THE NATIONAL QUALITY FORUM

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PATIENT OUTCOMES

MENTAL HEALTH STEERING COMMITTEE

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WEDNESDAY

APRIL 7, 2010

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

PRESENT:

TRICIA LEDDY, MS, Co-Chair, Rhode Island Department of Health
JEFFREY SUSMAN, MD, Co-Chair, University of Cincinnati
SHEILA R. BOTTS, PharmD, BCCP, University of Kentucky College of Pharmacy
RICHARD J. GOLDBERG, MD, MS, Lifespan Corporation
WILLIAM GOLDEN, MD, University of Arkansas for Medical Sciences
ERIC GOPLERUD, MD, Department of Health Policy
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

PRESENT: (CONT.)

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

ROBERT ROCA, MD, MBA, MPH, Sheppard Pratt Health System

JOEL STREIM, MD, University of Pennsylvania Medical Center

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

WILLIAM E. GOLDEN, MD University of Arkansas for Medical Sciences

VANESSA KUHN, MPH, Baltimore Substance Abuse*

DIANE MAYBERRY, MHA, RN, Minnesota Community Measurement

COLLETTE PITZEN, Minnesota Community Measurement

YNGVILD OLSEN, MD, MPH, Baltimore Substance Abuse *

*Present via telephone

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Adjourn

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

2 (9:33 a.m.)

3 CO-CHAIR LEDDY: Welcome,

4 everyone. We are going to begin. We are

5 going to begin with introductions. I'm Tricia

6 Leddy, and I'm co-chair of this group.

7 CO-CHAIR SUSMAN: And I am Jeff

8 Susman, your other co-chair. For those of you

9 who I haven't met somewhere before, I'm at the

10 University of Cincinnati and the chair of

11 family medicine there. And I guess we'll just

12 go around the room like this.

13 CO-CHAIR LEDDY: Ashley.

14 MS. MORSELL: I'm Ashley Morsell

15 I am on the NQF staff.

16 MR. CORBRIDGE: Good morning, Ian

17 Corbridge, also on NQF staff working on the

18 project.

19 DR. MANTON: Good morning. I am

20 Anne Manton, and I'm a psychiatric mental

21 health nurse practitioner at Cape Cod

22 Hospital.

1 MS. JAFFE: I am Darcy Jaffe from
2 Harvard View Medical Center.
3 DR. STREIM: I'm Joel Streim.
4 I'm an internist in geriatric psychiatry at
5 University of Pennsylvania.
6 DR. PHILLIPS: I am Glen
7 Phillips. I'm a senior research scientist at
8 Eli Lilly & Co.
9 MR. PELLETIER: I'm Luc
10 Pelletier, administrative liaison at Sharp
11 Mesa Vista Hospital.
12 DR. BOTTS: Sheila Botts,
13 University of Kentucky College of Pharmacy,
14 and clinical pharmacy specialist in the VA.
15 DR. KAUFER: I am Dan Kaufer,
16 behavioral and geriatric neurologist at UNC
17 Chapel Hill.
18 DR. GOLDEN: I am Bill Golden,
19 general internist, University of Arkansas, and
20 medical director for policy at Office of
21 Medicaid.
22 DR. GOLDBERG: I'm Rich Goldberg.

1 I'm a psychiatrist from the great state of
2 Rhode Island and head of a mental health or
3 health care system, regional health care
4 system, Lifespan Corporation.
5 DR. WAN: Good morning, everyone.
6 George Wan, senior director at Johnson &
7 Johnson North American Pharmaceuticals.
8 DR. HENNESSEY: Good morning,
9 everybody. I'm Maureen Hennessey. I'm a
10 psychologist and health coach, and I'm with
11 Gardener Health Systems Trauma Support Network
12 in the University of Missouri in Kansas City.
13 DR. ROCA: Good morning. I'm Bob
14 Roca. I'm a psychiatrist, and I'm also the
15 vice president of medical affairs at Sheppard
16 Pratt in Baltimore.
17 MS. WILKINS: Good morning, I'm
18 Carol Wilkins. I'm a consultant. I do a lot
19 of work on homelessness and mental health.
20 And for a long time I was the director of
21 policy and research at the Corporation for
22 Supportive Housing.

1 MS. MASLOW: Sorry I'm late.
2 I'm Katie Maslow. I'm from Alzheimer's
3 Association.
4 DR. WINKLER: Good morning,
5 everyone. I'm Reva Winkler. I welcome you
6 all back to work with us here at NQF. I'm the
7 program consultant as I have been at NQF for
8 the last nine years.
9 MS. BOSSLEY: Good morning, I'm
10 Heidi Bossley, a senior director in
11 performance measures at NQF.
12 MS. MAYBERRY: Diane Mayberry from
13 Minnesota Community Measurement.
14 MS. PITZEN: Collete Pitzen from
15 Minnesota Community Development.
16 Off-mic introductions)
17 CO-CHAIR SUSMAN: It's a great
18 group. We're very fortunate to have everybody
19 here today. I believe at least one person
20 might be joining us on the phone once they get
21 that hooked up.
22 Just to orient you where we are

1 with the process, and then we'll turn it over
2 to the NQF staff, we had two goals with this
3 project, one of which we are going to
4 concentrate on today which is the evaluation
5 of these candidate measures, and to decide
6 which ones we are going to pass along through
7 the process; the other that will I think come
8 up as we go through this, and I know some of
9 you are very interested in, are to identify
10 gaps, to look at areas that we really should
11 have measures, or there might be some outcomes
12 that we aren't assessing or measures that have
13 not been submitted, to identify those gaps and
14 to be able to document those.
15 Reva has told us that we will
16 probably want to circle around back to that,
17 so if we don't get to it, given the agenda
18 that we have, don't worry, we are conscious
19 that this is an important part of the process.
20 But if you see gaps or issues as we have the
21 discussions, I hope you will let us know so we
22 can keep that on the parking lot and make sure

1 that that is clearly identified.
2 Harold, do you want to introduce
3 yourself, please, because we've got some new
4 people.
5 DR. PINCUS: Okay, sorry I'm
6 late, I'm Harold Pincus, I'm vice chair of
7 psychiatry at Columbia University and director
8 of quality and outcomes research at New York
9 Presbyterian Hospital.
10 CO-CHAIR SUSMAN: So I think
11 Tricia and I will try to do our best to keep
12 us on time. We certainly envision the first
13 evaluation discussion of the measure that we
14 undertake will be a little bit longer, but we
15 will have to keep a pretty brisk pace. I also
16 would suggest that if on further reflection we
17 look at one of the candidate measures and
18 decide really it isn't an outcome but rather
19 a process measure, that we deal with that up
20 front, because that would be out of scope of
21 the project. It could save us some
22 substantial time in not having to go through

1 the whole process that is laid out before us
2 if we can say right up front, no, you know,
3 this really is a process measure after all.
4 With that, Tricia, do you want to
5 --
6 CO-CHAIR LEDDY: I think that
7 just following on what Jeff just said, which
8 is, if we do have process measures we can and
9 we feel that it is the only measure that has
10 to do with a certain subject, there isn't an
11 outcome measure, I think that in putting aside
12 the measure because it is process it will give
13 us potentially the opportunity and time to
14 identify what outcome measure we would like to
15 see, and therefore, use the time to not feel
16 bad about not having done that area, because
17 we can say, well, what really would be the
18 outcome measure, and then as in the report
19 there will be not only the measures that we
20 vote on but also a portion of the report that
21 will identify those specific gaps.
22 So if we can get very specific

