THE NATIONAL QUALITY FORUM

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PATIENT OUTCOMES

MENTAL HEALTH STEERING COMMITTEE

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THURSDAY

APRIL 8, 2010

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The Steering Committee met at the National Quality Forum, Suite 600 North, 601 13th Street, N.W., Washington, D.C., at 9:30 a.m., Tricia Leddy and Jeffrey Susman, Co-Chairs, presiding.

PRESENT:

TRICIA LEDDY, BS, MS, Co-Chair
JEFFREY SUSMAN, MD, Co-Chair
SHEILA R. BOTTS, PharmD, BCCP, University of Kentucky College of Pharmacy
MAUREEN HENNESSEY, PhD, CPCC, Gardener Health Systems
DARCY JAFFE, ARNP, Harborview Medical Center

DANIEL I. KAUFER, MD, FAAN, University of North Carolina at Chapel Hill
ANNE P. MANTON, PhD, Cape Cod Hospital
KATIE MASLOW, MSW, Alzheimer's Association *
LUC R. PELLETIER, MSN, APRN, FAAN, Sharp HealthCare
GLEN PHILLIPS, PhD, Eli Lilly and Company

HAROLD A. PINCUS, PhD, New York Presbyterian Healthcare System

PRESENT (Cont'd):
ROBERT ROCA, MD, MBA, MPH, Sheppard Pratt
Health System
JOEL STREIM, MD, University of Pennsylvania
Medical Center
KENNETH THOMPSON, Substance Abuse and Mental
Health Services Administration *
GEORGE J. WAN, PhD, MPH, Johnson & Johnson
CAROL WILKINS, MPP, Independent Consultant

NQF STAFF:
HEIDI BOSSLEY, MSN, MBA
IAN CORBRIDGE, RN, MPH
ASHLEY MORSELL
REVA WINKLER, MD, MPH

ALSO PRESENT:

LAURA GALBREATH, MPP, National Council for
Community Behavioral Healthcare *
RITA MUNLEY GALLAGHER, American Nurses
Association
FRANK GHINASSI, PhD, Western Psychiatric
Institute and Clinic *
CAROL ROTH, BSN, RAND *
PETER ROY-BYRNE, MD, Harborview Medical Center
LUCILLE SCHACHT, PhD, NRI *
KATHERINE WATKINS, MD, RAND *
DAVID WHITE, WPIC

*Present via telephone

C-O-N-T-E-N-T-S

P-R-O-C-E-E-D-I-N-G-S

(9:31 a.m.)

CO-CHAIR SUSMAN: Well, good morning. I appreciate everybody's prompt attendance, and you all look bright and shiny or at least present.

We're going to do the following today, just to give you an overview. First we're going to spend a little time talking about the Alzheimer's measures, dementia measures and lack thereof and an approach to helping rectify that situation.

Secondly, we're going to do a couple of measures left over from Group 4. Then I'll be passing the baton to Tricia, who will do the Group 3 measures.

We're hoping to leave some time at the end to talk about the gap analysis, looking at our original framework, and seeing if there are areas that we really need to have on that parking lot and hopefully get you out of here early or certainly on time.

So, let's first turn to a discussion about how we might deal with the lack of dementia/Alzheimer measures. And I'll ask Ian to give us some thoughts.

MR. CORBRIDGE: Good morning, everyone, and thank you very much for a productive day yesterday. I know -

CO-CHAIR SUSMAN: Katie, is that you on the line?

MS. MASLOW: Yes, some of that racket is me.

CO-CHAIR SUSMAN: Okay. We thought you were making a loud disturbance.

MS. MASLOW: I'll be quiet in a minute.

MR. CORBRIDGE: Good morning, Katie. We're actually just getting ready to talk about the dementia issue, as well as Alzheimer's.

So, a couple members of the Steering Committee identified early on that we really didn't receive any measures within the

actual submission for dementia measures. I know that was a key part of the scope of the project.

And a couple members identified if there was, you know, there are some potential measures out there and would like to really look at forming potentially a small workgroup to see if we can solicit some of those dementia measure and really see if we can move those forward.

There is a little bit of gap after this process where, if we get measures in quickly, we'll be able to kind of run through that process. I talked with Katie as well as Joel briefly, and Robert, just about potentially forming a small workgroup.

The members of that workgroup would really try to solicit those measures, review them internally just as a small workgroup, and then put that information forward for the rest of the Steering Committee to review and decide upon.

I guess another option is, if we aren't really, once again, able to get any dementia measures in, this small workgroup would, I think, hopefully better inform us of what are the gaps out there, where are there measures and what can we really do in terms of moving forward.

But this being a key portion with the project, as well as I know we have our National Priorities Partnership that is really categorizing Medicaid's top 20 conditions, Alzheimer's is right up there, I think, at Number 6 at this point.

So, it's a key issue and we just wanted to really open it up to the Steering Committee to look and see if there are individuals here who are interested in really participating on a small workgroup who would try to solicit those measures and work forward from there.

Katie, I don't know if you have anything else to add, or Joel or Robert.

MS. MASLOW: The only thing I would say - can you hear me okay?

MR. CORBRIDGE: Yes.

CO-CHAIR SUSMAN: Yes, we can.

MS. MASLOW: The only thing I would say is that Ian has talked to some people at RAND who have measures and are submitting them.

I think that most of them are processed, perhaps all, but there was an article in the Journal of American Geriatric Society this month with three outcome measures for dementia from the Netherlands.

And I had e-mailed the main author and she answered this morning and said yes, that she would be very interested in submitting them to us and that she'll get the forms to Ian by the end of April.

So, seems like something anyway.

CO-CHAIR SUSMAN: Harold.

DR. PINCUS: Two questions. Are we limiting this to dementia or to measures that

are particularly applicable to older people? So, that's one question.

And I know there are some out there that people have not submitted like the RAND's ACOG measures, but there also are measures that may be particularly applicable primarily to the over-65 group.

The other thing is, you know, when you look across what we actually have and what we're ultimately going to recommend, I mean, Alzheimer's is one example, but it's really across the board that we didn't get much in.

And so one thought is, should we think about some sort of second phase of encouragement across the board to try to identify measures or potential measure developers that haven't considered submitting, because several people have come to me and said, gee, you know, we have no idea about this stuff.

And so those are - and it's just that people just are not part of the network

of NQF typically. Even though we try to reach out, there's a lot of people that just don't - -

CO-CHAIR SUSMAN: Reva, you want to take a shot at that?

DR. WINKLER: Well, a couple of things. NQF is moving into a slightly different way of bringing measures in. We're sort of on a rotating - I think it's a three-year schedule addressing sort of all the variety of topic areas and rotating through them for the opportunity to review existing measures, bring in new measures and sort of look at the portfolio as a whole.

So, we envision, going forward, that there will be regular opportunities for all of the areas on about an every-three-year cycle.

MS. BOSSLEY: Yes. What it will be is - so, all the measures that you actually put forward today, I think, is a good example. Those go into a three-year maintenance cycle.

And what has happened in the past is we do one-off kind of projects, and then you have everything that's in maintenance, and there was no way to begin to determine what was best in class, determine where the gaps were, and for people to know in the development cycle where we would be in needing and doing a call for measure on a certain topic.

So, this new process ,assuming the Board approves it, it's out for comment right now, will start getting everything into a cycle. So, these measures will go into a cycle probably on mental health. And every three years we will do a review of every existing measure and a call for new measures.

So, it's starting to look up and see where either geriatrics or mental health would fall to see if we could see when the next call will be.

So, I think if we can get something in now, that's great, but I think

the other piece is, is we want to start building out that portfolio.

I think the gaps you identified, too, will also help inform developers so that as we have these cycles move forward, hopefully we'll get more robust measures on those areas you have identified. That's our hope.

DR. PINCUS: It's probably good even during this round to - because, I mean, it just seems dementia is important, but there is, you know, there is nothing. I don't think we're going to do for kids, for schizophrenia, for bipolar disorder. I mean, you know, which are all big - anxiety. So, there are lots of big areas that we don't have anything.

So, if it's possible to actually do a kind of additional search, that would be - for example, I mean actually just the other day at the translational science meetings, Len Bickman from Vanderbilt said, you know, we got into a conversation, I told him I was going to

this meeting. He said, oh, we've had a measure that's been adopted by 16 states for kids. I didn't know anything about it.

CO-CHAIR SUSMAN: Was the focus deliberately because of the CMS sponsorship on the adult population?

DR. WINKLER: Remember that part of the Outcomes Project; we actually have a separate effort on child health. So, any time you divide topics into areas it's arbitrary. But child health is being addressed, just not by this group as much as -

DR. PINCUS: Do they have mental health measures?

DR. WINKLER: They can have mental health measures.

DR. PINCUS: But do they, is the question.

DR. WINKLER: No.

DR. PINCUS: So, I mean, there are, you know, I mean, Glen actually has a whole big system. He actually e-mailed me about it.

MS. BOSSLEY: We're getting tight on time. So, we'd have to figure out - Ian probably knows best.

MR. CORBRIDGE: The reason we had really started looking at dementia early on is because we had identified that really up front right away because we didn't have anything. We had some measures, but we hadn't really vetted them and voted on as a Steering Committee.

So, we started looking early on and talk -

DR. PINCUS: I'm not criticizing. I'm simply saying that when you look at what's actually going to be the output of this.

CO-CHAIR SUSMAN: So, maybe one of the things we can do as we get to the gap analysis, is make sure we highlight those areas including potential contributors that we know of.

I think, given the lengthy and sort of stylized process that NQF follows,

we've got maybe a month of leeway. I think we'll be fortunate if we can get some of the dementia/Alzheimer's measures in and still meet the sort of timeline that NQF is on.

That's unfortunate because I agree with you, Harold. I think there is really huge gaps in what we're considering.

On the other hand, given the process, I think we're going to have to say, okay, in a year or two there will be another call to do a better job perhaps at getting some of the measure developers out there.

From an overall policy standpoint, I think NQF really needs to continue to look at how they interact with both the policy community, especially assessment, but also the research community which generally develops many of these measures, but really isn't keyed into this whole process and certainly isn't used to submitting in this process.

MR. CORBRIDGE: Yes, I guess I just would like to follow up on that comment and

that would be one thing hopefully the Steering Committee could help further inform NQF.

I know for this project we reached out to - I believe it was 117 different developers who NQF has been in contact with or developers which you yourself, the Steering Committee, put forward to us to reach out to.

So continuing to build that list I think is something where NQF has some area to expand. And if there are people who we need to be working with specifically within the mental health field, then it would be wonderful if you guys would be willing to provide that information for us to move forward.

DR. GOLDBERG: I'd just like to be clear, Jeff, on what you said.

Is there a window now of a month or two or not for other people who want to submit general measures? No window? Because it sounded ambiguous.

MR. CORBRIDGE: The window of

opportunity, I think, could -

DR. GOLDBERG: There's no right answer.

MR. CORBRIDGE: Correct. Just looking at the timeline of the project and where we started looking for dementia measures, we did it earlier on. And so that window potentially exists because we've already been talking with people.

Trying to then reach out and look at other measures specifically targeting in a broader sect of the mental health field really, unfortunately, probably won't fit within this project.

CO-CHAIR SUSMAN: Too late. Keep looking. We'll get in touch with you the next time this comes around, I think, is the real answer. It may not be -

MR. CORBRIDGE: And I guess maybe that should be - we should get in touch with them now just so we can follow up and make sure that Len Bickman is really within our

contacts, we make that initial up-front meeting.

And so next time, as Heidi indicated, in three years or two years when it comes around, that we actually have that contact and can move forward.

DR. GOLDBERG: I think we should get something in the literature someplace about the NQF process. Something more to make more people aware of how this is going on, the context of this measure development.

I hope it's not a narcissistic injury to you to hear that, but there's a lot of people like Harold says, who are somehow orthogonal to this. We have to get something into a different kind of literature that sort of briefly makes people aware of the process, the background, where we're going, what the importance of it is.

DR. PINCUS: Also, just the term measure developer is sort of off-putting. I don't think anybody that I know that's

developed a measure continues to think, I am a measure developer.

MS. BOSSLEY: Right. The Consensus Standard Approval Committee actually had a really nice discussion that I think you all saw the first examples of what they were talking about, which is those measures that haven't necessarily been publicly reported, used for accountability, but used for quality improvement in one system; how do we then encourage and find ways for them to get it to that next step, get the risk adjusted, get the testing, get it so that it's specified so that others can use it?

We're struggling with that, but I think that's the next piece that they'll be tackling and considering.

How do we then continue to get more robust measures that really have a good quality-improvement focus, but have moved to the point of accountability and public reporting?

CO-CHAIR SUSMAN: It seems like being somewhat familiar with the NQF and its process, that there's two areas that definitely bear improvement.

One is sort of a technical-assistance function where you can really reach out to people who have developed the system-level measures and can say okay, well, these are great for where they are, but here's the next step.

And the other is sort of a marketing function, but not the typical marketing function. It's marketing to a research audience, primarily, enhancing their understanding of what this process is all about and that no, you know, to be a measure developer doesn't mean that you've gotten a Ph.D. from Hopkins around some esoteric skill, but it's the stuff you're already doing, but take it a step further.

MS. WILKINS: I guess some of yesterday's conversation really opened my eyes

to some of the ways that NQF is looking at measures. Because, Ian, I think to sort of segue from what you were just saying, some of what we looked at yesterday are things that, for a program or a facility or for an agency, could be really good ways for them to look internally at their own performance and strengthen the quality and effectiveness of what they're doing.

And I think it is in that spirit in which some of those were submitted, because folks have done a lot of work to move toward a more rigorous way of looking at the quality and effectiveness of what they're doing, but they haven't yet taken it to that next step of being something that could be widely implemented and used for public accountability.

As I left last night, I was sort of thinking it's almost as if we would need a framework that would have two levels at which there would be some recognition that these are

tools that are good to use to strengthen quality.

One is tools that might be really good, measures that would be appropriate for agencies or programs to use, but they're not at the public-accountability level, but they certainly improve the quality of practice. Internal tools as opposed to external accountability tools. And I know that it sounds like that's not the charge to this group, but it sounds like there is an enormous hunger and need in the field for both sets of tools.

CO-CHAIR SUSMAN: Reva, you want to -

DR. WINKLER: Yes. This is by no means a new discussion point in NQF's ten years of existence, but frankly over the last few years the Board has pretty much settled on NQF's role in the quality enterprise to be around focusing on the public-reporting side of it and not on the quality improvement

recognizing that there are thousands of potential measures that individual programs or facilities or agencies might use internally for their own purposes and please have at it and do so, but that NQF's role is more focused in on the measures that are of a caliber suitable for public reporting, making comparisons and that level, and that is the focus they've chosen.

CO-CHAIR SUSMAN: So, let me go back to our original question which is, are there volunteers for the group working on dementia?

Okay. So, we've got Maureen, Bob Rich, Dan, Joel. You want to get those names? Keep your hands up to make sure we get them all. It sounds like a nice group and we'll try to turn this around fairly quickly.

You've got those, Ian?

MR. CORBRIDGE: Yes, I've got all of them.

MS. JAFFE: Can I ask for a point

of clarification in regard to the dementia?

Are we talking geriatric dementia or just dementia in general? I can't remember if it was clarified.

DR. WINKLER: The way we scoped it out was around mental health. Two of the topics that were specified came from a list from Medicaid. All right? And that's Alzheimer's and depression. All right?

We broadened it, realizing that that was a very narrow approach, and so we broadened it to not be inclusive of age, per se, but depression and other serious mental illnesses, that was part of the call, so that's inclusive, and then Alzheimer's and related dementia kind of thing.

So, geriatrics is sort of a large part of it, but it's not exclusively that.

DR. STREIM: I think in general, if we pay attention to principles of dementia care and do it well, it will apply across the lifespan to people with traumatic brain

injuries at young ages, because we're going to be seeing more of those in our health system, and I think having age cutoffs has been really problematic for the field of geriatrics.

We see 55-year-olds who need interdisciplinary geriatric approaches to care and 90-year-olds who don't. So, I think if we just do dementia care well, that will take care of everyone.

DR. ROCA: And I might add that it might even be a little bit confusing to have Alzheimer's in the descriptor because there are many other potential causes of dementia that we may want to use the same measures for.

CO-CHAIR SUSMAN: So, I'm hearing a general consensus that this is dementia broadly. Certainly, given the paucity of measures we've gotten in our general call, I'll be surprised if you all are overwhelmed with measures, but I think cast the net as broad as possible.

Dan.

DR. KAUFER: I'd just like to punctuate what Joel said. DSM-V is coming out with a new classification of dementia disorders which is hopefully finally putting to rest the age distinction about dementia onset and also will broaden the focus away from just Alzheimer's and other dementias to be more - to try to achieve more equipoise in dealing with other dementia syndromes.

So, I think the field is moving in that direction. So, I think to embrace it accordingly would be appropriate.

CO-CHAIR SUSMAN: Thanks. Okay. So, I think we have a plan and I thank the workgroup for willing to pitch in on yet another task.

So, we are going to move forward. And because the group that submitted the next measure on our list is on the West Coast, we're going to actually go to Measure 16, Retention in Treatment.

Is that right, Ian?

MR. CORBRIDGE: Correct.

CO-CHAIR SUSMAN: So, if you'd like to turn to 16, Retention in Treatment, I'll have Ian read the description and we'll get going.

MR. CORBRIDGE: All right. I'll give people just a bit to find -

MS. MASLOW: I'll turn it off so you don't have to listen to the announcements.

CO-CHAIR SUSMAN: Thank you very much, Katie. We really appreciate your willingness to help and phoning in.

MR. CORBRIDGE: Is anyone else on the phone?

MR. THOMPSON: This is Isaac Thompson. I'm on the phone, finally able to join you guys.

MR. CORBRIDGE: All right. Wonderful.

DR. WINKLER: Anyone else on the phone?

MS. GALBREATH: Laura Galbreath

from the National Council.

CO-CHAIR SUSMAN: National council of what?

DR. WINKLER: Of Community Mental Health Centers?

MS. GALBREATH: Yes.

CO-CHAIR SUSMAN: Thank you. So, you can hear us on the phone okay?

MR. THOMPSON: Wonderful. Especially now that the announcements are gone.

CO-CHAIR SUSMAN: Yes. Well, your flight to Newark has been delayed.

(Laughter)

MR. CORBRIDGE: All right. Do we have anyone from WPIC on the phone? I know this is a group, a measure we're reviewing right now.

PARTICIPANT: Yes.

MR. CORBRIDGE: And who do we have on the phone?

DR. WINKLER: Can you introduce

yourself from WPIC?

CO-CHAIR SUSMAN: Is anybody on the phone still?

DR. WINKLER: I heard "yes," and then -

PARTICIPANT: I'm still on the phone here. And I used to be from WPIC. I don't know if that counts.

CO-CHAIR SUSMAN: Well, you could represent them.

PARTICIPANT: No, I don't think they'd like that.

CO-CHAIR LEDDY: Anybody currently from WPIC on the phone?

DR. WHITE: Yes. Can you hear me?

CO-CHAIR LEDDY: Now, we can. Can you introduce yourself?

DR. WHITE: Yes. My name is David White.

CO-CHAIR SUSMAN: Okay, David. Thank you very much for joining us. We have a fairly stylized, rigorous process that we go

through here, but at various times we may ask for your input and certainly if there are points of clarification, we invite your participation.

So, thank you for phoning in today.

DR. WHITE: Yes.

MR. CORBRIDGE: All right. Wonderful. So, we're starting off on Measure Number 16. The title is Retention in Treatment.

Just going briefly over the description of this measure, it reads as follows: percent of patients who complete minimum of three additional ambulatory sessions within 90 of intake assessments, overall patients who complete an intake assessment. An ambulatory session includes any session with a doctor, clinician or medication management appointment.

The Numerator Statement reads as follows: total number of patients who receive

at least three additional sessions within 90 days of intake assessment.

Denominator Statement reads as: total number of patients that completed an intake assessment in an ambulatory clinic.

And this was, once again, Workgroup 4.

CO-CHAIR SUSMAN: Okay.

DR. PINCUS: Is there a specific definition of what an intake assessment is or how it's characterized in a routine way?

MR. PELLETIER: I don't remember reading a specific description of the assessment.

CO-CHAIR SUSMAN: For our measure developer, was there a way you defined intake assessment?

DR. WHITE: Yes. That's the standard intake assessment that's completed. It's a standardized form that is done on everybody that comes in at intake.

CO-CHAIR SUSMAN: Harold, do you

have any other questions?

DR. PINCUS: Well, I guess the question I have is if one were to expand it beyond a particular clinic that had a specific intake process, how would it be generalized?

Because typically, like - and obviously I'm thinking about the Washington Circle measures where there's a specific way in which they define the initial assessment with sort of a window of absence of service use.

CO-CHAIR SUSMAN: Do you have any further clarification from our measure developer?

CO-CHAIR LEDDY: David?

DR. WHITE: I'm sorry. Could you repeat that question?

CO-CHAIR SUSMAN: Is there any further clarification given Dr. Pincus' comments?

DR. WHITE: No. I mean, it's our standard intake assessment form that's

completed. If it were to be expanded, there would probably need to be some common equivalent with respect to expanding that.

CO-CHAIR SUSMAN: Okay. So, one of the first questions, if we go back to our process is in scope/out of scope. This I think is one of those measures where people depending on your willingness to accept a causal pathway, is retention in treatment a process or is it an outcome.

I won't poison that well but am interested in the group's opinion.

How about from Sheila, Luc, those of you who had an opportunity to review this?

MR. PELLETIER: I would vote that it is indeed an outcome measure.

DR. BOTTS: I feel like it's an intermediate outcome.

DR. PINCUS: I would actually agree with - I mean, particularly for substance use there's a fairly good body of evidence that retention in treatment is associated with

better outcomes from sort of clinical trial studies.

However, it's also worth noting that attempts to validate some of the Washington Circle measures have not been totally successful.

CO-CHAIR SUSMAN: Other comments from the group as a whole?

So, I'm seeing a lot of head nodding.

DR. STREIM: And I would add that I often think of engagement with substance abusers as an outcome unto itself that keeping them engaged is, again, as Harold said, highly correlated with other good outcomes that they become almost indistinguishable.

DR. GOLDBERG: The retention in treatment we're talking about is a generic comment not specifying three visits, eight visits, three months, six months. We're just saying if you're retained in treatment, you're more likely to have response than if you are

not. I mean, it's a little hard to argue with that.

DR. PINCUS: But I would say that my comments are specifically to substance abuse because I think there's a lot less evidence for other mental disorders.

CO-CHAIR SUSMAN: Okay. I'm seeing general agreement that we at least go through the process. I don't hear anybody strongly arguing for out of scope.

So, let's turn to importance. Remember this is importance of the concept in general and not necessarily the measure in particular.

Sheila, would you like to comment maybe on the importance elements?

DR. BOTTS: Well, again, I mean, I see the retention piece as an intermediate outcome. I think that it's clearly an important area to capture.

And as Harold was echoing, the disorder that you look at might be different.

So, rather than getting into the details of the tool or defining what retention is, the concept I felt like was important and something that we needed to measure. So, there's clearly a gap there.

I start to struggle when you look at what's the right follow-up and does the three apply across the board and what that evidence is based on, and clearly it's a measure that needs quite a bit of testing if it's grossly applied.

CO-CHAIR SUSMAN: Luc, any other thoughts about importance?

MR. PELLETIER: I think this is - I think this is definitely important. I would agree with Dr. Pincus that when I was reading it, I was thinking more about substance use care.

CO-CHAIR SUSMAN: Eric, are you on?

No? Ken?

DR. THOMPSON: I have no other comments than what people have been saying.

CO-CHAIR SUSMAN: Okay. Thank you.

DR. GOLDBERG: I do feel compelled to make one other comment about this, which is - and I'm in the part of the spectrum of seeing this - I know it's an intermediate outcome, but low, low intermediate.

It's part of my bias, which is there's lots of people who are retained in treatment, who are getting lousy treatment and they stay with their providers for all kinds of reasons.

They have huge practices, they're not providing evidence-based treatment. Just the fact that they're retained in somebody's practice is a problem in our field. And if we too quickly slide into accepting or acknowledging the importance of being retained in treatment and lose any focus on evidence-based care and what is the outcome of this, I think we're making a mistake.

So, it's hard for me to argue against including this in some way in the

discussion. But on the spectrum that Jeff always talks about, I'm really feeling myself at one end of that spectrum. I just feel compelled to say something about that.

DR. PINCUS: Yes. I completely agree that looking generically, there are big problems. For substance use specifically, it's a different issue. But we recently published a study looking at people who were in treatment for depression, and I think I mentioned this yesterday that if you look at it, that's the highest - that's the best way of finding people who are currently depressed.

(Laughter)

CO-CHAIR SUSMAN: Okay. Reva.

DR. WINKLER: As a matter of clarification reading the submission, the Denominator Statement is total number of patients that completed an intake assessment in the ambulatory clinic.

Is there a definition around what population that applies to? I mean, this

could be heart-failure patients or, you know, the definition seems somewhat ambiguous.

