

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

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

2 (9:31 a.m.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 MR. CORBRIDGE: Yes.

4 CO-CHAIR SUSMAN: Yes, we can.

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

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

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

19 So, seems like something anyway.

20 CO-CHAIR SUSMAN: Harold.

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

1 are particularly applicable to older people?

2 So, that's one question.

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

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

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

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

1 of NQF typically. Even though we try to reach
2 out, there's a lot of people that just don't -
3 -

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 DR. PINCUS: Do they have mental
14 health measures?

15 DR. WINKLER: They can have mental
16 health measures.

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

19 DR. WINKLER: No.

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

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

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

11 So, we started looking early on
12 and talk -

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

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

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

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

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

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

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

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

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

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

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

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

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

22 MR. CORBRIDGE: The window of

1 opportunity, I think, could -

2 DR. GOLDBERG: There's no right
3 answer.

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

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

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

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

1 contacts, we make that initial up-front
2 meeting.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 tools that are good to use to strengthen
2 quality.

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

14 CO-CHAIR SUSMAN: Reva, you want to
15 -

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

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

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

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

19 You've got those, Ian?

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

22 MS. JAFFE: Can I ask for a point

1 of clarification in regard to the dementia?

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

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

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

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

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

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

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

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

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

22 Dan.

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

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

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

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

22 Is that right, Ian?

1 MR. CORBRIDGE: Correct.

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

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

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

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

13 MR. CORBRIDGE: Is anyone else on
14 the phone?

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

18 MR. CORBRIDGE: All right.
19 Wonderful.

20 DR. WINKLER: Anyone else on the
21 phone?

22 MS. GALBREATH: Laura Galbreath

1 from the National Council.

2 CO-CHAIR SUSMAN: National council
3 of what?

4 DR. WINKLER: Of Community Mental
5 Health Centers?

6 MS. GALBREATH: Yes.

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

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

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

14 (Laughter)

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

19 PARTICIPANT: Yes.

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

22 DR. WINKLER: Can you introduce

1 yourself from WPIC?

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

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

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

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

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

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

15 DR. WHITE: Yes. Can you hear me?

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

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

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

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

5 So, thank you for phoning in
6 today.

7 DR. WHITE: Yes.

8 MR. CORBRIDGE: All right.

9 Wonderful. So, we're starting off on Measure
10 Number 16. The title is Retention in
11 Treatment.

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

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

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

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

6 And this was, once again,
7 Workgroup 4.

8 CO-CHAIR SUSMAN: Okay.

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

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

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

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

22 CO-CHAIR SUSMAN: Harold, do you

1 have any other questions?

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

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

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

15 CO-CHAIR LEDDY: David?

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

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

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

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

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

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

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

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

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

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

1 better outcomes from sort of clinical trial
2 studies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 CO-CHAIR SUSMAN: Eric, are you on?

20 No? Ken?

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

1 CO-CHAIR SUSMAN: Okay. Thank you.

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

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

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

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

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

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

14 (Laughter)

15 CO-CHAIR SUSMAN: Okay. Reva.

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

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

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

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

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

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

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

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

1 correct?

2 DR. WHITE: Correct.

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

5 Are we ready to vote? Any other
6 comments?

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

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

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

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

1 seems more problematic to me.

2 CO-CHAIR SUSMAN: Okay. Thank you.

3 Sheila.

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

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

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

19 Completely. Partially.

20 CO-CHAIR LEDDY: Ten.

21 CO-CHAIR SUSMAN: Okay. Minimally.

22 CO-CHAIR LEDDY: Five.

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

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

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

8 And not at all?

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

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

14 Okay. Thank you.

15 And then not at all?

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

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

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

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

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

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

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

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

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

12 Completely. Partially.
13 Minimally.

14 MR. CORBRIDGE: Two.

15 CO-CHAIR SUSMAN: And not at all.

16 Ken, do you have a vote? Ken are you on mute?

17 DR. THOMPSON: No, I'm here.

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

20 DR. THOMPSON: Not at all.

21 CO-CHAIR SUSMAN: Thank you.

22 MR. CORBRIDGE: That's 14, Reva?

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

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

7 Sheila, thoughts about usability?
8 Luc?

9 MR. PELLETIER: The developer -

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

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

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

1 for the Committee.

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

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

9 Thank you. Okay.

10 Comments further about
11 harmonization?

12 CO-CHAIR LEDDY: Reva has
13 something.

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

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

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

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

12 DR. WHITE: Okay.

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

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

18 DR. THOMPSON: Minimally.

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

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

1 Record or Claims Data Sources.

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

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

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

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

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

5 CO-CHAIR SUSMAN: Wonderful. Thank
6 you.

7 MR. CORBRIDGE: Thanks very much.

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

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

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

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

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

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

4 CO-CHAIR SUSMAN: Good point.
5 Other comments?

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

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

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

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

1 DR. WINKLER: Eight.

2 CO-CHAIR SUSMAN: Minimally.

3 DR. WINKLER: Seven.

4 CO-CHAIR SUSMAN: Not at all, and

5 Ken.

6 Ken, are you -

7 DR. THOMPSON: Not at all.

8 CO-CHAIR SUSMAN: Not at all.

9 Thank you.

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

12 MS. GALLAGHER: No.

13 CO-CHAIR SUSMAN: Thank you.

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

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

20 All those opposed, same sign.

21 And, Ken, are you opposed or in
22 favor?

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

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

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

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

14 DR. WHITE: Thank you.

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

19 (Discussion off mic)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 CO-CHAIR LEDDY: Fall Rate per
20 1,000 Patient Days.

21 MR. CORBRIDGE: Correct.

22 CO-CHAIR SUSMAN: Thank you.

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

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

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

16 And that was, once again,
17 Workgroup Number 3.

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

1 inpatient psychiatric stays.

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

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

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

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

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

18 DR. HENNESSEY: Yes.

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

20 DR. HENNESSEY: Yes, definitely.

21 MR. PELLETIER: Okay.

22 DR. PINCUS: Just as a general

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

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

11 And so, what's the rule?

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

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

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

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

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

17 DR. WINKLER: Right.

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

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

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

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

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

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

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

1 Indicators, NDNQI, which was previously
2 referenced.

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

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

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

22 MS. GALLAGHER: Yes, absolutely.

1 DR. PINCUS: Yes, stratifying it.

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

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

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

13 CO-CHAIR LEDDY: Anne is next.

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

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

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

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

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

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

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

4 CO-CHAIR LEDDY: Reva.

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

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

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

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

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

12 CO-CHAIR LEDDY: Robert.

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

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

21
22 MS. GALLAGHER: One point is that

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

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

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

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

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

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

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

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

22 And I think if we did that, that

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

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

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

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

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

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

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

20 CO-CHAIR LEDDY: I thought I heard
21 -

22 DR. HENNESSEY: You are? Okay.

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

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

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

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

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

11 MS. GALLAGHER: Vote on this one.

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

19 MS. GALLAGHER: Okay.

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

22 DR. ROCA: And that was going to be

1 our suggestion as a little group here.

2 CO-CHAIR SUSMAN: Oh, okay. Sorry.

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

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

10 Anybody on the phone like to
11 comment?

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

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

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

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

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

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

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

1 you're taking.

2 DR. WHITE: Thanks.

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

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

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

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

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

1 MR. CORBRIDGE: On this current
2 measure.

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

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

12 CO-CHAIR LEDDY: Okay.

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

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

21 How many vote for completely?
22 Partially.

1 MR. CORBRIDGE: Is there two?

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

6 DR. THOMPSON: I'm partial.

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

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

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

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

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

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

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

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

13 I think that makes it kind of
14 difficult.

15 CO-CHAIR LEDDY: Harold.

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

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

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

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

8 DR. ROCA: Yes.

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

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

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

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

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

3 So, somewhat vague.

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

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

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

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

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

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

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

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

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

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

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

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

6 DR. HENNESSEY: Staff reports.

7 DR. STREIM: Report.

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

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

14 MR. CORBRIDGE: Two.

15 CO-CHAIR LEDDY: Minimally.

16 MR. CORBRIDGE: 12.

17 CO-CHAIR LEDDY: Not at all.

18 MR. CORBRIDGE: Ken?

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

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

1 choice.

2 DR. THOMPSON: Minimally.

3 CO-CHAIR SUSMAN: Thank you.

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

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

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

21 CO-CHAIR LEDDY: Joel.

22 DR. STREIM: Yes. Here I would go

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

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

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

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

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

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

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

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

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

1 Those for completely. Partially.

2 MR. CORBRIDGE: One.

3 CO-CHAIR LEDDY: Minimally.

4 MR. CORBRIDGE: Eight.

5 DR. THOMPSON: Nine.

6 MR. CORBRIDGE: Okay. Ten, 11.

7 CO-CHAIR LEDDY: Okay. How many

8 for not at all?

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

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

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

17 So, minimally.

18 DR. ROCA: One.

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

21 Not at all.

22 CO-CHAIR SUSMAN: Peer pressure is

1 an important thing here.

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

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

8 CO-CHAIR LEDDY: Okay. Thank you.

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

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

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

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

4 CO-CHAIR LEDDY: The exclusions.

5 DR. ROCA: The exclusions, yes,
6 yes.

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

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

13 Partially. Minimally.

14 MR. CORBRIDGE: Nine.

15 CO-CHAIR LEDDY: Not at all.

16 MR. CORBRIDGE: Four.

17 CO-CHAIR LEDDY: And Ken on the
18 phone?

19 DR. THOMPSON: Minimal.

20 CO-CHAIR LEDDY: Minimal. Okay.

21 Thank you.

22 Any comments from the public, or

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

3 MS. GALLAGHER: Thank you for your
4 consideration.

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

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

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

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

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

19 How many do not recommend?

20 CO-CHAIR SUSMAN: Ken?

21 DR. THOMPSON: No recommend.

22 CO-CHAIR LEDDY: Okay. Thank you.

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

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

6 DR. STREIM: I move -

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

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

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

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

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

22 DR. STREIM: Existence of dementia

1 or not.

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

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

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

11 DR. WINKLER: Everybody.

12 CO-CHAIR LEDDY: And Ken?

13 DR. THOMPSON: Yes.

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

18 MR. CORBRIDGE: No, they're not.

19 CO-CHAIR LEDDY: Okay.

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

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

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

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

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

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

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

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

7 DR. BOTTS: It's a composite.

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

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

12 DR. WINKLER: We're looking at it.
13 Well, we do have - what we do have
14 is a composite measure of potentially
15 preventable adverse events for selected
16 indicators. It's an AHRQ measure and it's one
17 of the composites. And we have to go find the
18 -

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

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

1 DR. THOMPSON: Measure 0531.

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

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

6 MS. BOSSLEY: He was saying the
7 measure number.

8 DR. WINKLER: Right.

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

11 MS. BOSSLEY: He said "0531."

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

14 CO-CHAIR SUSMAN: Oh, okay.

15 MR. CORBRIDGE: Ken, the Measure
16 0531 is not a measure that was currently
17 submitted to this project. So, you wouldn't
18 have that in your documentation. It's a
19 measure that is currently endorsed by NQF and
20 would be on our website.

21 DR. THOMPSON: Okay.

22 CO-CHAIR SUSMAN: So, we're looking

1 at Number 9 right now.

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

4 MR. PELLETIER: But how about your
5 never events?

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

8 MR. PELLETIER: Okay.

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

11 DR. WINKLER: Those aren't
12 measures.

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

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

21 CO-CHAIR LEDDY: So, this measure
22 I've already described. Anybody from the

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

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

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

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

14 MS. BOSSLEY: I have it.

15 CO-CHAIR LEDDY: Oh, you found it?

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

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

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

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

8 DR. PHILLIPS: Is that numerator?

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

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

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

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

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

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

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

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

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

11 Okay. Completely.

12 DR. WINKLER: 13.

13 CO-CHAIR LEDDY: Partially.
14 Minimally.

15 DR. WINKLER: One.

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

18 DR. THOMPSON: Completely.

19 CO-CHAIR LEDDY: Okay.

20 DR. WINKLER: We lost one.

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

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

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

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

11 MS. BOSSLEY: The numerator.

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

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

1 serious adverse event.

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

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

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

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

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

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

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

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

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

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

20 DR. MANTON: Definitional
21 specificity was a current problem.

22 CO-CHAIR LEDDY: Right.

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

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

10 CO-CHAIR LEDDY: Right.

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

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

17 DR. MANTON: Right.

18 CO-CHAIR LEDDY: So, that -

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

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

4
5 CO-CHAIR LEDDY: The name and the
6 description are different.

7 DR. GOLDBERG: Yes.

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

10 CO-CHAIR SUSMAN: is the developer
11 here?

12 CO-CHAIR LEDDY: Is it
13 Presbyterian?

14 CO-CHAIR SUSMAN: Shadyside?

15 SHADYSIDE REPRESENTATIVE: We're
16 right here.

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

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

22 CO-CHAIR LEDDY: We're having a

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

4 DR. GOLDBERG: Serious injury or
5 death.

6 CO-CHAIR LEDDY: Sorry.

7 SHADYSIDE REPRESENTATIVE: Serious
8 Event or Adverse Event.

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

11 Is that what it is?

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

14 CO-CHAIR LEDDY: Is that what it
15 is?

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

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

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

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

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

14 SHADYSIDE REPRESENTATIVE: Yes.

15 CO-CHAIR SUSMAN: Okay. Thank you.

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

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

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

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

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

11 SHADYSIDE REPRESENTATIVE: Correct.

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

18 Could you address that question?

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

1 it across different settings.

2 CO-CHAIR SUSMAN: Okay. Thank you.

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

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

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

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

1 CO-CHAIR LEDDY: Okay. Thank you.

2 Any discussion?

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

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

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

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

1 which is not what they are currently doing.

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

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

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

22 So at least for me, it's kind of

1 premature until that's been done.

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

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

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

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

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

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

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

21 CO-CHAIR LEDDY: Inpatient psych,
22 Ken.

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

5 CO-CHAIR LEDDY: Not necessarily.

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

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

17 CO-CHAIR LEDDY: Yes.

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

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

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

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

14 CO-CHAIR SUSMAN: Good feedback.

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

19 So, do we have to make that
20 recommendation formally?

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

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

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

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

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

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

18 DR. KAUFER: I thought we -

19 CO-CHAIR LEDDY: We already voted
20 on importance?

21 (Simultaneous speaking)

22 CO-CHAIR LEDDY: Scientific

1 acceptability. Sorry. Scientific

2 acceptability.

3 CO-CHAIR SUSMAN: So, completely.

4 Partially.

5 CO-CHAIR LEDDY: Minimally.

6 DR. WINKLER: 11.

7 CO-CHAIR LEDDY: Okay. Not at all.

8 And Ken.

9 DR. THOMPSON: I'm coming in
10 minimally.

11 CO-CHAIR LEDDY: Okay. Thank you.

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

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

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

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

21 DR. GOLDBERG: Not at all.

22 CO-CHAIR LEDDY: Okay. One more

1 for not at all.

2 Do you have the numbers now?

3 Okay. So, we're okay with numbers?

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

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

10 (Off-record comments)

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

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

20 MR. CORBRIDGE: Nine.

21 CO-CHAIR LEDDY: Not at all.

22 DR. THOMPSON: What is this vote

1 again? I'm sorry.

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

4 DR. THOMPSON: Okay.

5 CO-CHAIR LEDDY: Do you have a
6 vote?

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

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

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

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

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

1 incident reports, I think, in current
2 practice.

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

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

12 Okay. Completely. Partially.
13 Minimally.

14 MR. CORBRIDGE: 13.

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

17 DR. THOMPSON: Minimally.

18 CO-CHAIR LEDDY: Minimally. Thank
19 you.

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

1 MS. GALLAGHER: No comment.

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

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

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

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

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

18 Would anyone like to do that?

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

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

1 group.

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

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

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

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

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

1 measure put forth.

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

6 CO-CHAIR SUSMAN: Good point.

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

10 CO-CHAIR SUSMAN: Ken?

11 DR. THOMPSON: Yes.

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

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

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

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

1 CO-CHAIR LEDDY: Before lunch?

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

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

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

10 CO-CHAIR LEDDY: Psychiatrist rated
11 assessment.

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

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

20 CO-CHAIR SUSMAN: Yes.

21 MS. GALLAGHER: Because the motion
22 is on.

1 CO-CHAIR SUSMAN: Yes.

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

4 CO-CHAIR SUSMAN: So moved.

5 MS. GALLAGHER: Thank you.

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

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

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

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

22 MR. CORBRIDGE: Starting off

1 probably on 5.