1 about what we do want to see in an outcome
2 measure in a certain area, then I think that
3 will get us eventually to the goal of having
4 outcome measures in those we think we are
5 important rather than feeling that we have to
6 accept a process measure.
7 CO-CHAIR SUSMAN: So I think
8 without further ado we will turn it over to
9 Reva. Harold, do you have a question?
10 DR. PINCUS: What is the path
11 that may get us further to -- what is the
12 pathway to getting us further? Because since
13 we are not developing --
14 CO-CHAIR LEDDY: Right, it
15 wouldn't be our group, you are absolutely
16 right, Harold. So I will throw that one to
17 Reva.
18 DR. WINKLER: And I can catch
19 that one easily. Because it is a specific
20 deliverable on this contract, and the contract
21 is with the Department of Health and Human
22 Services, they have indicated that it is their

1 intent to take these recommendations and use
2 the development resources within the
3 Department of HHS to address those gaps. So
4 that is why it's particularly important and a
5 very specific deliverable for this project.
6 DR. PINCUS: So we need to devote
7 a significant amount of time -- what we have
8 is disappointing.
9 DR. WINKLER: Right, exactly.
10 And you are not alone. Mental health is not
11 the only sort of orphan child in this area.
12 We've got several topic areas in the other
13 parts of the project where there were no
14 majors either, and there are certainly some
15 large gaps. So we are - the initial work that
16 we are doing is looking at the measures we do
17 have and evaluating them, because they have
18 several months worth of process to follow with
19 public comment and voting and all of that. So
20 we need to get them going on that track. But
21 then we do want to put in some thoughtful time
22 around what would be the desirable outcome

1 measures that we didn't get, don't exist yet,
2 need to be developed, and what would they look
3 like, and to be as specific as possible.
4 So we will need to continue
5 working with you as time goes on so we can
6 develop that part of the project, but it's
7 definitely a very important part of the
8 project, so it's not an afterthought, it's not
9 a sort of footnote. It really is one of the
10 two main deliverables for this project.
11 DR. PINCUS: So it also occurs to
12 me that as part of that discussion we should
13 revisit the ones that were seen as being out
14 of scope or into processing for ideas about
15 where we should go.
16 DR. WINKLER: I think that is
17 what Tricia was saying.
18 MS. MASLOW: What is going to be
19 the process for that? Is that going to be --
20 are we going to have specific time on the
21 agenda today? Or is that going to be a
22 substantive meeting? How will that work?

1 DR. WINKLER: I think it will be
2 a couple of things. Depending on how your
3 meeting goes in terms of making progress on
4 the agenda, if there is time I think it would
5 be worthwhile to begin to address that, but I
6 envision it more as follow up phone calls.
7 Because we just need to get this work done and
8 get it moving along, then we can take the time
9 to do some thoughtful addressing of the gaps.
10 CO-CHAIR SUSMAN: And I think if
11 something comes up, mention it, but we are not
12 going to have time to fully work it during
13 this process. If we get way ahead.
14 DR. GOLDEN: Before we get into
15 the individual measures, will we have some
16 time this morning to talk about some generic
17 questions that the measure set raised? CO-CHAIR
18 SUSMAN: I think what I would suggest we do
19 is first allow staff to give us an
20 orientation, and then perhaps as we work
21 through the first measure to talk about those
22 generic issues, because if we have something

1 specific before us it will help us really
2 focus some of the discussion around that.
3 If we want to spend a few minutes
4 up front talking about those, I think --
5 DR. GOLDEN: I have a specific
6 issue that applies to several of the measures
7 that I would like to discuss.
8 CO-CHAIR SUSMAN: Sure.
9 DR. WINKLER: I think that just
10 in terms of project status and where we are,
11 just a couple of things. I know that there
12 was a great deal of response to our notice of
13 intent, thank you to all of the work that you
14 all did in notifying all of your contacts.
15 Ian spent hours talking on the phone with all
16 sorts of people who would have been previously
17 unaware of NQF and now are aware of the work
18 we are doing. So that was the first real
19 significant work for you when you were -- A
20 plus on that. So we did get a lot of interest
21 and a lot of new organizations that had not
22 been involved.

1 When it came to the actual
2 submissions, again Ian did a lot of phone
3 calls with people asking questions, and this
4 issue of process versus outcome came up a lot,
5 so there was a certain amount of filtering
6 that happened at that point, because he would
7 tell them, we really want the outcome
8 measures. But again the actual formal
9 submission process, which is not a trivial
10 thing to do, measure developers put in the
11 time and resources to submitting them. We
12 still have some of the issues around process
13 outcome, and on your phone call that we did
14 three weeks ago or so you eliminated a few of
15 those. That's a filtering process that seems
16 to be ongoing so we will just have to address
17 it as we go along.
18 You have really gotten yourself
19 into the meat of the work by your initial
20 evaluation of the measures. It's very
21 important in the evaluation of the measures
22 that we use, the measure evaluation criteria.

1 We have given you all copies of it. That was
2 one of the directives from the CSAC was, be
3 sure the committee members have it in their
4 hand to refer to it. So there you go.
5 When we talk about the measures
6 and their strengths and weaknesses, we really
7 do want to couch them in terms of the
8 criteria; it either does or doesn't meet the
9 criteria. There is a problem with it because
10 it doesn't address this, or it's really great
11 because it does do this. So the criteria
12 really are the framework around the discussion
13 we'd like you to have, with the exception of
14 importance to measure and report. There are
15 no actual thresholds. So you do have to all
16 agree that it is important to measure and
17 report, and if you say it's not then that's
18 it; we stop right there.
19 We will need you to vote on your
20 evaluation of each of the four main criteria:
21 importance, scientific acceptability,
22 usability, feasibility, for each of the

1 measures. We are trying to give a little bit
2 of hard data on your assessment to the
3 subsequent audiences that are going to be
4 reviewing it during public comment, during
5 voting, for the CSAC, and for our board of
6 directors. So we are trying to capture those
7 ratings in a way that helps underpin your
8 ultimate recommendation.
9 There is no numerical adding,
10 subtracting -- you have to get a majority of
11 them have to completely meet the criteria, or
12 if you get half Cs, that's a good -- none of
13 those -- there are no magic formulas. There
14 is no math to this. They should be the things
15 you are thinking about and considering and
16 balancing, realizing there will be tradeoffs.
17 We have yet to see a perfect measure. We just
18 don't see them. There isn't anything that
19 completely meets all the criteria every time.
20 There are some that come close,
21 but none that have hit them all. So it's a
22 balancing act, but the rationale for

1 recommending the measure should be supported
2 by, we feel it's very important. We feel the
3 scientific acceptability is good enough. We
4 feel it is usable and provides meaningful
5 information. We believe it is feasible to do.
6 Those are the kinds of right reasoning, even
7 though the actual subcriteria may not be
8 perfect for each measure.
9 So I think you have all had
10 experience doing the several measures that
11 were assigned to you in your workgroups. The
12 purpose of that was to spread the work out.
13 You've got, what 18 measures? Seventeen
14 measures. And asking each of you to be
15 intimately involved with all 17 was
16 overwhelming. So by breaking it out we asked
17 each worker to spend some time with a limited
18 number of measures.
19 As we go through these today we
20 will expect the members of the workgroup who
21 are really familiar with the measure to kind
22 of lead that discussion and help the rest of