Can it be clarified a little bit more precisely as to what patients this is particular applied to?

DR. PINCUS: This was lumped with substance use stuff. I assumed, actually, that it was a substance use measure, but -

CO-CHAIR SUSMAN: Measure developer, do you want to clarify what populations, what clinics, what settings?

DR. WHITE: It's used in a general sense, but it is also targeted at the substance abuse population. So, where in terms of using it, we're using it in both manners understanding some of those limitations, but it's in a mental behavioral health ambulatory clinical setting.

CO-CHAIR SUSMAN: So, I think at least in one point it says care settings, ambulatory care, hospital outpatient, behavioral health, psychiatric unit; is that

correct?

DR. WHITE: Correct.

CO-CHAIR SUSMAN: Okay. So, let's turn back then to importance.

Are we ready to vote? Any other comments?

DR. THOMPSON: This is Ken Thompson. This is striking up a remembrance of a conversation I once had many years ago with Boris Astrachan looking at - we were going to look at exactly this issue at the Connecticut Mental Health Center.

And the comment from Boris was, how do you know that you haven't done a really good job in the first two visits if they don't show up for the third?

I'm a little bit concerned that the issue here is an - I'm not even sure it's an intermediate outcome. It's sort of an intermediate process outcome.

And I guess the more I've been thinking about it and hearing the comments, it

seems more problematic to me.

CO-CHAIR SUSMAN: Okay. Thank you.

Sheila.

DR. BOTTS: One other thing that I thought about when I look at this is from a patient-safety aspect as well in terms of the three follow-up visits particularly for drug therapy monitoring and - that's indicated from more than just substance abuse treatment, but that would be indicated for depression for adults or for kids.

CO-CHAIR SUSMAN: So, we will get to harmonization issues a little down the line, but thank you, Maureen, for calling that.

Any other comments about importance? I've heard a nice discussion. Okay.

Completely. Partially.

CO-CHAIR LEDDY: Ten.

CO-CHAIR SUSMAN: Okay. Minimally.

CO-CHAIR LEDDY: Five.

CO-CHAIR SUSMAN: Ken, are you voting? Ken, are you still there?

DR. THOMPSON: I'm minimal. Sorry, guys.

CO-CHAIR SUSMAN: Okay. Minimal. Thank you. We'll try to remember to call you out.

And not at all?

CO-CHAIR LEDDY: Katie, are you still there?

CO-CHAIR SUSMAN: Okay. Any members of the Committee other than Ken on the phone?

Okay. Thank you.

And then not at all?

Okay. Let's move on then. The next is scientific acceptability. And you can see the comments up there. I was fairly well struck that there wasn't much scientific measurement, psychometrics, risk adjustment. Almost any area you looked at there was not data presented.

MR. PELLETIER: The measure is based on expert opinion. And as I was reading it, I thought about the Washington Circle. I thought about NCQA measures that have been tested.

CO-CHAIR SUSMAN: For our measure developer, has there been further work done on the psychometrics, things like risk adjustment, validity, reliability testing?

DR. WHITE: We do have the ability to do the risk adjustment, but we haven't done much in the way of formal testing. It's a metric that we've developed and used. And we're right at the point of which to go deeper into those areas.

So, right now I'll just say that we would be able to do the risk adjustment aspects of it, but we don't have anything published with respect to the other components.

CO-CHAIR SUSMAN: Okay. Thank you. Thank you. I think, like many of the measure

submitters that we've worked with, I think for quality improvement and ongoing work within the system, many times attention to the psychometrics and so on are not a prime priority.

But of course there's more considering the accountability. That becomes much more of an importance.

Other comments about the scientific acceptability? If not, let's go ahead and vote.

Completely. Partially. Minimally.

MR. CORBRIDGE: Two.

CO-CHAIR SUSMAN: And not at all. Ken, do you have a vote? Ken are you on mute?

DR. THOMPSON: No, I'm here.

CO-CHAIR SUSMAN: Ken, do you have a vote on scientific acceptability?

DR. THOMPSON: Not at all.

CO-CHAIR SUSMAN: Thank you.

MR. CORBRIDGE: That's 14, Reva?

DR. WINKLER: Yes, that's what I got.

CO-CHAIR SUSMAN: Okay. Let's turn then to the next category of usability. And this is where your comments, Maureen, I think around harmonization and others would come in.

Sheila, thoughts about usability? Luc?

MR. PELLETIER: The developer -

CO-CHAIR SUSMAN: Sorry to put you on the spot.

MR. PELLETIER: Yes. The developer said that they did have information and maybe he could talk a little bit more about that, but the performance data that he did have was withheld. And he said that he's willing to share the data with national groups, so we really didn't see anything.

CO-CHAIR SUSMAN: So, we're now, measure developer, at the usability. And it was noted that you did have some data. I wonder if you might be able to summarize that

for the Committee.

DR. WHITE: the information that we have has been ongoing probably for about the past 18 months. And it's basic figures in terms of the percentage meeting the criteria on the definition.

CO-CHAIR SUSMAN: Any other questions for the measure developer?

Thank you. Okay.

Comments further about harmonization?

CO-CHAIR LEDDY: Reva has something.

DR. WINKLER: Just a question for the developer. In your facilities, do you use any of the NCQA measures or the Washington Circle measures, as well as these measures that you use, that you're presenting here?

DR. WHITE: Presently we do not. This measure was developed within our operations to target what was available with our data systems. We're not using the other

measures, but definitely we'd be willing to look at that.

CO-CHAIR SUSMAN: So, in looking toward the future it would be kind of interesting to see what the performance against things like Washington Circle might be, what the pros and cons of this measure versus existing measures. I think it would help us as a committee, better understand the role of this particular measure, the value added, if you will, of this measure.

DR. WHITE: Okay.

CO-CHAIR SUSMAN: Well, let's move then to voting unless anybody has further comments.

Seeing none, completely? Partially. Minimally. Not at all. Ken?

DR. THOMPSON: Minimally.

CO-CHAIR SUSMAN: Thank you. Okay. Let's then get to feasibility.

MR. PELLETIER: I didn't see any specificity around the Electronic Health

Record or Claims Data Sources.

CO-CHAIR SUSMAN: So, certainly one could imagine through an EHR, being able to count visits without a lot of burden.

Do you have a few comments on feasibility which includes the burden of collecting the measure, whether this is integrated into electronic record, any exclusion criteria, inaccuracies that might arise in data collection?

MEASURE DEVELOPER KHALIANI: The only exclusion criteria we apply to this measure are emergency room visits and intensive case management visits. We consider all our patient services with the exception of emergency room and intensive case management for this measure.

The data as far as Electronic Health Record is concerned is readily available to us because of our integrated outpatient system and inpatient system. So, we have that accessible - one of the things

that will not be available is any outpatient services or any other services the patient would be getting that is not within our system.

CO-CHAIR SUSMAN: Wonderful. Thank you.

MR. CORBRIDGE: Thanks very much.

CO-CHAIR SUSMAN: Sheila, did you have a comment or -

DR. BOTTS: With the exception of that particular issue, I mean, the data is probably feasible to get and generated as a byproduct of care. There's not a heavy burden as long as you have the electronic source.

CO-CHAIR SUSMAN: And I think the inaccuracy would be at least in this setting, where visits are occurring outside one system.

Clearly from an insurer/payer perspective, that data might be well available.

MS. JAFFE: Although, if we're talking about retention in treatment, I think

potentially random visits somewhere else don't necessarily have anything to do with this outcome.

CO-CHAIR SUSMAN: Good point. Other comments?

DR. GOLDBERG: Even now the feasibility in a lot of systems, you have a psychiatrist in one system, a therapist in another system, not that rare to happen. It's kind of hard to track - I mean, we know there's problems in communication between them let alone tracking how many visits have taken place.

It's embarrassing to say that about our healthcare system, but I see that a lot.

CO-CHAIR SUSMAN: Certainly carve-outs are very common still at least in my community.

Okay. Let's then vote unless there are any other questions about feasibility. Completely. Partially.

DR. WINKLER: Eight.

CO-CHAIR SUSMAN: Minimally.

DR. WINKLER: Seven.

CO-CHAIR SUSMAN: Not at all, and Ken.

Ken, are you -

DR. THOMPSON: Not at all.

CO-CHAIR SUSMAN: Not at all. Thank you.

Okay. Before we vote, any further comments from the public?

MS. GALLAGHER: No.

CO-CHAIR SUSMAN: Thank you.

CO-CHAIR LEDDY: Any public comments from the phone?

CO-CHAIR SUSMAN: Okay. Then we're going to go ahead and vote. All those in favor or recommending adoption of this measure, please raise your hand.

All those opposed, same sign.

And, Ken, are you opposed or in favor?

DR. THOMPSON: I raised my hand to the second question.

CO-CHAIR SUSMAN: Thank you. Thank you. My vision does not extend that far.

Any abstentions? Okay. So, this came out 16 against, zero for.

For our measure developers, I think there is certainly very important work to be done in this area, but certainly further work to take this from a performance improvement to accountability measure. And we hope you'll continue this excellent work as you go forward. Thank you.

DR. WHITE: Thank you.

CO-CHAIR SUSMAN: Okay. So, let us turn to our next measure. And let me confer for a moment with Ian and see if we're ready to get Seattle on the line.

(Discussion off mic)

MR. CORBRIDGE: I had spoken earlier and he was hoping to be on the line. He thought he might be driving in, but doesn't

seem like he's able to join us right now.

So, if we could just hold off at this point -

CO-CHAIR SUSMAN: So, it sounds like we're going to do Workgroup 3; is that right?

CO-CHAIR LEDDY: So, we can move to Workgroup 3 and then go back when the measure developer comes on line. Okay.

CO-CHAIR SUSMAN: So, I'm going to hand off to Tricia.

CO-CHAIR LEDDY: Okay. So, Workgroup 3, the measures are five, 21, eight, nine and 47. So, we're going to start with five. And the people who were in this workgroup -

So, Ian is going to take us through the first one or are we doing something -

MR. CORBRIDGE: Yes. Can we just hold on one second? We're trying to juggle things. We changed the schedule a little bit

yesterday, so we're trying to deal with measure developers trying to get online.

Do we still have the people from Presby Shadyside on the phone?

CO-CHAIR SUSMAN: Presby Shadyside, are you still there?

MR. CORBRIDGE: All right. So, we're just going to try to juggle things a little bit. Initially within Workgroup 3 we had Measure Number 5 going first. However, that was submitted by RAND from California. And the change in schedule, I just want to give them a little bit of time. It's still very early for them there. So, we'll wait and see if Carol gets back to me.

So, if we could move down to Measure Number 8 which was also submitted by Presby Shadyside, the title of the measure -

CO-CHAIR LEDDY: Fall Rate per 1,000 Patient Days.

MR. CORBRIDGE: Correct.

CO-CHAIR SUSMAN: Thank you.

MR. CORBRIDGE: So, I'll wait until people can bring that up. So, going forward from here looking at Measure Number 8, Fall Rate per 1,000 Patient Days, description reads as follows: All documented falls with or without injury experienced by patients on an eligible behavior health or psychiatric inpatient unit.

Numerator Statement reads as the total number of falls that all patients admitted to a hospital-based inpatient psychiatric setting experience.

Denominator Statement, number of psychiatric inpatient days included populations, all psychiatric inpatient days.

And that was, once again, Workgroup Number 3.

CO-CHAIR LEDDY: Did anyone want to comment about this? I think in general the measure developer pointed out with this that fall rates were particularly an issue in not just all stays, but in particular for

inpatient psychiatric stays.

DR. GOLDBERG: Does NQF have a fall measure for other disciplines? Certainly falls are an issue through the hospital.

Is that already an established measure somewhere and could you comment?

DR. WINKLER: Yes, NQF has fall measures for the hospital, and it addresses different units. I'd have to check to see if there was any specific mention of behavioral health units to see if it were at all -

DR. HENNESSEY: Well, according to the information that we received, it was not specified as one of the areas in which the data was collected.

MR. PELLETIER: Was it under the nurse incident measures?

DR. HENNESSEY: Yes.

MR. PELLETIER: It is, isn't it?

DR. HENNESSEY: Yes, definitely.

MR. PELLETIER: Okay.

DR. PINCUS: Just as a general

question, when you say that you want to apply an already existing measure to a specific sub-population or segment, does that require a whole new approval process or - as a separate measure?

Because, I mean, in many ways one of the things that actually is related to the paper I sent around, a lot of it is applying already existing measures to segmented denominators.

And so, what's the rule?

DR. WINKLER: I don't know that we could say that there's so much a rule, but what you're talking about is perhaps whether we're talking about specifying the measure, revising those specs to include a broader denominator. At which point the owner/developer would have to agree that that's a good thing to do.

The other would be whether you're talking about it in implementation. And for a measure whose specifications are not maybe

overly specific or exclude things, an implementer may choose to apply them to a specific population.

Things are a little less crisp on that, and some people may consider that an off-label use, if you will, or something like that. But especially if the underlying specifications are not overly specified to exclude, because I think a lot of times if measures that people think of, of hospitals, don't automatically include or exclude behavioral health. It sort of depends on your perspective and plans for the measure.

DR. PINCUS: Right. But if I'm running a psychiatric hospital and I'm looking at falls -

DR. WINKLER: Right.

DR. PINCUS: - the most relevant benchmark would be other psychiatric hospitals or units of general hospitals. So, if there was some way thinking about it from a national point of view that there was sort of a

segmentation, that that would allow me to have a reasonable comparison.

MR. PELLETIER: But there is no national database where you could get a benchmark.

NDNQI which are the nursing indicators, typically don't - it's difficult for a psychiatric hospital to get those numbers from anybody else.

DR. PINCUS: So, does that argue that it should be a separate measure or that the - because I understand that when you do recommend measures, you could specify certain aspects of segmentation in the measure specifications.

MS. BOSSLEY: I mean, Rita is from the American Nurses Association who has the fall rate measure we're talking about. So, maybe she'd like to speak to it.

MS. GALLAGHER: Rita. The American Nurses Association is the owner of the National Database for Nursing Quality

Indicators, NDNQI, which was previously referenced.

We are willing to open the unit categories to include psychiatric units if that would be the pleasure of the group. Psychiatric hospitals of course could engage in NDNQI should they so wish, and that's where the benchmark would come from.

We have currently submitted the falls and the falls with injury measures for consideration under the Nursing Home Project. So, we're willing and able to open it up to psychiatric hospitals should that be the wish of the group.

DR. PINCUS: Just one more question. Would you be willing to have the measure specifications also include the possibility - I don't know how you'd frame it, but the possibility of segmenting it based upon it being a psychiatric hospital or psychiatric unit.

MS. GALLAGHER: Yes, absolutely.

DR. PINCUS: Yes, stratifying it.

MS. GALLAGHER: The measure currently is stratified by hospital unit. So, it could - and it's by type of hospital, so it could be a psychiatric unit in a psychiatric hospital or a psychiatric unit in one of the other kinds of hospitals that are already -

DR. HENNESSEY: And are we only talking about psychiatric or are we also talking about substance abuse units?

MS. GALLAGHER: That would be at the pleasure of the group.

CO-CHAIR LEDDY: Anne is next.

DR. MANTON: Thank you. My comment was that, I mean, I understand the need for stratification. But if you had a separate measure for each thing, would you have another one?

I think stratification within one that already exists makes more sense than adding separate ones for each, you know, for OB units and pediatric units and medical units

when you could have all these measures that essentially are saying the same thing, unless you feel that there is a vast difference in what the specifications would be for each one. And it doesn't seem to me like that would be the case.

DR. PINCUS: I completely agree with you that it should be - in some ways that's an NQF broader policy issue about how you want to approach that.

Just taking this to another domain, you know, one thing that's increasingly important in terms of people with severe mental illness is the management of their other chronic medical conditions.

So for people, for example, on anti-psychotics, the management of diabetes and hypertension and lipids is critical. And there are different issues involved in managing it for those people as compared to people who have garden variety diabetes. And rather than creating a new measure if there

was a stratification in the existing measure, that would enable people to better be accountable for those things.

CO-CHAIR LEDDY: Reva.

DR. WINKLER: I think that there is a growing agreement to the sentiment of having fewer measures that address broader populations. And that if you have a specific interest or focus, you will segment it by whatever that group or focus is.

And rather than having a plethora of very, very similar measures for each different thing, we've certainly seen that in the past where we have - we did that with smoking measures. We've started out having a whole list of smoking measures for every condition. It was like no, no, no, one smoking measure for everybody. If you want to look at diabetics, look at them or whatever.

So, I think that's very consistent with sort of the way we want to move forward. And the fact that it's just nice that Rita is

here and able to talk about the willingness of the existing measure to be flexible and encompass a broader population probably is an excellent approach given the direction we want to move in.

MS. GALLAGHER: And were that to be the decision of the group that there would be that desire, we would also most likely make those same sorts of changes in the other measure which is falls with injury, because it would make sense that they would be parallel.

CO-CHAIR LEDDY: Robert.

DR. ROCA: Yes. In relation to this last issue there are two measures; falls and falls with injury.

I mean, what's your experience been so far in the virtue of having two different measures as opposed to having simply falls with injury which is, I think, the national patient safety goal. It's reducing -

MS. GALLAGHER: One point is that

there are more falls and they are still indicative of issues that need to be dealt with. Not everybody is hurt, but people still can't be falling.

And so there are clearly lesser numbers involved in the falls with injury, but the hospitals, and these of course are not psychiatric hospitals, but the hospitals prefer to be able to segment those two populations so as to be able to reflect on what it is that is actually happening within their settings.

DR. ROCA: I think that makes perfect sense. One of the things we're going to run into if we look further at this measure is an effort that this measure developer makes to distinguish what we all can think of as falls from what they're calling behaviorally-based falls, which this developer had made an effort to exclude from this count.

I mean, that's a very problematic distinction. I think it's a very difficult

distinction to make. And it seems like falls with injury in contrast to falls in general helps make that distinction.

MS. JAFFE: I have some concerns myself as having a psychiatric unit in a big medical system. And the idea of having a separate carve-out for behavioral health, I think, is problematic.

I think building on what we have seen in the general medical system makes a lot more sense.

DR. PINCUS: Not totally related to this particular measure, but when we talk about sort of areas for further development, one thing that if, you know, the kind of interaction that we had here with regard to nursing and the falls thing, one thing that we should probably place a high priority at is looking for other outcome measures in other domains that could be stratified for people with mental illness.

And I think if we did that, that

would give us more, quote, outcome measures relevant to those populations.

DR. WINKLER: I was just going to say one of the things we can do is look at some of our more general outcome measures, because often the specifications of the denominator population would not exclude behavioral or mental health patients such that we could highlight those and say we already have these measures that would apply to this population as a starting point and include them. And that's something we can certainly do to help make this whole picture more complete.

DR. STREIM: I just wanted to underscore Bob's point about the problematic nature of fall definitions that try to get a attributions. But in particular, I think it's important to look at any new measure and make sure that the definition really does - more than harmonize, I think you want to have pretty much standard definitions of falls.

This has become problematic in nursing home settings where falls are defined by federal regs and anybody who's found on the floor is assumed to have a fall. And I think hospitals, it's pretty much the same, but we actually do have nursing home patients who scoot on the floor by choice.

It's a behavior. It's not - so, there are issues like that, but I think the definitions really have to be consistent across measures.

CO-CHAIR LEDDY: So, it seems we can move forward and do a vote on this measure.

DR. HENNESSEY: I had a question. Am I hearing form this group then a preference to look at falls with injury as opposed to falls for psychiatric and substance abuse patients?

CO-CHAIR LEDDY: I thought I heard -

DR. HENNESSEY: You are? Okay.

CO-CHAIR LEDDY: I thought what I heard is that the group is looking at in place of potentially using - accepting this as a new separate measure that would be managed by this group, that indeed there is another - there are two existing measures that are already managed by an existing group that could be stratified for by diagnosis or by unit or whatever is - by unit, by psychiatric hospital or psychiatric unit?

Or substance abuse. And that that might be - right. So that the measure developer has suggested this as a falls per thousand as a measure and that we would vote potentially to adopt this, but have the measure be managed as a stratification by an existing group.

MS. GALLAGHER: And we would ask for your input, obviously, as to how the units should be sculpted in the definitions, because there's a very exquisite set of definitions around this measure.

MS. BOSSLEY: I mean, in reality you have two options. You could either put this measure forward so you recommend it, or instead say that there's a request to the developer that has the current existing measure, to expand it and stratify by the different substance use and behavioral health.

I think those are the two options in front of you. You don't really want to put this one -

MS. GALLAGHER: Vote on this one.

MS. BOSSLEY: Well, I think you should vote on this one, but you have the two options. Put this one forward, which would be a standalone separate measure from the current ones that ANA has, or put in a request that the ANA measures include behavioral health and substance use and stratify by that.

MS. GALLAGHER: Okay.

CO-CHAIR SUSMAN: I would make a motion that we do that latter, not the former.

DR. ROCA: And that was going to be

our suggestion as a little group here.

CO-CHAIR SUSMAN: Oh, okay. Sorry.

CO-CHAIR LEDDY: Okay. So, we're not going to vote then on each of the aspects, we're just going to vote to make that request.

So, before we vote, should we ask for any public comment on this discussion and sort of direction, including from the developer who suggested this?

Anybody on the phone like to comment?

DR. WHITE: No additional comments other than what was stated. This is one of our stronger measures that we rely on. We do a lot with it. We've got a lot of solid data on it and we are happy to receive the input and look forward to working with however it's included.

CO-CHAIR LEDDY: Okay. Carol has a comment to make.

MS. WILKINS: I guess I'm kind of curious for the measure developer given that

there is an existing measure that looks at falls, had you looked at that existing measure to see whether you could just use the one that already exists and use it in your facility?

Is there a reason that you felt that you needed to do something different from the existing tool, the existing measure?

DR. WHITE: We've developed ours based on a lot of the unique characteristics and situations here. So, we basically chose to develop our own path, have not explored the existing one in great depth, but would be willing to do so.

CO-CHAIR SUSMAN: You might well, I would think, be able to educate this committee if there is really important differences or there is value added that you see in comparing the existing measure. But I guess I'm hearing the wisdom of the Committee is that we use the existing falls measure and apply it to specific sub-populations, but you may find out that there's some added value in the approach

you're taking.

DR. WHITE: Thanks.

CO-CHAIR LEDDY: So, just before we vote, I would just like to thank the measure developer because what you've done is you have actually prompted NQF to potentially add a measure to its cadre of select measures.

So even though you may not be the one that maintains it, it may be an existing measure, it really will be considered something of added value to NQF. So, thank you.

So, with that I would like to ask the Committee for a vote on the motion.

MR. CORBRIDGE: Well, I think we're just trying to currently review our process because I know we're really looking at best in class of measures. So, we're seeing if we might need to go through the actual criterion.

CO-CHAIR LEDDY: On this measure or the one that we are preferring, which is a subset of an existing measure?

MR. CORBRIDGE: On this current measure.

MS. BOSSLEY: So, I guess I'm thinking about it through transparency for everyone externally?

When it comes time for them to review this report, I would hate to have this measure look like you kind of tabled it and didn't have this robust discussion and rate it for its importance in criteria, because I think -

CO-CHAIR LEDDY: Okay.

MS. BOSSLEY: - at face value it, but there's another measure that's currently endorsed -- that will come out. So, I think just to -

CO-CHAIR LEDDY: Okay. So, we will go to importance first. So, this is the general measure of fall rates that we're voting on now in importance.

How many vote for completely? Partially.

MR. CORBRIDGE: Is there two?

CO-CHAIR LEDDY: Minimally. Not at all or abstain. Okay. So, we have 14, but we have more than that in people, right? Ken, would you like to -

DR. THOMPSON: I'm partial.

CO-CHAIR LEDDY: So, you were completely or partially? Complete. Okay. So, one more completely. Okay.

The next category is scientific acceptability. This is for this particular measure as the developer submitted it with its particular exclusions as noted by Bob.

So, completely? Am I missing something, Ian? Do you want to have a discussion?

MR. CORBRIDGE: There are some comments from the workgroup about this.

CO-CHAIR LEDDY: Okay. Would you like to address this?

DR. ROCA: Well, without going through every single item, I think that the

main question has to do with the reliability of judgments about what is a behaviorally-based fall. It would seem that would be subject to a lot of subjectivity and even gaming.

Because if you wanted to have a low rate of falls, then you could define behaviorally-based in such a broad way that it would include the disobedient patient who refuses to ask for help when they get up to walk even though they've been instructed to do so.

I think that makes it kind of difficult.

CO-CHAIR LEDDY: Harold.

DR. PINCUS: It seems to me that issue cuts across both scientific acceptability and usability in terms of, you know, unless there is sort of evidence of the reliability of that assessment that was presented, and was there?

DR. ROCA: I don't believe so. I

think that is one of the areas that the developer felt needed to be addressed, because that is a somewhat unique aspect of this phenomenon in psychiatric settings.

DR. PINCUS: Yes. So, that both of those places, and then probably feasibility too.

DR. ROCA: Yes.

CO-CHAIR LEDDY: Are we ready to vote on scientific acceptability or any other comments on that?