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

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

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

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

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

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

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

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

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

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

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

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

3 MS. ROTH: And I'm Carol Roth.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4 Denominator Statement reads:
5 Patients from the denominator who are offered
6 services across the following domains within
7 12 months of a new treatment episode.

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

12 Do you have the Numerator
13 Statement available?

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

17 CO-CHAIR LEDDY: You need
18 Denominator Statement.

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

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

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

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

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

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

14 So, I think the -

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

17 DR. WINKLER: Yes.

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

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

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

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

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

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

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

22 Of course, if someone were offered

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

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

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

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

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

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

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

9 DR. HENNESSEY: I had a question.
10 Do you have some baseline data as
11 to the frequency of these two questions being
12 asked and recorded in the charts?

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

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

1 that. I'd be curious to know.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 CO-CHAIR LEDDY: Maureen has
7 another question.

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

10 DR. WATKINS: Yes.

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

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

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

22 DR. WATKINS: Yes.

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

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

11 DR. HENNESSEY: Okay. Thank you.

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

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

22 DR. WATKINS: So, this measure

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

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

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

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

22 Have you done anything to test the

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

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

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

15 CO-CHAIR LEDDY: Okay. Maureen.

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

22 DR. WATKINS: Substance abuse is in

1 there. Alzheimer's is not.

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

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

9 DR. WATKINS: Not at this point.

10 DR. HENNESSEY: Okay.

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

13 DR. HENNESSEY: Okay. Thank you.

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

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

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

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

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

8 Any discussion on that?

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

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

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

17 Any discussion about whether or
18 not this is -

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

1 outcomes.

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

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

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

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

22 It really did not go that far as

1 far as getting into an outcome, correct?

2 DR. WATKINS: That is correct.

3 That was because we felt the actual getting of
4 employment or getting of housing was subject
5 to constraints that were really outside the
6 healthcare system and would vary depending on
7 what state you are and, for example, what the
8 unemployment level is in your particular
9 region.

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

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

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

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

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

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

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

1 person actually makes, you know, finds
2 employment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 outcome.

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

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

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

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

1 working to increase them.

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

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

16 CO-CHAIR LEDDY: Jeff.

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

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

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

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

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

15 MS. GALLAGHER: No.

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

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

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

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

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

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

1 the specific goal.

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

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

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

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

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

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

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

22 And then secondly I would say in

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

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

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

1 better way to use the resources of the system.

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

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

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

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

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

1 (Laughter)

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

6 PARTICIPANT: Yes.

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

10 PARTICIPANT: Five, isn't it?

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

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

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

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

22 MR. CORBRIDGE: 12.

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

3 CO-CHAIR LEDDY: Are there any
4 abstentions?

5 DR. MANTON: Yes.

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

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

10 DR. THOMPSON: Out of scope.

11 CO-CHAIR LEDDY: Out of scope.

12 Okay. Thank you. And then we would maybe
13 entertain a recommendation that Maureen might
14 put forward regarding this issue as a gap.

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

17 DR. HENNESSEY: Sure. Thanks.

18 What I would say is that this workgroup
19 recognizes the importance of assessing for and
20 intervening with housing and employment as
21 indicated in the New Freedom Commission, the
22 President's New Freedom Commission on mental

1 health.

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

7 Anyone have anything to add to
8 that, please do.

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

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

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

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

1 support of housing.

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

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

9 All in favor.

10 DR. THOMPSON: In favor.

11 CO-CHAIR LEDDY: Ken is in favor.

12 Any no's or abstentions? Okay.

13 Unanimous. Thank you.

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

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

1 MS. GALLAGHER: No comment.

2 MS. GALBREATH: No comment.

3 CO-CHAIR LEDDY: Okay. Thank you.

4 So, we're going to vote on all who think this
5 is in scope as an outcome measure. Number 21.
6 Raise your hand.

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

9 You were out of scope, right?

10 DR. THOMPSON: Out of scope.

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

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

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

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

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

6 DR. WATKINS: Thank you.

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

14 PARTICIPANT: Four.

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

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

1 conversation. They submitted the three
2 readmission measures, the 48-hour, seven-day,
3 30-day readmission measures. So, they would
4 like to just have a recap of what our
5 discussion and decision was and maybe have a
6 little discussion about that. And Joel has
7 graciously agreed to provide that recap of our
8 discussion.

9 MR. CORBRIDGE: with your help, of
10 course.

11 CO-CHAIR LEDDY: Right. So, that
12 will be at 1:30. The only other thing we have
13 as far as a measure is concerned, is Number 47
14 which is Inpatient Consumer Survey. The
15 measure developer we do not think is able to
16 join us. That is in Group Number 3. Number
17 47.

18 DR. SCHACHT: Can you hear me?

19 CO-CHAIR LEDDY: Yes.

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

22 CO-CHAIR LEDDY: Oh, excellent.

1 CO-CHAIR SUSMAN: What perfect
2 timing.

3 CO-CHAIR LEDDY: Perfect timing.

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

6 CO-CHAIR LEDDY: Okay. Now, the
7 only other issue is that we haven't broken for
8 lunch yet and it's quarter of and you're on
9 the phone.

10 We could do this now, get lunch.
11 And then at one o'clock or soon thereafter -
12 so, we'll do Number 47 while the measure
13 developer is on the phone, and then break for
14 lunch and get the one o'clock people,
15 University of Washington, on the phone, or do
16 you want to take maybe a five-minute break
17 right now to get lunch and come back and do it
18 while we - eat lunch while 47 -

19 CO-CHAIR SUSMAN: That might be our
20 best -

21 CO-CHAIR LEDDY: So, would that be
22 okay with you, Measure Developer Number 47?

1 DR. SCHACHT: That's fine. My name
2 is Lucille.

3 CO-CHAIR LEDDY: Oh, that's much
4 easier. Thank you very much, Lucille. It's
5 too bad that we can't offer you lunch over the
6 phone.

7 So, we're just going to grab lunch
8 and come back, if that's -

9 DR. SCHACHT: That's great.

10 CO-CHAIR LEDDY: Okay.

11 (Whereupon, the meeting went off
12 the record at 12:45 p.m. for a brief lunch
13 recess and went back on the record at 12:53
14 p.m.)

15 CO-CHAIR LEDDY: So, the
16 measurement we are considering is Number 47,
17 which is Inpatient Consumer Survey. And this
18 is in Workgroup 3. The measure developer is
19 on the phone. Her name is Lucille.

20 Lucille, what's your last name?

21 DR. SCHACHT: Last name is Schacht,
22 S-C-H-A-C-H-T.

1 CO-CHAIR LEDDY: Okay. And you're
2 from what organization?

3 DR. SCHACHT: It's an acronym.
4 NRI, NASMHPD Research Institute.

5 CO-CHAIR LEDDY: Okay. Thank you.

6 So, Ian is going to start off with
7 a brief description.

8 MR. CORBRIDGE: Yes. Heidi is
9 actually bringing the document up. So, I
10 can't bring it up at this moment. So, she's
11 going to read over the brief description,
12 numerator/denominator statement.

13 CO-CHAIR LEDDY: Okay. Heidi is
14 going to do the brief description.

15 MS. BOSSLEY: Okay. So, the brief
16 description is survey developed to gather
17 client's evaluation of their inpatient care.
18 Each domain explored as the percentage of
19 adolescent clients age 13 to 17 years, and
20 adult clients at time of discharge or at
21 annual review who respond positively to the
22 domain on the survey for a given month. The

1 five domains in the survey include outcome,
2 dignity, rights, treatment and environment.
3 Questions in each domain are based on a
4 standard five-point scale evaluated on a scale
5 from strongly disagree to strongly agree.

6 And then if I go down, I'll start
7 with the denominator. That's always easier
8 for me. Denominator, number of clients
9 completing at least two items in the domain.
10 And those domains again are outcome, dignity,
11 rights, treatment and environment. Each
12 domain is calculated separately.

13 The Numerator Statement is number
14 of clients who respond positively to the
15 domain.

16 CO-CHAIR LEDDY: Okay. I know that
17 the end of the table caucused on this. Would
18 you like to comment on this measure, anybody
19 at the end of the table? Bob or Carol or
20 Maureen?

21 MS. WILKINS: I think overall we'll
22 get into the specifics as we review this, but

1 we felt that it definitely includes both some
2 very specific outcomes, as well as some
3 perceptions of the quality of care that could
4 have a strong impact on future outcomes.

5 I think overall we felt that the
6 submission was really strong and we took a
7 little time this morning to look at the actual
8 survey instrument itself and I think we really
9 liked what we saw. We can talk more about it
10 as we get into it.

11 DR. HENNESSEY: Yes. One of the
12 things I had noted in my comments that there
13 was no information about the reading level.
14 However in our subsequent research this
15 morning we did come across something that
16 suggested a 5.2 grade level for reading.

17 DR. ROCA: So, I mean, we thought
18 it was in scope, I think we thought it was
19 important and had a number of other virtues as
20 well that we'll get into as we discuss it in
21 more detail.

22 DR. GOLDBERG: So, it says right in

1 the description that it has something to do
2 with outcome. So, for now we should just
3 believe you about that and then we'll see
4 tomorrow.

5 It has the word, because the rest
6 of it isn't necessarily, I mean, asking people
7 about whether they're rights or - but it has
8 the word and you say it is. So, I'm willing
9 to open the door with -

10 DR. ROCA: Well, I think when you
11 look at the instrument, you see even the
12 sections that have to do with dignity and
13 rights are the kind of feedback that an
14 organization would like to have about how
15 their care is perceived.

16 We have it online here. We don't
17 have it in - and I think they're actionable.
18 They're the kinds of - it's the kind of
19 feedback that you would be able to act upon if
20 you got it.

21 CO-CHAIR LEDDY: Okay. So, are
22 there any questions for the measure developer

1 before we get into it? We can start with
2 importance.

3 DR. GOLDBERG: To vote on scope, or
4 not?

5 CO-CHAIR LEDDY: Oh, vote on scope?

6 DR. GOLDBERG: I thought that was
7 prior to the procedure process.

8 CO-CHAIR LEDDY: Okay. Is there a
9 question about whether this is an in-scope as
10 an outcome?

11 DR. ROCA: We thought it was in
12 scope, I think.

13 CO-CHAIR LEDDY: Do you need to
14 convince the group?

15 DR. GOLDBERG: I thought we had a
16 process where you had to vote to move on.

17 CO-CHAIR LEDDY: So, we'll vote.

18 MS. BOSSLEY: I don't think in this
19 instance you need to. There seems to be
20 general consensus.

21 DR. GOLDBERG: Okay. Fine.

22 CO-CHAIR LEDDY: I don't think we

1 voted on every one. Only where there was a
2 question.

3 DR. GOLDBERG: All right.

4 CO-CHAIR LEDDY: Okay. So,
5 importance to measure and report, any
6 discussion about that? This is a very patient
7 centered type, this measurement, which is -

8 DR. GOLDBERG: I'm still finding it
9 a little hard to comment without knowing more
10 of the details of what all the things are. I
11 mean, if they're important, I mean, what are
12 the things that are in there that are so
13 important.

14 CO-CHAIR LEDDY: How about if we
15 have the developer give a little summary.

16 Lucille, would you be willing to
17 do that?

18 DR. SCHACHT: Sure.

19 CO-CHAIR LEDDY: Thank you.

20 DR. SCHACHT: And are you looking
21 for a summary on the kinds of items that are
22 in the survey itself?

1 DR. GOLDBERG: Yes, especially the
2 ones that relate to outcomes.

3 DR. SCHACHT: Okay. There are
4 questions about - I'll pull up a copy of it
5 here.

6 In terms of outcomes, the
7 questions are that - and these are all self-
8 report by a client. I am better able to deal
9 with crisis, my symptoms are not bothering me
10 as much, I do better in social situations, I
11 deal more effectively with daily problems.

12 There's also a question related to
13 medication. But since medication is not
14 actually used by all clients, it's a given
15 item in here, but it's not counted actually in
16 the domain score.

17 In each of those domains that were
18 mentioned; dignity, rights, treatment,
19 involvement in treatment planning for
20 discharge, actually, and environment, each one
21 of those has four questions. And they're very
22 explicit questions.

1 For example, I was treated with
2 dignity and respect. Staff here believe I can
3 grow, change and recover. And the questions
4 were actually developed with a workgroup of
5 consumers back in about 2001.

6 Does that answer the question?

7 DR. GOLDBERG: Yes, that's good.

8 DR. SCHACHT: Okay.

9 CO-CHAIR LEDDY: Okay. Is there
10 any other comments on the importance of this,
11 of measuring this?

12 Would you like to vote? Ready to
13 vote on importance of measuring this?

14 Okay. How many people think it is
15 completely on importance to measure and report
16 on this particular measure?

17 MR. CORBRIDGE: 12.

18 CO-CHAIR LEDDY: Thank you, Luc.
19 This is the concept of this measure, not the
20 particular measure, right, as with the others.

21 Any partially?

22 MR. CORBRIDGE: Two.

1 CO-CHAIR LEDDY: Okay. And any
2 minimally or not at all or abstain? Do we
3 have everybody?

4 Ken, are you still on the phone?
5 Maybe not.

6 DR. HENNESSEY: I had another
7 question for the developer. The measure
8 itself referenced that adolescents could take
9 this measure. I didn't see any data in your
10 test development that included adolescents.

11 Were they included, Lucille?

12 DR. SCHACHT: During the initial
13 pilot back in 2000, there were a few
14 adolescents that were included in the study.
15 But we felt that it really wasn't enough of a
16 pool to truly assess it, so we continued to do
17 assessment after that and retested the
18 integrity of the instrument in terms of
19 whether the domain still held together for
20 adolescents, and they did.

21 And as we've used it over a number
22 of years, our adolescent response has grown.

1 And their domain still holds together the same
2 way as for the adult group.

3 DR. HENNESSEY: Thank you.

4 CO-CHAIR LEDDY: Okay. Can we move
5 down the screen down to the next category,
6 which is scientific acceptability?

7 Would anyone in the group like to
8 comment on this?

9 DR. ROCA: As you look through the
10 documentation provided by the developer,
11 there's really quite a lot of data on
12 reliability and such. What appears to be the
13 case, and the developer, Lucille, you can
14 maybe enlighten us on this, it looks as though
15 a lot of that which you documented in the
16 application here refers to work that was done
17 a number of years ago in State hospitals.

18 And my question was whether
19 there's more you can say about reliability or
20 validity testing in broader populations than
21 State hospital inpatients who are arguably
22 different from the kinds of patients who are

1 in psychiatric settings that are different
2 from that.

3 DR. SCHACHT: Okay. We actually do
4 have a number of requests from private
5 hospitals. We actually do have several
6 private hospitals that use the survey with us
7 along with State hospitals. We had a recent
8 request from the VA hospital to use the
9 instrument.

10 And I think that based on their
11 experiences in preparing available inpatient
12 pools geared for psychiatric care, we've had
13 a number of requests from the private
14 hospitals and they've used it as well. I've
15 gotten all positive feedback from them in
16 their use of it. And we do post our aggregate
17 rate so that they can use that for
18 benchmarking.

19 Does that answer the question?

20 DR. ROCA: Yes. And I guess the -
21 but the reliability and those kind, I mean,
22 these are organizations that are using it

1 clinically and finding it helpful, it sounds
2 like, but has it been tested in the kind of
3 rigorous way that it was tested in the State
4 hospitals, in other settings?

5 DR. SCHACHT: I would say no in
6 that we have not done a second formalized
7 test. We're currently doing a retest with out
8 current participants and we have maybe a half
9 a dozen participants who are not State-run
10 psychiatric hospitals. And we're
11 reconfirming, basically, the factor structure,
12 the domains that exist, that they'll hold
13 together with the cohort that's using the
14 study now which is like eight years after
15 original development.

16 So, we don't specifically do a
17 retest with non-State hospitals, no.

18 DR. ROCA: Okay. And this is also
19 a 28-item test at this point, isn't it? Is
20 that correct?

21 DR. SCHACHT: That's correct. It's
22 28 items.

1 DR. ROCA: And the original tested
2 version was 43?

3 DR. SCHACHT: Yes. The one that we
4 used in the pilot phase was 43 items. And
5 from the analysis of the pilot phase, we
6 dropped it down to a 28-item tool. And then
7 what we've done internally is a bit of a
8 confirmation test every year as the cohort
9 using it has grown to confirm that the factor
10 structure holds with the 28 items that we're
11 working on preparing a publication on that.

12 DR. ROCA: Okay. Great. That's
13 very helpful. Thank you.

14 DR. GOLDBERG: So, you're saying to
15 summarize it, this has only been validated on
16 a State hospital population from data that's
17 20 years old?