1 the group understand the strengths and
2 weaknesses of the measures as we go through
3 them so at the end of the day the ratings and
4 recommendations reflect the input of everybody
5 on the steering committee.
6 So that is essentially what we are
7 up to today. We are going to go measure by
8 measure. We will help you through the first
9 couple, and there is a learning curve so it
10 will take a little longer. But it's very
11 important that we hear your issues. You all
12 are here representing different stakeholder
13 perspectives. There should be some
14 disagreements among you; there should be
15 different points of view, and we need to make
16 sure that those are brought to the table and
17 that everyone has a chance to speak them and
18 have them heard. That is a fundamental part
19 of NQF consensus process is to have all of
20 that diversity of input.
21 So that is the reason you are
22 here, so we really do encourage everybody to

1 speak up, and if you are going to say
2 something that disagrees with the rest, please
3 do it; that's what you are here for.
4 So I think in terms of background
5 that is kind of the summary of how we got here
6 and what we are planning on doing today. And
7 I think, does anyone have any questions?
8 Okay, Bill had a question. We'll
9 see in a minute. Bill, did you have a
10 question?
11 DR. GOLDEN: I was going to - did
12 you answer his issue? I was going to ask a
13 question about scope.
14 DR. WINKLER: Okay.
15 DR. GOLDEN: About measures in
16 general.
17 MR. CORBRIDGE: Can we just hold
18 on one second? We are actually trying to get
19 the phone lines hooked up. So we just have to
20 go through the process of talking with the
21 actual operators. And I guess while we are
22 waiting for that, I'd just like to follow up.

1 Once again thank you everyone very much for
2 all of your participation so far and
3 dedication to the project. A couple of
4 housekeeping issues. This is actually not
5 NQF's workspace here. We are actually in a
6 law firm here. So they requested -- they are
7 obviously having some meetings today as well -
8 - so they requested that if any individuals do
9 have to make a phone call, need to step out,
10 if you actually need to make a phone call if
11 you can go down to the main lobby. They just
12 don't want to have people coming in and out
13 here, and they'd like us not be out in the
14 lobby making phone calls. So just one thing
15 as indicated by other staff members a couple
16 of members of the steering committee are
17 unable to make it this morning. I know Dr.
18 Thompson had some car issues, and Dr. Goplerud
19 had some previous appointments, so they should
20 be coming later on today. Maybe once we get
21 this phone line hooked up and answer some
22 questions, we will go over some of the

1 documentation you have in front of you as well
2 as what we are projecting on the screen.
3 So hold on just one second.
4 (Technical interruption)
5 MR. CORBRIDGE: I'm sorry, we
6 seem to be having some issues. So if you
7 would like to go ahead, Dr. Golden, and just
8 ask your question, I will see if we can get
9 this issue with the phone figured out and go
10 from there.
11 DR. GOLDEN: The question for the
12 staff in terms of just the measures
13 themselves, the unit of measure is sort of
14 interesting. Is the NQF still using for
15 outcomes and process decision making or impact
16 the provider as the unit of measure of the
17 community? Because some of these measures
18 were starting to go toward community units of
19 measure rather than provider units of measure,
20 and I was just curious where you all are?
21 DR. WINKLER: Well, we are
22 actually expanding. Traditionally in the past

1 most of the measures that NQF has addressed or
2 endorsed are focused on some level of
3 providers, whether it's the hospital, the
4 individual clinician, the group, the facility,
5 whatever. However one of the national
6 priorities partnership goals and priorities
7 areas is around population and health, and we
8 have -- and I guess you weren't at the meeting
9 on the call, Bonnie Zell who oversees our
10 population health work here at NQF is helping
11 us move into that population realm. So the
12 fact that some of the measures may be more
13 appropriate for communities or more population
14 rather than provider specific is something
15 that NQF is quite open to entertaining.
16 DR. GOLDEN: But it changes how
17 you apply the criteria, so that's why I was
18 asking. And I guess the other follow up, the
19 other issue there, is you talk about the
20 usability. Some of these measures are valid,
21 but they are useful in the process of care
22 rather than evaluating the care, and I was

1 just curious if you had thoughts on that as
2 well. I think people are coming to you with
3 tools to be used and endorsed as opposed to a
4 measuring tool.
5 DR. WINKLER: Right. Well, I
6 think underlying all of it, remember that
7 NQF's goal in all of the quality enterprise
8 is, we endorse measures used primarily for
9 accountability and public reporting, so using
10 the measure in that way, and suitability for
11 being used in that way, is really embedded in
12 many of the criteria, and certainly the one on
13 usability. So the 3(a) criteria on usability
14 is, is it useful for a variety of stakeholders
15 in terms of actionability, and is it usable,
16 understandable, meaningful if it's used in
17 public reporting?
18 So that is really the kind of
19 context you need to be thinking about these
20 measures going forward.
21 DR. GOLDEN: And my only comment
22 is on the usability statement in three. It

1 says, why they actually find them useful for
2 decision making, but it didn't put in there
3 for - and you need to maybe -
4 DR. WINKLER: Right, that's a
5 good point. I think, Bill, that sort of up
6 front as the overlay is the public reporting
7 part, but you are right, embedding it
8 specifically in the criteria statements would
9 be a good idea.
10 CO-CHAIR SUSMAN: So are there
11 any other general questions? I think, Harold,
12 you did have a question or comment?
13 DR. PINCUS: In terms of the
14 forms to be filled out, are they totally a
15 result of - do they go through editing or
16 someone intentioned by staff.
17 DR. WINKLER: No, essentially
18 what we have done is taken the information
19 submitted by the measure developer and
20 embedded those in the form. Those are the
21 unchangeable parts of the form.
22 The areas that have the rating,

1 and there are blocks for TAP comments if there
2 is a TAP project, or the steering committee
3 comments, those will be putting in your
4 assessment. So this is a document that grows
5 through the process. It starts with the
6 information that is submitted, then the
7 evaluative elements are added to it as it goes
8 forward through the process.
9 DR. PINCUS: A measure developer
10 unfamiliar with NQF is kind of clueless as to
11 what you are going for. Basically you're
12 stuck with what they have even though they
13 might have had some different measures.
14 DR. WINKLER: We can certainly
15 feed that back to the measure developer and
16 make the suggestions, and we do have a
17 mechanism by which they can edit it or change
18 it and revise things, to change the
19 information that is there in their portion of
20 it.
21 MS. BOSSLEY: And Ian spent some
22 time doing that already. So if we saw a big

1 section blank, so for example, the testing
2 pieces, the reliability, validity. He went
3 back and had a conversation with them to make
4 sure that indeed that does need to stay blank
5 because they haven't done that testing. If
6 they haven't, that's where he marked it as not
7 tested.
8 DR. PINCUS: A few more
9 questions, one, is the absence of information
10 on something indicate that there isn't any
11 information or that they didn't put it in.
12 And the second thing is, particularly with
13 regard to the harmonization piece, how do they
14 know what else is at NQF?
15 DR. WINKLER: Well, I can answer
16 your second question first. And that is,
17 NQF's website actually has a searchable
18 database on it. And you can search and find
19 out what measures NQF has endorsed. The NQF
20 staff also does the backstop on that.
21 DR. PINCUS: So that does have
22 editing by staff.

