to see that there's a set of measures, that while it may not -- or concepts that may not have been validated particularly for individuals with mental health conditions or cognitive impairment, I think we're really just talking about what are the dimensions of care that anybody should be caring about, or the outcomes that we should be influencing.

So, unless we as a group can find that there are the lacunae that are really strictly related to things in SMI, depression, cognitive impairment, then I don't worry about that.

But you may see some gaps that we really should be aware of, and if so, if the group sees these gaps, we really need to pay attention to them.

MS. MASLOW: I think that people with mental and people with dementia have special needs in all settings, and that their needs are related to those conditions, and that

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that's what we're supposed to be thinking about here. What is special about mental illness, cognitive impairment, dementia across settings, that needs to be measured?

NQF has got measures for everyone else. So it seems to me -- I'm not at all belittling what you say, I think it's a good point of view -- but it's sort of so we're done. Everyone should get the same thing. I don't think that that's right.

So I think that the identification issue in the setting is attached to the outcomes. This person has bipolar disease; this needs special attention. This outcome is important, as opposed to this is a healthy, mentally normal person going to school, great?

CO-CHAIR SUSMAN: So I mean, I can see, for example, issues of autonomy, of patient advocacy, of respect for the individual's decisions that may be a little bit different flavor, or maybe at more risk.

So if you have a patient with

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advanced Alzheimer's disease, or an individual with a very serious mental illness, you know, concerns about their ability to have a self-fulfillment, autonomous, person-directed sort of life may be greater.

But I don't see that that really, maybe at one extreme, but that's the same case as somebody who has, for example, advanced heart failure or a person who's suffered an MI. But I might be wrong, and that's why we're having this dialogue. So it would be interesting to hear what others have to say.

DR. MANTON: I think the categories are similar. I think it's the interpretation that's different, and I think it's okay that the categories are similar.

But what people will do with it, how they will interpret what we mean by symptoms and outcomes for symptoms, or how they will give us measures of function will be different for this population than it would be for the cardiac population, for instance.

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MS. MASLOW: That's exactly what I'm trying to say, but you're saying it better. So we need to identify the population in some way. The measures have to be associated with an identified population.

DR. GOLDBERG: Well, we wouldn't be here if there wasn't a perceived need for some kind of outcomes project for mental health and Alzheimer's, because otherwise they would have decided that the general categories that already exist in the previous groups would have worked for this.

So even though we may be reinventing, in a sense, or reidentifying categories that are generalizable across different domains of medicine, something in the prologue of this request for information for people, I think, does need to highlight the fact that, while there may be these categories that cut across domains of medicine, this particular request is specifically to address the outcomes in the area of mental health and Alzheimer's and

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dementias that have not been addressed up to now.

That will call forth, I think, the responses that we're looking for. So I think a prologue type statement in the call for responses --

MS. WINKLER: Yes. I would just like to say that I think that -- I mean do you want -- when you think about the population, that the population is everyone when we think about primary prevention. If you look at the bubble diagram, when you look at cardiac, they're really looking at ways to prevent cardiac problems in the first place.

So we do have our population, where the disease is already established. But really when we're looking at outcomes, I think we do want to think bigger than that, and think prevention as well.

So that the population is bigger than just people that have already been identified as having the disease.

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CO-CHAIR SUSMAN: That's an interesting concept, but do we have any good preventive interventions for preventing Alzheimer's or preventing serious mental illness?

DR. GOLDBERG: There are some child interventions, aren't there, about family health and maternal child behaviors. That's not my field, but I think there are preventive, emerging preventive interventions in that area, especially.

MS. JAFFE: Well, we look at suicide prevention. I mean there are some preventative interventions if we think bigger than some of the conversation that we've been having.

MS. MASLOW: The only way that I think you could get suicide prevention into a measure set that would be widely used, is to say in people who have X, suicide prevention. So you'd have to name the category. It's not

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MS. JAFFE: I don't think you can do that, because anyone can be suicidal. I mean --

DR. GOLDEN: Well something like we already have a measure on bipolar disease, because they're at a high risk of that kind of activity.

DR. GOLDBERG: We're back to being on the edge of the population studies, you know, comments, because after things about societal health stress levels and, you know, issues --

(Simultaneous discussion.)

DR. GOLDBERG: --as a society here?

MS. WINKLER: I'm responding more to what Katie was saying, and I think what she might be getting at is this.

If you have two, call it practice, large group plans whatever, but only ten percent of the patients in Plan A were screened for depression, dementia, whatever, and it's of that ten percent that then you figure out what the outcome is, to judge the

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quality of care for this type of situation.

But the other 90 percent could have a lot of patients with those conditions, but they weren't identified. Versus Plan B, that has screened 90 percent, and they have probably a pretty good -- identified their cohort of patients with those conditions, and then the outcome measures apply to them and the results are whatever they are.

So I think Katie is that what you're getting at, is if -- is in order to have the most robust measure, you have to be able to identify your patient population as a prerequisite to then measuring an outcome, because if you really have no way of identifying the population, do you really have comparable results?

That screening is not necessarily an outcome measure, but perhaps I can envision a compound measure where the first step is the percent of your patients that are screened, and of those screened, what outcome do you

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have?

Such that you provide the information of how extensively you may have done the screening?

CO-CHAIR SUSMAN: Let's all remember on the behavioral health tact, this was a really sort of difficult issue to wrestle with. Because if you only screen ten percent of the patients for depression, and you do real well with those ten percent, you might be doing far worse than the group that's screening all their patients for depression, and yet only gets, for argument's sake, half of them to remission.

So it is very challenging. If that's what you're getting at, I think it's something we need to acknowledge and work on. I'm sorry if I didn't understand.

MS. MASLOW: I think that that's a big part of it, and I think that's something we'll have to think about. But in asking for measures, somehow we'll need to communicate

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very clearly that this is about measures to measure these things in people with mental health and cognitive impairment or not.

If they're just measures, they're just measures. You don't need to say that. So it's very different, a very different call for measures to say.

DR. STREIM: Agreed. What I heard Tricia say before is that when the call for measures goes out to the field, these are outcome categories.

But there's going to be -- I keep having in mind that grid of the framework, where it's these measures as they relate to depression, Alzheimer's, other mental illnesses and other cognitive disorders, and you know, that when people are responding, they will be responding specifically to that, both again as we were saying, cross-sectionally, longitudinally, looking at measures in those people who have a single episode of illness or those who have a chronic

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condition or a deteriorating condition that goes over many years.