MS. WILKINS: The only other comment I would add is that the information provided in this section is really pretty minimal. So, it made it really hard to assess.

DR. ROCA: Did they present any risk adjustment data?

DR. HENNESSEY: No. One of the things I was struck by was that disparities in care in that section is listed as not applicable, yet they do say in another section

that sometimes they do conduct analysis on factors such as race, gender, age and SES.

So, somewhat vague.

DR. ROCA: And clearly it is an area where risk adjustment for age would be critical and maybe even for diagnosis, demented versus not demented and so forth and they certainly acknowledge that there will be a need for some sort of taking that into account.

Although, I don't believe they actually cite those considerations under the risk adjustment section. I think it's in the exclusions section, as I recall.

But in any case, I think they do acknowledge the need for risk adjustment, but don't really present any data.

DR. GOLDBERG: Does the NDNQI measure have a risk adjustment capability?

MS. GALLAGHER: It's stratified by a whole host of categories. We stratify by a whole host of categories; units, hospitals,

various patient types. So, I mean, that would be what you would want to put in as we amplify these measures to focus on psychiatric patients.

I'm sorry I don't have the expertise to know what's relevant and what isn't relevant, but I'm sure that the panel of experts that would be brought together to do that would be able to provide that direction.

I can't speak to it, but you all seem to know which categories should be appropriately included or not.

DR. GOLDBERG: That was your Board of Trustees. You're looking at safety in your units and you're comparing across other units. So, the characteristic, the risk stratification, the population is going to be very important to say anything meaningful about basic safety issues.

DR. HENNESSEY: Well, and one of the concerns that we had, too, was that it wasn't clear how reliability was being

measured. And they reference the fact that there are wide variations in the estimates, and yet they rely on staff reports.

DR. STREIM: I'm sorry. They rely on staff what?

DR. HENNESSEY: Staff reports.

DR. STREIM: Report.

CO-CHAIR LEDDY: Okay. Any other discussion about the scientific acceptability of this particular measure before we vote?

Okay. So, on scientific acceptability completely? Does it meet the criteria completely? Partially.

MR. CORBRIDGE: Two.

CO-CHAIR LEDDY: Minimally.

MR. CORBRIDGE: 12.

CO-CHAIR LEDDY: Not at all.

MR. CORBRIDGE: Ken?

DR. THOMPSON: I'm between minimally and not at all.

CO-CHAIR SUSMAN: We're not going to have yet another category. Now, make your

choice.

DR. THOMPSON: Minimally.

CO-CHAIR SUSMAN: Thank you.

CO-CHAIR LEDDY: Okay. Do we have all votes? Okay. So, we'll move on to the next category for this measure, which is usability.

Would anybody from the group like to talk about the usability?

DR. HENNESSEY: Sure. I think basically what our perspective was, was that there was a preference to take a look at the measure that we've been talking about with the ANA today. And we were also concerned about the notion that because of the high vulnerability particularly for SMI patients to morbidity and mortality for medical illnesses, that there needed to be better integration of this measure and its applicability with the medical population as well.

CO-CHAIR LEDDY: Joel.

DR. STREIM: Yes. Here I would go

on record as saying that it's not clear that this has added value beyond measures that already exist. And definitions of falls that actually already exist may be stronger and more usable in terms of applicability.

CO-CHAIR SUSMAN: And I think the key point of our previous discussion was that the harmonization here was really the key issue in that we favor harmonizing with the existing measure and doing the risk stratification and the population stratification rather than creating this new measure or adopting this new measure.

CO-CHAIR LEDDY: And in particular in harmonization with using the same exclusion criteria, which this would have different exclusion criteria evidently than the existing measure.

DR. HENNESSEY: I think the other thing we were concerned about is the whole issue of disparities and that using the same kind of measure that is used on a medical unit

could help us to identify if there are disparities in care that are contributory to possibly higher rates of falls with injury among psychiatric patients.

MS. JAFFE: And I agree with that. I think that now we're seeing more and more the line blurring a little bit between psychiatry and medicine and it's important that we maintain similar standards.

DR. STREIM: Here's also an area where age matters. And I think, you know, we were talking with the previous measure that defining an age cutoff for dementia care is not helpful, necessarily.

Here I think if you've got the same rate of falls on a unit with young people as the rate of falls on a unit with old people, that's a concern. And I think that argues for stratifying by age in many situations.

CO-CHAIR LEDDY: Okay. Are we ready to vote on usability for this measure?

Those for completely. Partially.

MR. CORBRIDGE: One.

CO-CHAIR LEDDY: Minimally.

MR. CORBRIDGE: Eight.

DR. THOMPSON: Nine.

MR. CORBRIDGE: Okay. Ten, 11.

CO-CHAIR LEDDY: Okay. How many for not at all?

DR. PINCUS: Actually, I'm changing mine to not at all.

MR. CORBRIDGE: I think we've got partially. Let's go back to minimally. Who would like to vote for -

CO-CHAIR LEDDY: Yes, the harmonization piece is very important in this one.

So, minimally.

DR. ROCA: One.

CO-CHAIR LEDDY: Okay. We're a very flexible group.

Not at all.

CO-CHAIR SUSMAN: Peer pressure is

an important thing here.

CO-CHAIR LEDDY: And, Ken, what would you like to vote?

DR. THOMPSON: I feel swayed, actually. So, peer pressure has worked over here. If this is harmonized, I think that that's an issue and I think it's not at all.

CO-CHAIR LEDDY: Okay. Thank you.

So, now we can go on to the - there's one more category. Feasibility. So, this includes how easy it is to collect this data, basically, and how accurate it might be, whether it's electronic.

Did anyone from the group want to speak to anything about this? There wasn't, as I recall, that much about his in the description.

DR. ROCA: I mean, this is something people are counting. Certainly people in hospital settings do count falls. I think everybody is doing it, so it wouldn't be an imposition in terms of data collection.

But I think the problems, the definitional problems we've talked about are kind of the fatal flaw here.

CO-CHAIR LEDDY: The exclusions.

DR. ROCA: The exclusions, yes, yes.

CO-CHAIR LEDDY: Any other discussion before we vote on feasibility?

So, we are voting on this particular submitted measure with its exclusions. So, how many would vote for completely?

Partially. Minimally.

MR. CORBRIDGE: Nine.

CO-CHAIR LEDDY: Not at all.

MR. CORBRIDGE: Four.

CO-CHAIR LEDDY: And Ken on the phone?

DR. THOMPSON: Minimal.

CO-CHAIR LEDDY: Minimal. Okay. Thank you.

Any comments from the public, or

did we already take comments from the public on this one?

MS. GALLAGHER: Thank you for your consideration.

CO-CHAIR LEDDY: Anyone on the hone have any comments like from the Community Mental Health Center Association?

Okay. Thank you very much. We're going to move on to the next measure.

Oh, the recommendation. Good point. So, now we are going on to the - now that we've heard from the public, or not, now to the recommended vote.

Are we going to vote to recommend this measure for inclusion in NQF or not?

So, first, how many recommend this particular measure? Raise your hand if you do.

How many do not recommend?

CO-CHAIR SUSMAN: Ken?

DR. THOMPSON: No recommend.

CO-CHAIR LEDDY: Okay. Thank you.

And now should we do the discussion about our alternative recommendation and make that officially?

Or did we do that? I don't think we -

DR. STREIM: I move -

CO-CHAIR LEDDY: We didn't really vote on it.

DR. STREIM: I move that we recommend that we ask the measure developer for the existing measure to expand the definition to include behavioral health populations with the proviso that stratification be done for the things we were discussing. I won't detail that again.

CO-CHAIR LEDDY: Okay. Like age and unit.

DR. STREIM: Such as age, diagnosis, unit, type of unit.

CO-CHAIR LEDDY: Okay. Any discussion before we -

DR. STREIM: Existence of dementia

or not.

MS. JAFFE: I might also add to make sure that co-occurring diagnoses also are included.

CO-CHAIR LEDDY: Okay. Anything else on the motion on the table? Are we ready to vote on that recommendation?

Okay. How many recommend what Joel just put on the table with the modifications? Votes for yes to recommend?

DR. WINKLER: Everybody.

CO-CHAIR LEDDY: And Ken?

DR. THOMPSON: Yes.

CO-CHAIR LEDDY: Yes. Okay. So, I think we're ready to go on to the next measure. Are the people from California on the phone?

MR. CORBRIDGE: No, they're not.

CO-CHAIR LEDDY: Okay.

MR. CORBRIDGE: But we do have another measure from Presby Shadyside.

CO-CHAIR LEDDY: Oh, we do. Okay.

MR. CORBRIDGE: So, moving on down to Measure Number 9, the title is Adverse/Serious Events, another measure put forward by Presby Shadyside.

The description reads as follows: Incidents that result in a serious injury or death reported as a rate per thousand patient days.

Numerator Statement reads as: Number of adverse/serious events that patients admitted to a hospital-based inpatient psychiatric setting experience. Include populations on patients for whom at least one adverse/serious event is reported during the month.

Denominator statement reads as follows: number of psychiatric inpatient days. Includes population's all psychiatric inpatient days.

DR. STREIM: So, is this another measure where there's an existing measure that applies to general medical populations?

DR. WINKLER: Actually, we were just checking that, and I'm not finding a measure. What we have is one of the serious reportable events that sort of address a lot of that, but not an actual, in the performance measure.

DR. BOTTS: It's a composite.

DR. WINKLER: That's what we're checking.

DR. BOTTS: So, it would be a composite of multiple -

DR. WINKLER: We're looking at it.

Well, we do have - what we do have is a composite measure of potentially preventable adverse events for selected indicators. It's an AHRQ measure and it's one of the composites. And we have to go find the -

MS. BOSSLEY: I mean, it was under the composite framework.

DR. WINKLER: So, you're talking about measure 0531?

DR. THOMPSON: Measure 0531.

CO-CHAIR SUSMAN: I'm sorry. What did you say, Ken?

DR. THOMPSON: I'm just trying to find this.

MS. BOSSLEY: He was saying the measure number.

DR. WINKLER: Right.

CO-CHAIR SUSMAN: Would you repeat your question or comment?

MS. BOSSLEY: He said "0531."

DR. THOMPSON: I'm just trying to find it.

CO-CHAIR SUSMAN: Oh, okay.

MR. CORBRIDGE: Ken, the Measure 0531 is not a measure that was currently submitted to this project. So, you wouldn't have that in your documentation. It's a measure that is currently endorsed by NQF and would be on our website.

DR. THOMPSON: Okay.

CO-CHAIR SUSMAN: So, we're looking

at Number 9 right now.

CO-CHAIR LEDDY: And we're trying to see if there's an existing similar measure.

MR. PELLETIER: But how about your never events?

CO-CHAIR LEDDY: That's what I'm saying.

MR. PELLETIER: Okay.

CO-CHAIR LEDDY: That's a serious reportable event, but those aren't -

DR. WINKLER: Those aren't measures.

MR. PELLETIER: When we say they're not measures, you mean they're not NQF measures?

DR. WINKLER: No, they are NQF-endorsed standards, but they are not specified as measures with a denominator and a numerator in the same way. They are just sort of a list of events.

CO-CHAIR LEDDY: So, this measure Ian already described. Anybody from the

workgroup want to comment or would we like to just go to importance?

DR. ROCA: Well, we looked at this. I think that we thought it was within scope. We thought it was important. There were some issues around the definitions, which definitions of serious events would apply. And they're obviously the harmonization issues, so we can proceed however you like.

But we certainly thought it was within scope and it was important.

CO-CHAIR LEDDY: Okay. Would we like to talk about importance?

MS. BOSSLEY: I have it.

CO-CHAIR LEDDY: Oh, you found it?

MS. BOSSLEY: Yes - well, that's the pediatric one. Hold on.

CO-CHAIR SUSMAN: So, I mean, while we're waiting, it seems like this is very important.

MS. BOSSLEY: So, the existing measure's composite developed by AHRQ, patient

safety for selected indicators. Denominator is all, the number of eligible adult discharges for decubitus ulcer, iatrogenic pneumothorax, selected infections due to medical care, postoperative hip fracture, postoperative DVT or PE, postoperative sepsis, postoperative wound dehiscence.

DR. PHILLIPS: Is that numerator?

MS. BOSSLEY: That's denominator. That's all the people in your denominator.

So, anyone who's discharged with an ulcer, pneumothorax -

DR. WINKLER: Those are like preventable hospital events, right?

CO-CHAIR LEDDY: So, numerator is the number of potentially preventable adverse events for that. So, we'll have to get into the specifications. I don't -

DR. WINKLER: Oh, because some of them may not have been preventable.

CO-CHAIR LEDDY: Right. So, I don't know that I would say that you could -

CO-CHAIR LEDDY: Okay. So, we looked at the existing measure and it's not the same. So, let's move forward with this one.

So, importance. Would anybody like to make a comment on how important it is to measure the occurrence of incidents that result in serious injury or death?

Sounds pretty important. Okay. Are we ready to vote on importance?

Okay. Completely.

DR. WINKLER: 13.

CO-CHAIR LEDDY: Partially. Minimally.

DR. WINKLER: One.

CO-CHAIR LEDDY: Not at all or abstentions. And what about Ken on the phone?

DR. THOMPSON: Completely.

CO-CHAIR LEDDY: Okay.

DR. WINKLER: We lost one.

CO-CHAIR LEDDY: Okay. So, we'll move to the next category which is -

DR. ROCA: Can I just ask Luc what we're missing that you see it as minimal?

MR. PELLETIER: This number is really small. This number, you don't have a lot of serious adverse events in a facility. And that serious and adverse event is managed by accreditation.

So, if you have one of these, you're doing a lot of work. So, the number, to me -

MS. BOSSLEY: The numerator.

MR. PELLETIER: - is really - so, it's just not important. It's what we do and all of what management does to respond to a serious adverse event of death. It's so much more important than this small number.

DR. ROCA: If I can make a comment, depending on how broadly or narrowly one defines "serious adverse event," I mean, that number could be very small or it could be substantial. And I think one of the problems has to do with how we're going to define

serious adverse event.

And if we restrict ourselves to the serious reportable adverse events that are on the NQF list or if we make it somewhat broader than that as anything that happens as unexpected that results in additional treatment being necessary, I mean, that could conceivably be a urinary tract infection in somebody who had a catheter inserted who needed antibiotics.

I mean, I think that is a complication of treatment that's not completely unanticipated, but is not planned for and it required extra treatment. So, if that's a serious adverse event, then potentially this is - that's a very substantial number, if it's - if the bar is set higher than that, then it's a much lower number.

CO-CHAIR LEDDY: In the description of this, the developer did say that it, I think, casts the net widely on what would be

an adverse event. In fact, in the definition it says serious adverse event or serious event, and then the description went on to be - was it - adverse events. They cited that the National Quality Forum has endorsed 27 adverse events that are serious.

And I think they were suggesting that all of those be included and didn't list what those 27 were though, or did they?

DR. ROCA: Well, I think they're on the NQF serious reportable adverse events list which we can go through, but it includes anything - it says death/disability associated with a medication error. I guess it depends on what the definition of disability is for this purpose.

And you all are probably more familiar with that than I am, but they also later on talk about a serious event is including any unanticipated injury requiring the delivery of additional health services to the patient, which is a very broad definition

which could make this a very large numerator as opposed to the kinds of things that we normally think about when we think about serious events.

CO-CHAIR SUSMAN: So, I assume that when we get to the scientific section that one of the issues is definitional here. Because when I read through the specification, it seemed like, well, at one point they're talking about a fairly defined group, and then at another point it seems like who knows what it is.

CO-CHAIR LEDDY: They cited literature from IOM where adverse events were between three and four percent of patients experienced adverse events that would be within their definition. Which they didn't exactly specify, but implying that it was fairly broad.

DR. MANTON: Definitional specificity was a current problem.

CO-CHAIR LEDDY: Right.

DR. MANTON: I think as is, the title is misleading because I think an adverse event such as a UTI that maybe you'd have another physician or provider look at and maybe order some treatment for, under what you're discussing, it would qualify.

But if I looked at the title of serious injury or death, I would not think of a UTI.

CO-CHAIR LEDDY: Right.

DR. MANTON: So, there's sort of a disconnect there in terms of -

CO-CHAIR LEDDY: They were using what they cited as the IOM definition of adverse event which is defined as injuries caused by medical management.

DR. MANTON: Right.

CO-CHAIR LEDDY: So, that -

DR. MANTON: Then I think that's what the title should reflect. Because if I were looking for something like that, I wouldn't look under serious injury or death.

DR. GOLDBERG: Well, we have to decide what measure we're looking at. Because at this point in the analysis we decide that -

CO-CHAIR LEDDY: The name and the description are different.

DR. GOLDBERG: Yes.

DR. MANTON: Is the developer on the line? Can we ask them what they -

CO-CHAIR SUSMAN: is the developer here?

CO-CHAIR LEDDY: Is it Presbyterian?

CO-CHAIR SUSMAN: Shadyside?

SHADYSIDE REPRESENTATIVE: We're right here.

CO-CHAIR LEDDY: Have you been listening to our discussion?

SHADYSIDE REPRESENTATIVE: Can you repeat the question? I got called out for a second.

CO-CHAIR LEDDY: We're having a

discussion regarding your submission where the name of the measure is Serious/Adverse Event or Death, something like that.

DR. GOLDBERG: Serious injury or death.

CO-CHAIR LEDDY: Sorry.

SHADYSIDE REPRESENTATIVE: Serious Event or Adverse Event.

CO-CHAIR LEDDY: Yes, serious injury or death.

Is that what it is?

MR. CORBRIDGE: Adverse/Serious Events. Measure Number 9.

CO-CHAIR LEDDY: Is that what it is?

DR. GOLDBERG: The measure name and the description name are different.

CO-CHAIR LEDDY: Right. And then the description further on talks about a serious event being defined fairly broadly as any event being caused by medical management or any injury caused by medical management,

which we thought - which really wouldn't necessarily be a serious event.

SHADYSIDE REPRESENTATIVE: A situation involving the clinical care of a patient in a medical facility that results in death or compromises a patient's safety and results in a non-anticipated injury requiring the delivery of additional healthcare services, that's how they define "serious event."

CO-CHAIR SUSMAN: So, would that include having a catheter in and getting a UTI, for example?

SHADYSIDE REPRESENTATIVE: Yes.

CO-CHAIR SUSMAN: Okay. Thank you.

DR. GOLDBERG: Would it include having to put a band-aid on somebody's hand because they got scratched?

SHADYSIDE REPRESENTATIVE: Well, that would not be included because it does not require additional healthcare services to the patient.

DR. ROCA: Well, it's a billable, isn't it?

DR. GOLDBERG: Yes. Well, I'm just raising a point that there are some definitional ambiguities here. That's what we're trying to bring out.

MR. PELLETIER: Following your lead here, during a seclusion or restraint if the person suffered some type of injury, that would be reportable.

SHADYSIDE REPRESENTATIVE: Correct.

CO-CHAIR SUSMAN: So, I guess one of the challenges I'm having here is in coming up with a standard definition that would be consistent across different settings and having different organizations use this measure in comparable ways.

Could you address that question?

SHADYSIDE REPRESENTATIVE: This measure is currently being recorded and reported and we could attest to it from our facility. I would not be able to talk about

it across different settings.

CO-CHAIR SUSMAN: Okay. Thank you.

DR. HENNESSEY: I have one other question. Is the definition that they are using for an adverse event, is that the Pennsylvania Patient Safety Reporting System definition, is it the NQF reporting - how are they defining, please.

SHADYSIDE REPRESENTATIVE: The definition is done by M-CARE. It is a reporting definition.

CO-CHAIR LEDDY: Can you repeat that, please?

SHADYSIDE REPRESENTATIVE: The measure definition is as defined by M-CARE. I can repeat the definition. It's an event or occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional healthcare services to the patient.

CO-CHAIR LEDDY: Okay. Thank you.

Any discussion?

MS. JAFFE: Well, I still think that we have a mismatch between the measure title and the measure description, and would need a little more clarity for my comfort level. Because to me, putting a band-aid on someone is not a serious injury, we're adding to this.

DR. GOLDBERG: It's just a matter of which do we want. I mean, we care. We've just got to be consistent so we know what we're talking about.

CO-CHAIR LEDDY: Right. So, we could go in like the examples, and the description goes in the direction of being broad. The definition goes in the direction of being narrow.

I think that what the developer is submitting and probably would be only willing to manage is what they're currently doing, which is broader, not a narrow definition,

which is not what they are currently doing.

So, we could, if NQF agrees, ask the measure developer to broaden the definition and/or change the definition to more accurately reflect the definition that they gave on the phone, and then vote on the measure according to what we think has been submitted.

DR. PINCUS: I think this is potentially a very important measure not just for mental health, but across the board. And it seems to me that there must be a lot of thinking going on about this kind of thing at NQF and at other places.

I know that Bill Munier at AHRQ is very involved in this kind of stuff. There is actually an international patient safety classification that's been developed. And so there's a lot of thinking about this stuff, and somehow this should be brought to bear on this whole issue.

So at least for me, it's kind of

premature until that's been done.

CO-CHAIR LEDDY: So, you would like to keep it to more of a standard definition and maybe go more toward the serious event. Is that what you're saying?

DR. PINCUS: No, I'm not saying that. This is looking just at scientific acceptability, this is not ready for prime time. That this needs a lot more clarification in collaboration with a lot of other people working in the same area.

CO-CHAIR SUSMAN: I mean, I think to echo Harold's comment here, we should really communicate to our NQF colleagues here that this is clearly a very important area. There's clearly tons of work going on here. And come on, gals and guys, help organize an effort to develop a rigorous, scientifically valid, well-constructed measure.

Certainly this group is doing some wonderful work locally, but we need a national measure in this arena.

DR. WINKLER: Yes. I think what we can do, it's very straightforward, is we will take this discussion to Peter Angood who sort of leads the patient safety work at NQF. And he's got a fair amount of work ongoing. And perhaps it's better looked at in that context than this one, and address a lot of these issues for you.

But I think your recommendation to get the clarity with the collaboration of all the many efforts that are going on, is an excellent one.

DR. THOMPSON: Can I ask a quick question? Is this specifically in reference to events in a psychiatric institution or a hospital in particular, or is this also - are we considering this or has this been conceived of as having any applicability in monitoring folks who are now living in community settings?

CO-CHAIR LEDDY: Inpatient psych, Ken.

DR. THOMPSON: It's all inpatient. So, it's heavily weighted to institutions that have people for particularly for long-term periods.

CO-CHAIR LEDDY: Not necessarily.

CO-CHAIR SUSMAN: No. I mean, you could think of this also for domiciliary type of arrangements. I mean, I think it could be certainly a broader concept, but I think the action that we're sort of foretelling here of sending it back to the experts at NQF make a lot of sense to me.

DR. THOMPSON: Let me just say one little other piece about this. If I've got this right, this originated out of Allegheny County out of Western Psych; is that correct?

CO-CHAIR LEDDY: Yes.

DR. THOMPSON: So, one of the things that I think has informed this, and I'm just putting this as an additional concern relative to the field, is that we recently closed a state hospital. And part of that

process meant moving a lot of people into community settings and also monitoring what was happening because there was a lot of increased interest in what was happening with people now domiciled in community settings.

And the whole issue of monitoring and keeping track of signal events or critical events really became unbelievably important to the whole process in that community service.

So, if we are sending it on to NQF, I would hope that we also suggest that it be looked at in a broader sense than purely within inpatient settings.

CO-CHAIR SUSMAN: Good feedback.

CO-CHAIR LEDDY: Okay. Everybody seems to like that suggestion, Ken. So, our recommendation will be to NQF, we'll add that caveat, that recommendation.

So, do we have to make that recommendation formally?

DR. WINKLER: Well, it's sort of the result of the action you have on this

measure. So, I think it would be good that the Committee weigh in formally on it.

CO-CHAIR LEDDY: Okay. So, how about if first we vote on the criteria for this particular measure as submitted, and then we will make a formal recommendation to NQF like we did last time.

So, importance of this measure. And so what we're voting on - whoops. I don't have my microphone on. Sorry.

What we're voting on now in importance is on the measure as a whole. Not the particular measure that's submitted, but the concept of this measure and the importance of it.

So, how many would like to vote for it completely?

DR. KAUFER: I thought we -

CO-CHAIR LEDDY: We already voted on importance?

(Simultaneous speaking)

CO-CHAIR LEDDY: Scientific

acceptability. Sorry. Scientific acceptability.

CO-CHAIR SUSMAN: So, completely. Partially.

CO-CHAIR LEDDY: Minimally.

DR. WINKLER: 11.

CO-CHAIR LEDDY: Okay. Not at all. And Ken.

DR. THOMPSON: I'm coming in minimally.

CO-CHAIR LEDDY: Okay. Thank you.

MR. CORBRIDGE: 13 for minimally, and we're missing Richard -

CO-CHAIR LEDDY: Should we vote again for minimally? Do you have the wrong number?

MR. CORBRIDGE: For partial, it was just one, correct? And not at all was zero.

CO-CHAIR LEDDY: Rich, did you want to vote on scientific acceptability?