1 MS. BOSSLEY: So what we would
2 do is if they included it in a separate
3 document or in some way indicated to you that
4 there is a comparable measure.
5 DR. PINCUS: Is that what's being
6 looked at?
7 DR. WINKLER: Correct.
8 MS. BOSSLEY: I don't think
9 there was anything. Ian, can you clarify?
10 MR. CORBRIDGE: If there are
11 similar measures to the measure that was
12 submitted to this project, it should be - I
13 can't remember the actual page number, but at
14 the very end of the evaluation document it
15 indicates if there are similar measures what
16 those measures are, providing the NQF number
17 and some specs for that.
18 MS. BOSSLEY: We try to do that
19 work for you as well, to try to help identify
20 --
21 CO-CHAIR LEDDY: Are there any
22 other questions before we launch into the

1 first measure?

2 DR. WINKLER: Ian, did you have

3 anything else?

4 MR. CORBRIDGE: All right, if

5 there are no more questions, I guess we'll

6 just go over some of the documentation that is

7 in front of you as well as some of the

8 documentation that we will be projecting up on

9 the screen.

10 In front of you you should have an

11 agenda for the day as well as a breakdown of

12 the measure evaluation workgroups within that

13 indicating what members of the steering

14 committee were a part of that workgroup, as

15 well as what measures for the title as well as

16 the NQF initial tag number with that measure.

17 As we've already gone over you do

18 have a copy of NQF's measure evaluation

19 criteria, so we just hope that you will be

20 able to refer to that as we go through this

21 process, and I'm sure you're probably had to

22 use it. We provided it in digital format as

1 you were reviewing these measures.
2 Projected up on the screen we will
3 be showing the survey of the subcriteria that
4 members of the steering committee worked on.
5 We tried to capture all the information that
6 was submitted to us yesterday, and we will be
7 projecting that up on the screen, and
8 hopefully that will serve as just a platform
9 to help facilitate the discussion and
10 dialogue. And from that standpoint we will
11 just kind of be able to dive deeper within
12 each measure and workgroup.
13 We also - and we'll project it a
14 little bit later on - once we get to the
15 points for the voting process, NQF, we are
16 going to be capturing the votes for each
17 measure. We will be looking at issues of
18 importance, scientific acceptability,
19 usability and feasibility. So those are the
20 four main NQF evaluation criteria. So we will
21 project that a little bit later on when we get
22 to that point.

1 For starting off each measure I'm
2 just going to open it up or read off the
3 number of the measure that we are going over
4 as well as the title. I will give you a brief
5 description, a numerator and denominator
6 statement if that will be helpful for members.
7 From that point we will really open it up to
8 the workgroups to really kind of head off and
9 further dive into that discussion. We tried
10 to seat each workgroup next to each other so
11 there can be conversations and dialogue
12 amongst each other, and we will go from there.
13 DR. PINCUS: Are we breaking into
14 workgroups?
15 MR. CORBRIDGE: No, not
16 specifically breaking into workgroups, but as
17 we are talking if you would like to share some
18 information, we just wanted to make sure that
19 you were sitting next to each other if there
20 was information you wanted to share or pass
21 along to each other.
22 Any additional questions regarding

1 that process? Does that seem clear to
2 everyone, like it will work?
3 Heidi is there any way that we can
4 --
5 CO-CHAIR LEDDY: Do you need it
6 bigger?
7 MR. CORBRIDGE: I don't know if
8 this was - we tried to have as quick a turn
9 around time as we could, so I emailed this out
10 to every member yesterday, and I do have some
11 limited hard copies, maybe I can just pass
12 this out to the back of the room as it is
13 difficult to see back here.
14 (Off the record comments)
15 MR. CORBRIDGE: Pass these
16 around.
17 All right, are there any
18 additional questions before we begin looking
19 at the first measure? And so as we go through
20 the process, when we get to the measure, if
21 the measure developer is on the line or is
22 here in person, if they would like to make

1 just a brief presentation, just talk about the
2 measure, the process, they are more than
3 welcome to if that's what the steering
4 committee would like as well as later on
5 throughout the process if there are any
6 questions from the steering committee members
7 please feel free to ask them of the measure
8 developer through the dialogue or at the end
9 of there are questions that are raised.
10 If there are no more questions I
11 guess we can start moving forward, to keep on
12 time.
13 CO-CHAIR LEDDY: So Ian, you are
14 going to describe each measure first?
15 MR. CORBRIDGE: Correct, yes. So
16 we are going to go over each measure first.
17 I'll just read a brief description of it and
18 we will move forward from there.
19 And I don't know if the
20 representatives from Johns Hopkins University,
21 are you on the line?
22 (No response)

1 MR. CORBRIDGE: I know they were
2 hoping to make it. But it doesn't seem like
3 we have anyone at this time. So we will just
4 proceed forward with the measure that we have
5 first on the agenda, and that is measure
6 number two, and that is patients' attitudes
7 towards and ratings of care, depression.
8 MEASURE 0T3-002: PATIENT ATTITUDES TOWARD
9 AND RATINGS OF CARE FOR DEPRESSION
10 (PARC-D 30) QUESTIONNAIRE
11 MR. CORBRIDGE: And so that was
12 the brief title. Just a brief description,
13 and this is the information being projected on
14 the screen for that measure, and that's the
15 information for the subcriteria.
16 A brief description of the measure
17 is, developers employed a comprehensive
18 patient-centered approach, developed an
19 instrument to measure primary care patients'
20 attitudes towards and ratings of care for
21 depression.
22 To help prioritize attitudes,

1 additional domains including 126 items
2 identified previously in focus groups, we
3 asked patients to rate the importance of each
4 aspect of depression care on a five-point
5 scale. Items were ranked according to a mean
6 score, and the percentage of patients ranking
7 the items as extremely important. The items
8 were selected for inclusion and an instrument
9 to measure patients' attitudes toward
10 depression care based on importance ratings.
11 We performed reliability and validity testing
12 on a scale compromising our 30 most important
13 items, and a shortened version that included
14 16 items. So they do go on further. Let me
15 just read to you the numerator statement for
16 that measure.
17 So the numerator statement for
18 this measure reads, patients in primary care
19 settings who complete a depression screener
20 such as a patient health questionnaire PHQ-9,
21 and score greater than or equal to five
22 indicating a mild or moderate depression.

1 Additional target populations include primary
2 care patients with clinically significant
3 depressive symptoms, minor depression,
4 dysthymia, major depressive disorders, in
5 partial remission or mixed anxiety depressive
6 conditions.
7 The denominator statement for that
8 measure reads: all primary care patients.
9 So that's just the intro for that
10 measure. That measure resided in workgroup
11 one, and members from workgroup one, I'm
12 sorry, would you mind raising your hands?
13 It's on the top of the slide, but just members
14 from workgroup one? All right, wonderful.
15 So that's just a brief way to
16 start off the measure. And we can look up on
17 the screen, the initial results for the
18 subcriteria for the main evaluation criterion,
19 importance projected up there. And if the
20 workgroup would like to add any insights on
21 that.
22 CO-CHAIR LEDDY: We would like

1 to comment on whether this is first, on
2 whether this is enough toward an outcome
3 measure to or whether it's clearly process at
4 this point?
5 MR. CORBRIDGE: Correct, I think
6 that would be a wonderful idea.
7 CO-CHAIR LEDDY: Maybe would
8 anyone in the workgroup like to comment on
9 that?
10 DR. PINCUS: I actually didn't
11 see how it was a performance indicator at all.
12 It's a research tool to assess patients'
13 attitudes toward depression care. And it
14 wasn't clear to me how insomnia - what one
15 would expect, to monitor everything in a
16 client someway.
17 DR. GOLDBERG: I think our
18 summary says a lot. It looks at the patient's
19 outcomes. You've scored it as two minimally,
20 one not applicable, and one partial. I
21 thought it was an interesting measure. My
22 comment is on engagement, it had something to

1 do with the engagement of a patient. I
2 didn't see it as an outcome measure,
3 primarily.
4 DR. WINKLER: Well, if you
5 recall, when we had our conversation in
6 November, we discussed the wide variety of
7 outcome measures, and types of outcome
8 measures. And you all spent a lot of time
9 expanding those fairly broad categories that
10 did include patient experience with care,
11 patient adherence, all of those sorts of
12 things, as a result. So you all kind of
13 defined outcomes that way. So the question
14 is, does this fit?
15 DR. PINCUS: I can see how one
16 could use it as an outcome measure. But as
17 currently defined, it's not even a measure of
18 depression care, it's a measure of depression
19 attitudes.
20 (Simultaneous speaking)
21 DR. PINCUS: Well, but it's
22 actually - so it's heterogeneous in that way.