I think once that's explained in the call, it will be clear that we're talking about mental illness. I think, you know, even in the outcomes though, one of the reasons before, as Harold and I and others were talking about disaggregating from the original table we had, patient function, symptoms, health-related quality of life, that really comes from mental illness models and Alzheimer's research models.

I mean I do Alzheimer's research and, you know, one of the things we measure, as you know well, is functional status over the course of the illness and we look at rates of decline.

So if we have measures of functional status in Alzheimer patients over time, that's captured under a separate category of function that we've teased out from this. So I think that does apply. But you're right. You have

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to tell them we're asking about all these other illnesses, including Alzheimer's, including other cognitive disorders.

MS. MASLOW: I'll shut up after I say this, but think about what you just said compared to what Jeff said. So he said it doesn't matter. It's the same measure, if I'm worried about the same things in my patients across the board.

So I think this is more than just we have a quick answer to it. I don't think we have a quick answer.

I think it's something we're going to need to think about in the sending out of the call, and in stating the measures, and that it's not unthinkable to say in patients with dementia, this is an outcome. In patients with bipolar, this is an outcome. So actually putting the population into the measure isn't unheard of.

DR. STREIM: I'm not seeing the problem. You're just saying these are the

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same categories, the same domains that we're interested in. But they do need to be applied specifically to the population.

CO-CHAIR SUSMAN: And you know, when we get down to it, I would think that we're going to also or the field will eventually be able to say well, at this early stage in Alzheimer's disease, you know, focusing on cognition is really important.

But by the time they have advanced Alzheimer's, in their last years of life, this may not be really an important outcome to be focused on. We should be more thinking about preserving autonomy and function and blah blah blah, safety issues.

So again, I guess I'm willing to let this dialogue stand where it is, reflecting what I think are two important views of the world, not having to have a sense to reconcile them, but being respectful of what you have to say and what it means for our families and patients with Alzheimer's, serious mental

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illnesses and so on.

DR. STREIM: Yes. I just wanted to say, I think that you're absolutely right. The call for measures has to be very explicit and clear, and I think part of the charge to this group is to make sure that by the time this all gets put together and the call goes out in January, we're all comfortable with that.

So I think this is working towards that process. I do think that what I said isn't really at odds at all with what Jeff was saying about harmonization.

So now wearing my hat as an internist and a psychiatrist, I have to say I too was very reassured by the fact that, for example, we're talking about functional measures which are important for someone with heart failure, who's so short of breath that they can't get themselves dressed without assistance.

That's really, what we're saying is pay attention to the Alzheimer patient who

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also can't get themselves dressed without assistance, but they can't do it not because of cardiac output and shortness of breath; they can't do it because of praxis and memory and other cognitive brain hard. But it's the same outcome, the ability to get dressed, that you're measuring.

So that's where harmonization, I think, is a good thing. But we want to make it clear that it applies to Alzheimer's just the same way, different illness, different needs to be sure. But a lot of it does look like health care in cardiac patients.

DR. GOLDEN: Well yes. But I mean the problem is how do you do -- is there a standardized tool for this outcome assessment?

It's not currently being done, and are we going to specify a mandated tool?

Anyway, when it comes to Alzheimer's, I'm not sure that would be the disease I'd pick as the -- for outcome assessment at this stage, in terms of other things we can do.

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But I'd rather stick to something like schizophrenia, where there's something you can actually treat more aggressively than Alzheimer's.

CO-CHAIR LEDDY: Okay. So if everyone agrees, we will put this -- we may come back to this issue of who is the population that we're talking about, measuring these outcome measures for. So we're going to put that in an official parking lot that Ian is going to keep. You are responsible for the new parking lot, Ian.

Okay. So we're going to try and get through some of these measures, so that we can hear the population from Bonnie. Bonnie? Sorry. Bonnie on the population health.

So the next one is -- did we do changes in health-related behaviors? No, we didn't. Change in health-related behaviors. So far we have under that patient self-management and advance directives. Does anyone want to provide a definition or

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examples for that one?

I think we talked about smoking cessation in that one, and I think it's -- in my opinion, smoking cessation can go in changes in health-related behaviors, and it can go in whether or not someone still has an addiction to nicotine, you know. Like in both I think is okay.

CO-CHAIR SUSMAN: So maybe adding --

MS. HENNESSEY: Medication. I'm sorry, medication adherence, looking at physical activity, looking at nutrition would be some of the ones that come to my mind.

CO-CHAIR SUSMAN: I think alcohol and substance abuse fall into the category of health-related behaviors, when they're comorbid with another condition like depression or bipolar illness.

But they may also be primary symptoms of alcohol and substance abuse. So there's another example of a category that can, depending on what the primary disease is, it

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might fall under one category or another. But again, I don't think the overlap is a problem.

I think this needs to be in there.

DR. GOLDBERG: I feel like there's something in here about patient-centered care that we ought to mention, that there's something about patients, you know, we have a traditionally sort of physician-driven centered care model, where the care providers are making all the decisions, and there's a, as you know, a current view that having the patient more involved in making those decisions and taking responsibility for those is an important type of health-related behavior, and there may be ways to B

CO-CHAIR SUSMAN: Self-efficacy.

MS. HENNESSEY: Patient engagement, patient empowerment.

CO-CHAIR SUSMAN: Patient problem-solving skills.

MS. HENNESSEY: Care decision-making too, patient decision-making. I think we're

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just trying --

DR. GOLDBERG: Give examples, broaden examples.

CO-CHAIR SUSMAN: Well maybe risky behaviors would be under here too.

MS. HENNESSEY: Risk reduction behaviors such as seat belts, safe sex, those kinds of things, yes.

CO-CHAIR LEDDY: Have we got all those in some place or another? How about the alcohol addiction? Did we put it in both places as suggested? Or does it matter?

CO-CHAIR SUSMAN: Under symptoms, I don't know that we need to put in a laundry list of every psychiatric symptom in the book.

CO-CHAIR LEDDY: Okay, fine.

CO-CHAIR SUSMAN: But drinking and drug use, of course, is another -- we could list it.

CO-CHAIR LEDDY: Okay. So are we ready to go onto the next one, which is secondary impact in the psychosocial

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environment?