DR. GOLDBERG: Not at all.

CO-CHAIR LEDDY: Okay. One more

for not at all.

Do you have the numbers now? Okay. So, we're okay with numbers?

MR. CORBRIDGE: It must be 14 for minimally, because we have 16 with Ken on the phone.

CO-CHAIR LEDDY: Okay. So, we're ready to go on to the next category. Sorry I tried to vote twice on importance.

(Off-record comments)

CO-CHAIR LEDDY: Okay. Usability is the next one. Now, we're voting on this particular measure and the usability of this particular measure given the discussion we had about the lack of clarity on what's included and not included.

Any discussion or are we ready to vote? Ready to vote. Okay. Completely. Partially. Minimally.

MR. CORBRIDGE: Nine.

CO-CHAIR LEDDY: Not at all.

DR. THOMPSON: What is this vote

again? I'm sorry.

CO-CHAIR LEDDY: This is on usability, Ken.

DR. THOMPSON: Okay.

CO-CHAIR LEDDY: Do you have a vote?

DR. THOMPSON: I'm going to go with partially.

CO-CHAIR LEDDY: Okay. Thank you. Last category is feasibility. So, this is how feasible it is to collect the data, is it an automatic byproduct of care, et cetera, or is it burdensome to collect.

DR. HENNESSEY: I think this kind of data is being collected in incident reports all over hospitals.

DR. GOLDBERG: The issue of inaccuracies, exclusions given our discussion, makes it problematic.

DR. ROCA: And there's certainly some things that might be included on this list that wouldn't necessarily generate

incident reports, I think, in current practice.

CO-CHAIR SUSMAN: And the way it was defined of being the UTI by instrumentation type of thing, a catheter-related UTI, I mean, you're not going to capture that on incident reports and it would take bizarre chart abstractions, at least in my setting.

CO-CHAIR LEDDY: Okay. Any further discussion about feasibility before we vote?

Okay. Completely. Partially. Minimally.

MR. CORBRIDGE: 13.

CO-CHAIR LEDDY: Not at all. And Ken.

DR. THOMPSON: Minimally.

CO-CHAIR LEDDY: Minimally. Thank you.

Are there any comments from the public on the phone or here before we make a final recommendation?

MS. GALLAGHER: No comment.

CO-CHAIR LEDDY: Okay. So, we'll vote on whether to recommend this measure as submitted, move forward to NQF or not.

So, those in favor of recommending this measure move forward as a recommendation. Those who do not recommend. And how about Ken.

DR. THOMPSON: I recommend that we send it on.

DR. HENNESSEY: Wasn't there going to be some sort of a discussion about something that we wanted to recommend to the Safety Committee?

CO-CHAIR LEDDY: Yes. So, like the last time, somebody made a very articulate recommendation summarizing our discussion.

Would anyone like to do that?

DR. HENNESSEY: I believe, Joel, you did that.

CO-CHAIR LEDDY: Joel, that was your second time that you did that in this

group.

DR. STREIM: Yes, I'm going to defer to someone else to try and capture it.

DR. PINCUS: So, I would move that we ask NQF in collaboration with other NQF members, to examine this measure in concert with other efforts that are taking place with regard to the measurement of adverse events.

CO-CHAIR LEDDY: Okay. Thank you. Any amendments to that statement of recommendation to NQF?

CO-CHAIR SUSMAN: I think it's probably understood, but the development of a measure is really what we're hoping the outcome will be rather than simply what we've done right at the current state.

DR. HENNESSEY: Yes, I think that just to - and this is not an amendment to the motion, but more a statement that this workgroup believes that the patient safety initiative is very important, it's vital, and we would like to see some sort of national

measure put forth.

CO-CHAIR LEDDY: And do we want to include what Ken mentioned about it being both for inpatient and for community settings, across settings?

CO-CHAIR SUSMAN: Good point.

CO-CHAIR LEDDY: Okay. So, how many would like to vote to recommend this to NQF for a yes?

CO-CHAIR SUSMAN: Ken?

DR. THOMPSON: Yes.

CO-CHAIR LEDDY: Okay. Unanimous. Excellent. Next measure, Ian, would you like to present the next measure?

MR. CORBRIDGE: I've been on the e-mail trying to get a hold of individuals from RAND. We can -

CO-CHAIR LEDDY: Do we only have RAND's left?

MR. CORBRIDGE: We have RAND, as well as one other individual. So, do you want to take a quick break?

CO-CHAIR LEDDY: Before lunch?

MR. CORBRIDGE: Would people like to take just a ten-minute break while I try to touch bases via e-mail with individuals -

DR. GOLDBERG: Are there any others we can do now?

MR. CORBRIDGE: The measure that we skipped from the substance abuse group, which was Measure Number 14 -

CO-CHAIR LEDDY: Psychiatrist rated assessment.

MR. CORBRIDGE: Correct. I've got an e-mail back from them. So, they're unavailable at this point in time, but they'll be available later on this afternoon.

MS. GALLAGHER: My apologies. Is it the pleasure of the group that both measures, both of the falls measures be worked upon for psychiatric -

CO-CHAIR SUSMAN: Yes.

MS. GALLAGHER: Because the motion is on.

CO-CHAIR SUSMAN: Yes.

MS. GALLAGHER: Maybe could we have a motion to that just -

CO-CHAIR SUSMAN: So moved.

MS. GALLAGHER: Thank you.

MR. CORBRIDGE: If we could maybe just move to take a ten-minute break, we can do some e-mails and we can just try to get things sorted out. I'm still trying to get a hold of them. I'm sorry. It's not RAND, but I'm still trying to get a hold of the developer.

(Whereupon, the meeting went off the record at 11:33 a.m. for a brief recess and went back on the record at 11:55 a.m.)

CO-CHAIR LEDDY: We are going to be doing Measures 5 and 21, which are in Workgroup 3. And that is the ones that are the last group on the agenda.

DR. HENNESSEY: Which one are we going to focus on first, please?

MR. CORBRIDGE: Starting off

probably on 5.

CO-CHAIR LEDDY: Five is Services Offered for Psychosocial Needs, and it is paired with 21. They have submitted them as paired measures, right, Ian - or Ian paired them.

DR. HENNESSEY: Do we want to start with 6, or do we want to start with 21, which I believe is the assessment, and it's paired with services offered.

CO-CHAIR LEDDY: Do you mind if we start with 21, Ian?

MR. CORBRIDGE: That's fine. I'm trying to -

CO-CHAIR LEDDY: Okay. So, we're going to start with 21 because it sort of comes before 5 in order of care. So, we're going to go 21, and then 5. And Ian is going to give us a little summary of 21.

MR. CORBRIDGE: All right. So, looking over Measure 21 submitted by RAND, the measure title reads as follows: Assessment of

Psychosocial Needs. The description of the measure is proportion of patients with a new treatment episode who receive a baseline assessment of psychosocial needs or deficits, Axis IV, across the domains of housing and employment.

Numerator Statement reads as follows: Patients from the denominator who receive a baseline assessment of the precise or absence of psychosocial needs or deficits, Axis IV, across all of the following domains within one month of the start of, I guess, new treatment episode, housing, employment status, work or other meaningful daily activities.

Denominator Statement, all patients with new treatment episodes for any mental health disorder.

And we do have measure developers from RAND on the line.

CO-CHAIR LEDDY: The measure developers from RAND, would you like to introduce yourselves?

DR. WATKINS: Hi. I'm Kate Watkins at RAND.

MS. ROTH: And I'm Carol Roth.

CO-CHAIR LEDDY: Okay. Thank you. So, it's Kate Watkins and Carol Roth from RAND.

Would anyone from the workgroup like to comment on this measure?

MS. WILKINS: Well, I'll start. I think this is an area that's clearly very, very important. And there's a lot more evidence than what was submitted by the measure developers.

It's certainly an area that I think as one member of our group - both housing and employment are cited in the New Freedom Commission on Mental Health, consumers consistently rank those as kind of their top priorities, so it's really, really important.

I'm not sure that what was submitted makes the case nearly as strongly as it could be.

DR. HENNESSEY: Yes. I pulled some information from the New Freedom Commission report and also some citations about 46 percent of homeless people are also thought to suffer mental illness. So, there is definitely a well-documented need.

The dilemma that this workgroup had was taking this measure and making the case that the interventions that are being measured are indeed going to be evidence-based measures to improve outcome.

There is actually research and well-defined evidence-based interventions for employment. There is less well-documented evidence-based interventions for homelessness.

In fact, I included in there a citation from Newman and Goldman that say that essentially this is one of the most visible failures of our behavioral health's delivery system.

So, I think it's very important. I think we all, you know, among the three of

us have had some discussion and believe it's important. The dilemma is the evidence-based piece.

DR. ROCA: And the only thing I might add to that, I certainly agree that it's important and that inquiring about these domains is really part of what we need to be doing whenever we see a patient.

But my question is a fundamental question as to whether this is really a response to the charge of this group. I mean, this seems like very much a process measure and not an outcome measure.

It arguably - the other measure we're to consider which has to do with delivering services could be seen as maybe an intermediate outcome of some sort, but this - but even that one seems like a process measure really, not an outcome measure. And it really depends on how broadly we want to define our charge here whether we consider this further or not.

DR. HENNESSEY: One of the dilemmas that I had with this is that, yes, this is a process measure. However, it would be the first step to what would be considered the companion measure, which from my perspective was really an intermediate outcome measure.

DR. GOLDBERG: So, we're back on that spectrum of where we stand. You've got to ask about housing. You've got to ask about employment.

If I go back home and tell them I came from the NQF Outcomes Committee meeting and we decided that it's important to ask patients whether they're employed and what their housing is, people are going to shoot me.

I mean, this is not an outcomes measure. I mean, yes, we've got to teach people to take a good history and record a history of domains that are relevant to taking care of people, and maybe the Committee will argue that we have to somehow talk yourselves

into calling it that for other purposes, but this is not an outcome.

DR. HENNESSEY: But, you know, we've already at one point made a recommendation of a measure yesterday that was a process measure, and we called it a process measure, which had to do with the PHQ-9. So, we do have a precedent for doing something like this.

CO-CHAIR LEDDY: Didn't we link that with something?

DR. GOLDBERG: PHQ-9, if that's the one you're saying, that's an outcome measure.

DR. HENNESSEY: No. What we did was we talked about just the plain administration of it was a process measure, and we went ahead and endorsed it.

CO-CHAIR LEDDY: We talked about, I think, the outcome or almost outcome measure. Intermediate. Thank you. Intermediate outcome measure first, and we endorsed that as an intermediate outcome measure. And then we

recommended to NQF that they endorse the linked process, clearly process measure.

So, if we want to consider that route, we would probably consider - we would look at Number 5 - is it - first. Go back to Number 5, which could be argued to be an intermediate outcome measure. And then go back to this one to see if we want to endorse it as a linked process measure.

Does everyone agree? Okay. So, Number 5, Ian, could you describe that one?

MR. CORBRIDGE: Yes. So, moving back to measure Number 5, the title of the measure is Services Offered for Psychosocial Needs. The description reads as follows: Proportion of patients with a new treatment episode and have evidence of need, deficit for housing or employment status who are offered services for psychosocial needs.

The Numerator Statement reads as follows: Patients from the denominator who were offered services across the following

domains within 12 months of the start of a new treatment episode, housing or employment status.

Denominator Statement reads: Patients from the denominator who are offered services across the following domains within 12 months of a new treatment episode.

I'm sorry. Those are the same. So member of the workgroup have that measure open? I think we must have a cross-posting of the -

Do you have the Numerator Statement available?

MS. BOSSLEY: What section is it? Oh, numerator. Yes. Numerator right here. Numerator or denominator?

CO-CHAIR LEDDY: You need Denominator Statement.

MS. BOSSLEY: I have the denominator right here. I have it. So, all patients with an NTE for any mental health disorder who also have evidence of

need/deficit across the domains of housing or employment status.

CO-CHAIR LEDDY: So, do you want to say what the numerator is, Ian, or do you -

MR. CORBRIDGE: Heidi, do you have that up or -

MS. BOSSLEY: Yes, I've got it.

DR. WINKLER: The numerator is the patients from that denominator that Heidi just mentioned, who are offered services across the following domains within 12 months of the start of a new treatment episode and those domains being housing or employment status.

So, I think the -

CO-CHAIR LEDDY: Why don't we ask RAND to provide you some background.

DR. WINKLER: Yes.

CO-CHAIR LEDDY: Why don't we ask the measure developer just to perhaps describe the measure itself. Would that be helpful?

I'm sorry. RAND, I don't know if you - I missed your name.

DR. WATKINS: I'm sorry. I didn't hear the question.

CO-CHAIR LEDDY: Can you provide just a little background on the intent of this measure and how the numerator and the denominator are structured?

DR. WATKINS: Yes. The denominator is people with need for housing or employment. And that's just by the NQF number. I think it's five.

And then the numerator is evidence that services were offered for either housing or employment. In some ways there are two measures that we've put together as one, but you could have a separate measure for housing and a separate measure for employment.

And for this particular measure we've been fairly generous in what we've defined as services for employment or services for housing. It tends to be something that's not well documented in the medical record.

Of course, if someone were offered

support in employment, that would also help in terms of being a service offered for employment problems or if someone were enrolled in a homeless program to try to get them housing.

So that's, again, more formal evidence of being in - of offering of service, but this measure also allows providers to ask if they are having conversations with the patient about either their housing and employment, recognizing that not all patients are ready for an evidence-based intervention.

They may be at the point of only being ready to have kind of a motivational interviewing type of intervention where you talk about what it is that they want and what their goals are. And that's going to be - that's going to be described in the chart, the way we've described it here.

The conversation has happened around - there was a brief intervention or did a motivational intervention to help patients

understand that he needed to change his housing situation or improve his housing situation.

So that the numerator is - both numerators are relatively broad in terms of what is acceptable.

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

DR. HENNESSEY: I had a question.

Do you have some baseline data as to the frequency of these two questions being asked and recorded in the charts?

DR. WATKINS: Yes. I don't have that at the tip of my fingers, but we do have that. We've actually piloted or tested these measures with about 6,000 people and so I can certainly get that information for you.

DR. HENNESSEY: Yes. I'm just kind of curious whether you're even seeing, you know, a third of, you know, clinicians are asking those questions or whether we're more like in the 65 percent range or something like

that. I'd be curious to know.

DR. WATKINS: I could get that for you, if you'd like, but I can't do it right this minute. I can't do it immediately.

MS. WILKINS: So, I just want to follow up with another question.

So, based on what you said, a conversation that says you really need to find housing or you'd be better off if you had housing or some motivational interviewing related to pursuing goals related to housing would count even if it's not accompanied by any linkage to a housing resource, or is it that the clinician actually was able to facilitate a connection to a resource that was actually available?

DR. WATKINS: I think one of the difficulties - it does not have to be linked with a specific resource like here is a list of shelters or here is a list of sober living programs. Although, that certainly would count that that was provided to the person.

Some patients don't want those kinds of things and are not ready for them. And that you need to - I mean, I think the important thing is that you meet the patient where they're at and you provide an intervention to move them along the continuum towards the next step. And that may be moving them from being completely uninterested in making a change in their housing situation or in their employment. They may work at a bar and have an alcohol problem, and they may be perfectly satisfied with that.

And so your conversation with them may move them along the continuum to say, oh, maybe I should think about not working in a bar and how that makes it harder for me to not drink, you know.

Certainly you could refer them to AA, but again the idea is that you are helping the patient move along the continuum from a point of having a problem with their housing or need for housing or employment, to a place

where they can actually make use of a service such as supported employment or a housing program.

CO-CHAIR LEDDY: I wanted to ask about reliability. My understanding from reading this is that this is chart abstraction based on abstraction by various chart reviewers of free-form text not so much in an electronic medical record or a pull-down menu or whether or not the clinician did or did not address the assessment or make an offer, give specific information about housing or employment.

And given that this would be an after-the-fact chart abstraction, I'm wondering if you've done tests on reliability of abstracters looking at free-form text of medical records to -

DR. WATKINS: We have, and that actually - we have not quite completed that, but that is almost completed since the time we have submitted the measure.

We've been doing it on a sample of - I think it's 6,000 charts with different diagnoses, and so we have not finished the final - I think SUD is the final diagnosis.

In the earlier diagnoses, the reliability, the prevalence adjusted reliability, it ranges between .6 something and .8 something. So, it's got reasonable reliability.

We'll be able to give you an overall reliability for all the disorders.

CO-CHAIR LEDDY: And considering the issue of replicability and feasibility of doing this in other settings given that it's not an automatically-generated report and that it requires an after-the-fact chart audit, could you comment on that?

DR. WATKINS: that is a problem. That would mean that data collection for this measure is more difficult and more time consuming. I don't think that there's any way around that.

MS. JAFFE: Could you comment on the decision to make the time frame 12 months?

DR. WATKINS: Again, that was not made with - there is no evidence for saying why it should be 12 months or six months or three months.

Our sense is that sometimes if someone is in the beginning of a new treatment episode, it may take some three or six months to stabilize to the point where again a conversation could be held. If someone comes in acutely psychotic, it wouldn't be appropriate to really assess their housing and have a conversation about housing when they first arrive on the inpatient unit.

And so we wanted to allow time for the patient to get better enough from the beginning of the new treatment episode so that a conversation would make sense, would be reasonable. And so that's why we were fairly generous in saying that process could take up to a year, but it may be that you're dealing

with other issues prior in the first six months related to just stabilization of symptoms or -

CO-CHAIR SUSMAN: So, are we at a point where we can go through -

CO-CHAIR LEDDY: Maureen has another question.

DR. HENNESSEY: I have one other question for Katie.

DR. WATKINS: Yes.

DR. HENNESSEY: Was there any consideration given to the group that developed this measure on - I believe there were people from all over the country - is that right - developing it, working with the measure development; is that correct?

DR. WATKINS: I'm sorry. Can you say that again?

DR. HENNESSEY: Yes. Were there people from around the country, various VAs working on the development of this measure?

DR. WATKINS: Yes.

DR. HENNESSEY: Okay. Was there any consideration given by the workgroup to really having two measures? One dealt with, as you were saying, supported evidence-based employment intervention versus the motivational interviewing that you were talking about for people who aren't yet ready for a more formal intervention?

DR. WATKINS: We did not discuss separating those two.

DR. HENNESSEY: Okay. Thank you.

CO-CHAIR LEDDY: Could I just go back to - I did ask before about reliability testing, which would be inter-abstracter reliability.

How about validity testing on whether or not this is even written in the chart and whether or not the abstracters are in fact catching what is a valid reflection of what happened during the clinician's patient visit.

DR. WATKINS: So, this measure

depends on the clinician documenting in the chart what in fact the clinician is doing in the session. And to the extent that the clinician doesn't document it, it's not a valid measure or the physician or social worker or psychologist hasn't provided any evidence that it actually existed.

Our inter-rater reliability, the way we tested for it, was to have pairs of raters re-abstract charts and then look and see whether or not they came up with the same answer.

And so to that extent, we were able to show that our trained nurse abstractors are able to reliably abstract this information from the chart.

CO-CHAIR LEDDY: But let's say that this was a clinically not-written-down occurrence by clinicians. Then your reliability might be very good, but the validity would not necessarily be good.

Have you done anything to test the

validity on whether or not what they found in the chart is actually what happened during the interview by -

DR. WATKINS: No. No, we have not observed interviews and then compared them to what is reported in the chart.

And I think if you were to find that it was not written in the chart, and I can again tell you the prevalence of what we found, if you were to find that it was not documented in the chart, then the intervention on the part of the provider would be to work on documentation and that that has to be the first step.

CO-CHAIR LEDDY: Okay. Maureen.

DR. HENNESSEY: Yes, I had a couple of questions. The first is I noticed that the definition that this measure is really only for psychiatric disorders. I didn't see substance abuse or Alzheimer's in there; is that correct?

DR. WATKINS: Substance abuse is in

there. Alzheimer's is not.

DR. HENNESSEY: Okay. Thanks. And then the other was at the time of this submission there wasn't any data available about the cost of collection and the cost of training abstractors.

Do you have any additional data on that now, please?

DR. WATKINS: Not at this point.

DR. HENNESSEY: Okay.

DR. WATKINS: We'll have some additional data, but it's not ready yet.

DR. HENNESSEY: Okay. Thank you.

CO-CHAIR LEDDY: Any other questions from the group before we discuss each category?

CO-CHAIR SUSMAN: We have to still decide whether it's in scope, don't we?

CO-CHAIR LEDDY: Oh, yes. You're right. So, we have to decide whether or not this particular one - so, this isn't whether or not the clinician did the assessment. This

is the second measure now whether or not they talked about the - well, recommended housing or employment options, right?

There were two measures, so everybody is straight on that. So, we've gone to the second measure and we want to decide if this is in scope as an intermediate outcome.

Any discussion on that?

PARTICIPANT: You said "second measure." Could you specify the number?

CO-CHAIR LEDDY: Okay. That's a good idea. Number 5.

Number 12 was the first one - sorry. 21 is the first one, the assessment measure. And Five is the second measure. So, now we're on Five.

Any discussion about whether or not this is -

MS. WILKINS: I guess I would say it seems to be a mix. On the one hand if a clinician actually facilitates access to housing, then indeed it is a way of looking at

outcomes.

If the clinician hands someone a list of shelters, from research on homelessness I can say that that is pretty useless. It's not likely to produce an outcome.

And so it seems that there is a - we may get into this, I think, when we get into the scientific properties here. But as it's been described, it's getting at a mix of outcomes and processes.

DR. ROCA: And I'm the outcomes purist in the group and I would say this is a process measure. Even this one a process measure more than an intermediate outcome.

CO-CHAIR LEDDY: I would go back to what Carol said and say that it really didn't describe - it really described only the if the clinician did something. It didn't even get into whether or not the person got shelter or got employment at all.

It really did not go that far as

far as getting into an outcome, correct?

DR. WATKINS: That is correct. That was because we felt the actual getting of employment or getting of housing was subject to constraints that were really outside the healthcare system and would vary depending on what state you are and, for example, what the unemployment level is in your particular region.

And so you may get variations in your levels of these outcomes that are really not -

DR. GOLDBERG: Well, it raises an interesting issue of holding people accountable for things that are outside their domain of what they can control. That's a problem.

On the other hand, we were talking yesterday about these kind of gaps in care the way our care is fragmented. So, medical people say, well, I couldn't address the depression because it's outside my domain of

expertise, or the psych people who say we didn't address the diabetes because it's outside our range of expertise and we're trying to push these things back together.

And maybe in ways of setting goals that we want to accomplish, we have to create the carrot to push people to say, well, if systems right now are not organized in a way to allow clinicians to work with people who can accomplish a housing goal, then we need to reorganize the system that allows that outcome to take place.

And if we don't challenge ourselves with creating that expectable outcome, we're never going to push the system or create any incentive in the system that forces them to push these pieces of the system together and will always say that's outside our domain of control.

DR. WATKINS: That's why the issue is, is that we are requiring permission of services, but we are not requiring that the

person actually makes, you know, finds employment.

DR. STREIM: Despite all the external constraints on successfully linking people to those services and resources, is there evidence you can point to that suggests that when the services, you know, the assessment is done and the services are indeed offered, that there is a link to better outcomes in terms of mental health outcomes?

DR. WATKINS: I don't think that I know of a linkage that is that direct. There is linkage that says that providing housing for - that getting people housed improves their mental health outcomes and providing them with an evidence-based like, for example, a supported employment intervention will both improve their employment outcomes as well as their mental health or substance abuse outcomes.

I don't know if there is linkage from the more general -

DR. STREIM: Well, how about even an intermediate linkage just between offering the services? And even if we know that there are some people who are in an impossible situation and you just aren't going to be able to successfully get them placed in appropriate housing, that there is a reasonable proportion who would benefit and then we can tell the story of how that does get linked to better mental health.

But to what extent is offering and actually producing a better housing outcome?

DR. WATKINS: It's a necessary precondition. Whether it's sufficient or not is, I think, open for discussion.

It also would be a difficult proposition to test in the sense that it would be difficult to design a study where you randomly assigned people to either get being a conversation or being offered housing assistance versus not getting housing assistance.

CO-CHAIR LEDDY: Anne, did you have a comment or question?

DR. MANTON: Yes, I do. As a provider, I would think that the outcome would not be so much if I recommended a particular housing agency or employment agency or something like that, but rather with the follow-up at the next visit with that patient would I then say did you contact - what kind of feedback did you get from the housing authority, what kind of feedback did you get from the employment people?

So, I feel like what's proposed falls short of anything that's useful because the usefulness would be if the person actually connected. And I may talk about that for several visits as things are going on.

So, just offering it just feels to me like that's incomplete.

MS. JAFFE: I would also comment if we're going to decide in mental health that services related to employment in housing are

part of the care process, then we need to hold ourselves accountable to the outcome being actual employment in housing. And if we're saying it's just too hard so we're not going to do that, then I think we need to rethink why we are in the business in the first place.

DR. PHILLIPS: And actually building on that point - well, my understanding was the developer was stating that because the differential in being able to offer housing or employment or actually getting housing or employment was one of the reasons - I mean, that can be adjusted for in the analysis, but I think that that's actually what needs to be highlighted.