18 DR. ROCA: Well, it's about ten
19 years old.

20 DR. GOLDBERG: Ten years old.

21 DR. ROCA: the data is about ten
22 years old.

1 DR. GOLDBERG: Okay.

2 DR. ROCA: I mean, and I think
3 that's a weakness. But compared to other
4 things we've been looking at, that's pretty
5 darn good.

6 DR. HENNESSEY: I have one other
7 question for the developer. You say that now
8 you're reviewing your data and re-analyzing
9 your data currently.

10 During your current process, have
11 you given any consideration to taking a look
12 at or segmenting the group that are from the
13 non-public psychiatric facilities to try to
14 get a sense of whether or not there is a
15 difference in their responses?

16 DR. SCHACHT: We do not have a
17 large enough cohort to do that yet. But what
18 we have done internally for our own users, we
19 produce a variety of stratified reports, one
20 of them being for forensic clients versus non-
21 forensic clients, to be sure that both have
22 benchmarks for a similar patient group.

1 And we also do more age breakouts
2 in our comparison so that adolescents are all
3 being compared in their scores versus older
4 adults are being compared, but we don't
5 currently have a large enough cohort of non-
6 state facilities to do that analysis.

7 We do allow people who are not
8 participating with us to use this. They don't
9 have to send us their data, which is why we
10 don't actually have a large enough cohort to
11 do that task.

12 DR. HENNESSEY: Thank you.

13 DR. SCHACHT: You're welcome.

14 CO-CHAIR LEDDY: Any other
15 questions or discussions on scientific
16 acceptability? Are we ready to go for a vote?
17 How many would vote completely? Partially.

18 DR. WINKLER: 14.

19 CO-CHAIR LEDDY: Minimally. Not at
20 all or abstain.

21 DR. PINCUS: Abstain. I missed the
22 discussion.

1 CO-CHAIR LEDDY: Okay. And now
2 we'll go on to the next category which is
3 usability.

4 DR. HENNESSEY: This is Maureen.
5 I'd just like to confirm my understanding is
6 that this is geared for a 5.2 reading level
7 grade-wise.

8 DR. SCHACHT: Yes, it was rated at
9 a 5.2 reading level so that we feel confident
10 with use among adolescents, but would not be
11 confident with use among children.

12 DR. HENNESSEY: And I believe this
13 also has a Spanish language version now; is
14 that right?

15 DR. SCHACHT: Yes, it actually has
16 two Spanish translations. One done in Texas
17 and one done for Puerto Rico.

18 DR. HENNESSEY: Excellent. Thank
19 you.

20 CO-CHAIR LEDDY: Reva.

21 DR. WINKLER: This is for inpatient
22 psychiatric hospitals, and does anyone know

1 are there other surveys that exist that are in
2 use by other hospitals that really try and
3 capture the same kind of data?

4 CO-CHAIR LEDDY: Luc.

5 MR. PELLETIER: Yes, there is one.
6 Proprietary though.

7 CO-CHAIR LEDDY: You know of one?

8 MR. PELLETIER: Press Ganey.

9 DR. PINCUS: Does Press Ganey have
10 a -

11 CO-CHAIR LEDDY: Microphones.

12 DR. PINCUS: Is Press Ganey
13 specific to psychiatry or do they use a
14 generic one?

15 MR. PELLETIER: Specific.

16 MS. JAFFE: They have a specific
17 version for psychiatry.

18 MR. PELLETIER: It is specific.

19 DR. GOLDBERG: You've walked in
20 really late. This is beyond the patient
21 experience. This has some other dimensions to
22 it as well.

1 DR. PINCUS: So, when you say it
2 has outcomes, does it have a pre and post?
3 So, how does it do outcomes if -

4 DR. ROCA: I mean, it asks the
5 patients whether they feel that as a result of
6 treatment they are better able to cope in
7 social situations, whether they're less
8 bothered by symptoms and that kind of thing.

9 So, it's asking patients their
10 judgment about whether they've improved.

11 DR. PINCUS: And when is it
12 administered?

13 DR. ROCA: At the time of discharge
14 or on patients who were there for an extended
15 period of time, periodically.

16 MS. BOSSLEY: it says during the
17 month of client discharge or during the month
18 of annual review for the client.

19 DR. GOLDBERG: Does the group that
20 does this also administer another patient
21 experience questionnaire like Press Ganey,
22 Lucille?

1 DR. SCHACHT: No, they do not.

2 DR. GOLDBERG: And remind me, you
3 may have said it already, how long it takes
4 the patient to fill this out.

5 DR. SCHACHT: It's a relatively
6 short survey. I think that most of our
7 hospitals have indicated it's ten or 15
8 minutes. Oftentimes they will have patient
9 advocates available to help a patient
10 understand what the question is asking if they
11 need that or to actually physically check off
12 boxes if they need help to actually do the
13 mechanics of the survey.

14 DR. GOLDBERG: Now, is the
15 potential overlap of this with Press Ganey,
16 are you familiar with that? Are there some
17 and is that a harmonization issue if there
18 are?

19 MR. PELLETIER: They're
20 proprietary.

21 DR. GOLDBERG: Okay. So, that's a
22 non-issue.

1 DR. ROCA: Yes. I mean, I would
2 like - this is probably more of a feasibility
3 issue, but I would like to highlight that ten
4 to 15 minutes in a setting where there may be
5 five or six admissions and discharges a day as
6 is the case in the private sector frequently
7 may be prohibitively time consuming.

8 I mean, I think that's just sort
9 of - I guess that might be a question I would
10 ask Lucille to respond to. Does she find that
11 people resist filling it out, do people have
12 to be sort of held in the chair while they
13 respond to the question or something like
14 this?

15 DR. SCHACHT: Well, ten to 15
16 minutes is when they for those hospitals that
17 tend to run sort of a discharge planning group
18 where they'll have a group of clients who are
19 ready for discharge and they'll help with the
20 planning of discharge and this will be one of
21 the things that will occur then.

22 We have a number of facilities who

1 just hand it to the client as part of the
2 discharge transition. It's a hundred percent
3 voluntary. So, if a client chooses not to
4 answer, that's still okay.

5 So, for many clients I would guess
6 that they can do this in a minute or two. For
7 other clients there's an opportunity for
8 assistance or reading questions or asking
9 questions. It's provided in more of a
10 networked assisted, you know, assistance
11 available kind of atmosphere.

12 CO-CHAIR SUSMAN: Do you have - and
13 I might have missed this or didn't see it in
14 the writeup - actual response rates in use?

15 DR. SCHACHT: Yes. We do actually
16 provide those back to our hospitals based on
17 how many discharges they had in a given month,
18 how many surveys should they have completed.
19 We also ask our hospitals to track that for
20 themselves of how many responses they're
21 getting.

22 We've had some low response rates

1 as low as 20 percent. We've got a couple of
2 facilities who have phenomenal response rates
3 up over 80 percent.

4 CO-CHAIR SUSMAN: So, on average?

5 DR. SCHACHT: On average I would
6 say it's probably around 40 to 50 percent of
7 people being discharged that are responding to
8 the survey at most of the hospitals. There
9 are a number of hospitals that continue to
10 have really low rates and they work on that,
11 and there are some hospitals that have
12 phenomenally high rates.

13 CO-CHAIR SUSMAN: Okay. That
14 sounds good.

15 DR. STREIM: In trying to
16 understand those discrepancies across
17 facilities with response rates, those are in
18 the range of health literacy problems in our
19 healthcare consumer audience. And I wonder if
20 there's anything that has been done or needs
21 to be done to try to assess the extent to
22 which limited health literacy actually affects

1 the response rates or the ability of patients
2 to do this.

3 I understand you've talked about
4 how some facilities provide assistance to
5 those patients who need it in filling out a
6 form, but it sounds like that's one area where
7 there might be some built in inequities in
8 terms of if people with low levels of literacy
9 are not in the pool of people who actually are
10 responding.

11 DR. SCHACHT: That is an area of
12 concern when you have a low response rate on
13 how generalizable your results are. And we
14 caution facilities who have low response rates
15 about the generalizability of that and to look
16 at what their practices are around their
17 distribution methods, their return methods,
18 their availability of assistance as ways to
19 increase their response rates.

20 And some facilities have found
21 that by having these sort of discharge
22 planning groups that the response rates go up.

1 And some facilities haven't been able to adopt
2 that, some of that is a staffing issue, the
3 availability of staff or consumer advocate
4 staff to be able to provide that service.

5 MR. PELLETIER: So, some facilities
6 would actually have a group in an inpatient
7 setting where you're filling out your -

8 DR. HENNESSEY: I had a question.
9 George was asking if he could take a look at
10 the reliability and validity information that
11 this workgroup had.

12 Has everyone had the opportunity
13 to look at that or do we need to have the
14 developer sort of summarize the research, what
15 they did with reliability and validity? Are
16 there questions on that?

17 CO-CHAIR SUSMAN: I guess I'm more
18 interested in the usability part of this.

19 MS. WILKINS: I just want to make a
20 point on a different dimension of usability,
21 which is the usability of the information that
22 comes out of this process. And I think one of

1 the things that at least struck me as a real
2 positive, is that there's already a track
3 record for public reporting on a website that
4 gets updated regularly so that there is the
5 ability for - I guess it's reported at the
6 facility level or the provider level, but
7 there is already an infrastructure in place
8 for public access to the outcome measures.

9 And I just thought compared to
10 most of the rest of what we're looking at,
11 that's a huge step forward.

12 DR. HENNESSEY: One of the unique
13 aspects of this was that this was developed
14 with consumer input.

15 CO-CHAIR LEDDY: So, are we ready
16 to vote on usability? Okay. Completely?
17 Anybody votes for completely on usability?
18 Partially.

19 DR. WINKLER: Everybody here.

20 CO-CHAIR LEDDY: How about, Ken,
21 are you on the phone? Ken? I think he's off.

22 And is that everybody? Okay. And

1 so now we'll go to feasibility. Any questions
2 from the group or Workgroup 3 or comments or
3 questions for the developer?

4 Jeff.

5 CO-CHAIR SUSMAN: Is there any
6 issue of social acceptability here
7 particularly when you're helping users
8 complete this, any fear of sanction,
9 unintended consequences, and have you looked
10 at that?

11 DR. SCHACHT: Well, one of the
12 things that we have on the survey tool itself
13 is a clear reminder to the facility using it
14 that they are responsible for telling the
15 consumer that this will not have a negative
16 impact on their care. And that's a statement
17 right on the tool itself.

18 So, we think that that's real
19 helpful in that regard.

20 CO-CHAIR SUSMAN: Thank you.

21 DR. STREIM: Are these done
22 anonymously then in any way? I mean, I

1 realize if you're doing it in a group it's not
2 very anonymous, but is anonymity something
3 that can be achieved?

4 DR. SCHACHT: Yes, actually the
5 facilities have that option. And if they want
6 it to be an identified survey, they have to
7 inform the consumers that it is an identified
8 survey. And that includes using a coding
9 number that they can decode back to the
10 consumer.

11 And we've done significant
12 training with our facilities about putting
13 code numbers on there that they can decode.
14 That means it is not anonymous and the
15 consumer needs to know that.

16 If the consumer wants to self-
17 identify, they can write their names on there.
18 There's nothing that says they can't do that.
19 It's really a facility/consumer choice about
20 anonymity.

21 DR. ROCA: Is there any concern
22 that it might be hard to interpret the results

1 if this were being used for comparative
2 purposes, if the person looking at the
3 comparative data didn't know whether the data
4 were anonymously obtained or not?

5 I mean, I've certainly been when I
6 get my car serviced, been prevailed upon by
7 the service director to be sure to fill this
8 out and be sure to put all fives here.

9 I mean, you could conceivably do
10 better in a setting where this was being
11 administered by an enthusiastic staff member
12 who was encouraging you to give positive
13 responses. I mean, it would seem to me if
14 you're trying to evaluate the institutional
15 response to this, you would be helpful to know
16 exactly how the data were being presented to
17 the patients at the time of discharge and you
18 would think you'd have a lot more confidence
19 in data that were collected anonymously than
20 data that might be collected with the
21 influence of the provider of care.

22 I'm just wondering if that's come

1 up or if that's been a concern.

2 DR. SCHACHT: Well, we do actually
3 in reporting purposes to us in developing our
4 comparative information that we provide that,
5 we do ask whether the survey was anonymous or
6 not.

7 We have not yet stratified by
8 that, but we've done some testing over the
9 years to see if there are any significant
10 differences in the responses in the ratings
11 themselves when surveys were anonymous versus
12 surveys not anonymous.

13 And one of the disadvantages of
14 being a large system is that once your N gets
15 really big, it's really - you can get
16 differences that are significant from a
17 statistic standpoint, but have no practical
18 meaning.

19 So, what we've found when we have
20 smaller Ns is that there were some cases where
21 there were marginal differences between
22 anonymous and non-anonymous surveys. But as

1 our population grows, that difference waters
2 out.

3 DR. GOLDBERG: Lucille, can you
4 give me an example of how you've used this
5 data to change outcomes in one of your
6 inpatient units?

7 DR. SCHACHT: Okay. Well, I can
8 tell you from examples from our facilities
9 that facilities have taken this information
10 and looked at their scores, say, on the
11 outcome domain where say they were scoring
12 only 75 percent, which is about, I think, what
13 the average is running right now.

14 And then what we do is we provide
15 them with an actual score for each one of the
16 questions in that domain, and then they
17 developed a plan to address the particular
18 question that was scoring the worst assuming
19 that that would help to improve overall
20 outcomes.

21 And they've done that with all of
22 their domains. The outcomes domain, as well

1 as rights and dignity and environment. We've
2 also had facilities who have worked on
3 response rates, and looked at holding a focus
4 group with the consumers around, their issues
5 around completing surveys, their concerns, and
6 then looking at strategies to help improve
7 response rates.

8 DR. GOLDBERG: Thank you.

9 DR. SCHACHT: You're welcome.

10 CO-CHAIR LEDDY: Any other
11 discussion? We're on feasibility.

12 Ready to vote on feasibility?
13 Completely. Partially. I think that's
14 everybody. Minimally. Not at all or abstain.

15 Any comments from the public
16 before we vote to recommend or not to
17 recommend this measure to go forward to NQF?

18 MS. GALLAGHER: No comment.

19 MS. GALBREATH: No comment.

20 CO-CHAIR LEDDY: Thank you. Okay.
21 We're ready to vote. Any discussion or
22 questions before we vote on whether to

1 recommend it go forward?

2 Okay. All in favor of
3 recommending this go forward?

4 DR. CORBRIDGE: Everybody.

5 CO-CHAIR LEDDY: Unanimous.

6 Congratulations, Lucille.

7 DR. SCHACHT: Thank you very much.
8 We're excited and we look forward to the next
9 step in our task related to that. Thank you
10 for this opportunity.

11 CO-CHAIR LEDDY: Well, thank you
12 for putting together such a well-documented
13 and comprehensive proposal.

14 DR. SCHACHT: Thank you.

15 CO-CHAIR LEDDY: Okay. So, the
16 next thing we're going to do is our one
17 o'clock. We're a little bit behind time,
18 right?

19 MR. CORBRIDGE: Yes. Peter, are
20 you on the line? Is anyone from University of
21 Washington on the line?

22 CO-CHAIR LEDDY: University of

1 Washington? Do you think they left?

2 MS. BOSSLEY: They may not have
3 joined yet.

4 CO-CHAIR LEDDY: Okay. How about
5 the 1:30? Anybody from Western Psych on the
6 phone? So, can you try and e-mail or contact
7 the Washington people?

8 CO-CHAIR SUSMAN: University of
9 Washington, are you there? Oslo?

10 MR. CORBRIDGE: I can try following
11 up, but his e-mail says he's here.

12 CO-CHAIR SUSMAN: What line is he
13 on?

14 CO-CHAIR LEDDY: Okay. So, I think
15 that we should go ahead and begin discussing
16 Number 14 while Ian tries to get Peter from
17 University of Washington on the phone, and
18 Number 14 is a new measure.

19 How about do you have Number 14,
20 Heidi?

21 MS. BOSSLEY: I certainly do.

22 CO-CHAIR LEDDY: Okay. While Ian

1 is trying to contact Peter, Heidi can give us
2 the basics on Number 14.

3 MS. BOSSLEY: Okay. So, Number 14,
4 psychiatrist rated assessment of psychiatric
5 inpatient's clinical status. The measure
6 provides a standardized psychiatrist rated 36-
7 item tool to assess adult inpatient
8 psychiatric patients with respect to their
9 clinical status, symptom and behavior domains.