DR. STREIM: Well, under change in health-related behaviors, diet and exercise. I guess we want to be somewhat complete, and nutrition is there.

CO-CHAIR LEDDY: Oh, physical activity and nutrition are there.

DR. STREIM: All right, okay, sorry. Got it.

CO-CHAIR LEDDY: Anything else we're missing? Okay. Secondary impact on psychosocial environment? There was a lot of discussion about that, so I'm sure there's going to be a lot of definitions.

CO-CHAIR SUSMAN: Someone explain it to me. I'm still not clear. Where's Harold when you need him?

CO-CHAIR LEDDY: I think people were talking about like school absenteeism, incarceration, the incidence of children being in foster homes. Those types of things, I think, were used as examples of this in the

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past discussion.

CO-CHAIR SUSMAN: So is it the name of the category here that's difficult to understand? At least it is for me. You know, if we called it something like psychosocial impacts or psychosocial consequences.

CO-CHAIR LEDDY: How about social environmental. I don't know if we need that "psycho."

(Laughter.)

CO-CHAIR SUSMAN: Yes, just throw that "psycho" out. This is the wrong group to do that.

CO-CHAIR LEDDY: No. We're talking about impacts of let's say mental health counseling. So I think that what we're talking about the impact on is on the normal environment, like the social and environmental environment. Like school absenteeism, or whether you're in prison or --

MS. WINKLER: Do we need a secondary? Does that help? Okay. Then I'm going to get

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rid of that. So we're talking about the impact on B

DR. GOPLERUD: I have a hard time, you know, teasing that apart from functioning, and then giving --

DR. STREIM: Yes. We have social role functioning, where we included work, school, play, family, social interaction.

I think, again I don't want to speak for Harold in his absence, but when he described it the first round, he was using examples like absenteeism, school attendance and those sorts of things which have to do with the social environment.

DR. GOPLERUD: Right. But I think we've got that now in the functioning category. I think it's confusing.

CO-CHAIR LEDDY: B- words up to the function.

DR. GOPLERUD: We already have them sort of up there. Work, school, play, family.

CO-CHAIR SUSMAN: So could we then

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would it be the group's wisdom to take the absenteeism, incarceration, presenteeism and put them up under work, school, blah blah blah blah. Is anybody opposed to that?

DR. WAN: Just a comment. When we look at the burden of illness or the cost of illness, so we focus on things that measurable, direct medical costs to health care.

But then these are the components that are typically viewed as indirect costs, work loss, productivity, premature death due to suicides and things like that, incarceration, homelessness.

So I don't know. I don't think indirect is not the right word for it, but it's still within the same category.

MS. WINKLER: Would this be characterized maybe as there could be multiple subcategories to explain function a little bit? And this one might be a different one, but it's still a part of function?

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CO-CHAIR LEDDY: I think it's different, in that we're talking about patient or population outcomes, and I think what you're talking about George is more of a system outcome. So you know, that goes to like cost effectiveness studies and that sort of thing, right?

DR. GOLDBERG: When this category came up, exactly what came up was the indirect costs of mental illness. That's what came up.

CO-CHAIR LEDDY: Exactly.

MS. WINKLER: I mean that has full acceptance --

DR. GOLDBERG: But it spills over into these other organizations and social agencies.

CO-CHAIR LEDDY: Absolutely.

CO-CHAIR SUSMAN: So it has both an individual impact of gee, I'm not working. I'm not able to take part in my social networks. I might be incarcerated. I might be homeless, and it also has an impact on the

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population and the effects at the workplace, the indirect costs that actually are the largest impact of mental illness beyond, way beyond the direct costs.

DR. STREIM: I would like to propose that we keep them separate, and that under function, the second bullet, that that's really --

I think the intent of all our examples there was to describe this at the organismic level, you know, how does it impact the individual person receiving that unit of health care, whereas the impact on psychosocial environment really is more effects on society, community, et cetera, which can be measured in terms of costs, as George was saying.

I think that it's so different than measuring it at the person level, that we should keep them separate.

CO-CHAIR LEDDY: We're kind of like second-guessing, what's his name, Donabedian?

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VOICES: Donabedian.

CO-CHAIR LEDDY: Donabedian, the guy who invented the definition of outcomes. But no, I think if we can add a separate -- it keeps coming up, that the group keeps saying well, we want to measure the impact on the health care system was mentioned beforehand, now on the environment, on social costs.

I think it keeps coming up, so we need to put it as a separate category somehow and see where it ends up.

DR. MANTON: Tricia, I wonder if we could -- if we change the heading, maybe it would make more sense, and if we said something like social/environmental impact, and then the other things sort of flow more readily.

DR. STREIM: And add homelessness to the list, because I think that's a nice example of how health care outcomes, poor mental health care outcomes, affect you when you walk down the street and see all those

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homeless people, and how it affects society at large.

MR. PELLETIER: I mean is this also where we would put involuntary conservatorship, those kinds of status, legal status?

CO-CHAIR LEDDY: B- for foster care, something that somebody else mentioned which is similar to that, right? So yes, can we put a couple of examples like that under this social impact one? Do we need any other examples? Can we go on to service utilization?

DR. GOPLERUD: No. Let me go back.

MR. PELLETIER: I think we need to put legal, in that there are some -- there are a bunch of legal. There are like many, many things under legal. Involuntary commitment, conservatorship, someone -- well, it goes toward incarceration. But that there are legal issues, consequences.

DR. GOPLERUD: In the commercial

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world, these measures that we're talking about as being environmental are measured at the individual level, as well as at the group level.

When disability management or disease management program works with a person who has diabetes and depression, to get them back to work in a shorter period of time, the outcome metric is how long are they out of work? So it's at an individual.

When an EAP has to measure, you know, what is the absenteeism or have people gotten back to work, it's at an individual and a population level. So let's -- and also I'm glad we took out the term "secondary," because for many folks, that's a primary.

CO-CHAIR LEDDY: So do you agree that it should be -- that it could stay separate though, that the impact on the social -- the social/environmental impact is separate from the impact on the population?

CO-CHAIR SUSMAN: What I'm hearing,

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if I'm not mistaken, is that it's in both areas.

DR. GOPLERUD: That's what I'm saying, it's in both areas.

CO-CHAIR SUSMAN: It's both an individual and it's also at a sort of population.