1 (Simultaneous speaking)
2 DR. PINCUS: But my sense was it
3 didn't meet the importance criteria.
4 CO-CHAIR SUSMAN: So it looked to
5 me at least in the description from staff that
6 there were sort of two components to this.
7 One was attitudes toward and the other part
8 was the perceptions of care itself. And that
9 to me is problematic, because you are mixing
10 an outcome and a process essentially, or an
11 attitude about their depression, so I was just
12 wondering whether this was even within scope,
13 given that complexity. But I'd be interested
14 in the folks who really spent a lot of time
15 with this.
16 DR. HENNESSEY: I have a
17 question. Is it true that the mission of this
18 group is to look at measures dealing with
19 patient engagement of care? Because if it is,
20 this may partially address that, but as you
21 pointed out, it looks like it's measuring two
22 different variables, so you can have some

1 murkiness there. But is that --
2 DR. WINKLER: You all have
3 defined outcomes to include patient experience
4 and care as an outcome of health care
5 delivery.
6 DR. HENNESSEY: Which makes
7 sense to me, but whether or not this is the
8 measure for that because of that is the
9 question on the table right now.
10 CO-CHAIR LEDDY: I think on the
11 phone call though, that's when you are
12 referring to, Reva, where we were fairly
13 broad?
14 DR. WINKLER: No, not the phone
15 call, your meeting.
16 CO-CHAIR LEDDY: I think the
17 discussion on the phone call at least was that
18 we wanted to be somewhat broad and inclusive
19 if there was any question because we didn't
20 have a lot of detail about the measure, and
21 that would give us more things to consider at
22 this meeting where we would be more strict and

1 --

2 DR. PINCUS: I don't think it's

3 necessarily just whether patient engagement -

4 for example, one of the items is, faith in God

5 will heal my depression. I'm not sure how

6 that is related to an engagement that you

7 monitor for quality.

8 DR. GOLDEN: I don't think this

9 is in our scope. I think if I were a provider

10 the information for this survey would help me

11 understand the patient, but it's not going to

12 make a lot of reflection on my management of

13 the patient or assessment of how I manage the

14 patient. So I recommend that this would not

15 be considered.

16 DR. GOLDBERG: I don't know if

17 you want to go further. Though our process

18 would be if it doesn't pass the first step -

19 (Simultaneous speaking)

20 DR. PINCUS: One other point

21 there is that on the harmonization it goes

22 further, it raises a sort of broader issue

1 about harmonization is, it wasn't mentioned
2 and I'm not sure whether in TAPS or ECHO could
3 have overlapped with some of the elements of
4 this as well. But it seems to me at least of
5 all the items that do relate to patient
6 perceptions of care, these overlook what the
7 overlap was. I consider these not with all
8 the others but just as a process issue.
9 DR. GOLDEN: You know I just
10 wanted to just introduce, just looking at the
11 measure evaluation criteria on the second page
12 it talks about these intermediate types of
13 process outcome measures. It seems like this
14 would fit under the patient experience or
15 assessment of patient experience of health
16 care outcomes and values. The values piece
17 will address that question of your faith in
18 God, things like that.
19 CO-CHAIR LEDDY: But I think
20 that the measure evaluation criteria is all
21 kinds of measures, not just outcomes. So this
22 is a generic tool and could be used for other

1 groups that are doing the process measures as
2 well as outcome, whereas what our assignment
3 is is to really stick to outcome measures, and
4 I think the Donabedian definition that they
5 gave us at the first meeting was really good.
6 It says, outcome refers to changes, either
7 desirable or undesirable, in individuals and
8 populations, that are attributed to health
9 care, and even down the paragraph it says that
10 an outcome would be something that the patient
11 is seeking care for, like improvement in
12 function, that sort of thing.
13 So if we stick to - I think that
14 is really what they want us to focus on as far
15 as outcomes, because there are other groups
16 that are going to be looking at process, I
17 assume.
18 DR. GOLDEN: A comment on
19 George's comment. The difference I think
20 though here is that on the values piece, I
21 think that we often are assessing the respect
22 of the values in the process of care rather

1 than the values themselves. So this tool
2 assesses what those values are as opposed to
3 how the health care system dealt with those
4 values. And I think that's a difference in
5 terms of how the measures deploy.
6 CO-CHAIR SUSMAN: It would seem
7 to me that feedback to this measure developer
8 might be that there are indeed some important
9 elements of the experience of care that
10 perhaps a submeasures within this could be
11 used as a valid measure of patient experience,
12 but there are other elements that are clearly
13 outside patient experience and led the
14 committee to say this wasn't a useful outcome
15 measure.
16 But one can imagine many of these
17 sub-elements they talk about - health care
18 providers' interpersonal skills, their
19 perception of treatment and effectiveness
20 might be very important measures given our
21 broad definition of outcomes. But the
22 admixture of other things like intrinsic

1 spirituality probably made us less excited
2 about this measure.
3 DR. PINCUS: It is not designed
4 to sort of pull out individual items. As
5 broad domains of potential interest, yes. But
6 as a measure, no.
7 CO-CHAIR LEDDY: So is the next
8 procedure that we vote, or have we achieved
9 consensus?
10 DR. WINKLER: It's sounding like
11 we do need to vote on the importance to
12 measure and report, because if it doesn't pass
13 then we are done with this and we can move on
14 to the next one.
15 DR. PINCUS: So is it a majority?
16 DR. WINKLER: Typically a
17 majority.
18 DR. PINCUS: A simple majority?
19 MR. CORBRIDGE: Chris, I guess
20 before we get to that vote we do need to make
21 sure we open up for public comment if there is
22 anyone on the phone line or anyone here who

1 would like to comment on the measure under
2 discussion.
3 (No response)
4 MR. CORBRIDGE: So NQF staff, I
5 don't know, Heidi, if you are able to - there
6 is just a show online, up on the screen, the
7 measure voting tool. So this is what staff
8 have on their screens. So we are just going
9 to capture throughout the process the
10 information and dialogue that is discussed
11 here as well as the votes for each. So we
12 will keep that. And so for this measure, if
13 we are just getting to importance, we will
14 just capture the importance vote, and then say
15 that it was tabled due to not meeting
16 importance.
17 Yes.
18 DR. ROCA: Is this an issue of
19 importance or scope?
20 DR. WINKLER: The two kind of
21 have a not a sharp edge between them. You can
22 eliminate it on scope if you are saying that