10 There is no denominator. The
11 numerator is the tool allows psychiatrists to
12 rate a spectrum of psychiatric symptom and
13 behavior domains of inpatient psychiatry
14 patients using 36 items with concrete
15 behavioral anchor points.

16 CO-CHAIR LEDDY: This one was in
17 your group. I think that this one at least on
18 the list is listed as potentially out of
19 scope. So, that's what we need to address
20 first.

21 MR. PELLETIER: They really don't
22 discuss doing the survey at Point A and then

1 Point B and then comparing that. They don't
2 talk about that.

3 The study is actually - the tool
4 is actually expert opinion. It's not taken
5 from valid, reliable sources. I thought that
6 the focus on discipline specific was limiting.

7 MS. JAFFE: I might be able to just
8 answer. I know a little bit about it.

9 CO-CHAIR LEDDY: Oh, good.

10 MS. JAFFE: It is actually done at
11 admission and discharge, but a psychiatrist
12 does have - I don't know. I didn't read the
13 thing. So, it might be helpful if Peter gets
14 on the phone, so there are - and it has been -
15 they've published some articles on it, so
16 there is some scientific stuff in there.

17 CO-CHAIR SUSMAN: Hello. Is this
18 Peter?

19 CO-CHAIR LEDDY: Peter, are you on
20 the phone?

21 DR. GHINASSI: No, this is Frank
22 Ghinassi. I was told to try to call around

1 1:30.

2 CO-CHAIR LEDDY: Okay. Thank you,
3 Frank. We're just running a little bit late.

4 DR. GHINASSI: Oh, that's quite all
5 right. Please, don't let me interrupt.

6 CO-CHAIR LEDDY: Okay. Now, what
7 about, Luc, could you address whether you
8 think this is in or out of scope as an
9 outcome?

10 MR. PELLETIER: I think that the
11 way it's described, it's out of scope.

12 DR. BOTTS: Yes, I agree the way
13 it's put forward is really just a measurement-
14 based care tool and there is no outcome
15 measure that's addressed. It's just the use
16 of the tool.

17 CO-CHAIR LEDDY: So, shall we vote
18 on whether it's in or out of scope? Is that
19 the -

20 DR. GOLDBERG: In theory if the
21 person gets on the line and says, oh, wait a
22 minute, I do this pre-test, post-test, this

1 isn't an outcome, does that change anything or
2 do we have to go by what is presented in the
3 written form?

4 CO-CHAIR LEDDY: Well, if they
5 clarify, then we could ask them to correct the
6 form.

7 So, why don't we then - he's not
8 on the phone yet, right?

9 And if we can't get him in the
10 next minute, we can go onto the next one then.

11 Right. Okay. Why don't we go to
12 the discussion while Frank is on the phone,
13 what we're going to do is go back to the three
14 readmission measures that we discussed
15 yesterday because Frank couldn't be on the
16 phone yesterday and the person that
17 represented his group couldn't hear us very
18 well.

19 So, Joel has agreed to provide an
20 overview to Frank and the rest of the group on
21 our discussion yesterday on the readmission
22 measures.

1 CO-CHAIR SUSMAN: And this was
2 Three, Four and Six.

3 CO-CHAIR LEDDY: Thank you, Joel.

4 DR. STREIM: Yes, that's Three,
5 Four and Six. And, hi, I'm sorry that you
6 weren't able to hear the discussion, but I'll
7 just try and hit highlights here and then you
8 can ask if you have any things you'd like us
9 to clarify.

10 I'll talk about all three of these
11 together to start, because the submissions
12 were identical except for the distinction
13 between 30-day, seven day and 48-hour
14 readmission rates.

15 I think in general the Steering
16 Committee members felt that all of these
17 measures were in scope for outcome measures.
18 So, all of them were candidates that we would
19 consider and there was consensus about that.

20 In terms of the importance to
21 report for the - here I will say the 30-day
22 measure, two-thirds of the Committee felt that

1 the importance was completely demonstrated and
2 only one-third felt partially.

3 But for the seven day and the 48-
4 hour, the Committee was pretty unanimous that
5 the importance to measure was partially met.

6 The discussion around that, I
7 think there was one comment from a reviewer -
8 actually, a couple of reviewers that the
9 evidence provided in the submission really
10 relied heavily on very old literature. But
11 the expertise among committee members, I
12 think, gave us confidence that this is a
13 direction the field is going in, that there
14 are other measures, non-mental health measures
15 that do look at particularly 30-day
16 readmission and that there's substantial
17 evidence from other fields within healthcare
18 that this is important to measure. So, I
19 think in general that part was well
20 established enough.

21 In terms of scientific
22 acceptability, there were concerns that this

1 measure - this set of measures has been
2 developed for use by a single healthcare
3 system for internal determinations of the rate
4 of service utilization. And that because it's
5 constructed primarily for that purpose, that
6 it may not generalize to use by other health
7 systems as well as that it may actually not
8 generalize well in terms of the - well, let me
9 say the fact that there is no real validity
10 testing that was cited here was a concern that
11 what we're looking for is a measure that can
12 be used beyond internal use for public
13 reporting and needs to be interpretable by a
14 community at large, not just internally.

15 And so that partly relates to the
16 scientific acceptability. It relates also to
17 usability. And it was really on usability
18 that I think the Committee had most of its
19 concerns that because the person who was on
20 the phone with us yesterday said that these
21 measures have been garnered from databases
22 that are essentially administrative databases

1 within the health system, not data from
2 payers, that it would be very difficult then
3 to get similar data beyond your own health
4 system.

5 If you wanted to look at
6 readmissions from other facilities in the
7 region to actually be able to do that, and
8 this is in terms of usability and feasibility
9 both now, it might be very difficult if we
10 aren't getting access to readmission rates
11 that are reported by payers or in payers'
12 databases.

13 And I think that the concern then
14 was that a measure that you've developed for
15 use internally may not be easy to expand
16 beyond your own organization. So, that was
17 the gist of the main concerns in terms of the
18 limits of these.

19 One other thing I would mention is
20 that although 30 days has become sort of the
21 standard for measuring readmission rates, I
22 think in our discussion and the person who was

1 on the phone from WPIC did say that of course
2 the proximity in time of the readmission to
3 the discharge makes it easier to attribute
4 readmission to something that happened during
5 the index hospital stay. So, 48 hours would
6 look like - I'm sorry. Readmissions at 48
7 hours would be the ones most easy to attribute
8 to in-hospital events.

9 That said, there was some concern
10 that we really don't have a lot of evidence to
11 guide us in knowing whether it makes sense to
12 measure at all three time intervals or only at
13 30 days because that's sort of an emerging
14 industry standard, or whether 48 hours has the
15 white heat of relevance and we ought to focus
16 on that.

17 So, those were the main points
18 that I can recall from yesterday's discussion.
19 And I would stop there and ask if you have -
20 well, let me ask other committee members if
21 there were other points that they felt were
22 important to highlight from that discussion

1 yesterday.

2 CO-CHAIR SUSMAN: Just to highlight
3 one point here, the measure as submitted
4 seemed to be tremendous within a given system.
5 But what I heard the Committee looking for was
6 to look at the data that might be more broadly
7 collected from, say, a payer or that would be
8 inclusive admissions outside of a given
9 system.

10 And that was a critical omission
11 in trying to move this from a QI or
12 performance improvement measure within a
13 system to an accountability measure.

14 DR. STREIM: Yes, I would add there
15 was more detailed discussion about this issue
16 of patients discharged from one hospital
17 system and then being readmitted, but to
18 another hospital system where those might not
19 be detected and, conversely, where there were
20 transfers from another hospital system back
21 into the hospital system where the index
22 hospitalization occurred, which creates some

1 challenges, but the question is whether those
2 could all be captured in a single region.

3 And the Committee felt that that
4 was easier to do, more feasible to do when you
5 had payer database rather than an
6 administrative database from a single system.

7 DR. GOLDBERG: Two comments. First
8 of all, the title is wrong. Should be 30-day
9 readmissions, not remissions.

10 DR. HENNESSEY: Oh, typo.

11 DR. GOLDBERG: Yes. At the risk of
12 my memory being gone for this, didn't we
13 discuss something about how we maybe didn't
14 need this specifically in mental health, that
15 this was a broader issue of - a discussion
16 about readmissions as a basic NQF measure that
17 we wanted maybe to defer to a non-specific
18 readmission measure because of the importance
19 of breaking down this barrier between psych-
20 to-psych readmissions? There was some
21 discussions about that.

22 And breaking down that barrier

1 between readmission psych-to-medicine,
2 medicine-to-psych, psych-to-psych, you know,
3 and that there was nothing specific about
4 psychiatry.

5 And in fact by keeping it limited
6 within behavioral health, we were really
7 creating a conceptual barrier that we don't
8 want to create.

9 MS. JAFFE: I recall the
10 conversation we were having was in regard to
11 the readmissions being counted only if they
12 were for psychiatric admissions versus any
13 admission.

14 DR. GOLDBERG: And that the next
15 step, therefore, was that this was really a
16 much more general measure of hospital care.

17 DR. STREIM: Yes, the example there
18 being a person discharged after inpatient
19 treatment for depression who gets readmitted
20 within the following month for an exacerbation
21 of their diabetes or -

22 DR. GOLDBERG: Or a trauma service.

1 CO-CHAIR SUSMAN: The other issue
2 was around risk adjustment. And particularly
3 as we're getting into an issue of
4 accountability measurement, some form of risk
5 adjustment might be very important.

6 CO-CHAIR LEDDY: Frank, did you
7 want to comment in response to this
8 discussion?

9 DR. GHINASSI: Sure. Thanks. And
10 then I think David and Khaliani are on the
11 line also.

12 Let me just start by saying thanks
13 for the opportunity to participate in this.
14 It's already been a learning experience for
15 us, and so we appreciate that.

16 First of all, I wanted to at least
17 go on record as saying that I agree completely
18 that the optimal data set here would be a
19 combined regional/national set that used
20 exclusively payer data.

21 I think one of the challenges are
22 for in even institutions of our size, is to

1 line up payers and to sort of get willingness
2 for people to provide those on a regular basis
3 when in fact you have, given the market or the
4 region, you may have as few as three or four,
5 and in some markets you may have as many as
6 ten or 12 payers.

7 I don't think that's impossible,
8 but I do think that if NQF pushes this forward
9 and if what ends up happening is the
10 recommendation is it's a payer-driven one, we
11 probably need to craft some model where that
12 participation is guaranteed because it's not
13 within the power of the systems always to get
14 that.

15 That said, I do want you to at
16 least know that we do regularly look at payer
17 data from the managed Medicare entity in
18 Allegheny County which oversees all of the
19 Medicaid population. However, that managed
20 care organization doesn't manage all of the
21 Medicare populations we might look at. And
22 again we have commercial payers who their

1 participation in giving us information is
2 variable.

3 The other issue had to do with
4 just more of a question. I think it was with
5 the 48, seven, 30-day readmission. And again
6 I just want to submit for the Committee's
7 consideration, I think that the 30-day measure
8 while a critical one whether you're talking
9 about behavioral health or other areas,
10 surgery, trauma, while it's a critical one, I
11 think it's perhaps too blunt of a tool to
12 really discern whether what you're seeing is
13 a failure of the inpatient facility to either;
14 A, deliver an adequate bolus of whatever it
15 was they were trying to address during the
16 stay, schizophrenia, depression, whatever the
17 presenting diagnostic issue was.

18 So; A, you have to take into
19 account was an adequate bolus of treatment
20 delivered in that level of care? And then
21 perhaps equally important, was there
22 sufficient effort made to recently both

1 motivate the individual to seek the next level
2 of care, and to do things that would ensure
3 that that initial connection happened.

4 And I think that if you're going
5 to try to tease some of that out to only look
6 at 30 days, may deprive an NQF measure of
7 being able to tease those factors out.

8 I think we've submitted 48 and
9 seven primarily because within our own system
10 we consider a 48-hour readmission to really be
11 a missed handoff. And we are very concerned
12 about those, as we are about all of them, but
13 those are ones where we really look inward
14 about what it is that did or did not happen.

15 The seven-day readmission is
16 frequently better able to help us tease out
17 was the connection made to the next level of
18 care and what was our role in that?

19 And then the 30 often helps us to
20 reflect a little bit on what the - even if the
21 connection was made, was the next bolus of
22 treatment sufficient?

1 So, I just wanted to submit that
2 thought as you're kind of looking through
3 this.

4 And then I guess the last one was
5 you had said that it might be hard to
6 generalize this because the institution that
7 submitted it was using it for - what was the
8 thing you said? Internal utilization
9 standards or -

10 DR. STREIM: Yes, that was how it
11 was stated in your submission. Let me see if
12 I can bring this up pretty quickly.

13 Yes, the validity was not
14 addressed with respect to quality of care or
15 time interval because this measure was
16 regarded as only a rate of service
17 utilization.

18 And, again, that was stated a
19 couple places in each of the measure
20 submissions. So, we took that to mean that
21 you use it internally that way and you know
22 how to interpret that rate of service

1 utilization.

2 The concern for using this as a
3 quality measure more broadly that's publicly
4 reported and used for QI purposes more widely
5 is that other entities might have trouble
6 interpreting these numbers generated this way
7 that that works for you and you have your
8 monthly meetings to make sense of these data,
9 but that that might not be a universal
10 experience.

11 And that is actually one of the
12 criteria for usability, but that was how we
13 were just responding to the - I'm sorry. We
14 were just responding the way it was written in
15 the submission.

16 DR. GHINASSI: No, I know. What I
17 was saying was that may have been a wording
18 error on our - I have to apologize. I'm off
19 site, so this data is not in front of my eyes,
20 but it is not - service utilization is an
21 unfortunate term. And if we - I'm sure we
22 used it, and we may have mislead you a bit on

1 that.

2 We used this as a measure of the
3 quality of the bolus of treatment that's
4 provided on the inpatient unit, the transfer
5 and handoff information that's communicated at
6 the next level of care and our ability to help
7 an individual engage and stay in that care in
8 such a way as to prevent coming back to a more
9 intensive level.

10 So, we may have mislead you with
11 that. Our apologies.

12 DR. STREIM: Well, it wasn't stated
13 quite that way in the submission. And I think
14 with the next submission, that kind of
15 explanation would be particularly important.

16 The other thing is we actually in
17 our phone discussion, although it was a tough
18 connection yesterday, we got the impression
19 that you didn't have access to any payer data,
20 and that also is an unfortunate
21 miscommunication.

22 DR. GHINASSI: Well, and again we

1 do not have what I think you folks are
2 accurately describing as the optimal state,
3 which would be that in any given region there
4 would be complete access to payer data that
5 would allow for transparency around
6 readmission not only in psychiatric
7 facilities, but also the physical and/or
8 psychiatric emergency rooms.

9 I agree with you wholeheartedly.

10 I think the challenge is that very often
11 entities that want to engage in these levels
12 of care do not have the ability to mandate
13 that. And I'm reflecting that back, because
14 I think that's one of the challenges, but I
15 don't think it's an insurmountable one.

16 We do have access to regular data
17 from a large behavioral health managed care
18 payer, but that's primarily because they are
19 within the larger network of systems we're a
20 part of.

21 DR. STREIM: Yes, we imagined it
22 might be that way. That's why we were

1 confused about the message we got yesterday.

2 MEASURE DEVELOPER KHALIANI: This
3 is Khaliani from Western Psych. I just wanted
4 to clarify the wordage that we used about rate
5 of service. I have our submission in front of
6 us.

7 When we stated that it was a rate
8 of service utilization and that validity
9 measures were not applicable, we meant that it
10 was not readily available because we were
11 measuring a proportion of service that we have
12 not done extensive validity testing for the
13 proportionate number.

14 So, when we said rate of service
15 utilization, we meant proportionate number.

16 CO-CHAIR SUSMAN: Yes, I think the
17 bottom line that I heard our committee talk
18 about is that as a performance improvement, an
19 internal system measure, this is great. And
20 that the direction this could go to be useful
21 as an accountability measure where there was
22 care to make sure that all readmissions were

1 captured and that there was some risk
2 adjustment so there could be meaningful
3 comparisons among systems, across systems,
4 would be a logical next step. And I think
5 people were very enthusiastic about seeing
6 that in a re-submission.

7 DR. WHITE: One last question I
8 have with your indulgence. We have used a
9 couple of risk adjustment factors.

10 Did the Committee generate - I had
11 to miss yesterday. Did the Committee generate
12 any thoughts or would you have any suggestions
13 about what as a group nationally you would see
14 as essentially important risk adjustment
15 variables?