DR. GOPLERUD: Right, and then back at the other place where we talk about function, up in that second bullet, in some ways we're using the way that people have traditionally thought about functional assessment, which is talking about ADLs or talking about symptom check or whatever, disability checklists.

In this bullet, we're talking about more hard numbers, or at least that's the way I would think of it. You know, how many kids are in out of home placements, or what are the rates of people who have mental illness who are in the jail?

CO-CHAIR SUSMAN: Harold, you have

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about two seconds to take a look and see if you agree. As long as he agrees.

CO-CHAIR LEDDY: So are you okay with what we did, Harold?

CO-CHAIR SUSMAN: He is smiling.

CO-CHAIR LEDDY: Okay. You can come back to it if you think about it and have other comments. So we can go on maybe to utilization, service utilization.

DR. PINCUS: The only thing I want to add about -- the only thing I'd add about social environmental impact is that going back to the DSM-IV problem list, is that you could actually extract from that problem list lots of examples that would be useful.

CO-CHAIR LEDDY: Okay. Anybody want to try for a definition of service utilization?

DR. MANTON: Well, I think the definition is easy, you know. It's how often and how consistently did they use services? But one of the things I would like to see some

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sort of measure of is, you know, do they keep appointments? Are they no-shows? Do they cancel a lot on the one hand.

And then other side of it is how often are they hospitalized; how often do they use emergency departments, that kind of thing.

So it's sort of what do they use and what don't they use.

MS. HENNESSEY: Yes. I kind of think of it in this sort of broad notion of resource consumption. So I'm thinking about it not only in the ways we've just discussed, but also medication, durable medical equipment.

DR. GOLDEN: Yes, but is that an assessment of the patient's behavior or that of the system taking care of the patient? I think if you're not careful, you're looking at an assessment of the patient and their disease, rather than the effectiveness of the health care system in managing the patient.

CO-CHAIR SUSMAN: Wouldn't that be risk adjusted or severity adjusted, in that

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someone with advanced Alzheimer's might interact with the system differently than somebody who was very early in their disease state?

DR. GOLDEN: Well no. You're not changing outcomes. You're talking about keeping appointments and other things and so forth, or using different kinds of services.

That's different from somebody, I mean I guess it's a question between the electiveness of what's going on versus the need for unscheduled use of, because of inappropriately managed care.

CO-CHAIR SUSMAN: So it's the appropriate use at the right place and the right time for the right setting, you know.

DR. GOLDEN: I think you're going to have to assume that some of these folks with mental illness will be using things inappropriately.

I think that's kind of the track record. The question, I guess, is going to be

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coming up with measures that are indicative of health system performance, rather than the endogenous disease itself.

DR. PINCUS: Well, first off, I think that the general definition is sort of appropriate and inappropriate, you know, utilization of health services, you know, and the idea is, I think, also is sort of -- thinking about it from a longitudinal perspective is sort of like at, you know, really looking forward to the next level of care, to the next stage of care in the episode-based model that we discussed before.

I think, you know, one of the issues that cuts across all of this is, you know, when you're talking about this in the context of a change, and for a lot of these categories at some point we'll talk about sort of what is a baseline, and so how do we sort of -- you know, how does one capture that information going forward, plus the whole issue of risk adjustment.

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But I think what we talk about makes sense. I think again, it's from which population. If you're holding steady the population of people with mental illness and certain types of mental illness, then that in a sense accounts for, you know, any kind of comparisons internally among those groups.

DR. GOLDBERG: I'm not sure exactly where this fits in, but I'm prompted by this comment to make this on service utilization. In some parts of medicine, although the data isn't solid, quality outcomes may have something to do with how much you provide of that service, that if you provide a lot of it, maybe you're better at it.

Is there anything that we're going to think about getting at, in terms of quality care, that has people reporting how much of it they treat?

If you are a consumer and you had psychotic depression, wouldn't you feel better if you went to somebody who treated a lot of

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that, than somebody -- or if you had an eating disorder?

So is there anything in our system that gets at capabilities that serve as volumes, the experience of the provider?

CO-CHAIR LEDDY: The surgery that's done a lot is very important.

DR. GOLDBERG: Or anything relevant to this? I'm just raising it.

(Simultaneous speakers.)

DR. PINCUS: There are very few studies that on the volume and the quality relationship in mental health. I think actually Ben Druss and I posed one of the few studies on it. There really is a limited amount of work being done.

DR. GOLDBERG: Well, does it point out gaps? Is that a gap that needs to be looked at?

DR. PINCUS: You're assuming that volume is a good, you know, is likely to be a good indicator.

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DR. GOLDBERG: I know many cases where I'm sure it isn't.

(Laughter.)

DR. GOLDBERG: Maybe it's necessary, but not sufficient, I mean because I know a lot of other cases where people are going to providers who really have no experience in treating the disorder, and their system isn't capable -- they're not set up or organized sufficiently to manage what they're treating.

MS. HENNESSEY: So is part of what you're talking about is utilization of evidence-based protocols?

DR. PINCUS: It's related.

DR. GOPLERUD: Those aren't outcomes. Those are processes.

CO-CHAIR SUSMAN: I mean I think at this juncture, aren't we looking at for given outcomes, where is the most appropriate use? Where are there examples of under-use? Where are there examples of waste?

So having a patient come to an

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emergency room for uncontrolled bipolar disorder, which could have been better managed as an outpatient, maybe even in a primary care setting that used evidence-based guidelines, we'd say well, there is some waste in that interchange.

DR. PINCUS: I think partly the way this fits into outcomes, Eric, is at least the way I think about this, is that subsequent to, you know, an initial component of care at time one, at time two people are more likely to get evidence-based care. They're more likely to get appropriate care.

So it's kind of an intermediate outcome, you know, thinking of it as one moves across the phases, as the phases of an episode of care. So that's the way I was thinking about it.

So it's in the same way that, you know, of reducing subsequent hospitalizations, where on the other hand it's increasing the use of evidence-based care, because you, you

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know, because of what was done at an earlier point in the course of the treatment.

DR. GOPLERUD: All right. So you're less talking about is CBT being used for depression, than do you have greater use of ambulatory behavioral health rather than emergency department or hospital utilization.

DR. PINCUS: Or I mean -- for example, I mean thinking about the whole issue of transitions in care and those kind of things, is it -- the people coming out of hospital A have a greater likelihood of getting CBT for depression as people coming out of hospital B.