1 it's not an outcome measure. On the other
2 hand what I heard more was that maybe it's
3 within the scope of the mental health
4 outcomes, but that this isn't a performance
5 measure that is important to measure and
6 report for public reporting that will provide
7 meaningful information to audiences.
8 DR. HENNESSEY: You know my
9 dilemma in this is from the importance
10 perspective I do think in terms of patient
11 engagement attitudes are quite important.
12 From what I'm hearing from this group that's
13 really looked at this measure, though, it
14 sounds like the psychometric properties of it
15 are not well delineated. That's one issue.
16 DR. PINCUS: Does it measure
17 performance? It's unclear whether doing
18 something, what the results would be that
19 would be a good result.
20 DR. KAUFER: When I look at -
21 there are seven main domains that these items
22 cover. And I look at these, and these just

1 strike me as being independent variables or
2 covariants, potential covariants, than they
3 are dependent variables.
4 DR. MANTON: I am wondering, in
5 terms of the process, if this is - if we vote
6 to not accept this, what happens to it? I
7 think there are some good elements to it. So
8 will there be feedback to the developer? It
9 almost feels like they could create two tools
10 from it, one just dealing with the outcomes,
11 and then one dealing with the patient issues.
12 And so I'm wondering if that is the kind of
13 thing that happens if it's voted down, or is
14 it just, sorry, but we are not accepting it?
15 DR. WINKLER: No, actually two
16 things happen. We do let - directly advise
17 the measure developers of the feedback from
18 the steering committee. But it's also your
19 discussions included in the report, and when
20 the measures go out for public comment, the
21 information is available and we actually
22 encourage people to comment on measures that

1 were not recommended. So there are
2 opportunities for this to have an ongoing
3 discussion about the usefulness of the
4 measure, providing that feedback. So it
5 doesn't just drop, no.
6 CO-CHAIR LEDDY: So is there a
7 certain way that we can vote? Or can we just
8 entertain a motion from the workgroup about
9 this measure and we'll all just vote on it?
10 Is that acceptable, Reva?
11 DR. WINKLER: What I need is a
12 vote from all of you, does this meet the
13 importance criteria, yes or no?
14 DR. GOLDBERG: The way I can say
15 that is - if you look, the relationship to
16 outcomes is so low that that is the important
17 category, in importance - tied together, so on
18 that basis -
19 DR. GOLDEN: The question I had is
20 on the importance measure. I have read
21 through the criteria. I could not tell if the
22 topic was the important issue or whether the

1 measure - it was very uncertain as I was
2 filling out the questionnaire.
3 DR. WINKLER: In this particular
4 case the importance is addressing the topic,
5 all right? So is this an important topic to
6 measure? Is there a variation in care? Is
7 this the topic that is being measured, have
8 relationship to outcomes? You start, when you
9 move into the scientific acceptability
10 criteria is when you are talking about this
11 measure specified with this numerator.
12 DR. GOLDEN: What is the topic?
13 Is the topic depression? Or is the topic
14 attitudes toward depression?
15 DR. WINKLER: Well, that's the
16 question I think for you all to consider.
17 DR. HENNESSEY: The question
18 down the line is whether or not this is
19 important.
20 DR. GOLDBERG: Aren't there seven
21 domains?
22 DR. HENNESSEY: I'm reading over

1 your shoulder here.

2 DR. GOLDBERG: Are you going to

3 have to have us vote on every one of these

4 elements for this meeting?

5 DR. WINKLER: The four elements.

6 CO-CHAIR SUSMAN: But one is the

7 entrance point to the rest, correct?

8 DR. PINCUS: Threshold.

9 CO-CHAIR SUSMAN: Threshold,

10 thank you.

11 MS. BOSSLEY: There is perhaps a

12 way to maybe handle these, if we are going to

13 go through a lot of these I think. So for the

14 ones that truly would be a process measure, I

15 think you should determine if they are in or

16 out of scope. Probably are going to say they

17 are out of scope. You won't do any voting.

18 They won't appear in a report. They won't go

19 further. Any feedback will go back to the

20 measure developer, so that they know what you

21 thought. And that's it.

22 But for the ones that fit within,

1 and this one I would say kind of fits in
2 within looking at how you define an outcome,
3 didn't go far enough, and that's part of it,
4 I would recommend we do have at least a vote
5 on importance. Because then it goes out in
6 the report, it's included in the final
7 document, and that information is put out to
8 the public. And you can include research
9 recommendations of where you think this
10 measure didn't go but we need to go next. But
11 I think this one is one of those kind of
12 squishy ones that it would be good to include
13 out in the public - you know, out in the
14 public and member comments. Does that seem to
15 make sense?
16 DR. PINCUS: Is this a motion?
17 Is this how you proceed? What rules are
18 followed?
19 MS. BOSSLEY: But I'm asking our
20 chairs too, does that seem like a reasonable
21 approach?
22 CO-CHAIR LEDDY: So it sounds

1 like we have a choice of whether to vote on
2 importance or determine it be in or out of
3 scope. So would any of the workgroup members
4 like to recommend one or the other that we
5 consider, either that we vote on importance -
6 determine first whether this is in or out of
7 scope as an outcome measure.
8 DR. GOLDEN: One more question
9 here for Reva. There is under importance, you
10 have three elements. There is no global vote
11 on importance. So are you asking us to vote
12 on the global?
13 DR. WINKLER: Yes, that is what
14 we will be asking you to do.
15 DR. GOLDEN: So the impact could
16 be high but the other - okay.
17 DR. GOLDBERG: So we have a
18 measure here that because we decided
19 engagement was within scope, maybe within
20 scope, but because this particular measure's
21 relation to outcomes is so low, that its
22 importance, bundled score of importance, is

1 going to be very low. It's within scope but
2 of such low importance that we are not going
3 to proceed to the additional measures.
4 DR. KAUFER: Is that a motion?
5 DR. STREIM: As a general
6 procedure, just to get us through all these
7 measures we are reviewing, what I would like
8 to propose is that we first consider the scope
9 question on all of these as a first cut, and
10 then if it is within scope then we look at
11 importance to measure. And I think that might
12 move it more quickly.
13 With respect to this particular
14 measure we are looking at, well, actually
15 maybe I'll come back to that. Harold, did you
16 have a comment on the process?
17 DR. PINCUS: I agree that we are
18 going to do that, at least from my thinking.
19 I hate to be picky about this. But we need to
20 have a fairly specific definition of what
21 scope is, and when we talk about measure
22 focus, what that means that we are determining

1 the importance of. Is it the topic of
2 depression which is basically what the
3 evidence that they've marshaled showing that
4 depression is a big problem and that there is
5 bad care. Or is it the focus being the
6 measurement of attitudes and engagement of
7 care as demonstrated by this measure?
8 MS. BOSSLEY: Right, so if you
9 look at the measure criteria, the extent to
10 which the specific measure focuses is
11 important.
12 DR. PINCUS: What does measure
13 focus mean?
14 MS. BOSSLEY: So it would be the
15 patient attitudes toward and ratings of.
16 Literally it gets down to that granularity.
17 DR. PINCUS: So it's not
18 depression.
19 MS. BOSSLEY: It's not
20 depression.
21 DR. PINCUS: Okay, that's
22 helpful.