16 DR. STREIM: Well, we did
17 acknowledge that the ones that you said you
18 sometimes apply are age, gender, zip code,
19 race and diagnosis, there was some mention
20 about severity of illness. And I know in the
21 submission it did discuss the fact that
22 readmission is not necessarily correlated with

1 severity of symptoms and we appreciate that as
2 well.

3 But in terms of using this more
4 widely, there was concern that there be an
5 approach to risk adjustment that might include
6 other aspects of the patients, the case mix in
7 the system.

8 DR. WHITE: Okay. That's great.
9 Thanks.

10 CO-CHAIR SUSMAN: I have two
11 questions, and a possible motion. One
12 question is, and this applies I guess as sort
13 of an NQF policy, if Frank had - instead of
14 his group had proposed this being from the
15 point of view of a payer, and that that was
16 the way in which this submission came in that
17 a payer having access to information about all
18 of their enrollees irrespective of site of
19 service delivery that they would be able to
20 look at readmissions, would that have made a
21 difference?

22 I mean, you could have proposed

1 that as a measure and it would have - it would
2 be essentially the same mechanics and it
3 wouldn't have been susceptible to some of the
4 criticisms.

5 DR. GHINASSI: Interesting point.

6 DR. WINKLER: Frank, this is Reva
7 from NQF. I think there are still a couple of
8 things. And that is the lack of information
9 around the validity and the lack of risk
10 adjustment.

11 So, those are both independent of
12 data source. So, you may have addressed one
13 issue, but perhaps not everything that was
14 problematic for you.

15 DR. GHINASSI: Great.

16 DR. WINKLER: So, it would depend
17 on how you could support that measure
18 respecified from a different data source in
19 terms of all of the rest of the sub-criteria.

20 DR. PINCUS: What's the issue about
21 validity?

22 DR. WINKLER: Well, the fact is

1 they said that validity wasn't addressed or
2 didn't need to be addressed. And so there
3 really was nothing.

4 DR. PINCUS: But what would be -
5 I'm trying to figure out what would be the
6 analysis that would support validity.

7 CO-CHAIR SUSMAN: Well, I mean
8 right now or with even a measure that was
9 vetted at the insurer level, for example, one
10 would want to know independently was there
11 substantial readmissions that weren't counted
12 that were leaked out into other parts of the
13 system, is just one example.

14 I mean, there are all sorts of
15 reasons why I could imagine that there would
16 be substantial potential readmissions
17 depending on the dataset available that might
18 not -

19 DR. PINCUS: I mean, you can say
20 that about almost any measure that you could -

21
22 CO-CHAIR SUSMAN: But this is more

1 important, I think.

2 DR. PINCUS: I'm just saying -

3 CO-CHAIR SUSMAN: Yes, I

4 understand.

5 DR. PINCUS: I'm trying to

6 understand like from the perspective of a

7 measure developer that one tweak in terms of

8 what they proposed and how they looked at it

9 would have -

10 Anyway, that was my first

11 question. The second question I had was what

12 is happening with regard to readmissions at

13 NQF more broadly.

14 DR. WINKLER: As we talked about

15 yesterday, NQF is recently and continues to

16 look at condition-specific 30-day all cause

17 readmission rates. We've already endorsed

18 measures for AMI, heart failure, pneumonia.

19 And I think in this outcomes project, the main

20 steering committee is looking at a couple of

21 other procedure type measures. So, it's

22 something that's growing.

1 DR. PINCUS: So, do you have a
2 template for how those are done? Are they
3 done consistently in the same way utilizing
4 the same risk adjustment methodology and the
5 same validity assessments?

6 DR. WINKLER: Yes. As it turns
7 out, they all are coming from the same measure
8 developer. So simply because of that fact
9 they are done in the same way, but it isn't
10 driven by NQF per se. It's the fact that the
11 folks who are doing that work -

12 DR. PINCUS: Who is that?

13 DR. WINKLER: It's Yale University
14 under contract with CMS.

15 CO-CHAIR LEDDY: So, is that the
16 definition that's used in the 30-day
17 readmission on -

18 DR. WINKLER: You got it. Yes.

19 CO-CHAIR LEDDY: So, perhaps our
20 Committee could -

21 DR. PINCUS: That leads to my third
22 problem which is a motion that NQF - sort of

1 the same thing we did for adverse events.
2 That NQF incorporate within whatever efforts
3 they are doing with regard to readmission as
4 a measure, to investigate the possibility of
5 encouraging condition-specific readmission
6 measures to be developed and aligned with the
7 other readmission measures in mental health.

8 DR. WINKLER: Do you mean the
9 converse?

10 DR. PINCUS: I mean in that health
11 - I probably just put the phrase in the wrong
12 place.

13 DR. WINKLER: Well, I think that in
14 just this theme of trying to keep things
15 aligned, harmonized degree possible to
16 minimize the chaos, that certainly we would
17 recommend one of the recommendations you can
18 make is for those folks within the mental
19 behavioral health field who want to look at
20 30-day readmissions, you know, take a look at
21 some of the other types of readmissions and
22 how they are done, because they are - actually

1 they use payer data and they are extensively
2 risk adjusted. So, I mean, there are some -

3 DR. PINCUS: So, I would officially
4 make that motion that we do that.

5 DR. WINKLER: We can do it as a
6 recommendation.

7 DR. STREIM: And just there wasn't
8 any discussion yesterday or recommendation
9 specifically that there needed to be tests of
10 construct validity or anything like that. I
11 think it was more the concern about the
12 interpretability of data coming from a system
13 that didn't really address case mix and the
14 crossover between systems and readmissions.

15 I think that's different than
16 validity testing, certainly.

17 DR. PINCUS: Anyway, I made that
18 motion hopefully that -

19 CO-CHAIR LEDDY: Bob.

20 DR. ROCA: Well, if you want to
21 vote on the motion first, that would be fine,
22 but I have a question for Frank, actually.

1 And if I'm out of order, the chair will tell
2 me.

3 But to Frank, you made the
4 speculation that the relationship between
5 something that took place on the inpatient
6 unit and readmission would be much more
7 compelling for a 48-hour readmission than for
8 a 30-day readmission.

9 And that certainly makes sense,
10 but is that something that you could say from
11 your own internal investigations of these
12 events that in fact that when you look at 48-
13 hour readmissions, that 75 percent of the time
14 you find that the ball was dropped on the
15 inpatient unit someplace along the way, but at
16 30 days you rarely find that?

17 DR. GHINASSI: We see, Bob, we've
18 seen trends. I would be misleading you if I
19 said that at this point I could lay out a very
20 nice graph that would show a clean distinction
21 along those lines because some of this has
22 been sort of our consensus about the way we do

1 work here.

2 We could certainly reexamine our
3 own data with that lens again to kind of make
4 that distinction, but I'd be misleading you if
5 I told you there was a clean study we could
6 publish right now.

7 DR. STREIM: I think the other
8 thing if you're contemplating a re-submission
9 at some point while I think the Committee
10 recognizes generally that there is variability
11 among facilities and readmission rates and
12 that probably is a good quality indicator,
13 that within your own system if you have that
14 kind of data or if there are data you can cite
15 from other studies just to support that, it's
16 a process issue here in terms of being able to
17 vet these measures.

18 DR. GHINASSI: That's a good point,
19 Bob.

20 CO-CHAIR LEDDY: Okay. So, we are
21 going back to Harold's motion that's on the
22 table that everybody remembers, I'm sure, his

1 recommendation. Do we have any further
2 amendments or comments about that, or are we
3 ready to vote?

4 Okay. All in favor of the group
5 supporting the recommendation that Harold
6 recommended, raise your hand. Any opposed or
7 abstain?

8 Okay. So, that was unanimous,
9 Frank, since you can't see us with our hands
10 raised. And so I would like to congratulate
11 you on submitting a measure that has resulted
12 in a recommendation to NQF that they look at
13 30-day readmission rates as -

14 DR. PINCUS: I didn't say 30 day.
15 I said just readmission rates in -

16 CO-CHAIR LEDDY: Readmission rates.
17 Okay.

18 DR. PINCUS: - a really parallel
19 way.

20 CO-CHAIR LEDDY: But specifically
21 for behavioral health.

22 DR. PINCUS: Right.

1 CO-CHAIR LEDDY: So, thank you very
2 much for all your work in submitting this
3 measure.

4 CO-CHAIR LEDDY: So, now we are
5 back to 14.

6 Do we have the measure developer
7 on the phone? Peter?

8 DR. ROY-BYRNE: Yes, I am here. I
9 can probably be here for about another 15
10 minutes or so because I just heard about this
11 today and I have to go over to the university
12 to give a lecture.

13 CO-CHAIR LEDDY: Okay.

14 DR. ROY-BYRNE: I do have the other
15 individual, Dr. Jutta Joesch, who kind of
16 manages most of our quality assurance and
17 really prepared much of this application and
18 is even more familiar than I with some of the
19 more technical/analytic aspects of the
20 measure.

21 CO-CHAIR LEDDY: Okay. So, you're
22 both on the phone?

1 DR. ROY-BYRNE: Yes, we are.

2 CO-CHAIR LEDDY: Okay. So, Ian,
3 will you take us through the summary of Number
4 14.

5 MR. CORBRIDGE: Yes. I think we
6 already did that.

7 CO-CHAIR LEDDY: Yes, we already
8 did this.

9 MR. CORBRIDGE: There are some
10 questions about -

11 CO-CHAIR LEDDY: That's right. So,
12 Number 14 is -

13 MR. CORBRIDGE: This is the
14 psychiatric-rated assessment of psychiatric
15 inpatients' clinical status. Psychiatrist-
16 rated.

17 CO-CHAIR LEDDY: Psychiatrist-rated
18 assessment of patients' clinical status.
19 Something like that.

20 CO-CHAIR SUSMAN: So, I think the
21 one question, Peter, this is Jeff Susman, was,
22 was this really an outcome measure or not?

1 The way it was presented within
2 the submission, those of us who had a chance
3 to review this more in depth wasn't sure that
4 it was interpretable as an outcome measure for
5 accountability purposes. We could see perhaps
6 how it would be used within the process of
7 care, for quality improvement, performance
8 improvement, but the specification of the
9 measure didn't allow me to understand how this
10 would be an outcome measure that could be
11 compared across institutions, across settings
12 and so forth.

13 DR. ROY-BYRNE: Yes, I think that's
14 a very good measure. Obviously most of our
15 interest here has been in developing measures
16 that could use dual purposes. And you're
17 correct that measure was used more heavily for
18 better understanding case mix, relationship of
19 different conditions and sub-conditions and
20 how they impacted level of care and program
21 development, but we also do use the measure
22 and repeat the measure and obtain changes in

1 these clinical metrics over time.

2 And I think it's a challenge in
3 that those that kind of looked - struggled
4 with was developing a measure that would apply
5 to the very heterogeneous nature of
6 psychiatric inpatients. And so that's
7 probably even been a bit more of a challenge
8 from the outcome dimension, but we do repeat
9 this measure and we use it to understand, for
10 example, the efficiency of length of stay,
11 what's the degree of improvement that people
12 have had and how that - and how efficient the
13 improvement has been over the number of days
14 they've been in the hospital.

15 CO-CHAIR SUSMAN: Thank you very
16 much for that summary. We're talking a bit
17 among - we're talking a bit among ourselves
18 about making sure that we're all on the same
19 page.

20 CO-CHAIR LEDDY: We've gone through
21 so many measures. We're just sort of
22 orienting ourselves back to okay, which

1 measure was this. And I think that was Luc
2 and Sheila that talked most about this measure
3 and could you just for even this group, give
4 us a few-sentence recap about this, what you
5 thought about this.

6 We talked mostly about how it was
7 in or out of scope.

8 MR. PELLETIER: What I talked about
9 before was that the tool - and we didn't know
10 prior to this that the tool is used often in
11 discharge, but the focus on discipline-
12 specific measure is limiting.

13 How did you develop the tool?

14 DR. ROY-BYRNE: How did I develop
15 the tool?

16 MR. PELLETIER: Right.

17 DR. ROY-BYRNE: Well, I actually
18 developed the tool, I came here to run the
19 psychiatry program actually in the early '90s,
20 and we thought that measurement-based care
21 would be crucial in us having the most state-
22 of-the-art psychiatric inpatient program.

1 And I went around the country and
2 talked to a whole bunch of different people
3 and was a little bit deflated to learn that
4 there were many individual measures that would
5 measure different conditions. And it seemed
6 to me totally unworkable and unwieldy to have
7 a large, diverse set of measures for
8 individual conditions particularly because
9 individuals that are hospitalized
10 psychiatrically have more than one condition.

11 So, that was totally not workable
12 and I, therefore, attempted to work to develop
13 something that would be more generically
14 usable across a heterogeneous group of
15 individuals that would tap into the major
16 behavioral health domains that would affect
17 these individuals and be relevant for both
18 program planning, level of care and treatment.

19 And then also try to make sure
20 that we would have concrete behaviorally-
21 relevant anchor points so that these could be
22 used by clinicians that were practicing on the

1 units and would not require the same kind of
2 rating scale training that more traditional
3 research instruments that are used in research
4 studies would have.

5 And so we ultimately felt that a
6 BPRS-like measure would be effective, but that
7 that had the wrong anchor points. And then
8 became aware that there was an adaptation of
9 that by someone from the National Institute of
10 Mental Health, Dr. Bigelow, years ago who I
11 actually knew when I was there, but didn't
12 know that he had had this. And then we tried
13 to adapt this to our particular setting and do
14 some reliability and validity testing on it.

15 And also create some additional
16 measures that were not particularly part of
17 this scale, but obviously would need to be
18 part of any scale that would be used in an
19 inpatient psychiatric facility.

20 And I think I had sent to you a
21 number of the papers that were published that
22 outlined the development of this particular

1 scale, but that's sort of anecdotally how it
2 was done.

3 MR. PELLETIER: Is the tool being
4 used anywhere else, or is it pretty much just
5 your unit?

6 DR. ROY-BYRNE: Well, it's
7 interesting. It's used across the entire
8 program. We actually have three units here at
9 Harborview. We have had some discussions with
10 the state hospital here about whether they
11 might want to adapt it, but in truth I have
12 not engaged in much of a publicity of the
13 measure to try to spread the word, as it were.

14 So, you're right. I mean, it's
15 still only local use which obviously is a
16 limitation.

17 CO-CHAIR SUSMAN: So, to use an
18 analogy, in a previous discussion we were
19 talking about the PHQ and demonstrating
20 remission. So, it wasn't just a well-
21 validated measure or instrument. It was using
22 that in a way to get at an outcome.

1 And what I see, and I'm talking
2 just as one member of this committee, what I
3 see, the gap here is that it hasn't gone the
4 next step to specify a measurement quality
5 measure. We've got a validated tool, but we
6 don't have a validated quality measure that's
7 been developed from that tool.

8 DR. ROY-BYRNE: I could respond to
9 that if I could understand a little better
10 what you specifically mean since we have used
11 that measure to measure several different
12 kinds of outcomes. And in particular, our
13 hospital has used length of stay efficiency to
14 try to understand the degree of symptom and
15 behavior improvement as a function of the time
16 that someone has spent in the hospital.

17 CO-CHAIR SUSMAN: Well, I guess
18 what I see on the submission is not a well-
19 explicated numerator and denominator that
20 would link with this use of the tool and could
21 be then used, risk-adjusted across each of
22 different populations.

1 It seems to me what has been
2 submitted is concentrated and done a very good
3 job of demonstrating the validity of the tool,
4 but not necessarily the next step of the
5 validity of the measure.

6 DR. ROY-BYRNE: Well, I do think, I
7 mean, you're making a good point. I don't
8 know that I can give you specific numerators
9 and denominators. And, again, it is an
10 instrument that is a little bit atypical, I'm
11 sure, of a number of the measures that you
12 might take a look at in the forum.

13 And, you know, we just were
14 encouraged by our hospital to think about
15 submitting this because they thought it was
16 somewhat unique in what we were able to do
17 with it.

18 I don't know that we've tapped all
19 the potential uses of it in terms of outcome
20 and particularly in terms of establishing bars
21 or standards of what specific degrees of
22 improvement would mean. And we clearly have

1 only used it in the public sector community
2 hospital population we have here, which is a
3 population largely funded by Medicaid and
4 Medicare and uninsured and disproportionate
5 share and much less frequently actual private
6 insurance payers.

7 CO-CHAIR SUSMAN: So, for example,
8 a quality measure might specify the use of
9 this tool upon admission and discharge among
10 some population of patients and demonstrate
11 that there is validity, reliability and that
12 there's some appropriate case adjustment. And
13 then that potentially would be a very valuable
14 measure.