Overall, what is the influence on the episode of care, cost and quality, the value?

So it may well be that doing more CBT by trained cognitive behavioral therapists, will lead to more utilization and net backs. But then the overall episode might diminish the costs and improve quality. I think it is something we obviously don't know.

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DR. GOPLERUD: I read a very interesting case study looking at hospital discharges from a psych hospital recently, and looked at referrals or lack of referrals for medical conditions, which didn't exist.

So you know, one of the things might be if people have medical conditions, is there follow-up utilization for those medical conditions?

DR. BOTTS: I think the utilization, and this may be a process measure, but for improving medication outcomes and particularly medication safety will be tied into the frequency of service utilization and getting appropriate follow-up and management.

CO-CHAIR LEDDY: And in this category, re-hospitalization is often used as an outcome measure. That's a common, more common.

MS. HENNESSEY: We also at one time discussed having care coordination or transition of care planning as being under the

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service utilization category.

CO-CHAIR LEDDY: Yes, that's a good point, right. Can we put care coordination? Thank you.

MS. WINKLER: Well, we can. You had it in the parking lot, so we can move it out.

CO-CHAIR LEDDY: Are we ready to go on from service utilization to the next category, which is direct physiologic?

Physiologic, sorry. It seems like it's missing a noun, measures. Thank you. Direct physiologic measures. Okay. Who suggested that one?

(Off mic comment.)

CO-CHAIR LEDDY: Oh Harold, that was on your list. You get to give us the definition.

(Off-mic comment.)

CO-CHAIR LEDDY: Light please, light please.

DR. PINCUS: It was also mine on this also.

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DR. STREIM: Physiologic, biochemical, clinical outcomes was the second box.

DR. PINCUS: Right. I mean there's clearly an overlap with this, but I don't think it's a problematical overlap with the general medical outcomes.

So really, because there are none to my knowledge of direct physiological measures for mental health conditions, except for sleep disorders.

But you know, I'm hard-pressed to think of any that are directly.

DR. GOPLERUD: There are some not very good ones in the dictionary.

DR. PINCUS: Well, for -- yes. But also, you know, you're in school and that kind of stuff. I mean you know --

DR. GOPLERUD: Blood alcohol level.

DR. PINCUS: Yes. I mean so I would include those things, but also you know, a lot of these are, you know, in the general medical

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area. So blood pressure, you know, pulmonary function, glycemic control --

CO-CHAIR LEDDY: So do we want to combine this with general medical outcomes?

DR. PINCUS: I think again, for the purposes that we have now of trying to get it out to the world, so people, you know, don't not think of direct physiological measurement that they can propose.

DR. GOLDBERG: But there's a difference between general medical outcomes and medical outcomes that are specific to our treatment, like lipid profiles with atypical anti-psychotics.

DR. PINCUS: Well, I was using the term "general medical community," non-psych, non-mental health. Not meaning general. That's a term we use in the DSM, to get away from use of the word "physical."

CO-CHAIR LEDDY: I guess I'm wondering if you would include under that, you know, like sort of the kinds of things that

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you would want to measure before and during a particular treatment, you know, lithium levels, you know, electrolytes, EKG if you were going to have somebody on --

DR. GOPLERUD: Oh, liver function.

CO-CHAIR LEDDY: Liver function. I mean I'm wondering if --

DR. GOPLERUD: Diabetes.

CO-CHAIR LEDDY: If that would come there or if it would come under adverse events that you're trying to avoid.

DR. STREIM: I think, you know, some of those may come under safety, some of them may come under adherence, and that's okay. Again, we've captured this broadly, and we can worry about -- we don't even need to feed them in categories later. We just want to bring this in.

CO-CHAIR LEDDY: Right. But I don't think we have anywhere written down that I see this issue that a few people have said now, about things that you measure because you

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might be on a psych drug, for example. Do we have that?

CO-CHAIR SUSMAN: So medication monitoring?

DR. BOTTS: Those are process measures. They're not the outcome of the med treatment. They ensure the safety and the appropriate dosing, but they're not the outcome.

DR. GOLDBERG: Adverse effects are an outcome.

DR. MANTON: We don't know what you're looking for, but they might be an outcome.

CO-CHAIR LEDDY: Well, do you want them on the list or not?

DR. MANTON: I mean they can go either way.

CO-CHAIR LEDDY: Do we want them in one of these categories? I just didn't see that it was down anywhere, and three people mentioned, you know, liver profiles or you

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know, whatever it was.

DR. BOTTS: I think in this, I would say this is a CB, a cerebral vascular event with an anti-psychotic. A cerebral vascular event would be the bad outcome of using drug therapy, or metabolic syndrome secondary to anti-psychotic treatment, or death.

DR. PINCUS: Yes. I think we're talking about whether you measure it versus, you know, the measure of glycemic control, as a measure of --

VOICE: Your mic is still off.

DR. PINCUS: As a measure of, you know, as a measure of outcome, as compared to whether or not you're measuring it.

CO-CHAIR LEDDY: Okay. So we have it enough for everybody.

DR. ROCA: What about something like BMI? Would that go into this category?

DR. PINCUS: Yes, yes.

DR. ROCA: Would that go into this category or yes.

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CO-CHAIR LEDDY: Okay. What about -- okay, the next one is patient -- are we ready to go on to the next category?

DR. BOTTS: I would suggest as a future measure, pharmacogenomic indicators will probably be important. Probably not at press time, but they're coming.

CO-CHAIR LEDDY: Under direct physiologic?

DR. BOTTS: Yes.

CO-CHAIR LEDDY: Okay. Pharmacogenomics. I'm not a doctor.

(Simultaneous discussion.)

CO-CHAIR SUSMAN: It's more of a process measure, again, unless you're planning on changing it.

DR. BOTTS: No. That was not my suggestion, although that would be cool. But as a measure of getting the right drug therapy versus not, and being able to have appropriate selection up front and not a reactive position.

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DR. STREIM: I think that those are from the outcome point of view.

DR. BOTTS: Process?

DR. STREIM: Yes.

CO-CHAIR LEDDY: Okay. Reva's got it down, right?

MS. WINKLER: I'm leaving it there for the time being. You can erase it later on. I'm just pleased I sort of got it up there.

CO-CHAIR LEDDY: Okay, and patient-caregiver experience and satisfaction.