1 MS. BOSSLEY: So it's getting at
2 the aspect of care that we are really trying
3 to measure here, is that important.
4 DR. PINCUS: And the problem is
5 that this is an and rather than an or. That
6 patient engagement, yes; attitudes towards,
7 no.
8 DR. STREIM: I think another
9 comment about scope as it relates to this
10 particular measure, if scope actually for
11 outcome measures, and really does depend on
12 the goal of - the goals of treatment. So when
13 you are looking at the importance to measure
14 an outcome, you have to have some sense of
15 what the goal of that treatment is, otherwise
16 we don't know what we are talking about.
17 So in this example, let's say in the
18 course of treatment for depression perhaps a
19 patient becomes - has a change in their
20 attitude, and values treatment for depression
21 more or less as a result of their own
22 experience during the course of treatment,

1 that is a kind of outcome. But we don't
2 really as a field, we don't have an
3 established set of goals about whether we
4 should be getting our patients to love
5 treatment for depression or hate it. We do
6 care about things like engagement, but I think
7 the way this particular set of - this measure
8 with its 126 various independent variables is
9 not linked to a widely accepted goal of
10 treatment, mental health treatment. So
11 therefore it may be interesting, but I'm not
12 sure what health care consumers in general
13 would say if they could vote on what kind of
14 attitudinal changes we would hope for. That
15 is kind of far afield of where we are with
16 outcomes right now.
17 DR. HENNESSEY: I have a question
18 for the people who are really looking at this
19 - a measure says that they are developing -
20 that they are looking at treatment
21 effectiveness, treatment problems, patient
22 understanding about treatment, health care

1 providers, interpersonal skills. Do they
2 demonstrate, do the developers demonstrate
3 that there is evidence that what they are
4 measuring has an impact on engagement and
5 outcome?
6 DR. PINCUS: No, and that is the
7 problem.
8 DR. HENNESSEY: Thank you.
9 DR. PINCUS: At least within here.
10 Under the criteria as a process if it is
11 linked to outcomes then it is appropriate.
12 But there is no data here that says that.
13 DR. HENNESSEY: Thank you.
14 CO-CHAIR SUSMAN: And just one
15 final comment. If you look at the elements in
16 the numerator, there are things like: faith in
17 God will heal my depression. Prayer alone can
18 heal depression. Thanking God helps
19 depression to get better. Asking God for
20 forgiveness will help heal my depression. And
21 while they may be important elements, they
22 aren't outcomes, and I don't suspect that I

1 can influence those effectively during the
2 course of treatment. They are intrinsic
3 spirituality elements.
4 So for me again it gets back to the
5 motion I think on the table here which is, I
6 think, we've got some elements of engagement
7 which are very important, but we also have
8 some intrinsic elements that I don't see
9 directly related to outcomes. So I think we
10 really should circle back to Richard's motion.
11 MS. BOSSLEY: So your motion is to
12 vote on these, correct?
13 DR. PINCUS: Yes.
14 DR. WINKLER: So it is a yes-no
15 vote. So essentially we will ask you, how
16 many of you agree that it meets the importance
17 criteria?
18 (A show of hands)
19 MS. BOSSLEY: Any abstentions?
20 DR. WINKLER: Eighteen nos.
21 MR. CORBRIDGE: Dr. Thompson, are
22 you joining us on the phone?

1 CO-CHAIR LEDDY: Okay, so we are
2 done with our first measure. How long was
3 that?
4 Our objective for us would be a
5 little more just getting through the process.
6 Eric, did you introduce yourself?
7 DR. GOPLERUD: Yes. I just
8 arrived, Eric Goplerud, I'm a research
9 professor at George Washington University, and
10 I primarily work on substance abuse issues,
11 though I have also done mental health
12 performance measurement work. And this being
13 NQF, I have no conflicts to declare.
14 CO-CHAIR LEDDY: So we are going to
15 move on to our second measure to consider, and
16 Ian is going to take us through the basics.
17 MR. CORBRIDGE: Thank you. So we
18 are moving on to measure number 11. This was
19 submitted by Minnesota Community Measurements.
20 The measure developers have actually joined us
21 today. So we may want to open it up to them
22 to see if they would like to talk about the

1 measures briefly, or if at the end we can have
2 the dialogue with the measure developers as
3 well.
4 MEASURE OT3-011: DEPRESSION REMISSION AT
5 TWELVE MONTHS
6 MR. CORBRIDGE: So moving along to
7 the measures presented up on the screen,
8 measure number 11, depression remission at 12
9 months, so just a brief description of the
10 measure. Adult patients aged 18 or older with
11 major depression or dysthymia, and an initial
12 PHQ-9 score less than nine to demonstrate
13 remission at 12 months defined as a PHQ-9
14 score less than five. This measure applies to
15 both patients with newly diagnosed and
16 existing depression whose current PHQ-9 score
17 indicates a need for treatment.
18 The patient's health questionnaire,
19 PHQ-9, is a widely accepted standardized tool.
20 All rights reserved. This measure
21 additionally promotes ongoing contact between
22 the patient and provider as patients do not

1 have follow up PHQ-9 scores at 12 months, plus
2 or minus 30 days are also included in the
3 denominator.
4 So just a brief description of the
5 numerator statement. It reads: adults aged 18
6 and older with a diagnosis of major
7 depression, dysthymia, and initial PHQ-9 score
8 greater than 9, to achieve remission at 12
9 months as demonstrated by 12 months plus or
10 minus 30 days a PHQ-9 score less than five.
11 The denominator statement reads,
12 adults aged 18 or older with diagnosis of
13 major depression or dysthymia, and an initial
14 PHQ-9 score greater than nine.
15 That's just the initial specs from
16 that measure, and that is once again measure
17 workgroup number one.
18 CO-CHAIR LEDDY: So do we want to
19 invite the measure developers to present
20 before we consider --
21 MR. CORBRIDGE: Yes, if that is
22 agreeable to the workgroup, if you'd like just

1 a brief, five minutes, come up and present
2 that, if that would help move the discussion
3 forward.
4 DR. GOPLERUD: I know you folks
5 have come from Minnesota, and we want to say
6 hi to them and all of that. But I'm wondering
7 if there are questions it might make sense to
8 ask them. Whereas I'm not sure that it may be
9 in some ways the converse, I may be trying to
10 read too much, maybe the converse of the first
11 measure, in that there may not be a whole lot
12 of question about it, and so if what they are
13 doing in some ways is say preaching to the
14 choir, it's wonderful to preach but it may not
15 be necessary. So I kind of don't want to take
16 15 minutes of our time having them present
17 things where there really isn't a whole lot of
18 controversy.
19 CO-CHAIR LEDDY: That is a good
20 point. And this is intended to be
21 interactive, I think.
22 DR. GOPLERUD: So I would kind of

1 recommend that we at least have a preliminary
2 discussion of the measure and decide if we
3 really need a pitch on it.
4 CO-CHAIR LEDDY: Okay.
5 MR. CORBRIDGE: I think it has been
6 run both ways at different committees. So
7 it's really up to the judgment of what the
8 workgroup would like to see. So if you feel
9 it would be more informative as I guess you
10 indicate Dr. Goplerud to have that discussion
11 afterwards, or ask questions as needed, then
12 we can proceed with that, that would be more
13 helpful. If more clarification is needed at
14 the end, then we can proceed that way.
15 DR. GOLDEN: I do have a question
16 for them in the beginning. In the beginning
17 it said this measurement tool is widely
18 accepted, quote unquote. So the question is:
19 what does that mean? And what major
20 specialist societies have endorsed it for its
21 use as a standard of care?
22 MS. PITZEN: I guess I just wanted