15 DR. ROY-BYRNE: Right. And, again,
16 I think we still have an interest in
17 developing this further and even using it more
18 than just one time, I mean, more than just one
19 discharge rating. We are actually exploring
20 getting it electronically utilized, because we
21 have a growing, you know, an electronic
22 medical record system here. And we're even

1 looking and in the process of analyzing to
2 simplify the number of items so that it could
3 be more repetitively administered in a more
4 easy way by our clinicians, but that is for
5 the future.

6 CO-CHAIR LEDDY: So, it sounds as
7 though you have a great tool. And that
8 potentially in the future you might consider
9 submitting some measurement of outcome to this
10 committee that would be garnered from the use
11 of this tool if you would have a way to
12 collect patient outcomes for the future.

13 DR. ROY-BYRNE: Again, I just have
14 to keep assessing because - and I don't mean
15 to be sort of a little bit dull about
16 understanding this, but we do use this tool to
17 measure the outcome of patients and the
18 difference in how they were doing on admission
19 and when they were discharged.

20 So, to me that does seem to be an
21 outcome of sorts though I do understand your
22 point that that has not been standardized as

1 a metric that could be easily interpretable
2 across other populations.

3 CO-CHAIR LEDDY: I think that the
4 issue is that that was - what you describe is
5 not evident from what you submitted in
6 writing.

7 What you submitted in writing is
8 more about the tool and not the outcomes that
9 you've derived from the tool. So, we would
10 encourage you to - it sounds as though you
11 might even be able to do that and potentially
12 at a different time resubmit an outcome
13 measure using this tool, but not to submit the
14 tool itself, but a set of outcome measures or
15 even one outcome measure that you could
16 suggest be a valid, reliable measurement
17 utilizing this tool.

18 DR. ROY-BYRNE: Yes. Well, we have
19 that data already. We could formulate the
20 answer to that and provide information in a
21 future submission.

22 CO-CHAIR LEDDY: Okay. And that

1 would probably take a while for you to do?

2 DR. ROY-BYRNE: Well, yes, I mean,
3 just because we're doing a lot of different
4 things. We have the data. It's not like we
5 need to collect it. We have it and it's
6 computerized.

7 CO-CHAIR LEDDY: Okay. So, I'm
8 sure that NQF is going to keep you on their
9 list. We will ask them to for any future
10 requests for these kind of outcome measures,
11 and encourage you to submit your data. And
12 there are people at NQF that can work with you
13 prior to submission to make sure that the
14 submission is in the direction that they're
15 looking for.

16 DR. ROY-BYRNE: So, would we be
17 able to get something electronically that
18 would just tell us the outcome of your
19 deliberations and what your suggestions and
20 guidance are so that we could pursue this?

21 CO-CHAIR SUSMAN: Yes, that's part
22 of the process.

1 DR. ROY-BYRNE: Okay. Great.

2 CO-CHAIR LEDDY: Thank you very
3 much for your interest in getting on the phone
4 today to discuss this with us.

5 DR. ROY-BYRNE: Okay. Thank you
6 very much.

7 CO-CHAIR LEDDY: Okay. Thank you.

8 CO-CHAIR SUSMAN: Thank you.

9 CO-CHAIR LEDDY: Okay. So, we're
10 going to vote.

11 The vote is scope. Okay. So,
12 we're going to vote on scope.

13 Is this in scope as an outcome
14 measure? Anybody who feels this is in scope,
15 raise your hand. Anybody who feels it is out
16 of scope.

17 MR. CORBRIDGE: 12.

18 CO-CHAIR LEDDY: Okay. Thank you.
19 Thanks so much, Sheila and Luc, for providing
20 that technical expertise.

21 MR. PELLETIER: People have done so
22 much work and they're so passionate about what

1 they've done and I think we have to
2 acknowledge that.

3 CO-CHAIR LEDDY: Oh, yes.

4 MR. PELLETIER: But we have to come
5 back to okay, is this - is it or isn't it at
6 this time.

7 CO-CHAIR LEDDY: Right. Okay.

8 Carol.

9 MS. WILKINS: It just does strike
10 me hearing how perplexed he sounded in the
11 conversation and thinking about the
12 conversation we had earlier today, this
13 distinction between measuring outcomes at the
14 client level, which I think this in many ways
15 was analogous to the efforts in the milestones
16 of recovery scale, that folks are really doing
17 very, very creative work to take a holistic
18 and to take a really different look at how to
19 measure client outcomes at that level.

20 The distinction between that kind
21 of outcome measurement and the accountability-
22 oriented outcome measurement that kind of

1 clearly emerged from our discussions as the
2 task for this group, I would think that it
3 would be really valuable to go back and look
4 at the call for measures and see if that
5 distinction was clearly communicated to folks
6 who submitted it. And particularly for those
7 who were really strong on the thing that we
8 weren't looking for, to be able to communicate
9 in some way that really acknowledges the
10 groundbreaking work that they're doing and
11 that that just was not exactly what we were
12 looking for.

13 CO-CHAIR LEDDY: I'm thinking also
14 that maybe another step in the process might
15 help.

16 Like with a lot of things like
17 this, you have - like grants are often like
18 this where you submit, you say well, I'm going
19 to be an intended grant submitter. And they
20 have that initial, yes, I'd like to intend to
21 submit.

22 The reason they do that is so that

1 you not only get the mail, but you're invited
2 to a bidder's conference where you get on the
3 phone, you go from the A, B, Cs, basics of
4 what we're looking for, people ask questions,
5 because a lot of people were very confused by
6 what we were looking for.

7 And a lot of times that kind of
8 interaction might be worthwhile, and I know
9 that Ian did reach out to people, but some of
10 them were still confused. I don't know if
11 they didn't reach you or -

12 MR. PELLETIER: I think we have to
13 remind ourselves how long it took us to agree
14 and understand, because we didn't - I didn't
15 when I first walked in, in November. So, it
16 took us -

17 CO-CHAIR LEDDY: Right.

18 CO-CHAIR SUSMAN: And I think the
19 key issue here is that measurement doesn't
20 equal measures. And the fact that there's a
21 wonderful tool that measures things in a
22 valid, reliable way is wonderful. I mean,

1 that really is the evidence basis on which
2 then a quality measure could be built. But
3 it's that second step that I think Peter just
4 doesn't quite connect up with right now.

5 CO-CHAIR LEDDY: But it means we're
6 not effectively communicating it.

7 CO-CHAIR SUSMAN: Well, I mean, you
8 know, I think it's everybody's responsibility
9 to be part of that conversation.

10 DR. WINKLER: I think there's a
11 learning curve going on because we're seeing
12 it in the other parts of the project as well,
13 because there are - a lot of these tools are
14 known sort of in the general realm of patient-
15 reported outcomes.

16 And so when you use that term
17 "outcomes," they're focusing in on it and I
18 think the outcomes has been the part that sort
19 of has ended up in the largest caps and the
20 biggest bold. And for accountability and
21 public reporting and performance, sort of
22 NQF's reason for existence, may have been

1 overshadowed by the outcomes in big bold.

2 So, you're right. It's actually a
3 communications thing. And also in the realm
4 of mental health we were, thanks to you all,
5 reaching out to people who probably were not
6 as familiar with the work we do whereas the
7 more mainstream.

8 For instance, you were talking
9 about your bidder's conference. We actually
10 have had measure developer's conferences,
11 invite a hundred folks to come in and tell
12 them the story, how to do it, what the, you
13 know. And I think the last one was last
14 September.

15 So, I mean, you know, we don't do
16 it every week, but you're absolutely right.
17 It's an ongoing effort in recruiting new
18 people who haven't participated before. There
19 is a learning curve. All of your comments and
20 observations are absolutely on target, and
21 it's an ongoing effort on our part to bring
22 people up to speed in exactly what we're doing

1 and what the focus is.

2 DR. HENNESSEY: Reva, so in the
3 future the people who submitted measures here,
4 will they be invited to one of those
5 conferences?

6 DR. WINKLER: We will put them on
7 the list, and they will, you know.

8 DR. HENNESSEY: Whether they come
9 or not is their choice.

10 DR. WINKLER: Right. I mean,
11 that's how we create the list of invitees is
12 anybody who somehow connects with us in some
13 way, shape or form. So, submitting one is a
14 real good place to start.

15 CO-CHAIR SUSMAN: I wonder if an
16 even more targeted approach, and it's right
17 along the same lines, is to say to people like
18 Peter, you know, you got this all over, you
19 got such a wonderful instrument here. We'd
20 really like to work with you. Bring your
21 stuff for - let's call it a measurement to
22 measures conference or something along that

1 line that gets a little bit more specific.

2 It says okay, bring us your stuff.

3 Let's work on real world problems with real
4 world measurement and try to use that as a
5 case example, if you will.

6 Again, it's a wild thought. I
7 know there are a lot of logistical challenges
8 to do something like that, which fortunately
9 I don't have to worry about.

10 DR. WINKLER: Well, actually I
11 think one of the benefits of NQF membership is
12 being able to hook up with other members who
13 do this. And that's one of the avenues that
14 is quite potential without us being
15 necessarily right in the nexus of it all.

16 MR. CORBRIDGE: And I just wanted
17 to point one thing out. While Rita is not an
18 NQF staff member, she actually brings to my
19 attention that there is a measure developer's
20 conference or call on April 19th. So, there
21 are engagements or processes for that.

22 (Off record comments)

1 DR. STREIM: There is a Catch-22
2 though and I think Harold made a comment
3 before that kind of rung true that a lot of
4 people who are well poised to be measure
5 developers, that's not their title and their
6 day job. And they don't even think
7 conceptually about it because they haven't
8 taken Measures 101.

9 Measurement 101, maybe, Tool
10 Development 101, but Measures 101 is about
11 putting it all together. And actually the
12 fact that you had to do the concept
13 development for this group here says something
14 about this emerging field. It's an evolving
15 field.

16 And I think that I can think of
17 lots of colleagues who do work that's
18 critically related to the stuff we're talking
19 about, but they've never put together a
20 measure, they don't really know all the
21 principles and the basic criteria.

22 But even when you put out an April

1 19th call for, you know, get on the phone and
2 join in the teleconference, if they haven't
3 already self-identified as someone who perhaps
4 could be working in this field or could
5 contribute to this, then they're not going to
6 join the call.

7 So, the Catch-22 is to figure out
8 how to more broadly educate - I think we've
9 identified three sort of target audiences;
10 people who work in industry and do proprietary
11 stuff, people who work in academics, and there
12 are the clinical researchers and the health
13 services researchers. And I think that
14 getting at those folks is just with some basic
15 concept building.

16 It's more than communication.
17 It's they've got to get the concepts in their
18 head. And the second element is incentives.
19 We're not paying them to do it. They get paid
20 in their day job for something and they have
21 to be able to perceive that there's some
22 incentive to submit, because it does take

1 work.

2 CO-CHAIR SUSMAN: I mean recently
3 there was the NIMH Implementation Conference
4 that I attended. That would be a great
5 audience to have a workshop or two around
6 turning measurement into measures. It's the
7 right audience in that this is about
8 implementation science and there really is an
9 evolving science here.

10 So, I think thinking about how to
11 connect at least with the research community
12 that might be interested, engaged here is
13 probably something that at least you could
14 explore. I recognize there's only so many
15 places and so many things you all can do.

16 DR. STREIM: That brings to mind
17 one interesting target group which is program
18 officers at the NIH. And even at the
19 foundations, one of the things - when they put
20 money into research, they want their dollars
21 well invested.

22 And what that means, in part, is

1 they want their investigators to have a
2 product at the end that can be disseminated
3 widely and translated into clinical care and
4 improvements in care.

5 And so the funders who are, I
6 mean, that's where the, you know, follow the
7 dollars, they're basically providing the
8 salary support for the people who are doing
9 this work. And if those people then
10 understand that my boss who is my program
11 officer expects me to do the dissemination
12 step after I get my results and I publish them
13 and all that, I'm not done, then I need to
14 think about the next step. How can we move
15 this into the field at large.

16 And I think the program officers
17 when they write their program announcements
18 even when they use the word "dissemination,"
19 they don't really get very specific and maybe
20 they should include the example of such as,
21 you know, submitting measures or establishing
22 these outcomes as measures for whatever.

1 I think that that may be what
2 gives you some leverage to get more people on
3 board with the whole enterprise.

4 CO-CHAIR LEDDY: Someone on the
5 phone wants to say something.

6 DR. THOMPSON: Ken Thompson back
7 again. I apologize for my absence, but I
8 wanted to just reinforce the gentleman who
9 just spoke and what they were saying.

10 CO-CHAIR LEDDY: Joel.

11 DR. THOMPSON: Because I just
12 actually have had a couple of conversations
13 with Tom Insel and with folks at SAMHSA and
14 with Pam Hyde now at SAMHSA coming in with a
15 particular focus on a couple things.

16 One is telling the story about the
17 path use for mental health services to help
18 people recover and to have lives that they
19 want to live. One of the profound issues that
20 we're facing which you guys have been talking
21 about for the last two days is how the heck
22 are we going to measure that and how do

1 services show that they're doing that. So,
2 she's got a measure focused on data.

3 Tom Insel is increasingly
4 interested in the whole issue of dissemination
5 and implementation. And I think it may
6 actually be a useful time to consider some
7 kind of a public-private partnership looking
8 at the development of the kinds of measures
9 that at least from what I heard over the phone
10 we're sort of in need of and have some
11 approximations of but have a lot of work to do
12 yet to get there.

13 DR. KAUFER: I'd just like to
14 comment. I think what has just been said
15 makes perfect sense. The problem is I think
16 one of the reasons why we're facing the
17 challenges we are, why there is such a dearth
18 of material that's usable that's relevant is
19 because historically these are not the kind of
20 endeavors that NIH has supported.

21 In fact, it has been exactly what
22 they have not supported. They have

1 specifically not wanted to fund these type of
2 proposals and not want to provide salary
3 support for people to do this kind of work.

4 This historically falls more under
5 the problems of AHRQ, which I think is
6 probably more aligned philosophically with
7 what the goals and aims are of this.

8 But I hope it's not to say that
9 NIH - NIH should be more involved in this.
10 And I think the tide has turned with the
11 renewed interest in translational type of
12 research. I think this piggybacks well onto
13 that. And I think hopefully the tide will
14 come in as far as NIH waking up to the
15 importance of these kinds of projects.

16 CO-CHAIR LEDDY: I think the
17 movement of payment reform toward performance-
18 based payment or results-based payment will
19 also incentivize this to be considered
20 important for development.

21 CO-CHAIR SUSMAN: And the whole
22 NIMH, this was the third conference on

1 implementation, dissemination research.
2 Francis Collins was there talking it up.
3 Everybody is talking about T3\T4 research.

4 I think there is a much more
5 fertile ground at, at least NIMH than there
6 ever has been in the past. And it's probably
7 time to more formally try to cross that
8 divide, if you will.

9 I think there's some real money
10 out there for this type of research and it is
11 not at all beyond the purview that was
12 discussed at that conference of quality
13 measure development, implementation and
14 looking at community health improvement
15 overall.

16 DR. THOMPSON: Don't leave SAMHSA
17 out of that conversation because we're
18 actually much more concerned about the
19 pragmatic realities of doing it and using it
20 in a productive, useful way.

21 So, it's got to be developed, but
22 we also have a need to have it done.

1 DR. WINKLER: Right. In response,
2 I think it's a good segue into sort of the
3 Part 2 of the work for this group in terms of
4 trying to come up with that agenda, if you
5 will, in as granular terms as possible.

6 I mean, it's very easy for any
7 group to say we need more outcome measures for
8 depression, and just walk away from that.

9 The question I think that would be
10 most helpful moving forward and is part of
11 what we're hoping to see out of this, is to be
12 a little bit more specific. And as a result
13 of the discussions of some of these measures
14 today, you came up with some, you know, this
15 is the way it is, it shouldn't look like this,
16 it should look like this instead.

17 And to the degree that we can
18 create a set of recommendations on types of
19 measures for the different elements of
20 mental/behavioral health, substance abuse,
21 wherever you want to put the parameters around
22 it and dementia, if you recall back to the

1 work you did in November, I mean what I can
2 envision and what other steering committees
3 are envisioning is like for the area of
4 dementia we have nothing. So, the boxes are
5 blank, but we have this whole column of types
6 of measures.