I mean, if you have a group of providers in a state that are doing a very good job of offering it and there's something preventing people from getting the services, that needs to be highlighted. And so it's a quality outcome for a different level than the provider, but it's an important quality

outcome.

CO-CHAIR LEDDY: I think Ken on the phone was trying to make a comment.

DR. THOMPSON: Thank you. Thank you very much. I appreciate that.

I just wanted to comment I think the dilemma is the issue of where the quality is, and if the burden is placed on the clinician or the person who is getting service, then your dilemma that is described in terms of actually having control over housing or employment is very, very problematic.

If it's placed at a higher level, and there are examples of this around the world right now. Actually in the UK right now there is a major effort to make sure folks who have been excluded from the labor market, the greatest distance from the labor market, actually included and they're doing that by measuring the percentage of people who are at a present time excluded from the labor market,

working to increase them.

So, a way to think about this would be how many people are currently getting Social Security Disability who are able to get back into the labor market and move beyond that?

Now, there's obviously lots of problems systematically in making that happen. But I think that whoever talked earlier about the fact that unless we hold larger system accountable, we can work forever to get people jobs if there's nobody working to actually get them into the job, or if there is are no jobs being made available to them then we'll never get anywhere.

CO-CHAIR LEDDY: Jeff.

CO-CHAIR SUSMAN: I'd like to go back to the comment previously about whether this is really an adequate outcomes measure or not. I think an outcome that really reflects patients would be getting housing or getting employment. And I would be a hundred percent

that's within our scope and we should be looking at that.

This measure, however, I'm not comfortable with as an outcomes measure for a variety of reasons that we've already discussed.

So, I think what we should do at least for a process perspective is go ahead and say is it in or out of scope, and then go onto the next step if it's voted to continue with it.

CO-CHAIR LEDDY: So, shall we vote whether it's in or out of scope at this time? Are there any comments from the public?

MS. GALLAGHER: No.

CO-CHAIR LEDDY: How about the Community Mental Health Association? Are you on the phone still?

MS. GALBREATH: Yes. I mean, I think we struggle with some of the same things that you've been discussing in terms of the importance of that being a measurement. But

exactly how this measurement accomplishes that, there's, I think, some questions.

But in terms of importance, definitely very supportive of including these types of measures and outcomes.

CO-CHAIR LEDDY: Okay. I would like to make one other comment going back to the discussion that we had before about whether or not we can be held accountable as providers for things that are maybe outside of our control and what Rich said about that we're not going to change anything unless we do hold ourselves accountable.

From my perspective and my experiences having been a payer for a performance and what I would say is that even with something like mammography, a payer would set a standard in performance that would be never a hundred percent. You would always expect there to be a human patient factor that the provider cannot be held accountable for. So, your goal may be 80 percent of achieving

the specific goal.

And what is what you're being held accountable for measured against risk assessing, adjusting for risk adjustment, would be how you compare to other like providers in getting toward that goal and whether you're improving toward that goal not being accountable for a hundred percent.

So, in this instance I think it's very important that we recognize as Rich said, that we really need to focus on the outcome and of course not expect that we will be able to reach a hundred percent of it, but certainly we could compare against like risk adjusted populations and how we compare against other systems or providers in accomplishing the ultimate goal. And in addition, how much we are improving within our own domain.

So, from a payer perspective, that's what I looked for. And it reconciles with what we are talking about which is

holding ourselves accountable for the outcome, but yet not being expected to achieve a hundred percent.

MS. WILKINS: I also think this is an area in which if we look beyond the provider level to the mental health system, mental health systems in many states, states or counties depending on how it's organized, control a significant amount of resources for housing.

A very significant percentage of the support of housing that exists in the United States today is funded, receives funding through the mental health system. And, in fact, the VA currently has 30,000 vouchers for homeless veterans for whom VA medical centers are the gatekeepers.

So, particularly with respect to the VA, the VA has an extraordinarily high level of influence today over access to actual housing resources.

And then secondly I would say in

California the AB 34/AB 2034 programs that were highlighted in the New Freedom Commission Report as well, held themselves accountable for achieving consumer outcomes in housing status and in employment status.

And I think what that really did was to drive counties to examine and to compare the extent to which they were improving outcomes for consumers whether by helping the consumer qualify for housing, helping consumers get on waiting lists from Day 1 of a crisis rather than the day before they were being discharged, or by actually investing and creating housing.

So, I just want to echo what's been said that when you focus on the consumer outcome, the system reexamines how the system is gatekeeping with respect to access to housing or employment opportunities, or changes its investment strategy because paying for housing if it reduces hospitalizations or if it gets you better outcomes, may be a

better way to use the resources of the system.

DR. HENNESSEY: One other thing that I would add is should we decide that this is not an outcome because it is to be recommended because it's considered to be a process outcome, I would recommend that we make a strong statement that we do believe that this is a gap in measurement right now.

MS. JAFFE: I agree with that, and I want to also comment that we are in King County where I'm from, being held accountable for outcomes related to employment and housing if you have supported employment or supporting housing programs. So, it's possible to do.

And echoing what Tricia said, we're not held to 80 percent employment. There are places that are seeing ten percent, but they're leading for improvement.

DR. HENNESSEY: Actually, I wish you had submitted your measure.

MS. JAFFE: Yes, I don't think it would pass this group, but it's a start.

(Laughter)

CO-CHAIR LEDDY: Okay. Any other discussion? I think that what we are looking for at this point is an in scope/out of scope vote; do you agree?

PARTICIPANT: Yes.

CO-CHAIR LEDDY: Okay. So, this is Measurement Number 12 now that we've been discussing - 21. I don't know why I keep -

PARTICIPANT: Five, isn't it?

CO-CHAIR LEDDY: All right. I thought we did it the other way. So, we're on Five, services offered. Okay. Excellent. Sorry.

So, we are 5, services offered by the clinician. How many vote that this is in scope as an outcome measure?

Okay. So, we have one vote for intermediate outcome measure.

How about votes for out of scope as an outcome measure?

MR. CORBRIDGE: 12.

CO-CHAIR SUSMAN: But I concur with what was said, Maureen.

CO-CHAIR LEDDY: Are there any abstentions?

DR. MANTON: Yes.

CO-CHAIR LEDDY: Okay. Ian abstained. One abstention.

And how about Ken on the phone? Did you have a vote?

DR. THOMPSON: Out of scope.

CO-CHAIR LEDDY: Out of scope. Okay. Thank you. And then we would maybe entertain a recommendation that Maureen might put forward regarding this issue as a gap.

Would you like to say something about that that we could vote on?

DR. HENNESSEY: Sure. Thanks. What I would say is that this workgroup recognizes the importance of assessing for and intervening with housing and employment as indicated in the New Freedom Commission, the President's New Freedom Commission on mental

health.

And that we believe that there is a need for the development of a measure that actually measures improvements in homelessness and employment from an outcomes perspective as opposed to an intervention perspective.

Anyone have anything to add to that, please do.

CO-CHAIR LEDDY: Okay. So, Maureen's recommendation -

DR. THOMPSON: This is Ken. I just wanted say, we did a little bit of work in this regard and the supported employment activities have been demonstrated to be evidence-based.

So, they must have some evidence base to support that, and there must be some measure of employment in that process.

MS. WILKINS: And I would just add parenthetically I keep being told that it's about to come out, but CMHS is also about to release an evidence-based practice toolkit in

support of housing.

So, there is a significant body of evidence. It's just that we need to get to the outcome measures.

CO-CHAIR LEDDY: Okay. Any further discussion on Maureen's recommendation? Would we like to vote on that recommendation, that this group make that recommendation to NQF?

All in favor.

DR. THOMPSON: In favor.

CO-CHAIR LEDDY: Ken is in favor.

Any no's or abstentions? Okay. Unanimous. Thank you.

And now we'll move to Number 21, which is the associated measure. And this is assessment of psycho-social needs. So, this was the actual whether or not the clinician did use the assessment tool.

So, I think we'll take a vote on this one on whether or not it is in or out of scope as an outcome measure. But before we do that, we would like to invite public comment.

MS. GALLAGHER: No comment.

MS. GALBREATH: No comment.

CO-CHAIR LEDDY: Okay. Thank you. So, we're going to vote on all who think this is in scope as an outcome measure. Number 21. Raise your hand.

All who think this is out of scope, raise your hand. Any abstentions?

You were out of scope, right?

DR. THOMPSON: Out of scope.

CO-CHAIR LEDDY: Okay. So, this was voted as unanimous out of scope. Thank you.

DR. THOMPSON: I also was out of scope, just so you know.

CO-CHAIR LEDDY: Oh, thank you very much, Ken. And thank you very much to the measure developers, Kate and Carol, I believe it was, who put this forward. Your submission has resulted in a recommendation to NQF that a measurement of homelessness and - or resolution of homelessness and employment are

extremely important measures with a recommendation that NQF pursue this as important outcome measures.

So, your work was really well worth the submission. Thank you.

DR. WATKINS: Thank you.

CO-CHAIR LEDDY: Okay. At this point I'm going to tell you what the rest of the schedule is. Okay. We have at one o'clock, we have University of Washington on the phone, which is a new measure, Number 14, which is in Workgroup 3 - oh, no, it's not Workgroup 3.

PARTICIPANT: Four.

CO-CHAIR LEDDY: Workgroup 4. The measure is Psychiatrist-Rated Assessment of Psychiatric Inpatients' Clinical Status. So, that is at one o'clock when the measure developer will be on the phone.

At 1:30 we have Western Psych on the phone. And they were on the phone yesterday, but couldn't hear much of the

conversation. They submitted the three readmission measures, the 48-hour, seven-day, 30-day readmission measures. So, they would like to just have a recap of what our discussion and decision was and maybe have a little discussion about that. And Joel has graciously agreed to provide that recap of our discussion.

MR. CORBRIDGE: with your help, of course.

CO-CHAIR LEDDY: Right. So, that will be at 1:30. The only other thing we have as far as a measure is concerned, is Number 47 which is Inpatient Consumer Survey. The measure developer we do not think is able to join us. That is in Group Number 3. Number 47.

DR. SCHACHT: Can you hear me?

CO-CHAIR LEDDY: Yes.

DR. SCHACHT: This is the measure developer for the Inpatient Consumer Survey.

CO-CHAIR LEDDY: Oh, excellent.

CO-CHAIR SUSMAN: What perfect timing.

CO-CHAIR LEDDY: Perfect timing.

DR. SCHACHT: I was wondering if I was on the line correctly. That's great.

CO-CHAIR LEDDY: Okay. Now, the only other issue is that we haven't broken for lunch yet and it's quarter of and you're on the phone.

We could do this now, get lunch. And then at one o'clock or soon thereafter - so, we'll do Number 47 while the measure developer is on the phone, and then break for lunch and get the one o'clock people, University of Washington, on the phone, or do you want to take maybe a five-minute break right now to get lunch and come back and do it while we - eat lunch while 47 -

CO-CHAIR SUSMAN: That might be our best -

CO-CHAIR LEDDY: So, would that be okay with you, Measure Developer Number 47?

DR. SCHACHT: That's fine. My name is Lucille.

CO-CHAIR LEDDY: Oh, that's much easier. Thank you very much, Lucille. It's too bad that we can't offer you lunch over the phone.

So, we're just going to grab lunch and come back, if that's -

DR. SCHACHT: That's great.

CO-CHAIR LEDDY: Okay.

(Whereupon, the meeting went off the record at 12:45 p.m. for a brief lunch recess and went back on the record at 12:53 p.m.)

CO-CHAIR LEDDY: So, the measurement we are considering is Number 47, which is Inpatient Consumer Survey. And this is in Workgroup 3. The measure developer is on the phone. Her name is Lucille.

Lucille, what's your last name?

DR. SCHACHT: Last name is Schacht, S-C-H-A-C-H-T.

CO-CHAIR LEDDY: Okay. And you're from what organization?

DR. SCHACHT: It's an acronym. NRI, NASMHPD Research Institute.

CO-CHAIR LEDDY: Okay. Thank you.

So, Ian is going to start off with a brief description.

MR. CORBRIDGE: Yes. Heidi is actually bringing the document up. So, I can't bring it up at this moment. So, she's going to read over the brief description, numerator/denominator statement.

CO-CHAIR LEDDY: Okay. Heidi is going to do the brief description.

MS. BOSSLEY: Okay. So, the brief description is survey developed to gather client's evaluation of their inpatient care. Each domain explored as the percentage of adolescent clients age 13 to 17 years, and adult clients at time of discharge or at annual review who respond positively to the domain on the survey for a given month. The

five domains in the survey include outcome, dignity, rights, treatment and environment. Questions in each domain are based on a standard five-point scale evaluated on a scale from strongly disagree to strongly agree.

And then if I go down, I'll start with the denominator. That's always easier for me. Denominator, number of clients completing at least two items in the domain. And those domains again are outcome, dignity, rights, treatment and environment. Each domain is calculated separately.

The Numerator Statement is number of clients who respond positively to the domain.

CO-CHAIR LEDDY: Okay. I know that the end of the table caucused on this. Would you like to comment on this measure, anybody at the end of the table? Bob or Carol or Maureen?

MS. WILKINS: I think overall we'll get into the specifics as we review this, but

we felt that it definitely includes both some very specific outcomes, as well as some perceptions of the quality of care that could have a strong impact on future outcomes.

I think overall we felt that the submission was really strong and we took a little time this morning to look at the actual survey instrument itself and I think we really liked what we saw. We can talk more about it as we get into it.

DR. HENNESSEY: Yes. One of the things I had noted in my comments that there was no information about the reading level. However in our subsequent research this morning we did come across something that suggested a 5.2 grade level for reading.

DR. ROCA: So, I mean, we thought it was in scope, I think we thought it was important and had a number of other virtues as well that we'll get into as we discuss it in more detail.

DR. GOLDBERG: So, it says right in

the description that it has something to do with outcome. So, for now we should just believe you about that and then we'll see tomorrow.

It has the word, because the rest of it isn't necessarily, I mean, asking people about whether they're rights or - but it has the word and you say it is. So, I'm willing to open the door with -

DR. ROCA: Well, I think when you look at the instrument, you see even the sections that have to do with dignity and rights are the kind of feedback that an organization would like to have about how their care is perceived.

We have it online here. We don't have it in - and I think they're actionable. They're the kinds of - it's the kind of feedback that you would be able to act upon if you got it.

CO-CHAIR LEDDY: Okay. So, are there any questions for the measure developer

before we get into it? We can start with importance.

DR. GOLDBERG: To vote on scope, or not?

CO-CHAIR LEDDY: Oh, vote on scope?

DR. GOLDBERG: I thought that was prior to the procedure process.

CO-CHAIR LEDDY: Okay. Is there a question about whether this is an in-scope as an outcome?

DR. ROCA: We thought it was in scope, I think.

CO-CHAIR LEDDY: Do you need to convince the group?

DR. GOLDBERG: I thought we had a process where you had to vote to move on.

CO-CHAIR LEDDY: So, we'll vote.

MS. BOSSLEY: I don't think in this instance you need to. There seems to be general consensus.

DR. GOLDBERG: Okay. Fine.

CO-CHAIR LEDDY: I don't think we

voted on every one. Only where there was a question.

DR. GOLDBERG: All right.

CO-CHAIR LEDDY: Okay. So, importance to measure and report, any discussion about that? This is a very patient centered type, this measurement, which is -

DR. GOLDBERG: I'm still finding it a little hard to comment without knowing more of the details of what all the things are. I mean, if they're important, I mean, what are the things that are in there that are so important.

CO-CHAIR LEDDY: How about if we have the developer give a little summary.

Lucille, would you be willing to do that?

DR. SCHACHT: Sure.

CO-CHAIR LEDDY: Thank you.

DR. SCHACHT: And are you looking for a summary on the kinds of items that are in the survey itself?

DR. GOLDBERG: Yes, especially the ones that relate to outcomes.

DR. SCHACHT: Okay. There are questions about - I'll pull up a copy of it here.

In terms of outcomes, the questions are that - and these are all self-report by a client. I am better able to deal with crisis, my symptoms are not bothering me as much, I do better in social situations, I deal more effectively with daily problems.

There's also a question related to medication. But since medication is not actually used by all clients, it's a given item in here, but it's not counted actually in the domain score.

In each of those domains that were mentioned; dignity, rights, treatment, involvement in treatment planning for discharge, actually, and environment, each one of those has four questions. And they're very explicit questions.

For example, I was treated with dignity and respect. Staff here believe I can grow, change and recover. And the questions were actually developed with a workgroup of consumers back in about 2001.

Does that answer the question?

DR. GOLDBERG: Yes, that's good.

DR. SCHACHT: Okay.

CO-CHAIR LEDDY: Okay. Is there any other comments on the importance of this, of measuring this?

Would you like to vote? Ready to vote on importance of measuring this?

Okay. How many people think it is completely on importance to measure and report on this particular measure?

MR. CORBRIDGE: 12.

CO-CHAIR LEDDY: Thank you, Luc. This is the concept of this measure, not the particular measure, right, as with the others.

Any partially?

MR. CORBRIDGE: Two.

CO-CHAIR LEDDY: Okay. And any minimally or not at all or abstain? Do we have everybody?

Ken, are you still on the phone? Maybe not.

DR. HENNESSEY: I had another question for the developer. The measure itself referenced that adolescents could take this measure. I didn't see any data in your test development that included adolescents.

Were they included, Lucille?

DR. SCHACHT: During the initial pilot back in 2000, there were a few adolescents that were included in the study. But we felt that it really wasn't enough of a pool to truly assess it, so we continued to do assessment after that and retested the integrity of the instrument in terms of whether the domain still held together for adolescents, and they did.

And as we've used it over a number of years, our adolescent response has grown.

And their domain still holds together the same way as for the adult group.

DR. HENNESSEY: Thank you.

CO-CHAIR LEDDY: Okay. Can we move down the screen down to the next category, which is scientific acceptability?

Would anyone in the group like to comment on this?

DR. ROCA: As you look through the documentation provided by the developer, there's really quite a lot of data on reliability and such. What appears to be the case, and the developer, Lucille, you can maybe enlighten us on this, it looks as though a lot of that which you documented in the application here refers to work that was done a number of years ago in State hospitals.

And my question was whether there's more you can say about reliability or validity testing in broader populations than State hospital inpatients who are arguably different from the kinds of patients who are

in psychiatric settings that are different from that.

DR. SCHACHT: Okay. We actually do have a number of requests from private hospitals. We actually do have several private hospitals that use the survey with us along with State hospitals. We had a recent request from the VA hospital to use the instrument.

And I think that based on their experiences in preparing available inpatient pools geared for psychiatric care, we've had a number of requests from the private hospitals and they've used it as well. I've gotten all positive feedback from them in their use of it. And we do post our aggregate rate so that they can use that for benchmarking.

Does that answer the question?

DR. ROCA: Yes. And I guess the - but the reliability and those kind, I mean, these are organizations that are using it

clinically and finding it helpful, it sounds like, but has it been tested in the kind of rigorous way that it was tested in the State hospitals, in other settings?

DR. SCHACHT: I would say no in that we have not done a second formalized test. We're currently doing a retest with out current participants and we have maybe a half a dozen participants who are not State-run psychiatric hospitals. And we're reconfirming, basically, the factor structure, the domains that exist, that they'll hold together with the cohort that's using the study now which is like eight years after original development.

So, we don't specifically do a retest with non-State hospitals, no.

DR. ROCA: Okay. And this is also a 28-item test at this point, isn't it? Is that correct?

DR. SCHACHT: That's correct. It's 28 items.

DR. ROCA: And the original tested version was 43?

DR. SCHACHT: Yes. The one that we used in the pilot phase was 43 items. And from the analysis of the pilot phase, we dropped it down to a 28-item tool. And then what we've done internally is a bit of a confirmation test every year as the cohort using it has grown to confirm that the factor structure holds with the 28 items that we're working on preparing a publication on that.

DR. ROCA: Okay. Great. That's very helpful. Thank you.

DR. GOLDBERG: So, you're saying to summarize it, this has only been validated on a State hospital population from data that's 20 years old?

DR. ROCA: Well, it's about ten years old.

DR. GOLDBERG: Ten years old.

DR. ROCA: the data is about ten years old.

DR. GOLDBERG: Okay.

DR. ROCA: I mean, and I think that's a weakness. But compared to other things we've been looking at, that's pretty darn good.

DR. HENNESSEY: I have one other question for the developer. You say that now you're reviewing your data and re-analyzing your data currently.

During your current process, have you given any consideration to taking a look at or segmenting the group that are from the non-public psychiatric facilities to try to get a sense of whether or not there is a difference in their responses?

DR. SCHACHT: We do not have a large enough cohort to do that yet. But what we have done internally for our own users, we produce a variety of stratified reports, one of them being for forensic clients versus non-forensic clients, to be sure that both have benchmarks for a similar patient group.

And we also do more age breakouts in our comparison so that adolescents are all being compared in their scores versus older adults are being compared, but we don't currently have a large enough cohort of non-state facilities to do that analysis.

We do allow people who are not participating with us to use this. They don't have to send us their data, which is why we don't actually have a large enough cohort to do that task.

DR. HENNESSEY: Thank you.

DR. SCHACHT: You're welcome.

CO-CHAIR LEDDY: Any other questions or discussions on scientific acceptability? Are we ready to go for a vote? How many would vote completely? Partially.

DR. WINKLER: 14.

CO-CHAIR LEDDY: Minimally. Not at all or abstain.

DR. PINCUS: Abstain. I missed the discussion.

CO-CHAIR LEDDY: Okay. And now we'll go on to the next category which is usability.

DR. HENNESSEY: This is Maureen. I'd just like to confirm my understanding is that this is geared for a 5.2 reading level grade-wise.

DR. SCHACHT: Yes, it was rated at a 5.2 reading level so that we feel confident with use among adolescents, but would not be confident with use among children.

DR. HENNESSEY: And I believe this also has a Spanish language version now; is that right?

DR. SCHACHT: Yes, it actually has two Spanish translations. One done in Texas and one done for Puerto Rico.

DR. HENNESSEY: Excellent. Thank you.

CO-CHAIR LEDDY: Reva.

DR. WINKLER: This is for inpatient psychiatric hospitals, and does anyone know

are there other surveys that exist that are in use by other hospitals that really try and capture the same kind of data?

CO-CHAIR LEDDY: Luc.

MR. PELLETIER: Yes, there is one. Proprietary though.

CO-CHAIR LEDDY: You know of one?

MR. PELLETIER: Press Ganey.

DR. PINCUS: Does Press Ganey have a -

CO-CHAIR LEDDY: Microphones.

DR. PINCUS: Is Press Ganey specific to psychiatry or do they use a generic one?

MR. PELLETIER: Specific.

MS. JAFFE: They have a specific version for psychiatry.

MR. PELLETIER: It is specific.

DR. GOLDBERG: You've walked in really late. This is beyond the patient experience. This has some other dimensions to it as well.

DR. PINCUS: So, when you say it has outcomes, does it have a pre and post? So, how does it do outcomes if -

DR. ROCA: I mean, it asks the patients whether they feel that as a result of treatment they are better able to cope in social situations, whether they're less bothered by symptoms and that kind of thing.

So, it's asking patients their judgment about whether they've improved.

DR. PINCUS: And when is it administered?

DR. ROCA: At the time of discharge or on patients who were there for an extended period of time, periodically.

MS. BOSSLEY: it says during the month of client discharge or during the month of annual review for the client.

DR. GOLDBERG: Does the group that does this also administer another patient experience questionnaire like Press Ganey, Lucille?

DR. SCHACHT: No, they do not.

DR. GOLDBERG: And remind me, you may have said it already, how long it takes the patient to fill this out.

DR. SCHACHT: It's a relatively short survey. I think that most of our hospitals have indicated it's ten or 15 minutes. Oftentimes they will have patient advocates available to help a patient understand what the question is asking if they need that or to actually physically check off boxes if they need help to actually do the mechanics of the survey.

DR. GOLDBERG: Now, is the potential overlap of this with Press Ganey, are you familiar with that? Are there some and is that a harmonization issue if there are?

MR. PELLETIER: They're proprietary.

DR. GOLDBERG: Okay. So, that's a non-issue.

DR. ROCA: Yes. I mean, I would like - this is probably more of a feasibility issue, but I would like to highlight that ten to 15 minutes in a setting where there may be five or six admissions and discharges a day as is the case in the private sector frequently may be prohibitively time consuming.

I mean, I think that's just sort of - I guess that might be a question I would ask Lucille to respond to. Does she find that people resist filling it out, do people have to be sort of held in the chair while they respond to the question or something like this?

DR. SCHACHT: Well, ten to 15 minutes is when they for those hospitals that tend to run sort of a discharge planning group where they'll have a group of clients who are ready for discharge and they'll help with the planning of discharge and this will be one of the things that will occur then.

We have a number of facilities who

just hand it to the client as part of the discharge transition. It's a hundred percent voluntary. So, if a client chooses not to answer, that's still okay.