MS. WINKLER: Anything else?

CO-CHAIR LEDDY: Does that say it all, or do we want to say some examples?

DR. GOLDBERG: You already have the ECHO study in there as one of them, don't you? It's already in. Actually, the ECHO assessment.

CO-CHAIR LEDDY: So we probably don't need any more explanation or examples of that one? Okay. We can move on to the next one?

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Okay. Safe living and environment. Anything to add to that one? We have talked about some of those things before.

CO-CHAIR SUSMAN: Safe environment, just so I'm sure what everybody's talking about.

CO-CHAIR LEDDY: Okay. Who suggested this one? Oh yes, copy that. It's on your slide on -- it was on Slide 44.

DR. GOLDBERG: It looks like it fits in someplace we already covered.

CO-CHAIR LEDDY: So do we want to just move that one up into the --

DR. PINCUS: Social environmental impact, and I'd use it as an example, an example under social environmental impact. I mean the examples that were in the slide. I'd put that under social --

CO-CHAIR LEDDY: Okay. So we could make a note that we want to add some examples from Slide 41 to that.

CO-CHAIR SUSMAN: So family violence.

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MS. HENNESSEY: It's Slide 44.

CO-CHAIR LEDDY: Oh 44, thank you.

Thank you, Maureen.

MS. WINKLER: So we remove it as an individual spot?

CO-CHAIR LEDDY: Yes.

DR. PINCUS: Yes. It's the third one down on Slide 44.

DR. ROCA: Yes, and is that where something like homelessness would go?

CO-CHAIR LEDDY: Yes. We've already got it. Okay, the next one is patient safety, adverse effects, medication side effects and complications. Do we need anymore to that one? Suicide?

CO-CHAIR SUSMAN: I mean I think suicide would be a nice one to include in the mental health. I mean is it a patient-oriented outcome, suicide attempts? I'd say probably it is.

DR. MANTON: Yes. I'd look at attempts and completions.

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MS. JAFFE: You could just generalize it to self harm.

CO-CHAIR LEDDY: Okay, self harm, excellent.

MS. HENNESSEY: Actually, I'd rather see self harm be separate from suicide attempts and completions.

DR. STREIM: So we're talking about measuring alteration and risk and protective factors for self harm.

DR. GOLDBERG: After all the other sentinel events in here too, you know, restraints and elopement, restraint and seclusion, utilization.

DR. PINCUS: Traffic accidents.

DR. GOPLERUD: In the addiction area, we talk about reductions in risky use, which could be needle sharing or drinking and driving.

DR. ROCA: And things like falls. Falls are certainly things that are being looked at in other settings, but clearly in an

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inpatient setting, falls would be important.

DR. STREIM: And again, the things that we're measuring there are things that the health system can do to reduce the risk factors, the modifiable risk factors that lead to falls, to suicide, et cetera.

CO-CHAIR SUSMAN: Does delirium come in here?

DR. STREIM: Yes, I think there's literature on prevention. I don't know. Measurement is going to be the challenge.

DR. PINCUS: Well, again, actually, I think it's not going to, because there are a lot of different mental health side effects. I mean, you know, depression can be a source.

CO-CHAIR SUSMAN: I'm thinking particularly in your elders, who are giving, you know -- absolutely.

DR. WAN: What about medication errors? I don't know if that's something that falls in there. The other thing about, I think we talked about this earlier, around

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having some infrastructures in place such as health information, HIT available to reduce some of those.

VOICE: Isn't that the process measure?

DR. WAN: Would that go under a process measure?

CO-CHAIR SUSMAN: I think that's the means to reducing these outcomes, bad outcomes.

MS. HENNESSEY: Question. Where would people see health literacy fitting in there? That could be a patient experience; it could also be patient safety. What does --

CO-CHAIR SUSMAN: Assessing the whole issue of cultural factors in care.

DR. PINCUS: -- caregiver experience.

MS. HENNESSEY: Health literacy and cultural competency. You would put those there. I'm fine.

DR. PINCUS: I think it fits under patient caregiver experience.

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MS. HENNESSEY: Yes. We just might want to elucidate patient experience a little bit more with those two, and cultural competency.

CO-CHAIR SUSMAN: You mean so it's culturally appropriate care. Presumably that's an outcome that matters to patients.

DR. PINCUS: Right. But the patients perceive that they were, that the caregiver, that the providers were attending to their cultural needs and cultural --

CO-CHAIR SUSMAN: Recognizing the patient can't read the instructions on the bottle that you handed them, yes.

DR. PINCUS: Yes, things were too complicated for them.

CO-CHAIR LEDDY: Okay. Do we need anymore in that category? The next one is patient safety, adverse events.

VOICE: We're doing that again?

CO-CHAIR LEDDY: Oh, we just did that one, sorry. Where are we? Non-mental health

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medical outcomes.

CO-CHAIR SUSMAN: I think we at least need a parents that says general medical. I know you don't like that, but I think that the field by and large. I don't know. If I saw non-mental --

DR. PINCUS: Well, you know, when we were doing DSM-IV, we had sort of an internal contest to come up with a better name for mental disorders and a better name for physical disorders. And nobody won for mental disorders.

DR. PINCUS: But for physical disorders, we sort of came up with sort of half-assed general medical conditions.

CO-CHAIR SUSMAN: We just need to maintain the mediocrity here.

CO-CHAIR LEDDY: So do we need any, any particular --

DR. PINCUS: Well actually, I'm assuming some of these conditions are part of the mental health thing.

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DR. GOPLERUD: No. I was just referring back to the IOM title.

DR. PINCUS: Yes, mental and substance use, yes. But yes. I mean we should be explicit actually throughout this, that we're talking about mental and substance use conditions throughout, and so this is non-mental health/substance use medical outcomes, or general medical conditions, whatever we want to call it.

But here, we're talking about all comorbidities, all general medical comorbidities, as well as prevention of general medical comorbidities. So you know --

DR. GOLDBERG: I think this category emerged to distinguish it from medical outcomes like diabetes from anti-psychotic use, was a medical outcome associated with mental health treatment, versus you know, hypertension and people's inability to achieve control of hypertension because of their behaviors or their lack of medical, you know,

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care involvement, because of their condition.

VOICE: Is that why it emerged?