7 Do you have that, Ian?

8 MR. CORBRIDGE: I did.

9 DR. WINKLER: You had it yesterday.

10 But if you remember, the first one was about
11 symptoms. Outcomes of symptoms.

12 Maybe it's not applicable for
13 dementia. It might be for depression. It may
14 not be for schizophrenia, whatever. But then
15 other things are functional status, you know.
16 What's a functional status outcome for
17 Alzheimer's disease or dementia? What would
18 that look like? How would you describe that
19 kind of a measure?

20 So, the question is as we go down
21 the list of the types of outcome measures,
22 what might they look like? What are the

1 salient, important elements of those types of
2 conditions?

3 And for this group, we'll have
4 several types of conditions. We'll have the
5 depressions and then however many serious
6 other mental health conditions, schizophrenia,
7 bipolar, anxiety, however many you want to
8 include.

9 But it's not just one outcome.
10 There are a whole variety of types of
11 outcomes. There's not going to be a measure
12 for every box, but there should be several
13 types of outcome measures for each of these
14 categories that you could begin to envision
15 based on the conversations, based on your lack
16 of enthusiasm for what we have so far.

17 It's like what would have made you
18 happy? What were the measures that should be
19 on the list that didn't come in the door?
20 That's what we're asking you to really think
21 about and use your expertise.

22 You look at the list and go yuck.

1 What would a good list have contained? What
2 should be the measures on that list?

3 So, here is just a printed
4 version. But if you all remember, this is
5 what we put out in the call for measures. So,
6 there's a whole bunch of types of outcomes.
7 Symptom outcomes, functional outcomes, health-
8 related quality of life or well-being, change
9 in health behaviors, social determinants to
10 health in a built environment particularly
11 around populations, but also individuals.
12 Service utilization, we saw some of that with
13 the - oh, you've got it. Great. All right.

14 Patient and care giver experience,
15 we've seen some of those. Direct physiologic
16 measure, you know, not sure that's necessarily
17 going to be most useful in this group. But
18 drug screening, for instance, or some sort of
19 physiologic assessment.

20 Non-mental health outcomes, I
21 think this is something Harold kept going on
22 and on about because of the overlap, the

1 considerable overlap between patients with
2 mental behavioral health and other things.
3 And the two are intricate. You can't separate
4 them out in the care or the overall management
5 of the patient.

6 So, I think what we're looking at
7 are gaps. We really would like to work with
8 you to be able to come up with a reasonably
9 specific - it would be very easy to say oh,
10 yes, we need more measures of this and that be
11 the end of it, but I think we - this is the
12 opportunity to try and give us something that
13 would look more like the description of a
14 measure or at least closer around what
15 population and what element are you trying to
16 assess.

17 We don't want you to spec it out,
18 we don't want you to develop a measure, but,
19 I mean, what is it. In what population of
20 patients, what outcome is it that you think
21 would be very important and useful around
22 symptoms, function, experience, safety,

1 recovery?

2 CO-CHAIR SUSMAN: I think there's
3 some themes that we've sounded throughout our
4 couple of days here. One is to try to align
5 mental health measures with the NQF priority
6 measures and a common set of definitions that
7 apply whether it's mental health or physical
8 health, that it's an arbitrary Balkanization
9 of the patient. Patients are whole beings.

10 DR. WINKLER: Yes. And I think to
11 lead off your set of recommendations with
12 something just like that. And I think to
13 support that, one of the ideas you've given
14 me/us is the idea of going back and looking at
15 all of our more general measures and see which
16 ones actually already include mental - or
17 don't exclude mental behavioral health
18 patients, but also let's look at the ones that
19 maybe do, but should they.

20 CO-CHAIR SUSMAN: Right.

21 DR. WINKLER: That's the question.
22 Should they be excluded? Could it be more of

1 a simple fix of just including them instead of
2 excluding them? But rather than, as you say,
3 maintain the Balkanization, do your best to
4 break down the borders.

5 So, I think that's one approach,
6 but then there are going to be things that are
7 specific to these particular patient
8 populations that you will want to look at that
9 are unique.

10 CO-CHAIR SUSMAN: I think the other
11 area that we've touched on is this idea of
12 coordination of care hand-offs, and clearly
13 that's another NQF focus.

14 To think that somehow we can
15 arbitrarily separate the care in a hospital,
16 a nursing home, the outpatient sector, the
17 mental health community, I mean, it's kind of
18 crazy.

19 I mean, people touch on multiple
20 communities of healthcare providers or
21 providers of service. We need to think about
22 measures that can be applied across any of

1 those and make systems accountable for the
2 outcomes no matter where those services are
3 delivered.

4 DR. HENNESSEY: What I think about
5 from a public health perspective is that many
6 of the things that we deal with as clinicians
7 particularly, for example, when you think
8 about trauma, have their roots in violence and
9 other more public health measures, so to
10 speak. And we haven't really looked at that
11 or talked about how those could be used in
12 some way to help promote, for example,
13 decrease violence, which would then promote
14 less trauma.

15 DR. WINKLER: Yes, I think if you
16 recall in our November meeting, one of my
17 colleagues, Bonnie Zell, came in and we were
18 talking about population health. And Bonnie
19 is leading the work around population health
20 for NQF.

21 And I think one of the messages
22 from this group that I can certainly transmit

1 to her is don't exclude mental and behavioral
2 health. Include them. Bring them in and
3 don't separate these areas. And to the degree
4 whenever possible, keep it all inclusive.

5 MS. JAFFE: And I'd like to
6 piggyback on that a little bit in regards to
7 some of the chronic disease management
8 initiatives that are going on and the
9 similarities between a lot of those
10 initiatives and how we manage some of the more
11 chronic mental illnesses. I think there are
12 a lot more similarities than differences.

13 With medical home and the
14 inclusion of behavioral health integration
15 into medical home, I would really push that we
16 try to be one whole system and really have
17 very few carve-outs.

18 DR. HENNESSEY: I think along with
19 that is we talk a lot about what are the
20 measures from a psychiatric perspective that
21 we want to include for people with behavioral
22 health conditions, but the other part of it

1 is, is what are we doing to promote their
2 physical well-being.

3 And I think that often gets
4 overlooked and we should be looking at those
5 as we look at measures.

6 DR. WINKLER: Yes, that was one of
7 Harold's big points.

8 DR. HENNESSEY: Yes, that's a very
9 big concern given the morbidity and mortality
10 that we're seeing with the SMI patients.

11 MR. PELLETIER: I think another
12 place we can look are clinical practice
13 guidelines.

14 So, we have a lot of them. And
15 clinical practice guidelines are evidence-
16 based, typically, and they do talk about
17 excellent care. So, to grab a measure out of
18 those would probably be useful.

19 CO-CHAIR LEDDY: So, can we review
20 which measures we actually endorsed?

21 DR. STREIM: Actually, did we do
22 retention? Did I miss that?

1 CO-CHAIR LEDDY: Yes.

2 CO-CHAIR SUSMAN: Yes.

3 DR. KAUFER: One of the real
4 important take-home lessons for me is that the
5 measures that we endorse from the Minnesota
6 group about the time, the six month and 12
7 month remission of depression, I talked to
8 them and they said the key thing, they work
9 with payers.

10 This is through a healthcare
11 system and this was motivated by payers and
12 done in conjunction with payers. And I think
13 to me that's a really important take-home
14 point that ultimately if you want something
15 that will be useable and feasible and desired,
16 that the payers are ultimately going to demand
17 these types of assessments that don't exist
18 now.

19 So, they need to be part of the -
20 they need to be involved in the development of
21 these kinds of tools.

22 CO-CHAIR SUSMAN: Another push you

1 might think about connecting, and perhaps you
2 already do, is with places like Robert Wood
3 Johnson with their aligning forces effort. I
4 mean, we're one of the 15 communities across
5 the country, AF4Q. And clearly measuring
6 outcomes on a community basis and doing it in
7 a multi-stakeholder including payer
8 participation is something that we have an
9 advantage over a lot of parts of the country.

10 And if we could make sure that we
11 advocate as a group and NQF advocates for
12 measurement that includes behavioral and
13 mental health outcomes, I think could be very
14 important and many of these communities are
15 doing really wonderful work. And it's much
16 more comprehensive because it's on a
17 population basis.

18 DR. THOMPSON: I just want to throw
19 two thoughts out. One is there is a unique
20 problem and I'm not sure necessarily that we
21 are only folding ourselves into the medical
22 home. I think actually in some ways we're

1 going to have to help steer the direction of
2 the medical home.

3 And I'll just use one way to think
4 about an idea that the mind and the brain are
5 the executive organs of the person. And one
6 of the issues that you're going to find I
7 think with the stuff that we were talking
8 about today is what we're trying to do is to
9 increase in the care of somebody, we're trying
10 to increase their capability to move
11 themselves to make the decision, do the choice
12 and implement the behaviors and what they have
13 to do to make their lives be what they want
14 them to be.

15 And that in some way suggests that
16 there are so many possible things that people
17 might want to attain than whether or not we're
18 controlling their heart, their CHF or their
19 asthma or whatever, but they're actually
20 attaining things with their new capabilities
21 or their recovered capabilities.

22 And I wonder sometimes if maybe

1 our system might not need to be based on
2 actually asking people what it is that you
3 hope to attain in this period of treatment,
4 you know, where would you like to go and can
5 we work with you to help you get there, and
6 identify that as the outcomes, maybe suggest
7 some domains in which they would like to be
8 moving along the lines that we've sort of had
9 outlined, and use it more in kind of an
10 emergent sense.

11 So, that's just maybe a totally
12 bizarre idea, but I wanted to throw that out
13 because I think it fits with the recovery-
14 oriented approach.

15 CO-CHAIR SUSMAN: Yes, I was just
16 going to say it seems like it's part and
17 parcel to the recovery model.

18 DR. THOMPSON: Yes. The second
19 issue, and I think Harold can - if he hasn't
20 talked about this, I'm sure he will at a later
21 point. We're looking at how other countries
22 are doing this. And, you know, measures

1 particularly of social inclusion which are the
2 measures that most people are actually being
3 able to take advantage of and participate and
4 be in that community of the whole in some way
5 that they feel comfortable with, that those
6 are measures that are being developed
7 elsewhere around the world and we could
8 probably profitably benefit from looking at
9 them as well.

10 CO-CHAIR SUSMAN: I think
11 integration with what's going on in the PCPCC
12 and patient-centered medical home efforts,
13 there's a whole behavioral health group that
14 have participated in off and on where a lot of
15 people are really excited about the
16 integration of mental health into the patient-
17 centered medical home, and yet are struggling
18 to find measures that integrate easily and
19 reflect the sort of outcomes we have discussed
20 over the last couple of days.

21 So, having some more formal
22 interaction, purposeful interactions and

1 thinking about okay, well, if we had some
2 ideal measures, what would they look like,
3 what would be their attributes, how would we
4 be able to use them to demonstrate outcomes
5 that are clearly the sorts of things that we
6 want to get to.

7 DR. WAN: I just want to get it
8 back to the earlier comment about working or
9 collaborating with the payers when it comes to
10 relevance of some of the measures and
11 execution of those or implementation.

12 I know that there's other
13 organizations out there from the payer side
14 not so much - but indirectly the Pharmacy
15 Quality Alliance and how potentially NQF could
16 work with PQA or even NCQA, because they all
17 have their own measures that they develop as
18 well as endorse.

19 DR. WINKLER: And we have worked
20 with both of those groups extensively.

21 MR. CORBRIDGE: And I guess one
22 comment just to follow up with, George and

1 Jeff, what you have talked on, one, I guess,
2 benefit of being an NQF member is that there
3 are different organizations who are part of
4 NQF and we have different councils. There's
5 eight different councils here at NQF.

6 And at some of our meetings, as
7 well as other times, we try to make sure those
8 different councils are working together and
9 collaborating.

10 And so I know one council that I
11 sit on as a liaison is the Public Community
12 Health Agency Council, I've had an opportunity
13 to meet with the providers or payer councils.
14 And so I think that was a very informative
15 discussion and dialogue. And so those are
16 some of our efforts in trying to move forward
17 and really facilitate those discussions.

18 And actually AFRQ is a part of
19 that. And Diane who presented for the
20 Minnesota measurement, she is actually a co-
21 chair on that council. So, I know those
22 discussions and talks are really trying to

1 move forward and really make sure that every
2 member is working together.

3 DR. STREIM: I know that we asked
4 about this back in November in terms of NQF
5 membership, but my understanding is that it's
6 mostly other organizations that represent
7 relevant fields.

8 Is there any kind of individual
9 membership or sort of a smaller group level of
10 participation in terms of not just NQF, but in
11 terms of participation in associations that
12 deal with quality improvement?

13 DR. WINKLER: If you look at the
14 NQF membership, you're going to see
15 organizations of all sizes. NQF does not at
16 this point, doesn't have individual members,
17 but some of our members are of organizations
18 that are essentially one or two folks.

19 They don't have to be gigantic.
20 Particularly some of our consumer
21 organizations, some of those groups are very
22 tiny. They're a handful of part-time people

1 kind of thing aside from their executive
2 director or something like that.

3 So, size is not a qualifier by any
4 means.

5 DR. STREIM: Where I was going with
6 this is you're talking about the April meeting
7 where individuals can call up and participate
8 in a meeting.

9 DR. WINKLER: Sure.

10 DR. STREIM: And I was actually
11 thinking that if we're trying to help people
12 sort of acquire the concepts that relate to
13 measure development and stewardship and it's
14 such an incremental process and different
15 people work in different corners of this, some
16 are doing a validation study, some actually
17 develop a tool, but that's not the measure.

18 And if all the people who are sort
19 of cogs in that incremental process that bring
20 us to the point where somebody can actually
21 submit something where there has been
22 validity, reliability established where

1 they've actually looked at feasibility,
2 usability parameters and now it's ready for
3 prime time and you can get a submission that's
4 really meritorious that is worthy.

5 I think what we're getting, the
6 reason we're getting such weak submissions is
7 because people don't get that. So, how can
8 they learn it?

9 Well, one thing is to have a phone
10 conference. But maybe on a more aggressive
11 scale, to think about having regional/national
12 meetings of - I'm basically saying start an
13 association of, you know, call it whatever,
14 quality improvement that could be the
15 brainchild of NQF and actually see if you can
16 get people to come and present their work even
17 when it's in developmental stages. Talk to
18 one another. Foster the collaborations
19 because there are all these people who are on
20 someone else's payroll.

21 And as a non-profit you're getting
22 grants to do stuff like this, but not to

1 actually develop those measures. If you're
2 going to rely on the field going forward to do
3 that, then you need an army.

4 And I think that in a way it's the
5 stewardship of that village, but a village
6 needs a town hall and a town forum for
7 bringing people together who are part of a
8 community that can collaborate and create
9 this.

10 I think that the scientific
11 community and the corporate health community
12 aren't really there as a, you know, the
13 collegiality that you need to have
14 productivity isn't there.

15 DR. WINKLER: Joel, just one
16 observation I would make is I think different
17 sectors within the healthcare arena are in
18 different places on a continuum.

19 DR. STREIM: Yes.

20 DR. WINKLER: Because I would say
21 that in some areas they are very, very much
22 ahead of, you know, measurement is an everyday

1 thing. The developers who develop the
2 measures have been doing it for years and they
3 know what they're doing in some areas.

4 But I think there are areas within
5 healthcare and perhaps mental and behavioral
6 health might be one of them, where they just
7 aren't in that realm. They're trailing much
8 farther behind.

9 And also I think the silos of the
10 healthcare system, you don't necessarily
11 benefit from what's going on in the general
12 medical, that sphere which I think might have
13 a little bit more of that or be ahead of the
14 game compared to your experience.

15 So, the question is how do we
16 break down the silos, how do we bring in the
17 folks in areas that have been lagging behind
18 and kind of pull them in?

19 And it's a struggle and I think
20 it's been one of the roles NQF has tried to
21 play with our twice-a-year meetings. We bring
22 people together, we talk about measures, we

1 talk about measure implementation, how they
2 work, what worked, what people are doing in
3 development and things like that.

4 It sounds like there's always need
5 for more.

6 DR. STREIM: It was very
7 informative for me when I got my subgroup
8 assignment, workgroup assignment, to actually
9 see some of the stuff that the NQF staff had
10 inserted on existing measures and related
11 measures to see how there really is stuff
12 that's well-developed that's really state-of-
13 the-art.

14 And I was thinking to myself
15 reading these, if the measure developer who
16 submitted could see that, it's all the
17 background stuff that if they were really on
18 top of the field and knew about this, would
19 have been in their submission.

20 You guys had to add it, but I
21 think that it would open their eyes and it's
22 sort of like modeling for them. This is what

1 it looks like when it's done well.