So, for many clients I would guess that they can do this in a minute or two. For other clients there's an opportunity for assistance or reading questions or asking questions. It's provided in more of a networked assisted, you know, assistance available kind of atmosphere.

CO-CHAIR SUSMAN: Do you have - and I might have missed this or didn't see it in the writeup - actual response rates in use?

DR. SCHACHT: Yes. We do actually provide those back to our hospitals based on how many discharges they had in a given month, how many surveys should they have completed. We also ask our hospitals to track that for themselves of how many responses they're getting.

We've had some low response rates

as low as 20 percent. We've got a couple of facilities who have phenomenal response rates up over 80 percent.

CO-CHAIR SUSMAN: So, on average?

DR. SCHACHT: On average I would say it's probably around 40 to 50 percent of people being discharged that are responding to the survey at most of the hospitals. There are a number of hospitals that continue to have really low rates and they work on that, and there are some hospitals that have phenomenally high rates.

CO-CHAIR SUSMAN: Okay. That sounds good.

DR. STREIM: In trying to understand those discrepancies across facilities with response rates, those are in the range of health literacy problems in our healthcare consumer audience. And I wonder if there's anything that has been done or needs to be done to try to assess the extent to which limited health literacy actually affects

the response rates or the ability of patients to do this.

I understand you've talked about how some facilities provide assistance to those patients who need it in filling out a form, but it sounds like that's one area where there might be some built in inequities in terms of if people with low levels of literacy are not in the pool of people who actually are responding.

DR. SCHACHT: That is an area of concern when you have a low response rate on how generalizable your results are. And we caution facilities who have low response rates about the generalizability of that and to look at what their practices are around their distribution methods, their return methods, their availability of assistance as ways to increase their response rates.

And some facilities have found that by having these sort of discharge planning groups that the response rates go up.

And some facilities haven't been able to adopt that, some of that is a staffing issue, the availability of staff or consumer advocate staff to be able to provide that service.

MR. PELLETIER: So, some facilities would actually have a group in an inpatient setting where you're filling out your -

DR. HENNESSEY: I had a question. George was asking if he could take a look at the reliability and validity information that this workgroup had.

Has everyone had the opportunity to look at that or do we need to have the developer sort of summarize the research, what they did with reliability and validity? Are there questions on that?

CO-CHAIR SUSMAN: I guess I'm more interested in the usability part of this.

MS. WILKINS: I just want to make a point on a different dimension of usability, which is the usability of the information that comes out of this process. And I think one of

the things that at least struck me as a real positive, is that there's already a track record for public reporting on a website that gets updated regularly so that there is the ability for - I guess it's reported at the facility level or the provider level, but there is already an infrastructure in place for public access to the outcome measures.

And I just thought compared to most of the rest of what we're looking at, that's a huge step forward.

DR. HENNESSEY: One of the unique aspects of this was that this was developed with consumer input.

CO-CHAIR LEDDY: So, are we ready to vote on usability? Okay. Completely? Anybody votes for completely on usability? Partially.

DR. WINKLER: Everybody here.

CO-CHAIR LEDDY: How about, Ken, are you on the phone? Ken? I think he's off.

And is that everybody? Okay. And

so now we'll go to feasibility. Any questions from the group or Workgroup 3 or comments or questions for the developer?

Jeff.

CO-CHAIR SUSMAN: Is there any issue of social acceptability here particularly when you're helping users complete this, any fear of sanction, unintended consequences, and have you looked at that?

DR. SCHACHT: Well, one of the things that we have on the survey tool itself is a clear reminder to the facility using it that they are responsible for telling the consumer that this will not have a negative impact on their care. And that's a statement right on the tool itself.

So, we think that that's real helpful in that regard.

CO-CHAIR SUSMAN: Thank you.

DR. STREIM: Are these done anonymously then in any way? I mean, I

realize if you're doing it in a group it's not very anonymous, but is anonymity something that can be achieved?

DR. SCHACHT: Yes, actually the facilities have that option. And if they want it to be an identified survey, they have to inform the consumers that it is an identified survey. And that includes using a coding number that they can decode back to the consumer.

And we've done significant training with our facilities about putting code numbers on there that they can decode. That means it is not anonymous and the consumer needs to know that.

If the consumer wants to self-identify, they can write their names on there. There's nothing that says they can't do that. It's really a facility/consumer choice about anonymity.

DR. ROCA: Is there any concern that it might be hard to interpret the results

if this were being used for comparative purposes, if the person looking at the comparative data didn't know whether the data were anonymously obtained or not?

I mean, I've certainly been when I get my car serviced, been prevailed upon by the service director to be sure to fill this out and be sure to put all fives here.

I mean, you could conceivably do better in a setting where this was being administered by an enthusiastic staff member who was encouraging you to give positive responses. I mean, it would seem to me if you're trying to evaluate the institutional response to this, you would be helpful to know exactly how the data were being presented to the patients at the time of discharge and you would think you'd have a lot more confidence in data that were collected anonymously than data that might be collected with the influence of the provider of care.

I'm just wondering if that's come

up or if that's been a concern.

DR. SCHACHT: Well, we do actually in reporting purposes to us in developing our comparative information that we provide that, we do ask whether the survey was anonymous or not.

We have not yet stratified by that, but we've done some testing over the years to see if there are any significant differences in the responses in the ratings themselves when surveys were anonymous versus surveys not anonymous.

And one of the disadvantages of being a large system is that once your N gets really big, it's really - you can get differences that are significant from a statistic standpoint, but have no practical meaning.

So, what we've found when we have smaller Ns is that there were some cases where there were marginal differences between anonymous and non-anonymous surveys. But as

our population grows, that difference waters out.

DR. GOLDBERG: Lucille, can you give me an example of how you've used this data to change outcomes in one of your inpatient units?

DR. SCHACHT: Okay. Well, I can tell you from examples from our facilities that facilities have taken this information and looked at their scores, say, on the outcome domain where say they were scoring only 75 percent, which is about, I think, what the average is running right now.

And then what we do is we provide them with an actual score for each one of the questions in that domain, and then they developed a plan to address the particular question that was scoring the worst assuming that that would help to improve overall outcomes.

And they've done that with all of their domains. The outcomes domain, as well

as rights and dignity and environment. We've also had facilities who have worked on response rates, and looked at holding a focus group with the consumers around, their issues around completing surveys, their concerns, and then looking at strategies to help improve response rates.

DR. GOLDBERG: Thank you.

DR. SCHACHT: You're welcome.

CO-CHAIR LEDDY: Any other discussion? We're on feasibility.

Ready to vote on feasibility? Completely. Partially. I think that's everybody. Minimally. Not at all or abstain.

Any comments from the public before we vote to recommend or not to recommend this measure to go forward to NQF?

MS. GALLAGHER: No comment.

MS. GALBREATH: No comment.

CO-CHAIR LEDDY: Thank you. Okay. We're ready to vote. Any discussion or questions before we vote on whether to

recommend it go forward?

Okay. All in favor of recommending this go forward?

DR. CORBRIDGE: Everybody.

CO-CHAIR LEDDY: Unanimous. Congratulations, Lucille.

DR. SCHACHT: Thank you very much. We're excited and we look forward to the next step in our task related to that. Thank you for this opportunity.

CO-CHAIR LEDDY: Well, thank you for putting together such a well-documented and comprehensive proposal.

DR. SCHACHT: Thank you.

CO-CHAIR LEDDY: Okay. So, the next thing we're going to do is our one o'clock. We're a little bit behind time, right?

MR. CORBRIDGE: Yes. Peter, are you on the line? Is anyone from University of Washington on the line?

CO-CHAIR LEDDY: University of

Washington? Do you think they left?

MS. BOSSLEY: They may not have joined yet.

CO-CHAIR LEDDY: Okay. How about the 1:30? Anybody from Western Psych on the phone? So, can you try and e-mail or contact the Washington people?

CO-CHAIR SUSMAN: University of Washington, are you there? Oslo?

MR. CORBRIDGE: I can try following up, but his e-mail says he's here.

CO-CHAIR SUSMAN: What line is he on?

CO-CHAIR LEDDY: Okay. So, I think that we should go ahead and begin discussing Number 14 while Ian tries to get Peter from University of Washington on the phone, and Number 14 is a new measure.

How about do you have Number 14, Heidi?

MS. BOSSLEY: I certainly do.

CO-CHAIR LEDDY: Okay. While Ian

is trying to contact Peter, Heidi can give us the basics on Number 14.

MS. BOSSLEY: Okay. So, Number 14, psychiatrist rated assessment of psychiatric inpatient's clinical status. The measure provides a standardized psychiatrist rated 36-item tool to assess adult inpatient psychiatric patients with respect to their clinical status, symptom and behavior domains.

There is no denominator. The numerator is the tool allows psychiatrists to rate a spectrum of psychiatric symptom and behavior domains of inpatient psychiatry patients using 36 items with concrete behavioral anchor points.

CO-CHAIR LEDDY: This one was in your group. I think that this one at least on the list is listed as potentially out of scope. So, that's what we need to address first.

MR. PELLETIER: They really don't discuss doing the survey at Point A and then

Point B and then comparing that. They don't talk about that.

The study is actually - the tool is actually expert opinion. It's not taken from valid, reliable sources. I thought that the focus on discipline specific was limiting.

MS. JAFFE: I might be able to just answer. I know a little bit about it.

CO-CHAIR LEDDY: Oh, good.

MS. JAFFE: It is actually done at admission and discharge, but a psychiatrist does have - I don't know. I didn't read the thing. So, it might be helpful if Peter gets on the phone, so there are - and it has been - they've published some articles on it, so there is some scientific stuff in there.

CO-CHAIR SUSMAN: Hello. Is this Peter?

CO-CHAIR LEDDY: Peter, are you on the phone?

DR. GHINASSI: No, this is Frank Ghinassi. I was told to try to call around

1:30.

CO-CHAIR LEDDY: Okay. Thank you, Frank. We're just running a little bit late.

DR. GHINASSI: Oh, that's quite all right. Please, don't let me interrupt.

CO-CHAIR LEDDY: Okay. Now, what about, Luc, could you address whether you think this is in or out of scope as an outcome?

MR. PELLETIER: I think that the way it's described, it's out of scope.

DR. BOTTS: Yes, I agree the way it's put forward is really just a measurement-based care tool and there is no outcome measure that's addressed. It's just the use of the tool.

CO-CHAIR LEDDY: So, shall we vote on whether it's in or out of scope? Is that the -

DR. GOLDBERG: In theory if the person gets on the line and says, oh, wait a minute, I do this pre-test, post-test, this

isn't an outcome, does that change anything or do we have to go by what is presented in the written form?

CO-CHAIR LEDDY: Well, if they clarify, then we could ask them to correct the form.

So, why don't we then - he's not on the phone yet, right?

And if we can't get him in the next minute, we can go onto the next one then.

Right. Okay. Why don't we go to the discussion while Frank is on the phone, what we're going to do is go back to the three readmission measures that we discussed yesterday because Frank couldn't be on the phone yesterday and the person that represented his group couldn't hear us very well.

So, Joel has agreed to provide an overview to Frank and the rest of the group on our discussion yesterday on the readmission measures.

CO-CHAIR SUSMAN: And this was Three, Four and Six.

CO-CHAIR LEDDY: Thank you, Joel.

DR. STREIM: Yes, that's Three, Four and Six. And, hi, I'm sorry that you weren't able to hear the discussion, but I'll just try and hit highlights here and then you can ask if you have any things you'd like us to clarify.

I'll talk about all three of these together to start, because the submissions were identical except for the distinction between 30-day, seven day and 48-hour readmission rates.

I think in general the Steering Committee members felt that all of these measures were in scope for outcome measures. So, all of them were candidates that we would consider and there was consensus about that.

In terms of the importance to report for the - here I will say the 30-day measure, two-thirds of the Committee felt that

the importance was completely demonstrated and only one-third felt partially.

But for the seven day and the 48-hour, the Committee was pretty unanimous that the importance to measure was partially met.

The discussion around that, I think there was one comment from a reviewer - actually, a couple of reviewers that the evidence provided in the submission really relied heavily on very old literature. But the expertise among committee members, I think, gave us confidence that this is a direction the field is going in, that there are other measures, non-mental health measures that do look at particularly 30-day readmission and that there's substantial evidence from other fields within healthcare that this is important to measure. So, I think in general that part was well established enough.

In terms of scientific acceptability, there were concerns that this

measure - this set of measures has been developed for use by a single healthcare system for internal determinations of the rate of service utilization. And that because it's constructed primarily for that purpose, that it may not generalize to use by other health systems as well as that it may actually not generalize well in terms of the - well, let me say the fact that there is no real validity testing that was cited here was a concern that what we're looking for is a measure that can be used beyond internal use for public reporting and needs to be interpretable by a community at large, not just internally.

And so that partly relates to the scientific acceptability. It relates also to usability. And it was really on usability that I think the Committee had most of its concerns that because the person who was on the phone with us yesterday said that these measures have been garnered from databases that are essentially administrative databases

within the health system, not data from payers, that it would be very difficult then to get similar data beyond your own health system.

If you wanted to look at readmissions from other facilities in the region to actually be able to do that, and this is in terms of usability and feasibility both now, it might be very difficult if we aren't getting access to readmission rates that are reported by payers or in payers' databases.

And I think that the concern then was that a measure that you've developed for use internally may not be easy to expand beyond your own organization. So, that was the gist of the main concerns in terms of the limits of these.

One other thing I would mention is that although 30 days has become sort of the standard for measuring readmission rates, I think in our discussion and the person who was

on the phone from WPIC did say that of course the proximity in time of the readmission to the discharge makes it easier to attribute readmission to something that happened during the index hospital stay. So, 48 hours would look like - I'm sorry. Readmissions at 48 hours would be the ones most easy to attribute to in-hospital events.

That said, there was some concern that we really don't have a lot of evidence to guide us in knowing whether it makes sense to measure at all three time intervals or only at 30 days because that's sort of an emerging industry standard, or whether 48 hours has the white heat of relevance and we ought to focus on that.

So, those were the main points that I can recall from yesterday's discussion. And I would stop there and ask if you have - well, let me ask other committee members if there were other points that they felt were important to highlight from that discussion

yesterday.

CO-CHAIR SUSMAN: Just to highlight one point here, the measure as submitted seemed to be tremendous within a given system. But what I heard the Committee looking for was to look at the data that might be more broadly collected from, say, a payer or that would be inclusive admissions outside of a given system.

And that was a critical omission in trying to move this from a QI or performance improvement measure within a system to an accountability measure.

DR. STREIM: Yes, I would add there was more detailed discussion about this issue of patients discharged from one hospital system and then being readmitted, but to another hospital system where those might not be detected and, conversely, where there were transfers from another hospital system back into the hospital system where the index hospitalization occurred, which creates some

challenges, but the question is whether those could all be captured in a single region.

And the Committee felt that that was easier to do, more feasible to do when you had payer database rather than an administrative database from a single system.

DR. GOLDBERG: Two comments. First of all, the title is wrong. Should be 30-day readmissions, not remissions.

DR. HENNESSEY: Oh, typo.

DR. GOLDBERG: Yes. At the risk of my memory being gone for this, didn't we discuss something about how we maybe didn't need this specifically in mental health, that this was a broader issue of - a discussion about readmissions as a basic NQF measure that we wanted maybe to defer to a non-specific readmission measure because of the importance of breaking down this barrier between psych-to-psych readmissions? There was some discussions about that.

And breaking down that barrier

between readmission psych-to-medicine, medicine-to-psych, psych-to-psych, you know, and that there was nothing specific about psychiatry.

And in fact by keeping it limited within behavioral health, we were really creating a conceptual barrier that we don't want to create.

MS. JAFFE: I recall the conversation we were having was in regard to the readmissions being counted only if they were for psychiatric admissions versus any admission.

DR. GOLDBERG: And that the next step, therefore, was that this was really a much more general measure of hospital care.

DR. STREIM: Yes, the example there being a person discharged after inpatient treatment for depression who gets readmitted within the following month for an exacerbation of their diabetes or -

DR. GOLDBERG: Or a trauma service.

CO-CHAIR SUSMAN: The other issue was around risk adjustment. And particularly as we're getting into an issue of accountability measurement, some form of risk adjustment might be very important.

CO-CHAIR LEDDY: Frank, did you want to comment in response to this discussion?

DR. GHINASSI: Sure. Thanks. And then I think David and Khaliani are on the line also.

Let me just start by saying thanks for the opportunity to participate in this. It's already been a learning experience for us, and so we appreciate that.

First of all, I wanted to at least go on record as saying that I agree completely that the optimal data set here would be a combined regional/national set that used exclusively payer data.

I think one of the challenges are for in even institutions of our size, is to

line up payers and to sort of get willingness for people to provide those on a regular basis when in fact you have, given the market or the region, you may have as few as three or four, and in some markets you may have as many as ten or 12 payers.

I don't think that's impossible, but I do think that if NQF pushes this forward and if what ends up happening is the recommendation is it's a payer-driven one, we probably need to craft some model where that participation is guaranteed because it's not within the power of the systems always to get that.

That said, I do want you to at least know that we do regularly look at payer data from the managed Medicare entity in Allegheny County which oversees all of the Medicaid population. However, that managed care organization doesn't manage all of the Medicare populations we might look at. And again we have commercial payers who their

participation in giving us information is variable.

The other issue had to do with just more of a question. I think it was with the 48, seven, 30-day readmission. And again I just want to submit for the Committee's consideration, I think that the 30-day measure while a critical one whether you're talking about behavioral health or other areas, surgery, trauma, while it's a critical one, I think it's perhaps too blunt of a tool to really discern whether what you're seeing is a failure of the inpatient facility to either; A, deliver an adequate bolus of whatever it was they were trying to address during the stay, schizophrenia, depression, whatever the presenting diagnostic issue was.

So; A, you have to take into account was an adequate bolus of treatment delivered in that level of care? And then perhaps equally important, was there sufficient effort made to recently both

motivate the individual to seek the next level of care, and to do things that would ensure that that initial connection happened.

And I think that if you're going to try to tease some of that out to only look at 30 days, may deprive an NQF measure of being able to tease those factors out.

I think we've submitted 48 and seven primarily because within our own system we consider a 48-hour readmission to really be a missed handoff. And we are very concerned about those, as we are about all of them, but those are ones where we really look inward about what it is that did or did not happen.

The seven-day readmission is frequently better able to help us tease out was the connection made to the next level of care and what was our role in that?

And then the 30 often helps us to reflect a little bit on what the - even if the connection was made, was the next bolus of treatment sufficient?

So, I just wanted to submit that thought as you're kind of looking through this.

And then I guess the last one was you had said that it might be hard to generalize this because the institution that submitted it was using it for - what was the thing you said? Internal utilization standards or -

DR. STREIM: Yes, that was how it was stated in your submission. Let me see if I can bring this up pretty quickly.

Yes, the validity was not addressed with respect to quality of care or time interval because this measure was regarded as only a rate of service utilization.

And, again, that was stated a couple places in each of the measure submissions. So, we took that to mean that you use it internally that way and you know how to interpret that rate of service

utilization.

The concern for using this as a quality measure more broadly that's publicly reported and used for QI purposes more widely is that other entities might have trouble interpreting these numbers generated this way that that works for you and you have your monthly meetings to make sense of these data, but that that might not be a universal experience.

And that is actually one of the criteria for usability, but that was how we were just responding to the - I'm sorry. We were just responding the way it was written in the submission.

DR. GHINASSI: No, I know. What I was saying was that may have been a wording error on our - I have to apologize. I'm off site, so this data is not in front of my eyes, but it is not - service utilization is an unfortunate term. And if we - I'm sure we used it, and we may have mislead you a bit on

that.

We used this as a measure of the quality of the bolus of treatment that's provided on the inpatient unit, the transfer and handoff information that's communicated at the next level of care and our ability to help an individual engage and stay in that care in such a way as to prevent coming back to a more intensive level.

So, we may have mislead you with that. Our apologies.

DR. STREIM: Well, it wasn't stated quite that way in the submission. And I think with the next submission, that kind of explanation would be particularly important.

The other thing is we actually in our phone discussion, although it was a tough connection yesterday, we got the impression that you didn't have access to any payer data, and that also is an unfortunate miscommunication.

DR. GHINASSI: Well, and again we

do not have what I think you folks are accurately describing as the optimal state, which would be that in any given region there would be complete access to payer data that would allow for transparency around readmission not only in psychiatric facilities, but also the physical and/or psychiatric emergency rooms.

I agree with you wholeheartedly. I think the challenge is that very often entities that want to engage in these levels of care do not have the ability to mandate that. And I'm reflecting that back, because I think that's one of the challenges, but I don't think it's an insurmountable one.

We do have access to regular data from a large behavioral health managed care payer, but that's primarily because they are within the larger network of systems we're a part of.

DR. STREIM: Yes, we imagined it might be that way. That's why we were

confused about the message we got yesterday.

MEASURE DEVELOPER KHALIANI: This is Khaliani from Western Psych. I just wanted to clarify the wordage that we used about rate of service. I have our submission in front of us.

When we stated that it was a rate of service utilization and that validity measures were not applicable, we meant that it was not readily available because we were measuring a proportion of service that we have not done extensive validity testing for the proportionate number.

So, when we said rate of service utilization, we meant proportionate number.

CO-CHAIR SUSMAN: Yes, I think the bottom line that I heard our committee talk about is that as a performance improvement, an internal system measure, this is great. And that the direction this could go to be useful as an accountability measure where there was care to make sure that all readmissions were

captured and that there was some risk adjustment so there could be meaningful comparisons among systems, across systems, would be a logical next step. And I think people were very enthusiastic about seeing that in a re-submission.

DR. WHITE: One last question I have with your indulgence. We have used a couple of risk adjustment factors.

Did the Committee generate - I had to miss yesterday. Did the Committee generate any thoughts or would you have any suggestions about what as a group nationally you would see as essentially important risk adjustment variables?

DR. STREIM: Well, we did acknowledge that the ones that you said you sometimes apply are age, gender, zip code, race and diagnosis, there was some mention about severity of illness. And I know in the submission it did discuss the fact that readmission is not necessarily correlated with

severity of symptoms and we appreciate that as well.

But in terms of using this more widely, there was concern that there be an approach to risk adjustment that might include other aspects of the patients, the case mix in the system.

DR. WHITE: Okay. That's great. Thanks.

CO-CHAIR SUSMAN: I have two questions, and a possible motion. One question is, and this applies I guess as sort of an NQF policy, if Frank had - instead of his group had proposed this being from the point of view of a payer, and that that was the way in which this submission came in that a payer having access to information about all of their enrollees irrespective of site of service delivery that they would be able to look at readmissions, would that have made a difference?

I mean, you could have proposed

that as a measure and it would have - it would be essentially the same mechanics and it wouldn't have been susceptible to some of the criticisms.

DR. GHINASSI: Interesting point.

DR. WINKLER: Frank, this is Reva from NQF. I think there are still a couple of things. And that is the lack of information around the validity and the lack of risk adjustment.

So, those are both independent of data source. So, you may have addressed one issue, but perhaps not everything that was problematic for you.

DR. GHINASSI: Great.

DR. WINKLER: So, it would depend on how you could support that measure respecified from a different data source in terms of all of the rest of the sub-criteria.

DR. PINCUS: What's the issue about validity?

DR. WINKLER: Well, the fact is

they said that validity wasn't addressed or didn't need to be addressed. And so there really was nothing.

DR. PINCUS: But what would be - I'm trying to figure out what would be the analysis that would support validity.

CO-CHAIR SUSMAN: Well, I mean right now or with even a measure that was vetted at the insurer level, for example, one would want to know independently was there substantial readmissions that weren't counted that were leaked out into other parts of the system, is just one example.

I mean, there are all sorts of reasons why I could imagine that there would be substantial potential readmissions depending on the dataset available that might not -

DR. PINCUS: I mean, you can say that about almost any measure that you could -

CO-CHAIR SUSMAN: But this is more

important, I think.

DR. PINCUS: I'm just saying -

CO-CHAIR SUSMAN: Yes, I understand.

DR. PINCUS: I'm trying to understand like from the perspective of a measure developer that one tweak in terms of what they proposed and how they looked at it would have -

Anyway, that was my first question. The second question I had was what is happening with regard to readmissions at NQF more broadly.

DR. WINKLER: As we talked about yesterday, NQF is recently and continues to look at condition-specific 30-day all cause readmission rates. We've already endorsed measures for AMI, heart failure, pneumonia. And I think in this outcomes project, the main steering committee is looking at a couple of other procedure type measures. So, it's something that's growing.

DR. PINCUS: So, do you have a template for how those are done? Are they done consistently in the same way utilizing the same risk adjustment methodology and the same validity assessments?

DR. WINKLER: Yes. As it turns out, they all are coming from the same measure developer. So simply because of that fact they are done in the same way, but it isn't driven by NQF per se. It's the fact that the folks who are doing that work -

DR. PINCUS: Who is that?

DR. WINKLER: It's Yale University under contract with CMS.

CO-CHAIR LEDDY: So, is that the definition that's used in the 30-day readmission on -

DR. WINKLER: You got it. Yes.