DR. STREIM: Sometimes you have lousy glycemic control, because you're on an anti-psychotic drug. Sometimes you have lousy glycemic control because you're not on an anti-psychotic drug and you're so disorganized so that you're not taking, following your diet and taking your insulin. Or other possibilities. Or other.

DR. PINCUS: Yes. I think, well I think there's three broad categories in this. I mean number one is, you know, the consequences, you know, essentially the secondary consequences of treatment or of having the condition that, you know, makes it more likely that you're going to have more difficulty controlling the outcomes.

Number two is the fact that just the fact that you're, that you have a mental disorder and you also have diabetes means that there's some, there ought to be some mutual

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responsibility between the mental health side and the general medical side, responsibility for both the depression and the diabetes.

DR. GOLDBERG: All right. I'd echo that and take another shot at it.

DR. PINCUS: Let me just finish. Number three is the preventive side. So that, you know, if you have a mental disorder, you know, you ought to be -- that you ought to be assessed for the extent to which your providers are providing you with all the expected preventive services.

CO-CHAIR SUSMAN: Rich?

DR. GOLDBERG: Just I'm sorry for interrupting, Harold. But the huge number of people with serious mental illness who don't get medical care, that they don't see anybody. That's what I think maybe we're getting at. So I think Harold did cover it by the categories he mentioned.

DR. STREIM: The other example that I think should go in here, since we've made a

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point before of separating out symptoms and functional status, is excess disability, meaning, you know, the COPDer who's got such a bad anxiety disorder that their dyspnea is made worse not so much by their pulmonary function, but by their anxiety. So they can't walk more than a block.

CO-CHAIR SUSMAN: Good. You know, it seems like this would be a great area to get some unique composite measures, that really look at the medical and mental together rather than separately.

DR. GOPLERUD: Let's also add dental.

CO-CHAIR SUSMAN: Good. Dental is a great example.

DR. PINCUS: Good point.

CO-CHAIR LEDDY: Okay. Are we ready to go on the next category, which is mortality?

VOICE: There's not much more to say about that.

CO-CHAIR SUSMAN: Would someone

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define this?

DR. GOPLERUD: I like Sheila describing it as a physiological outcome.

DR. STREIM: So while we're on dental, I like that so well, I would put also under the non-mental health medical outcomes.

DR. PINCUS: Oh yes. No, I thought that was the intent.

DR. STREIM: Well, it ended up in composite measures. It used to be in both. That's great.

CO-CHAIR SUSMAN: I think we all understand mortality.

CO-CHAIR LEDDY: Okay. How about recovery?

CO-CHAIR SUSMAN: If in denial.

CO-CHAIR LEDDY: How about recovery? Did we cover recovery already in the sort of workplace, school type --

DR. PINCUS: Well, I think there is a kind of ethos about recovery, that probably Joel keeps shutting it off.

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DR. STREIM: I'm sorry.

CO-CHAIR SUSMAN: I mean I've got a model here, a recovery model that I brought, and it's got a lot of specific elements that, you know, we either want to include, explicitly or not.

DR. PINCUS: A lot of this feels like shared decision-making, and some people like Bob Drake don't like the use of the word recovery for shared decision-making. But you know, there are sort of elements, you know, in terms of sort of hopefulness and optimism, associated with outcomes that would be relevant.

CO-CHAIR SUSMAN: I mean you know, if you look at at least this model that I pulled, hope, spirituality, choice, wellness, understanding, trust, respect, competence and then treatment supports, family and friends, peer support, meaningful work, income support. I mean I can just hand it over.

DR. PINCUS: I mean there are

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actually outcome measures, in terms of whether, you know, people are meeting their sort of self-directed bonus goals.

CO-CHAIR SUSMAN: Right. So I mean you can measure satisfaction with work as an example, or you could measure how much income support is needed, SSI and so on and so forth.

So each one of these could be translated and sometimes are, in these programs that are based on a recovery model.

MS. HENNESSEY: I was also looking again at the famous Slide 44, health and well-being, and they talk about absence of disease or reduction in disease status or patient-reported happiness.

DR. PINCUS: Yes. I mean there's a little of overlap. There's more than a little bit of overlap with health-related quality of life, but that's okay.

CO-CHAIR LEDDY: So did you want to add some words from that Slide 44 in recovery, in the recovery one? So Reva, can you just

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note Slide 44 on the recovery one, and we'll take a few words from that slide under recovery.

MS. HENNESSEY: It's the fourth one, health and well-being on Slide 44.

CO-CHAIR LEDDY: Okay. The next is incidence and prevalence of disease. Oh, I think I should just --

CO-CHAIR SUSMAN: So is this beyond what we have up in non-mental health medical, and if so, what is implied here?

DR. GOPLERUD: Are we meaningfully treating the proportion of people with major depressive episode, and are they engaged in active treatment, as an alternative to the AMM measures?

DR. PINCUS: Although I'm not sure it's an outcome measure.

DR. GOPLERUD: I think that actually it's the way that Tricia was presenting it. The outcome has, and it's kind of like the Dee Eddington. Are you reducing the prevalence of

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people with that condition over time?

CO-CHAIR LEDDY: In the population.

DR. GOPLERUD: This is definitely a population base. It's really hard to do this at a personal level.

DR. PINCUS: Yes. You know, it's hard to imagine any, you know, any feasible possibility of truly measuring that. I mean we may be sort of, you know, sort of having people bark up the wrong tree, because it's --

DR. GOPLERUD: At a population level, I think it's reasonable for holding a system accountable for treated prevalence. But I don't think it makes sense at an individual level.

DR. PINCUS: Right. But treated prevalence is not the same as reducing the prevalence, because if you're measuring treated prevalence, you want to increase the treated prevalence. That's what you're holding accountable for.

DR. GOPLERUD: Right. But that is

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one of the things that Dee is trying to push.

DR. PINCUS: And I think what Dee is trying to push is reducing the prevalence, assuming you actually have a measure that would measure prevalence.

DR. GOPLERUD: True, or --

DR. PINCUS: Whereas what Catherine is talking about is, you know, are you getting, you know, of the proportion of your enrollees, you know, do you have any sort of reasonable proportion that are actually getting treated?

DR. GOPLERUD: Those are two very different things.

DR. STREIM: But at the facility level, you can look at incidence of things like depression, anxiety, delirium, right?

DR. PINCUS: But the problem here is that, you know, the reality is that given the inadequate access to care, that in most cases you want to see this increase. But you know, if you really had valid measures at a

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population level, we really would want to see it decrease.