2 And how do you learn to write your
3 first grant? You read somebody else's and get
4 a mentor to help you.

5 DR. WINKLER: We heard from the
6 very early years of NQF as we evaluated
7 measures, that one of the key elements was
8 feeding back to measure developers the rich
9 discussion and the elements so that they could
10 understand more what the issues were.

11 And, again, that's where we've
12 arriving at this, you know, the measure
13 evaluation criteria are as detailed as they
14 are now, but they certainly weren't six,
15 seven, eight years ago. It's been an
16 evolutionary process.

17 And so for people who are just now
18 entering the game it may be a bit on the
19 overwhelming side because they haven't been
20 part of that growth. So, I really do
21 appreciate the difficulties that folks are
22 trying to learn this because the learning

1 curve is steep.

2 This isn't stuff that is either
3 intuitive or used by average folks every day,
4 so it's a relatively specialized area that
5 it's a bit of a struggle to learn it.

6 DR. MANTON: When people submit
7 like in December when they submitted an intent
8 to submit, did they get a copy or somewhere
9 along the line did they get a copy of this?

10 DR. WINKLER: It's actually
11 embedded in the submission form.

12 DR. MANTON: Right. But I'm
13 wondering if there's any kind of
14 interpretative guidelines that go along with
15 it. Because I think for people who are really
16 familiar with it, it makes perfect sense. I
17 think for people who are not, some of it needs
18 translation.

19 DR. WINKLER: Yes, and there is
20 actually the translation document that goes -
21 the report when those were issued. And it
22 runs, I don't know, 20, 30 pages where, you

1 know, why was this chosen and what were the
2 discussion points around different elements.

3 And that is available and I think
4 we do direct people to read it. It's on our
5 website as a document that's available.

6 MR. CORBRIDGE: Yes, I mean it is
7 one of part of the kind of help toolboxes that
8 measure developers have on our website.

9 DR. WINKLER: Right.

10 MR. CORBRIDGE: I think kind of
11 going further to your point is that we are
12 looking at possibly doing some webinars or
13 online education programs to really try to
14 help, have something online that people can
15 access that helps them walk through the
16 process, because that is something that we
17 have for -

18 DR. MANTON: That's exactly what I
19 was getting at is once people submit a letter
20 of intent or whatever or even if it's people
21 that you know might be interested maybe not
22 wait for them to do that, but to offer a

1 webinar that people could walk through it so
2 that you don't get so many that are missing
3 pieces.

4 I think your chances are going to
5 be better at getting something that probably
6 meets the criteria.

7 MR. CORBRIDGE: And NQF, I guess,
8 is only ten years old and so as Jeff said we
9 still have a lot on our plate and it's still
10 growing, but that is definitely something that
11 we're working on. And we actually have an
12 education department on this floor, but those
13 are the type of issues that they're looking
14 at.

15 DR. MANTON: Webinars work really
16 well.

17 DR. BOTTS: Do they also get a copy
18 of a complete submission of this is what a
19 good one looks like?

20 As you said that, I thought when
21 you go online to shop or something and you
22 hover over an item too long and there's an

1 immediate iChat thing that comes up, like you
2 can't pick out that pair of shoes, so would
3 you like to speak with me about it?

4 (Laughter)

5 DR. BOTTS: That's almost what
6 needs to exist as you struggle with an
7 individual item, perhaps, Ian, you would pop
8 up and say let me help you walk through this.

9 MR. CORBRIDGE: And we do have
10 dialogues and follow-ups with measure
11 developers from the list that came in under
12 the intent to submit. We do then have
13 conversations with some of the developers,
14 question what do I need to put here, how do I
15 fill this out. And so those dialogues do
16 happen if the measure developer is willing to
17 engage in that.

18 And I guess just one thing, Joel,
19 to kind of follow up where you were going, I
20 know this probably doesn't answer completely
21 where you want to get, but I did meet with
22 individuals. I don't know if the Steering

1 Committee is aware of this group: National
2 Association for Behavioral Health.

3 Here, actually, they're a member
4 of NQF. And so one thing that NQF is willing
5 to do for members is being willing to act as
6 kind of that convenient entity for members, I
7 guess for entities who are members.

8 And I was speaking with Rob Miller
9 who is the president there. And as an
10 organization who really is wanting to start
11 looking at quality improvement in
12 measurements, they were left with where do we
13 go from here. And they were really trying to
14 look for, you know, where are other colleagues
15 out in the field that we can connect with, and
16 so NQF was willing to serve as that really
17 convening body for that purpose.

18 And I know one thing I've been
19 working with membership is trying to find a
20 list of people who they need to be speaking
21 with, and I think that's hopefully something
22 that we'll be able to get from every member of

1 the Steering Committee is are there
2 individuals or entities out there that
3 developers or individuals within this field
4 who want to start looking at quality
5 improvement need to be speaking with.

6 DR. HENNESSEY: Yes, I would just
7 say that when you do the webinars and do the
8 training, I would incorporate specific
9 examples from behavioral health or other folks
10 because my experience is that our field in
11 general tends to be less trained I think in
12 population-based and epidemiologic approaches
13 to care.

14 DR. PHILLIPS: Actually, I have
15 kind of a related point. As you talk about
16 giving feedback to members, and I don't know
17 who are members of National Quality Forum or
18 who you connected with, but psychometricians,
19 I mean, there's groups of researchers out
20 there who I'm sure you could hook people up
21 with.

22 In looking at this, my background

1 is in clinical psychology, I have extensive
2 background in psychometrics, and what I saw in
3 most of these was appalling as far as that
4 goes.

5 And so being able to as we've
6 identified these areas and we have people who
7 are interested in developing them, hook them
8 up with people who do that kind of research
9 and can maybe aid them, it ends up benefitting
10 both.

11 Folks like this are always looking
12 for research projects. Maybe not always, but
13 you could probably find someone interested.
14 Even graduate students who would be looking
15 for some type of project along these lines
16 would be an amazing service to provide to
17 people.

18 DR. STREIM: I think, too, this
19 whole issue of extending this to people who
20 don't see themselves as measure developers,
21 but also who don't see themselves as working
22 in the field of quality improvement or

1 measuring quality.

2 I think that when Glen was talking
3 about all these people who are out there, I
4 can think of colleagues who do lots of good
5 stuff. They develop tools. They measure
6 clinical outcomes. They do assessment. They
7 look at care processes, health services,
8 delivery and they're not - but they wouldn't
9 self-identify as working in the area of
10 quality or quality improvement, but they do.

11 The joke 20 years ago when I first
12 got into - or 25 years ago when I got into
13 geriatrics was - I was working at the
14 interface of medicine and psychiatry and
15 working with a lot of older adult populations
16 and the other health professionals who take
17 care of them, and then realized, gee, I guess
18 I'm a geriatrician.

19 But I think - and actually I had a
20 mentor when I was a fellow, who was a
21 hematologist oncologist who did work on tumor
22 senescence, but he didn't think of himself as

1 an aging researcher. And he ended up
2 ultimately after people pointed out that you
3 could do these collaborations and work in this
4 area and we need somebody to be a leader of
5 this group, he ended up as director of a
6 geriatric research center. So, he was not
7 originally a card-carrying geriatrician, but
8 he did enough work in areas so relevant to
9 tumors and aging and immunology and aging that
10 it was a no-brainer in terms of taking a
11 fairly senior investigator and sort of
12 retooling his career - actually, not so much
13 retooling as just re-conceptualizing. And he
14 ended up going to some different meetings
15 after that.

16 So, I just tell that story because
17 I think there are a lot of people out there
18 who are working in fields and doing that
19 incremental work that's so clearly related,
20 but they're not even beginning to think of
21 themselves as belonging in this enterprise.

22 And I think that's a challenge

1 because you can't just put out a call for
2 measures, and you can't just say we're working
3 on quality because they're not - quality is
4 not something they identify with.

5 So, how do you get at that? I
6 think that's something that takes a broader
7 kind of conceptual reeducation of - and maybe
8 looking at certain target groups. I'll have
9 to think more strategically about how you
10 would get at those folks, but they're out
11 there.

12 And I think that there's, I mean,
13 I think Glen was saying there's a ton of great
14 work going on that really fits. We're just
15 not tapping it.

16 CO-CHAIR SUSMAN: One area where I
17 think NQF and mental health could better
18 intersect is on the overuse/underuse waste.
19 We talked a little bit that is because you
20 keep somebody in treatment for three visits,
21 for argument's sake, a good thing, a bad thing
22 or something in between? And the reality is

1 we don't have very much good data about that.

2 And I think to try to align the
3 broad themes that NQF is pursuing and that are
4 being pursued in the national healthcare
5 reform debate, would help move our field of
6 mental health forward as well.

7 The other comment I wanted to make
8 was NQF often has a theme or at least some
9 subthemes at its annual conferences and member
10 meetings. To highlight mental health at one
11 of those very specifically, I think would help
12 really move the field along as well as bring
13 some of the experts in this arena together and
14 it would be a relatively accomplishable sort
15 of task.

16 CO-CHAIR LEDDY: Our next step is
17 to do Task 2, which I don't think we have time
18 to do today, which is gaps.

19 Do you think we have time?

20 DR. WINKLER: Well, I think what
21 you've done, you've been doing that for the
22 last 30 minutes in many ways. It's been

1 embedded in a lot of ways.

2 And I think you've put in a really
3 good two days worth of work. And I don't know
4 about you, but my brain is tired.

5 And so I think that with the very
6 richness of what you've discussed that we're
7 going to be able to begin to draft something,
8 that we start to summarize some of these
9 concepts and formulate it in a way that will
10 allow you to look at it critically and say
11 okay, let's make it this and this and change
12 it here and change it there rather than start
13 with a blank piece of paper.

14 I think you've given us enough
15 good ideas to start and to build something,
16 but then you can go back and react and edit
17 and change and embellish and do whatever you
18 want to it.

19 And I think until we get something
20 a little more solid for you to work with, it
21 may be not the best use of time right now
22 especially after you've spent two solid days

1 doing the other stuff.

2 Just in terms of where we're going
3 to go in next steps is we will be writing this
4 up in terms of a summary. It will include the
5 votes, discussion points and all of that.
6 You'll get to see it and be sure we captured
7 it accurately.

8 Additionally, this is being
9 recorded and transcribed. And so the
10 transcription, the recording we'll share with
11 you and it will be posted on our website. So,
12 you can relive these two days any time you
13 want to.

14 So, I can tell you that that
15 transcript is actually vital to doing these
16 write-ups because we can go back and use your
17 words. I use your words and quote them all
18 the time. So, that's really where we're going
19 for.

20 And most of your decisions I think
21 are pretty solid. I don't think we have a lot
22 of follow-up in terms of the measures.

1 Anne, you were going to review
2 which measures the group ultimately decided to
3 move forward.

4 DR. MANTON: How many did we get?

5 DR. STREIM: I have five that we
6 endorsed for recommended, and 13 that we
7 deemed.

8 CO-CHAIR LEDDY: How does that
9 compare to some of the other ones?

10 DR. STREIM: I was trying to
11 remember. We did not recommend retention,
12 right?

13 CO-CHAIR LEDDY: No, we did not.

14 MR. CORBRIDGE: I think it was
15 four. We had the three measures submitted by
16 Minnesota Community Measurement. That was
17 Measure Number 11, Depression Remission at 12
18 Months; Measure Number 12, Depression
19 Remission at Six Months, and that was - the
20 other measure that was the real, I guess,
21 linking measure was Measure 22, Depression
22 Utilization of the PHQ-9 Tool. And as a

1 group, it looked like we were voting on that
2 to link to those other two measures previously
3 discussed.

4 The last measure that the Steering
5 Committee ultimately decided to push forward
6 was Measure Number 47. That was the Inpatient
7 Consumer Survey that we discussed a little
8 bit.

9 DR. STREIM: Oh, I was counting
10 falls, but that wasn't the falls as submitted.
11 That was the recommendation to -

12 DR. WINKLER: That made several
13 formal recommendations.

14 DR. STREIM: Okay.

15 DR. WINKLER: And it will be
16 important for you all to review as we go back
17 and write those out, because they are just as
18 much the recommendation of measures to be
19 endorsed, your recommendations for some other
20 things because there are implications around,
21 say, the falls measure, the serious adverse
22 events measure. Those sort of things are very

1 important outcomes of what you've done here.

2 Not only the summary of this
3 meeting, we will then be turning it into a
4 draft report that will go out for public
5 comment. And so that's Ian's main chore for
6 the next couple of weeks.

7 With any follow-up, sometimes
8 there's some clarifications. You had some
9 questions. Are we doing the follow-up? And
10 I believe - what's the schedule for going out
11 for public comment? Early June?

12 MR. CORBRIDGE: You know, I don't
13 actually have it open right now.

14 DR. WINKLER: Yes, I think it's
15 early June. So, we've got a few weeks to kind
16 of do some back and forth and review and get
17 the wording right and all of that kind of
18 stuff and get it edited.

19 But it will go out for a 30-day
20 public comment NQF member review. We get
21 comments. Sometimes we get a hundred, 200
22 comments. Sometimes we get 800 comments. It

1 really just - it's highly variable.

2 And so we will then be looking to
3 respond to each of those comments and circle
4 back with you to help us do that and perhaps
5 comments might change some of your
6 recommendations. Who knows. There may be
7 enough feedback that you want to reconsider
8 things, and that will be the purpose of that.

9 So, then after that we will -
10 after that's been shaken down, all the
11 revisions made, we'll then take it out to NQF
12 members for voting. Those votes then go to
13 the Consensus Standards Approval Committee and
14 the board of directors with anticipated
15 endorsement of the measures by November, I
16 believe it is.

17 So, that's kind of where the rest
18 of the year comes out. I do think, Ian, were
19 there any other follow-ups you wanted to
20 mention?

21 MR. CORBRIDGE: I have two other
22 points I want to talk about, but if you want

1 to finish -

2 DR. WINKLER: No, I think that's
3 what you can expect from us. And we'll try
4 and keep you posted on anything as it's
5 happening certainly to let you know.

6 DR. HENNESSEY: And Alzheimer's
7 we're going to get some -

8 MR. CORBRIDGE: That was one of the
9 other points I was going to follow up on. So,
10 for those kind of who are interested in
11 participating in an Alzheimer's/dementia
12 workgroup, for those who are here, if you want
13 to just briefly talk before you leave, I think
14 Katie said that she would be willing to head
15 that subgroup up. So, I've been working with
16 her. I know she's actively soliciting some
17 outcome measures that she's identified out
18 there. So, I can share that with this small
19 workgroup, who wants to participate, and we
20 can move forward from there.

21 And I think this work will really
22 have to be done, you know, it's not going to

1 be another in-person meeting, but this will be
2 done via phone conference or online voting if
3 we do get measures in terms of reviewing.

4 I guess overall we'd very much
5 like to thank everyone for your participation.
6 Greatly appreciate it. It's been a wonderful
7 experience.

8 And one thing that I would greatly
9 appreciate as well as I know other members or
10 entities as part of NQF, if you do have
11 suggestions of individuals or entities who we
12 should be working with or having a dialogue
13 with, I would greatly appreciate it if you
14 could just shoot me an e-mail. Whether it be
15 a name of an organization or a specific
16 contact somewhere, I think that would be very
17 informative as we try to move forward and work
18 through some of these gaps just to make sure
19 that we have the right people at the table or
20 are helping to educate the right people in the
21 NQF process.

22 So with that, thank you very much.

1 DR. STREIM: I just want to say I
2 think Jeff and Tricia did a great job. And
3 particularly with some of the measure
4 developers who while we were there sort of
5 criticizing hopefully constructively, I think
6 the two of you did a particularly good job of
7 being encouraging and supportive. And I think
8 that was an important ambassador role.

9 CO-CHAIR SUSMAN: I want to thank
10 all of you because you made our job very easy
11 as co-chairs. I think the high quality of
12 this group, your willingness to share your
13 opinions and the immense, immense knowledge
14 base you bring was just spectacular.

15 I really appreciate the
16 opportunity to work with all of you and of
17 course the NQF staff.

18 CO-CHAIR LEDDY: And the workgroups
19 that we were assigned to, the small workgroups
20 really gelled and provided that kind of cogent
21 expertise. That was very helpful.

22 MR. CORBRIDGE: I guess just one

1 last point. If you do have those NQF measure
2 evaluation forms and you're not going to use
3 them again and you're just going to recycle
4 them, we can actually take those back from you
5 and we'll reuse them at another Steering
6 Committee meeting. So, we'll save some trees.
7 So, thank you very much.

8 (Whereupon, at 3:17 p.m. the
9 meeting was adjourned.)

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