CO-CHAIR LEDDY: So, perhaps our Committee could -

DR. PINCUS: That leads to my third problem which is a motion that NQF - sort of

the same thing we did for adverse events. That NQF incorporate within whatever efforts they are doing with regard to readmission as a measure, to investigate the possibility of encouraging condition-specific readmission measures to be developed and aligned with the other readmission measures in mental health.

DR. WINKLER: Do you mean the converse?

DR. PINCUS: I mean in that health - I probably just put the phrase in the wrong place.

DR. WINKLER: Well, I think that in just this theme of trying to keep things aligned, harmonized degree possible to minimize the chaos, that certainly we would recommend one of the recommendations you can make is for those folks within the mental behavioral health field who want to look at 30-day readmissions, you know, take a look at some of the other types of readmissions and how they are done, because they are - actually

they use payer data and they are extensively risk adjusted. So, I mean, there are some -

DR. PINCUS: So, I would officially make that motion that we do that.

DR. WINKLER: We can do it as a recommendation.

DR. STREIM: And just there wasn't any discussion yesterday or recommendation specifically that there needed to be tests of construct validity or anything like that. I think it was more the concern about the interpretability of data coming from a system that didn't really address case mix and the crossover between systems and readmissions.

I think that's different than validity testing, certainly.

DR. PINCUS: Anyway, I made that motion hopefully that -

CO-CHAIR LEDDY: Bob.

DR. ROCA: Well, if you want to vote on the motion first, that would be fine, but I have a question for Frank, actually.

And if I'm out of order, the chair will tell me.

But to Frank, you made the speculation that the relationship between something that took place on the inpatient unit and readmission would be much more compelling for a 48-hour readmission than for a 30-day readmission.

And that certainly makes sense, but is that something that you could say from your own internal investigations of these events that in fact that when you look at 48-hour readmissions, that 75 percent of the time you find that the ball was dropped on the inpatient unit someplace along the way, but at 30 days you rarely find that?

DR. GHINASSI: We see, Bob, we've seen trends. I would be misleading you if I said that at this point I could lay out a very nice graph that would show a clean distinction along those lines because some of this has been sort of our consensus about the way we do

work here.

We could certainly reexamine our own data with that lens again to kind of make that distinction, but I'd be misleading you if I told you there was a clean study we could publish right now.

DR. STREIM: I think the other thing if you're contemplating a re-submission at some point while I think the Committee recognizes generally that there is variability among facilities and readmission rates and that probably is a good quality indicator, that within your own system if you have that kind of data or if there are data you can cite from other studies just to support that, it's a process issue here in terms of being able to vet these measures.

DR. GHINASSI: That's a good point, Bob.

CO-CHAIR LEDDY: Okay. So, we are going back to Harold's motion that's on the table that everybody remembers, I'm sure, his

recommendation. Do we have any further amendments or comments about that, or are we ready to vote?

Okay. All in favor of the group supporting the recommendation that Harold recommended, raise your hand. Any opposed or abstain?

Okay. So, that was unanimous, Frank, since you can't see us with our hands raised. And so I would like to congratulate you on submitting a measure that has resulted in a recommendation to NQF that they look at 30-day readmission rates as -

DR. PINCUS: I didn't say 30 day. I said just readmission rates in -

CO-CHAIR LEDDY: Readmission rates. Okay.

DR. PINCUS: - a really parallel way.

CO-CHAIR LEDDY: But specifically for behavioral health.

DR. PINCUS: Right.

CO-CHAIR LEDDY: So, thank you very much for all your work in submitting this measure.

CO-CHAIR LEDDY: So, now we are back to 14.

Do we have the measure developer on the phone? Peter?

DR. ROY-BYRNE: Yes, I am here. I can probably be here for about another 15 minutes or so because I just heard about this today and I have to go over to the university to give a lecture.

CO-CHAIR LEDDY: Okay.

DR. ROY-BYRNE: I do have the other individual, Dr. Jutta Joesch, who kind of manages most of our quality assurance and really prepared much of this application and is even more familiar than I with some of the more technical/analytic aspects of the measure.

CO-CHAIR LEDDY: Okay. So, you're both on the phone?

DR. ROY-BYRNE: Yes, we are.

CO-CHAIR LEDDY: Okay. So, Ian, will you take us through the summary of Number 14.

MR. CORBRIDGE: Yes. I think we already did that.

CO-CHAIR LEDDY: Yes, we already did this.

MR. CORBRIDGE: There are some questions about -

CO-CHAIR LEDDY: That's right. So, Number 14 is -

MR. CORBRIDGE: This is the psychiatric-rated assessment of psychiatric inpatients' clinical status. Psychiatrist-rated.

CO-CHAIR LEDDY: Psychiatrist-rated assessment of patients' clinical status. Something like that.

CO-CHAIR SUSMAN: So, I think the one question, Peter, this is Jeff Susman, was, was this really an outcome measure or not?

The way it was presented within the submission, those of us who had a chance to review this more in depth wasn't sure that it was interpretable as an outcome measure for accountability purposes. We could see perhaps how it would be used within the process of care, for quality improvement, performance improvement, but the specification of the measure didn't allow me to understand how this would be an outcome measure that could be compared across institutions, across settings and so forth.

DR. ROY-BYRNE: Yes, I think that's a very good measure. Obviously most of our interest here has been in developing measures that could use dual purposes. And you're correct that measure was used more heavily for better understanding case mix, relationship of different conditions and sub-conditions and how they impacted level of care and program development, but we also do use the measure and repeat the measure and obtain changes in

these clinical metrics over time.

And I think it's a challenge in that those that kind of looked - struggled with was developing a measure that would apply to the very heterogeneous nature of psychiatric inpatients. And so that's probably even been a bit more of a challenge from the outcome dimension, but we do repeat this measure and we use it to understand, for example, the efficiency of length of stay, what's the degree of improvement that people have had and how that - and how efficient the improvement has been over the number of days they've been in the hospital.

CO-CHAIR SUSMAN: Thank you very much for that summary. We're talking a bit among - we're talking a bit among ourselves about making sure that we're all on the same page.

CO-CHAIR LEDDY: We've gone through so many measures. We're just sort of orienting ourselves back to okay, which

measure was this. And I think that was Luc and Sheila that talked most about this measure and could you just for even this group, give us a few-sentence recap about this, what you thought about this.

We talked mostly about how it was in or out of scope.

MR. PELLETIER: What I talked about before was that the tool - and we didn't know prior to this that the tool is used often in discharge, but the focus on discipline-specific measure is limiting.

How did you develop the tool?

DR. ROY-BYRNE: How did I develop the tool?

MR. PELLETIER: Right.

DR. ROY-BYRNE: Well, I actually developed the tool, I came here to run the psychiatry program actually in the early `90s, and we thought that measurement-based care would be crucial in us having the most state-of-the-art psychiatric inpatient program.

And I went around the country and talked to a whole bunch of different people and was a little bit deflated to learn that there were many individual measures that would measure different conditions. And it seemed to me totally unworkable and unwieldy to have a large, diverse set of measures for individual conditions particularly because individuals that are hospitalized psychiatrically have more than one condition.

So, that was totally not workable and I, therefore, attempted to work to develop something that would be more generically usable across a heterogeneous group of individuals that would tap into the major behavioral health domains that would affect these individuals and be relevant for both program planning, level of care and treatment.

And then also try to make sure that we would have concrete behaviorally-relevant anchor points so that these could be used by clinicians that were practicing on the

units and would not require the same kind of rating scale training that more traditional research instruments that are used in research studies would have.

And so we ultimately felt that a BPRS-like measure would be effective, but that that had the wrong anchor points. And then became aware that there was an adaptation of that by someone from the National Institute of Mental Health, Dr. Bigelow, years ago who I actually knew when I was there, but didn't know that he had had this. And then we tried to adapt this to our particular setting and do some reliability and validity testing on it.

And also create some additional measures that were not particularly part of this scale, but obviously would need to be part of any scale that would be used in an inpatient psychiatric facility.

And I think I had sent to you a number of the papers that were published that outlined the development of this particular

scale, but that's sort of anecdotally how it was done.

MR. PELLETIER: Is the tool being used anywhere else, or is it pretty much just your unit?

DR. ROY-BYRNE: Well, it's interesting. It's used across the entire program. We actually have three units here at Harborview. We have had some discussions with the state hospital here about whether they might want to adapt it, but in truth I have not engaged in much of a publicity of the measure to try to spread the word, as it were.

So, you're right. I mean, it's still only local use which obviously is a limitation.

CO-CHAIR SUSMAN: So, to use an analogy, in a previous discussion we were talking about the PHQ and demonstrating remission. So, it wasn't just a well-validated measure or instrument. It was using that in a way to get at an outcome.

And what I see, and I'm talking just as one member of this committee, what I see, the gap here is that it hasn't gone the next step to specify a measurement quality measure. We've got a validated tool, but we don't have a validated quality measure that's been developed from that tool.

DR. ROY-BYRNE: I could respond to that if I could understand a little better what you specifically mean since we have used that measure to measure several different kinds of outcomes. And in particular, our hospital has used length of stay efficiency to try to understand the degree of symptom and behavior improvement as a function of the time that someone has spent in the hospital.

CO-CHAIR SUSMAN: Well, I guess what I see on the submission is not a well-explicated numerator and denominator that would link with this use of the tool and could be then used, risk-adjusted across each of different populations.

It seems to me what has been submitted is concentrated and done a very good job of demonstrating the validity of the tool, but not necessarily the next step of the validity of the measure.

DR. ROY-BYRNE: Well, I do think, I mean, you're making a good point. I don't know that I can give you specific numerators and denominators. And, again, it is an instrument that is a little bit atypical, I'm sure, of a number of the measures that you might take a look at in the forum.

And, you know, we just were encouraged by our hospital to think about submitting this because they thought it was somewhat unique in what we were able to do with it.

I don't know that we've tapped all the potential uses of it in terms of outcome and particularly in terms of establishing bars or standards of what specific degrees of improvement would mean. And we clearly have

only used it in the public sector community hospital population we have here, which is a population largely funded by Medicaid and Medicare and uninsured and disproportionate share and much less frequently actual private insurance payers.

CO-CHAIR SUSMAN: So, for example, a quality measure might specify the use of this tool upon admission and discharge among some population of patients and demonstrate that there is validity, reliability and that there's some appropriate case adjustment. And then that potentially would be a very valuable measure.

DR. ROY-BYRNE: Right. And, again, I think we still have an interest in developing this further and even using it more than just one time, I mean, more than just one discharge rating. We are actually exploring getting it electronically utilized, because we have a growing, you know, an electronic medical record system here. And we're even

looking and in the process of analyzing to simplify the number of items so that it could be more repetitively administered in a more easy way by our clinicians, but that is for the future.

CO-CHAIR LEDDY: So, it sounds as though you have a great tool. And that potentially in the future you might consider submitting some measurement of outcome to this committee that would be garnered from the use of this tool if you would have a way to collect patient outcomes for the future.

DR. ROY-BYRNE: Again, I just have to keep assessing because - and I don't mean to be sort of a little bit dull about understanding this, but we do use this tool to measure the outcome of patients and the difference in how they were doing on admission and when they were discharged.

So, to me that does seem to be an outcome of sorts though I do understand your point that that has not been standardized as

a metric that could be easily interpretable across other populations.

CO-CHAIR LEDDY: I think that the issue is that that was - what you describe is not evident from what you submitted in writing.

What you submitted in writing is more about the tool and not the outcomes that you've derived from the tool. So, we would encourage you to - it sounds as though you might even be able to do that and potentially at a different time resubmit an outcome measure using this tool, but not to submit the tool itself, but a set of outcome measures or even one outcome measure that you could suggest be a valid, reliable measurement utilizing this tool.

DR. ROY-BYRNE: Yes. Well, we have that data already. We could formulate the answer to that and provide information in a future submission.

CO-CHAIR LEDDY: Okay. And that

would probably take a while for you to do?

DR. ROY-BYRNE: Well, yes, I mean, just because we're doing a lot of different things. We have the data. It's not like we need to collect it. We have it and it's computerized.

CO-CHAIR LEDDY: Okay. So, I'm sure that NQF is going to keep you on their list. We will ask them to for any future requests for these kind of outcome measures, and encourage you to submit your data. And there are people at NQF that can work with you prior to submission to make sure that the submission is in the direction that they're looking for.

DR. ROY-BYRNE: So, would we be able to get something electronically that would just tell us the outcome of your deliberations and what your suggestions and guidance are so that we could pursue this?

CO-CHAIR SUSMAN: Yes, that's part of the process.

DR. ROY-BYRNE: Okay. Great.

CO-CHAIR LEDDY: Thank you very much for your interest in getting on the phone today to discuss this with us.

DR. ROY-BYRNE: Okay. Thank you very much.

CO-CHAIR LEDDY: Okay. Thank you.

CO-CHAIR SUSMAN: Thank you.

CO-CHAIR LEDDY: Okay. So, we're going to vote.

The vote is scope. Okay. So, we're going to vote on scope.

Is this in scope as an outcome measure? Anybody who feels this is in scope, raise your hand. Anybody who feels it is out of scope.

MR. CORBRIDGE: 12.

CO-CHAIR LEDDY: Okay. Thank you. Thanks so much, Sheila and Luc, for providing that technical expertise.

MR. PELLETIER: People have done so much work and they're so passionate about what

they've done and I think we have to acknowledge that.

CO-CHAIR LEDDY: Oh, yes.

MR. PELLETIER: But we have to come back to okay, is this - is it or isn't it at this time.

CO-CHAIR LEDDY: Right. Okay. Carol.

MS. WILKINS: It just does strike me hearing how perplexed he sounded in the conversation and thinking about the conversation we had earlier today, this distinction between measuring outcomes at the client level, which I think this in many ways was analogous to the efforts in the milestones of recovery scale, that folks are really doing very, very creative work to take a holistic and to take a really different look at how to measure client outcomes at that level.

The distinction between that kind of outcome measurement and the accountability-oriented outcome measurement that kind of

clearly emerged from our discussions as the task for this group, I would think that it would be really valuable to go back and look at the call for measures and see if that distinction was clearly communicated to folks who submitted it. And particularly for those who were really strong on the thing that we weren't looking for, to be able to communicate in some way that really acknowledges the groundbreaking work that they're doing and that that just was not exactly what we were looking for.

CO-CHAIR LEDDY: I'm thinking also that maybe another step in the process might help.

Like with a lot of things like this, you have - like grants are often like this where you submit, you say well, I'm going to be an intended grant submitter. And they have that initial, yes, I'd like to intend to submit.

The reason they do that is so that

you not only get the mail, but you're invited to a bidder's conference where you get on the phone, you go from the A, B, Cs, basics of what we're looking for, people ask questions, because a lot of people were very confused by what we were looking for.

And a lot of times that kind of interaction might be worthwhile, and I know that Ian did reach out to people, but some of them were still confused. I don't know if they didn't reach you or -

MR. PELLETIER: I think we have to remind ourselves how long it took us to agree and understand, because we didn't - I didn't when I first walked in, in November. So, it took us -

CO-CHAIR LEDDY: Right.

CO-CHAIR SUSMAN: And I think the key issue here is that measurement doesn't equal measures. And the fact that there's a wonderful tool that measures things in a valid, reliable way is wonderful. I mean,

that really is the evidence basis on which then a quality measure could be built. But it's that second step that I think Peter just doesn't quite connect up with right now.

CO-CHAIR LEDDY: But it means we're not effectively communicating it.

CO-CHAIR SUSMAN: Well, I mean, you know, I think it's everybody's responsibility to be part of that conversation.

DR. WINKLER: I think there's a learning curve going on because we're seeing it in the other parts of the project as well, because there are - a lot of these tools are known sort of in the general realm of patient-reported outcomes.

And so when you use that term "outcomes," they're focusing in on it and I think the outcomes has been the part that sort of has ended up in the largest caps and the biggest bold. And for accountability and public reporting and performance, sort of NQF's reason for existence, may have been

overshadowed by the outcomes in big bold.

So, you're right. It's actually a communications thing. And also in the realm of mental health we were, thanks to you all, reaching out to people who probably were not as familiar with the work we do whereas the more mainstream.

For instance, you were talking about your bidder's conference. We actually have had measure developer's conferences, invite a hundred folks to come in and tell them the story, how to do it, what the, you know. And I think the last one was last September.

So, I mean, you know, we don't do it every week, but you're absolutely right. It's an ongoing effort in recruiting new people who haven't participated before. There is a learning curve. All of your comments and observations are absolutely on target, and it's an ongoing effort on our part to bring people up to speed in exactly what we're doing

and what the focus is.

DR. HENNESSEY: Reva, so in the future the people who submitted measures here, will they be invited to one of those conferences?

DR. WINKLER: We will put them on the list, and they will, you know.

DR. HENNESSEY: Whether they come or not is their choice.

DR. WINKLER: Right. I mean, that's how we create the list of invitees is anybody who somehow connects with us in some way, shape or form. So, submitting one is a real good place to start.

CO-CHAIR SUSMAN: I wonder if an even more targeted approach, and it's right along the same lines, is to say to people like Peter, you know, you got this all over, you got such a wonderful instrument here. We'd really like to work with you. Bring your stuff for - let's call it a measurement to measures conference or something along that

line that gets a little bit more specific.

It says okay, bring us your stuff. Let's work on real world problems with real world measurement and try to use that as a case example, if you will.

Again, it's a wild thought. I know there are a lot of logistical challenges to do something like that, which fortunately I don't have to worry about.

DR. WINKLER: Well, actually I think one of the benefits of NQF membership is being able to hook up with other members who do this. And that's one of the avenues that is quite potential without us being necessarily right in the nexus of it all.

MR. CORBRIDGE: And I just wanted to point one thing out. While Rita is not an NQF staff member, she actually brings to my attention that there is a measure developer's conference or call on April 19th. So, there are engagements or processes for that.

(Off record comments)

DR. STREIM: There is a Catch-22 though and I think Harold made a comment before that kind of rung true that a lot of people who are well poised to be measure developers, that's not their title and their day job. And they don't even think conceptually about it because they haven't taken Measures 101.

Measurement 101, maybe, Tool Development 101, but Measures 101 is about putting it all together. And actually the fact that you had to do the concept development for this group here says something about this emerging field. It's an evolving field.

And I think that I can think of lots of colleagues who do work that's critically related to the stuff we're talking about, but they've never put together a measure, they don't really know all the principles and the basic criteria.

But even when you put out an April

19th call for, you know, get on the phone and join in the teleconference, if they haven't already self-identified as someone who perhaps could be working in this field or could contribute to this, then they're not going to join the call.

So, the Catch-22 is to figure out how to more broadly educate - I think we've identified three sort of target audiences; people who work in industry and do proprietary stuff, people who work in academics, and there are the clinical researchers and the health services researchers. And I think that getting at those folks is just with some basic concept building.

It's more than communication. It's they've got to get the concepts in their head. And the second element is incentives. We're not paying them to do it. They get paid in their day job for something and they have to be able to perceive that there's some incentive to submit, because it does take

work.

CO-CHAIR SUSMAN: I mean recently there was the NIMH Implementation Conference that I attended. That would be a great audience to have a workshop or two around turning measurement into measures. It's the right audience in that this is about implementation science and there really is an evolving science here.

So, I think thinking about how to connect at least with the research community that might be interested, engaged here is probably something that at least you could explore. I recognize there's only so many places and so many things you all can do.

DR. STREIM: That brings to mind one interesting target group which is program officers at the NIH. And even at the foundations, one of the things - when they put money into research, they want their dollars well invested.

And what that means, in part, is

they want their investigators to have a product at the end that can be disseminated widely and translated into clinical care and improvements in care.

And so the funders who are, I mean, that's where the, you know, follow the dollars, they're basically providing the salary support for the people who are doing this work. And if those people then understand that my boss who is my program officer expects me to do the dissemination step after I get my results and I publish them and all that, I'm not done, then I need to think about the next step. How can we move this into the field at large.

And I think the program officers when they write their program announcements even when they use the word "dissemination," they don't really get very specific and maybe they should include the example of such as, you know, submitting measures or establishing these outcomes as measures for whatever.

I think that that may be what gives you some leverage to get more people on board with the whole enterprise.

CO-CHAIR LEDDY: Someone on the phone wants to say something.

DR. THOMPSON: Ken Thompson back again. I apologize for my absence, but I wanted to just reinforce the gentleman who just spoke and what they were saying.

CO-CHAIR LEDDY: Joel.

DR. THOMPSON: Because I just actually have had a couple of conversations with Tom Insel and with folks at SAMHSA and with Pam Hyde now at SAMHSA coming in with a particular focus on a couple things.

One is telling the story about the path use for mental health services to help people recover and to have lives that they want to live. One of the profound issues that we're facing which you guys have been talking about for the last two days is how the heck are we going to measure that and how do

services show that they're doing that. So, she's got a measure focused on data.

Tom Insel is increasingly interested in the whole issue of dissemination and implementation. And I think it may actually be a useful time to consider some kind of a public-private partnership looking at the development of the kinds of measures that at least from what I heard over the phone we're sort of in need of and have some approximations of but have a lot of work to do yet to get there.

DR. KAUFER: I'd just like to comment. I think what has just been said makes perfect sense. The problem is I think one of the reasons why we're facing the challenges we are, why there is such a dearth of material that's usable that's relevant is because historically these are not the kind of endeavors that NIH has supported.

In fact, it has been exactly what they have not supported. They have

specifically not wanted to fund these type of proposals and not want to provide salary support for people to do this kind of work.

This historically falls more under the problems of AHRQ, which I think is probably more aligned philosophically with what the goals and aims are of this.

But I hope it's not to say that NIH - NIH should be more involved in this. And I think the tide has turned with the renewed interest in translational type of research. I think this piggybacks well onto that. And I think hopefully the tide will come in as far as NIH waking up to the importance of these kinds of projects.

CO-CHAIR LEDDY: I think the movement of payment reform toward performance-based payment or results-based payment will also incentivize this to be considered important for development.

CO-CHAIR SUSMAN: And the whole NIMH, this was the third conference on

implementation, dissemination research. Francis Collins was there talking it up. Everybody is talking about T3\T4 research.

I think there is a much more fertile ground at, at least NIMH than there ever has been in the past. And it's probably time to more formally try to cross that divide, if you will.

I think there's some real money out there for this type of research and it is not at all beyond the purview that was discussed at that conference of quality measure development, implementation and looking at community health improvement overall.

DR. THOMPSON: Don't leave SAMHSA out of that conversation because we're actually much more concerned about the pragmatic realities of doing it and using it in a productive, useful way.

So, it's got to be developed, but we also have a need to have it done.

DR. WINKLER: Right. In response, I think it's a good segue into sort of the Part 2 of the work for this group in terms of trying to come up with that agenda, if you will, in as granular terms as possible.

I mean, it's very easy for any group to say we need more outcome measures for depression, and just walk away from that.

The question I think that would be most helpful moving forward and is part of what we're hoping to see out of this, is to be a little bit more specific. And as a result of the discussions of some of these measures today, you came up with some, you know, this is the way it is, it shouldn't look like this, it should look like this instead.

And to the degree that we can create a set of recommendations on types of measures for the different elements of mental/behavioral health, substance abuse, wherever you want to put the parameters around it and dementia, if you recall back to the

work you did in November, I mean what I can envision and what other steering committees are envisioning is like for the area of dementia we have nothing. So, the boxes are blank, but we have this whole column of types of measures.

Do you have that, Ian?

MR. CORBRIDGE: I did.

DR. WINKLER: You had it yesterday. But if you remember, the first one was about symptoms. Outcomes of symptoms.

Maybe it's not applicable for dementia. It might be for depression. It may not be for schizophrenia, whatever. But then other things are functional status, you know. What's a functional status outcome for Alzheimer's disease or dementia? What would that look like? How would you describe that kind of a measure?

So, the question is as we go down the list of the types of outcome measures, what might they look like? What are the

salient, important elements of those types of conditions?

And for this group, we'll have several types of conditions. We'll have the depressions and then however many serious other mental health conditions, schizophrenia, bipolar, anxiety, however many you want to include.

But it's not just one outcome. There are a whole variety of types of outcomes. There's not going to be a measure for every box, but there should be several types of outcome measures for each of these categories that you could begin to envision based on the conversations, based on your lack of enthusiasm for what we have so far.

It's like what would have made you happy? What were the measures that should be on the list that didn't come in the door? That's what we're asking you to really think about and use your expertise.

You look at the list and go yuck.

What would a good list have contained? What should be the measures on that list?

So, here is just a printed version. But if you all remember, this is what we put out in the call for measures. So, there's a whole bunch of types of outcomes. Symptom outcomes, functional outcomes, health-related quality of life or well-being, change in health behaviors, social determinants to health in a built environment particularly around populations, but also individuals. Service utilization, we saw some of that with the - oh, you've got it. Great. All right.

Patient and care giver experience, we've seen some of those. Direct physiologic measure, you know, not sure that's necessarily going to be most useful in this group. But drug screening, for instance, or some sort of physiologic assessment.