CO-CHAIR SUSMAN: But I mean we have analogously a big effort about hospital-acquired infections. What if we had a big effort around delirium, which is a huge problem in hospitalized patients, particularly our elders with cognitive impairment.

It seems like, you know, that would be just as valid for our interventions as hospital-acquired infections or ventilator-associated pneumonia.

DR. GOPLERUD: We worked on a measure like this a long time ago on nursing homes, and reducing the levels of depression as measured in whatever it is, the semi-annual reports, and a measure of nursing home effectiveness was a reduction in the proportion of people with depression, who were measured as a population.

DR. PINCUS: But that's because you have the universal mandated assessment.

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DR. GOPLERUD: That's right, right.

DR. PINCUS: Yes. So it would have to be in an environment where there's universal mandated assessment.

DR. GOPLERUD: You know, a secondary one would be in a company that incents using an HRA, and do you have reductions over time in depression or smoking or other conditions?

DR. PINCUS: Yes. It's not -- it's reasonable to consider that.

CO-CHAIR SUSMAN: Or just look what is happening with JAHCO and pain. I mean you know, now you can't walk into a hospital as a visitor and not say oh, you had paid. Rate it from 1 to 5.

CO-CHAIR LEDDY: I think that since our purpose is to elicit feedback, if we think that, you know, the measurement of incidence of disease is important, then we can look for those kinds of -- elicit that kind of feedback. Maybe it may be surveys.

DR. PINCUS: Yes, no. If the health

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plan wanted to do some kind of survey for their, you know, like nursing homes, that's a good example.

The thing just maybe also to think about, we might want to say up at the very top, where we have symptoms, is to put something about improvement/remission, because I think that's one of the issues in terms of thinking about this. A lot of the push is that towards remission.

DR. GOLDBERG: Yes. Now that we've generated this huge list, we've got things we've called maybe process outcomes, and then we have this term intermediate outcomes, which kind of implies that there's enough that you can keep going on that spectrum, to high performance outcomes. I'm not sure what the terms are.

I wonder whether there ought to be anything in the direction that gives a sense of this kind of evolution of outcomes, from process to intermediate to high performance,

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because otherwise a lot of people are going to cascade us, I think, with lower level process measures, which I think we have enough of already.

The real harder conceptual problem here facing the field is to get to higher level, I'm not sure what the right term is, outcomes.

I don't want us to set ourselves up for getting people to spend a lot of energy identifying more, I don't know what the right term, but lower level process, intermediate outcomes that might have some validity. They're measurable, you can do them, which is why they're used.

DR. PINCUS: Although Rich, I think you have to realize that for the purposes of a call like this, the only things that are really eligible to be submitted are things that have been tested essentially, or that have been sort of well thought-through. So that you're only going to capture sort of

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things that are out there.

I think that by having a very broad, you know, I don't think it -- you know, I do think we want to emphasize the things that are more outcomes, because that's the focus of it.

But I think by -- but ultimately, when it comes down to what we're going to get in, my guess is that it's going to be really a quite limited sort of batch of things that are appropriate.

A lot of our report is going to be around what needs to be done.

DR. GOLDBERG: Okay, fair enough.

DR. PINCUS: So I think there are going to be just actually, just you know in the few weeks of when this call for measures is out there, is actually going to be developing the measures. They're looking and see what's on the shelf.

DR. MANTON: I just want to say I think we need to clarify that incidence/prevalence of disease, because I'm

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not sure people that receive it will know what disease we're talking about. Because above it, we have the non-mental health.

So I think just clarifying that, to make sure that they know we're talking about mental illness there, at least I think that's what we're talking about.

DR. PINCUS: Yes, yes. It's in this prevalence of mental/substance use disorders.

DR. MANTON: Yes.

CO-CHAIR LEDDY: So does anybody want to say anything about end of life or palliative care besides what's there?

DR. WAN: Actually, I wanted to go back to the incidence prevalence discussion.

CO-CHAIR LEDDY: Okay.

DR. WAN: When we talked about screening for mental illness, I know that's more of a process-related measure. But it might be important to focus on screening of mental illness and general medical conditions.

For instance, there is with epilepsy or after

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an acute MI, but the incidence of depression is quite high.

So just having, you know, applying that as screening for mental illness in general medical populations.

CO-CHAIR SUSMAN: So what you're advocating is enriched populations doing the case finding, and is that really an outcome? It may be an intermediate.

I mean I'm not arguing. But does a patient really care about that? No. They care about whether their MI is better or their depression is better.

DR. WAN: Right.

CO-CHAIR SUSMAN: What do people feel?

DR. GOLDBERG: Well, I guess people, like in stroke, what's your outcome with your post-stroke depression patients? Well, it's pretty good, because we don't have any of those patients.

CO-CHAIR SUSMAN: It's a chicken and

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egg issue.

DR. GOLDBERG: Yes.

CO-CHAIR LEDDY: Okay. Are there any other comments on any of the measures? Not that this is the last opportunity, because Ian and Reva are going to write this up, and we'll have another crack at it tomorrow, if we'd like to, once we can look at it. And Bonnie has also graciously agreed to move her presentation until tomorrow, because we've gone so late. Thank you, Bonnie.

And it is past the time when we said we were going to adjourn, which was 4:30. So it's 4:40. So I think we'll adjourn for the evening, right?

DR. STREIM: We still need to capture the suggestion on that third to the last bullet. That should read incidence/prevalence of mental and substance use disorders.

CO-CHAIR LEDDY: Did you get that Reva? Okay.

CO-CHAIR SUSMAN: Evidently, do we

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have to ask for public comment?

CO-CHAIR LEDDY: Oh, yes.

MS. WINKLER: See if anybody's on the phone.

NQF Member/Public Comment

CO-CHAIR LEDDY: Oh yes. Is there anybody on the phone or any National Quality Forum members or public that have comments at this point?

(No response.)

CO-CHAIR LEDDY: Okay. I don't think we have anybody on the phone. It's good to ask. Thanks for the reminder, and what time are we convening in the morning. Okay. So 8:30 a.m. here again, continental breakfast and the meeting will start at nine, and Bonnie will do her presentation on population-based health. Thank you.

(Whereupon, at 4:43 p.m., the above-entitled matter was concluded.)

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