Non-mental health outcomes, I think this is something Harold kept going on and on about because of the overlap, the

considerable overlap between patients with mental behavioral health and other things. And the two are intricate. You can't separate them out in the care or the overall management of the patient.

So, I think what we're looking at are gaps. We really would like to work with you to be able to come up with a reasonably specific - it would be very easy to say oh, yes, we need more measures of this and that be the end of it, but I think we - this is the opportunity to try and give us something that would look more like the description of a measure or at least closer around what population and what element are you trying to assess.

We don't want you to spec it out, we don't want you to develop a measure, but, I mean, what is it. In what population of patients, what outcome is it that you think would be very important and useful around symptoms, function, experience, safety,

recovery?

CO-CHAIR SUSMAN: I think there's some themes that we've sounded throughout our couple of days here. One is to try to align mental health measures with the NQF priority measures and a common set of definitions that apply whether it's mental health or physical health, that it's an arbitrary Balkanization of the patient. Patients are whole beings.

DR. WINKLER: Yes. And I think to lead off your set of recommendations with something just like that. And I think to support that, one of the ideas you've given me/us is the idea of going back and looking at all of our more general measures and see which ones actually already include mental - or don't exclude mental behavioral health patients, but also let's look at the ones that maybe do, but should they.

CO-CHAIR SUSMAN: Right.

DR. WINKLER: That's the question. Should they be excluded? Could it be more of

a simple fix of just including them instead of excluding them? But rather than, as you say, maintain the Balkanization, do your best to break down the borders.

So, I think that's one approach, but then there are going to be things that are specific to these particular patient populations that you will want to look at that are unique.

CO-CHAIR SUSMAN: I think the other area that we've touched on is this idea of coordination of care hand-offs, and clearly that's another NQF focus.

To think that somehow we can arbitrarily separate the care in a hospital, a nursing home, the outpatient sector, the mental health community, I mean, it's kind of crazy.

I mean, people touch on multiple communities of healthcare providers or providers of service. We need to think about measures that can be applied across any of

those and make systems accountable for the outcomes no matter where those services are delivered.

DR. HENNESSEY: What I think about from a public health perspective is that many of the things that we deal with as clinicians particularly, for example, when you think about trauma, have their roots in violence and other more public health measures, so to speak. And we haven't really looked at that or talked about how those could be used in some way to help promote, for example, decrease violence, which would then promote less trauma.

DR. WINKLER: Yes, I think if you recall in our November meeting, one of my colleagues, Bonnie Zell, came in and we were talking about population health. And Bonnie is leading the work around population health for NQF.

And I think one of the messages from this group that I can certainly transmit

to her is don't exclude mental and behavioral health. Include them. Bring them in and don't separate these areas. And to the degree whenever possible, keep it all inclusive.

MS. JAFFE: And I'd like to piggyback on that a little bit in regards to some of the chronic disease management initiatives that are going on and the similarities between a lot of those initiatives and how we manage some of the more chronic mental illnesses. I think there are a lot more similarities than differences.

With medical home and the inclusion of behavioral health integration into medical home, I would really push that we try to be one whole system and really have very few carve-outs.

DR. HENNESSEY: I think along with that is we talk a lot about what are the measures from a psychiatric perspective that we want to include for people with behavioral health conditions, but the other part of it

is, is what are we doing to promote their physical well-being.

And I think that often gets overlooked and we should be looking at those as we look at measures.

DR. WINKLER: Yes, that was one of Harold's big points.

DR. HENNESSEY: Yes, that's a very big concern given the morbidity and mortality that we're seeing with the SMI patients.

MR. PELLETIER: I think another place we can look are clinical practice guidelines.

So, we have a lot of them. And clinical practice guidelines are evidence-based, typically, and they do talk about excellent care. So, to grab a measure out of those would probably be useful.

CO-CHAIR LEDDY: So, can we review which measures we actually endorsed?

DR. STREIM: Actually, did we do retention? Did I miss that?

CO-CHAIR LEDDY: Yes.

CO-CHAIR SUSMAN: Yes.

DR. KAUFER: One of the real important take-home lessons for me is that the measures that we endorse from the Minnesota group about the time, the six month and 12 month remission of depression, I talked to them and they said the key thing, they work with payers.

This is through a healthcare system and this was motivated by payers and done in conjunction with payers. And I think to me that's a really important take-home point that ultimately if you want something that will be useable and feasible and desired, that the payers are ultimately going to demand these types of assessments that don't exist now.

So, they need to be part of the - they need to be involved in the development of these kinds of tools.

CO-CHAIR SUSMAN: Another push you

might think about connecting, and perhaps you already do, is with places like Robert Wood Johnson with their aligning forces effort. I mean, we're one of the 15 communities across the country, AF4Q. And clearly measuring outcomes on a community basis and doing it in a multi-stakeholder including payer participation is something that we have an advantage over a lot of parts of the country.

And if we could make sure that we advocate as a group and NQF advocates for measurement that includes behavioral and mental health outcomes, I think could be very important and many of these communities are doing really wonderful work. And it's much more comprehensive because it's on a population basis.

DR. THOMPSON: I just want to throw two thoughts out. One is there is a unique problem and I'm not sure necessarily that we are only folding ourselves into the medical home. I think actually in some ways we're

going to have to help steer the direction of the medical home.

And I'll just use one way to think about an idea that the mind and the brain are the executive organs of the person. And one of the issues that you're going to find I think with the stuff that we were talking about today is what we're trying to do is to increase in the care of somebody, we're trying to increase their capability to move themselves to make the decision, do the choice and implement the behaviors and what they have to do to make their lives be what they want them to be.

And that in some way suggests that there are so many possible things that people might want to attain than whether or not we're controlling their heart, their CHF or their asthma or whatever, but they're actually attaining things with their new capabilities or their recovered capabilities.

And I wonder sometimes if maybe

our system might not need to be based on actually asking people what it is that you hope to attain in this period of treatment, you know, where would you like to go and can we work with you to help you get there, and identify that as the outcomes, maybe suggest some domains in which they would like to be moving along the lines that we've sort of had outlined, and use it more in kind of an emergent sense.

So, that's just maybe a totally bizarre idea, but I wanted to throw that out because I think it fits with the recovery-oriented approach.

CO-CHAIR SUSMAN: Yes, I was just going to say it seems like it's part and parcel to the recovery model.

DR. THOMPSON: Yes. The second issue, and I think Harold can - if he hasn't talked about this, I'm sure he will at a later point. We're looking at how other countries are doing this. And, you know, measures

particularly of social inclusion which are the measures that most people are actually being able to take advantage of and participate and be in that community of the whole in some way that they feel comfortable with, that those are measures that are being developed elsewhere around the world and we cold probably profitably benefit from looking at them as well.

CO-CHAIR SUSMAN: I think integration with what's going on in the PCPCC and patient-centered medical home efforts, there's a whole behavioral health group that have participated in off and on where a lot of people are really excited about the integration of mental health into the patient-centered medical home, and yet are struggling to find measures that integrate easily and reflect the sort of outcomes we have discussed over the last couple of days.

So, having some more formal interaction, purposeful interactions and

thinking about okay, well, if we had some ideal measures, what would they look like, what would be their attributes, how would we be able to use them to demonstrate outcomes that are clearly the sorts of things that we want to get to.

DR. WAN: I just want to get it back to the earlier comment about working or collaborating with the payers when it comes to relevance of some of the measures and execution of those or implementation.

I know that there's other organizations out there from the payer side not so much - but indirectly the Pharmacy Quality Alliance and how potentially NQF could work with PQA or even NCQA, because they all have their own measures that they develop as well as endorse.

DR. WINKLER: And we have worked with both of those groups extensively.

MR. CORBRIDGE: And I guess one comment just to follow up with, George and

Jeff, what you have talked on, one, I guess, benefit of being an NQF member is that there are different organizations who are part of NQF and we have different councils. There's eight different councils here at NQF.

And at some of our meetings, as well as other times, we try to make sure those different councils are working together and collaborating.

And so I know one council that I sit on as a liaison is the Public Community Health Agency Council, I've had an opportunity to meet with the providers or payer councils. And so I think that was a very informative discussion and dialogue. And so those are some of our efforts in trying to move forward and really facilitate those discussions.

And actually AFRQ is a part of that. And Diane who presented for the Minnesota measurement, she is actually a co-chair on that council. So, I know those discussions and talks are really trying to

move forward and really make sure that every member is working together.

DR. STREIM: I know that we asked about this back in November in terms of NQF membership, but my understanding is that it's mostly other organizations that represent relevant fields.

Is there any kind of individual membership or sort of a smaller group level of participation in terms of not just NQF, but in terms of participation in associations that deal with quality improvement?

DR. WINKLER: If you look at the NQF membership, you're going to see organizations of all sizes. NQF does not at this point, doesn't have individual members, but some of our members are of organizations that are essentially one or two folks.

They don't have to be gigantic. Particularly some of our consumer organizations, some of those groups are very tiny. They're a handful of part-time people

kind of thing aside from their executive director or something like that.

So, size is not a qualifier by any means.

DR. STREIM: Where I was going with this is you're talking about the April meeting where individuals can call up and participate in a meeting.

DR. WINKLER: Sure.

DR. STREIM: And I was actually thinking that if we're trying to help people sort of acquire the concepts that relate to measure development and stewardship and it's such an incremental process and different people work in different corners of this, some are doing a validation study, some actually develop a tool, but that's not the measure.

And if all the people who are sort of cogs in that incremental process that bring us to the point where somebody can actually submit something where there has been validity, reliability established where

they've actually looked at feasibility, usability parameters and now it's ready for prime time and you can get a submission that's really meritorious that is worthy.

I think what we're getting, the reason we're getting such weak submissions is because people don't get that. So, how can they learn it?

Well, one thing is to have a phone conference. But maybe on a more aggressive scale, to think about having regional/national meetings of - I'm basically saying start an association of, you know, call it whatever, quality improvement that could be the brainchild of NQF and actually see if you can get people to come and present their work even when it's in developmental stages. Talk to one another. Foster the collaborations because there are all these people who are on someone else's payroll.

And as a non-profit you're getting grants to do stuff like this, but not to

actually develop those measures. If you're going to rely on the field going forward to do that, then you need an army.

And I think that in a way it's the stewardship of that village, but a village needs a town hall and a town forum for bringing people together who are part of a community that can collaborate and create this.

I think that the scientific community and the corporate health community aren't really there as a, you know, the collegiality that you need to have productivity isn't there.

DR. WINKLER: Joel, just one observation I would make is I think different sectors within the healthcare arena are in different places on a continuum.

DR. STREIM: Yes.

DR. WINKLER: Because I would say that in some areas they are very, very much ahead of, you know, measurement is an everyday

thing. The developers who develop the measures have been doing it for years and they know what they're doing in some areas.

But I think there are areas within healthcare and perhaps mental and behavioral health might be one of them, where they just aren't in that realm. They're trailing much farther behind.

And also I think the silos of the healthcare system, you don't necessarily benefit from what's going on in the general medical, that sphere which I think might have a little bit more of that or be ahead of the game compared to your experience.

So, the question is how do we break down the silos, how do we bring in the folks in areas that have been lagging behind and kind of pull them in?

And it's a struggle and I think it's been one of the roles NQF has tried to play with our twice-a-year meetings. We bring people together, we talk about measures, we

talk about measure implementation, how they work, what worked, what people are doing in development and things like that.

It sounds like there's always need for more.

DR. STREIM: It was very informative for me when I got my subgroup assignment, workgroup assignment, to actually see some of the stuff that the NQF staff had inserted on existing measures and related measures to see how there really is stuff that's well-developed that's really state-of-the-art.

And I was thinking to myself reading these, if the measure developer who submitted could see that, it's all the background stuff that if they were really on top of the field and knew about this, would have been in their submission.

You guys had to add it, but I think that it would open their eyes and it's sort of like modeling for them. This is what

it looks like when it's done well.

And how do you learn to write your first grant? You read somebody else's and get a mentor to help you.

DR. WINKLER: We heard from the very early years of NQF as we evaluated measures, that one of the key elements was feeding back to measure developers the rich discussion and the elements so that they could understand more what the issues were.

And, again, that's where we've arriving at this, you know, the measure evaluation criteria are as detailed as they are now, but they certainly weren't six, seven, eight years ago. It's been an evolutionary process.

And so for people who are just now entering the game it may be a bit on the overwhelming side because they haven't been part of that growth. So, I really do appreciate the difficulties that folks are trying to learn this because the learning

curve is steep.

This isn't stuff that is either intuitive or used by average folks every day, so it's a relatively specialized area that it's a bit of a struggle to learn it.

DR. MANTON: When people submit like in December when they submitted an intent to submit, did they get a copy or somewhere along the line did they get a copy of this?

DR. WINKLER: It's actually embedded in the submission form.

DR. MANTON: Right. But I'm wondering if there's any kind of interpretative guidelines that go along with it. Because I think for people who are really familiar with it, it makes perfect sense. I think for people who are not, some of it needs translation.

DR. WINKLER: Yes, and there is actually the translation document that goes - the report when those were issued. And it runs, I don't know, 20, 30 pages where, you

know, why was this chosen and what were the discussion points around different elements.

And that is available and I think we do direct people to read it. It's on our website as a document that's available.

MR. CORBRIDGE: Yes, I mean it is one of part of the kind of help toolboxes that measure developers have on our website.

DR. WINKLER: Right.

MR. CORBRIDGE: I think kind of going further to your point is that we are looking at possibly doing some webinars or online education programs to really try to help, have something online that people can access that helps them walk through the process, because that is something that we have for -

DR. MANTON: That's exactly what I was getting at is once people submit a letter of intent or whatever or even if it's people that you know might be interested maybe not wait for them to do that, but to offer a

webinar that people could walk through it so that you don't get so many that are missing pieces.

I think your chances are going to be better at getting something that probably meets the criteria.

MR. CORBRIDGE: And NQF, I guess, is only ten years old and so as Jeff said we still have a lot on our plate and it's still growing, but that is definitely something that we're working on. And we actually have an education department on this floor, but those are the type of issues that they're looking at.

DR. MANTON: Webinars work really well.

DR. BOTTS: Do they also get a copy of a complete submission of this is what a good one looks like?

As you said that, I thought when you go online to shop or something and you hover over an item too long and there's an

immediate iChat thing that comes up, like you can't pick out that pair of shoes, so would you like to speak with me about it?

(Laughter)

DR. BOTTS: That's almost what needs to exist as you struggle with an individual item, perhaps, Ian, you would pop up and say let me help you walk through this.

MR. CORBRIDGE: And we do have dialogues and follow-ups with measure developers from the list that came in under the intent to submit. We do then have conversations with some of the developers, question what do I need to put here, how do I fill this out. And so those dialogues do happen if the measure developer is willing to engage in that.

And I guess just one thing, Joel, to kind of follow up where you were going, I know this probably doesn't answer completely where you want to get, but I did meet with individuals. I don't know if the Steering

Committee is aware of this group: National Association for Behavioral Health.

Here, actually, they're a member of NQF. And so one thing that NQF is willing to do for members is being willing to act as kind of that convenient entity for members, I guess for entities who are members.

And I was speaking with Rob Miller who is the president there. And as an organization who really is wanting to start looking at quality improvement in measurements, they were left with where do we go from here. And they were really trying to look for, you know, where are other colleagues out in the field that we can connect with, and so NQF was willing to serve as that really convening body for that purpose.

And I know one thing I've been working with membership is trying to find a list of people who they need to be speaking with, and I think that's hopefully something that we'll be able to get from every member of

the Steering Committee is are there individuals or entities out there that developers or individuals within this field who want to start looking at quality improvement need to be speaking with.

DR. HENNESSEY: Yes, I would just say that when you do the webinars and do the training, I would incorporate specific examples from behavioral health or other folks because my experience is that our field in general tends to be less trained I think in population-based and epidemiologic approaches to care.

DR. PHILLIPS: Actually, I have kind of a related point. As you talk about giving feedback to members, and I don't know who are members of National Quality Forum or who you connected with, but psychometricians, I mean, there's groups of researchers out there who I'm sure you could hook people up with.

In looking at this, my background

is in clinical psychology, I have extensive background in psychometrics, and what I saw in most of these was appalling as far as that goes.

And so being able to as we've identified these areas and we have people who are interested in developing them, hook them up with people who do that kind of research and can maybe aid them, it ends up benefitting both.

Folks like this are always looking for research projects. Maybe not always, but you could probably find someone interested. Even graduate students who would be looking for some type of project along these lines would be an amazing service to provide to people.

DR. STREIM: I think, too, this whole issue of extending this to people who don't see themselves as measure developers, but also who don't see themselves as working in the field of quality improvement or

measuring quality.

I think that when Glen was talking about all these people who are out there, I can think of colleagues who do lots of good stuff. They develop tools. They measure clinical outcomes. They do assessment. They look at care processes, health services, delivery and they're not - but they wouldn't self-identify as working in the area of quality or quality improvement, but they do.

The joke 20 years ago when I first got into - or 25 years ago when I got into geriatrics was - I was working at the interface of medicine and psychiatry and working with a lot of older adult populations and the other health professionals who take care of them, and then realized, gee, I guess I'm a geriatrician.

But I think - and actually I had a mentor when I was a fellow, who was a hematologist oncologist who did work on tumor senescence, but he didn't think of himself as

an aging researcher. And he ended up ultimately after people pointed out that you could do these collaborations and work in this area and we need somebody to be a leader of this group, he ended up as director of a geriatric research center. So, he was not originally a card-carrying geriatrician, but he did enough work in areas so relevant to tumors and aging and immunology and aging that it was a no-brainer in terms of taking a fairly senior investigator and sort of retooling his career - actually, not so much retooling as just re-conceptualizing. And he ended up going to some different meetings after that.

So, I just tell that story because I think there are a lot of people out there who are working in fields and doing that incremental work that's so clearly related, but they're not even beginning to think of themselves as belonging in this enterprise.

And I think that's a challenge

because you can't just put out a call for measures, and you can't just say we're working on quality because they're not - quality is not something they identify with.

So, how do you get at that? I think that's something that takes a broader kind of conceptual reeducation of - and maybe looking at certain target groups. I'll have to think more strategically about how you would get at those folks, but they're out there.

And I think that there's, I mean, I think Glen was saying there's a ton of great work going on that really fits. We're just not tapping it.

CO-CHAIR SUSMAN: One area where I think NQF and mental health could better intersect is on the overuse/underuse waste. We talked a little bit that is because you keep somebody in treatment for three visits, for argument's sake, a good thing, a bad thing or something in between? And the reality is

we don't have very much good data about that.

And I think to try to align the broad themes that NQF is pursuing and that are being pursued in the national healthcare reform debate, would help move our field of mental health forward as well.

The other comment I wanted to make was NQF often has a theme or at least some subthemes at its annual conferences and member meetings. To highlight mental health at one of those very specifically, I think would help really move the field along as well as bring some of the experts in this arena together and it would be a relatively accomplishable sort of task.

CO-CHAIR LEDDY: Our next step is to do Task 2, which I don't think we have time to do today, which is gaps.

Do you think we have time?

DR. WINKLER: Well, I think what you've done, you've been doing that for the last 30 minutes in many ways. It's been

embedded in a lot of ways.

And I think you've put in a really good two days worth of work. And I don't know about you, but my brain is tired.

And so I think that with the very richness of what you've discussed that we're going to be able to begin to draft something, that we start to summarize some of these concepts and formulate it in a way that will allow you to look at it critically and say okay, let's make it this and this and change it here and change it there rather than start with a blank piece of paper.

I think you've given us enough good ideas to start and to build something, but then you can go back and react and edit and change and embellish and do whatever you want to it.

And I think until we get something a little more solid for you to work with, it may be not the best use of time right now especially after you've spent two solid days

doing the other stuff.

Just in terms of where we're going to go in next steps is we will be writing this up in terms of a summary. It will include the votes, discussion points and all of that. You'll get to see it and be sure we captured it accurately.

Additionally, this is being recorded and transcribed. And so the transcription, the recording we'll share with you and it will be posted on our website. So, you can relive these two days any time you want to.

So, I can tell you that that transcript is actually vital to doing these write-ups because we can go back and use your words. I use your words and quote them all the time. So, that's really where we're going for.

And most of your decisions I think are pretty solid. I don't think we have a lot of follow-up in terms of the measures.

Anne, you were going to review which measures the group ultimately decided to move forward.

DR. MANTON: How many did we get?

DR. STREIM: I have five that we endorsed for recommended, and 13 that we deemed.

CO-CHAIR LEDDY: How does that compare to some of the other ones?

DR. STREIM: I was trying to remember. We did not recommend retention, right?

CO-CHAIR LEDDY: No, we did not.

MR. CORBRIDGE: I think it was four. We had the three measures submitted by Minnesota Community Measurement. That was Measure Number 11, Depression Remission at 12 Months; Measure Number 12, Depression Remission at Six Months, and that was - the other measure that was the real, I guess, linking measure was Measure 22, Depression Utilization of the PHQ-9 Tool. And as a

group, it looked like we were voting on that to link to those other two measures previously discussed.

The last measure that the Steering Committee ultimately decided to push forward was Measure Number 47. That was the Inpatient Consumer Survey that we discussed a little bit.

DR. STREIM: Oh, I was counting falls, but that wasn't the falls as submitted. That was the recommendation to -

DR. WINKLER: That made several formal recommendations.

DR. STREIM: Okay.

DR. WINKLER: And it will be important for you all to review as we go back and write those out, because they are just as much the recommendation of measures to be endorsed, your recommendations for some other things because there are implications around, say, the falls measure, the serious adverse events measure. Those sort of things are very

important outcomes of what you've done here.

Not only the summary of this meeting, we will then be turning it into a draft report that will go out for public comment. And so that's Ian's main chore for the next couple of weeks.

With any follow-up, sometimes there's some clarifications. You had some questions. Are we doing the follow-up? And I believe - what's the schedule for going out for public comment? Early June?

MR. CORBRIDGE: You know, I don't actually have it open right now.

DR. WINKLER: Yes, I think it's early June. So, we've got a few weeks to kind of do some back and forth and review and get the wording right and all of that kind of stuff and get it edited.

But it will go out for a 30-day public comment NQF member review. We get comments. Sometimes we get a hundred, 200 comments. Sometimes we get 800 comments. It

really just - it's highly variable.

And so we will then be looking to respond to each of those comments and circle back with you to help us do that and perhaps comments might change some of your recommendations. Who knows. There may be enough feedback that you want to reconsider things, and that will be the purpose of that.

So, then after that we will - after that's been shaken down, all the revisions made, we'll then take it out to NQF members for voting. Those votes then go to the Consensus Standards Approval Committee and the board of directors with anticipated endorsement of the measures by November, I believe it is.

So, that's kind of where the rest of the year comes out. I do think, Ian, were there any other follow-ups you wanted to mention?

MR. CORBRIDGE: I have two other points I want to talk about, but if you want

to finish -

DR. WINKLER: No, I think that's what you can expect from us. And we'll try and keep you posted on anything as it's happening certainly to let you know.

DR. HENNESSEY: And Alzheimer's we're going to get some -

MR. CORBRIDGE: That was one of the other points I was going to follow up on. So, for those kind of who are interested in participating in an Alzheimer's/dementia workgroup, for those who are here, if you want to just briefly talk before you leave, I think Katie said that she would be willing to head that subgroup up. So, I've been working with her. I know she's actively soliciting some outcome measures that she's identified out there. So, I can share that with this small workgroup, who wants to participate, and we can move forward from there.

And I think this work will really have to be done, you know, it's not going to

be another in-person meeting, but this will be done via phone conference or online voting if we do get measures in terms of reviewing.

I guess overall we'd very much like to thank everyone for your participation. Greatly appreciate it. It's been a wonderful experience.

And one thing that I would greatly appreciate as well as I know other members or entities as part of NQF, if you do have suggestions of individuals or entities who we should be working with or having a dialogue with, I would greatly appreciate it if you could just shoot me an e-mail. Whether it be a name of an organization or a specific contact somewhere, I think that would be very informative as we try to move forward and work through some of these gaps just to make sure that we have the right people at the table or are helping to educate the right people in the NQF process.

So with that, thank you very much.

DR. STREIM: I just want to say I think Jeff and Tricia did a great job. And particularly with some of the measure developers who while we were there sort of criticizing hopefully constructively, I think the two of you did a particularly good job of being encouraging and supportive. And I think that was an important ambassador role.

CO-CHAIR SUSMAN: I want to thank all of you because you made our job very easy as co-chairs. I think the high quality of this group, your willingness to share your opinions and the immense, immense knowledge base you bring was just spectacular.

I really appreciate the opportunity to work with all of you and of course the NQF staff.

CO-CHAIR LEDDY: And the workgroups that we were assigned to, the small workgroups really gelled and provided that kind of cogent expertise. That was very helpful.

MR. CORBRIDGE: I guess just one

last point. If you do have those NQF measure evaluation forms and you're not going to use them again and you're just going to recycle them, we can actually take those back from you and we'll reuse them at another Steering Committee meeting. So, we'll save some trees. So, thank you very much.

(Whereupon, at 3:17 p.m. the meeting was adjourned.)

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