1 to say in our state it's a widely accepted
2 tool that many practitioners are using. We
3 have 233 clinics submitting data to us
4 currently.
5 DR. GOLDEN: Have any national
6 medical societies endorsed this as a standard
7 of care?
8 DR. GOPLERUD: The American
9 Psychiatric Council, the PHQ-9, and they have
10 done collaborative studies on - I'm not sure
11 that they said that is, but they have used it
12 in a major research --
13 DR. GOLDEN: Are they saying that
14 every patient should be having this done as a
15 standardized tool?
16 DR. GOPLERUD: On this specific
17 measure, I don't think so.
18 CO-CHAIR SUSMAN: No, but as a tool
19 for measuring outcomes.
20 DR. GOLDEN: But this is important,
21 because if this is a performance measure that
22 we endorse, it becomes a standard of care. So

1 I'm asking is this considered a standard of
2 care to use a standardized tool in practice
3 like this?
4 CO-CHAIR LEDDY: Can the NQF staff
5 address that?
6 DR. GOLDEN: You're basically
7 requiring people, an insurance company to say,
8 NQF has endorsed a measure saying anybody with
9 this diagnosis should have this tool being
10 used.
11 MR. CORBRIDGE: No, no, that's not
12 what it says. These NQF measures are really
13 up to individual entities to adopt the measure
14 if they would like to at their facility. So
15 an NQF endorsed measure doesn't mean that it
16 is put out there and then everyone has to
17 abide by that and measure that.
18 DR. GOLDEN: I disagree with you.
19 Having dealt with this, if an NQF measure
20 comes along, okay, then you are going to see
21 Medicaid and you are going to see insurance
22 companies say this is a national standard, and

1 that we believe that anybody with this
2 diagnosis should have this tool done for
3 reporting.
4 CO-CHAIR SUSMAN: You know to me
5 one of the salient questions, just to frame up
6 is, should we be tying measurement in this
7 area to a PHQ or is there a more general need
8 to measure remission? And it might not
9 necessarily have to be a PHQ. By doing a PHQ
10 you are narrowing the measurement focus, and
11 I would think also not endorsing, you are
12 recommending the use of a single tool. I
13 think the tool itself is great.
14 DR. PINCUS: You are setting
15 yourselves up so that you are between a rock
16 and a hard place. On the one hand if you want
17 to endorse something you have to have a
18 certain level of evidence and you are not
19 going to get the evidence if you have
20 something that is generic that you can't
21 capture the performance standards, especially
22 when you are talking about outcomes. So

1 ultimately if you want to meet this criteria
2 of having sufficient evidence and
3 documentation of the implementation it's going
4 to have to be a specific tool. If you are
5 leaving it up to whatever people want to use
6 as a rating system, it will never get the
7 evidence necessary.
8 CO-CHAIR SUSMAN: I certainly agree
9 with that, but I'm thinking why PHQ. I mean
10 one could choose a CSD, where there's plenty
11 of psychometric data about CSD.
12 DR. PINCUS: It has been proposed.
13 And there is to my mind there is more than
14 sufficient evidence to recommend it. If you
15 want to go to medication developers and say,
16 gee, why don't you modify your measures to use
17 any one of these six different options, you
18 could do that, but it'd raise a lot of
19 questions. Not all of them have been tested
20 the same way in the same populations and so
21 forth, and you wind up getting picky about all
22 these things.

1 It seems to me, I mean my own view
2 is that this is an exemplary measure of what
3 we are talking about, and it doesn't - I don't
4 believe that NQF endorsing a measure requires
5 that everybody does it. It's simply an option
6 for insurers or even local clinics to say we
7 want to measure --
8 DR. GOLDEN: I would be very
9 cautious about that assumption, very cautious.
10 Hey, I'm an old board member of NQF; I've
11 been doing this for years. And I can tell you
12 that an NQF endorsement of a measure would
13 essentially say to a number of decision makers
14 that this is considered to be an accepted
15 national standard that we expect providers to
16 adhere to.
17 DR. GOPLERUD: Let me suggest two
18 analog situations. One is on the alcohol
19 screening brief intervention CPT measure in
20 which it specifies the use of a standardized
21 instrument such as the AUDIT, the ASSIST or
22 the DAST. So it says, for example, but it

1 basically puts the thumb on the weighting
2 scale so it uses these measures.
3 The second is, if you take a look at
4 say the diabetes NCQA measures, they don't
5 specify what blood pressure cuff you have to
6 use; they say you have to monitor blood
7 pressure. They don't say what lipid test you
8 use, what strip you use or what assay you use.
9 But they do specify what the number is. What
10 we could do with a measure like this is to
11 say, endorse it or other standardized metric
12 demonstrating 50 percent reduction or
13 something along those lines.
14 CO-CHAIR SUSMAN: Just for
15 clarification from the NQF staff, as I
16 understand our goal, our task if you will is
17 to deal with the measures before us. And that
18 we have been given the PHQ, and that is sort
19 of - and this is the measure where the
20 psychometrics have all been worked out on, and
21 to get to Harold's comments that really this
22 is what we have to deal with.

1 I agree, and that was sort of where
2 I was coming from in my general remarks, but
3 at the end of the day we have to deal with
4 this single measure that is before us.
5 DR. PINCUS: I think the reality
6 is, that if we throw out something that
7 specific then we might as well go home,
8 because there is nothing that is generic that
9 will meet the criteria.
10 DR. KAUFER: I see this as a
11 harmonization issue. I think we need to, if
12 the data exists for something, I think just
13 the wording can be softened to say that this
14 is an example of an appropriate standard, and
15 that certainly other candidate measures if
16 they show evidence supporting that as an
17 outcome, could be equally well qualified. But
18 we have an instrument where we have the data
19 in hand, I don't see any problem with moving
20 forward.
21 DR. STREIM: I think the kind of
22 statement you are talking about really has to

1 do with how these measures are viewed and
2 used. And I think our job today is to endorse
3 measures or not. I think if you have concerns
4 about whether a measure by being endorsed will
5 implicitly be regarded by legal entities and
6 insurers as a national standard of care, I
7 actually - first of all I don't think that is
8 a bad thing necessarily, but I think in terms
9 of what other measures could be used, I
10 believe Medicare individuals, private
11 insurers, and health care systems, are still
12 quite free to use Hamilton depression rating
13 scales, or other, Beck rating scales, to have
14 - with defined parameters for remission, just
15 as you could with a PHQ. But I think the
16 question before us, as I understand it is,
17 does this measure meet muster and I think that
18 is all we have to answer. I appreciate what
19 you were saying before about what the
20 implications are. I think it's a good thing
21 if we actually have a measure that is endorsed
22 that looks at remission at 12 months as an

1 important outcome.
2 DR. GOLDEN: To follow up I would
3 agree. I think that the measurement tool may
4 be valid and useful, the measure that we might
5 want to have is some sort of standardized way
6 of assessing outcome. But the way the measure
7 is written probably would not pass muster to
8 be - because it really does define the method
9 of how that assessment should be done.
10 DR. STREIM: But you have to have a
11 measure to have a measure.
12 DR. GOLDEN: I understand. But
13 having wandered through this world and forest,
14 there will be many many entities that will say
15 that this is the way to do it, just go do it.
16 And you will then essentially create a
17 standard of care.
18 CO-CHAIR LEDDY: I think that what
19 the disagreement is if we endorse one scale
20 that that becomes a standard of care for all
21 care, that there may be other scales that
22 could be endorsed as Eric said. So if we

1 endorse this scale, perhaps we could have
2 Minnesota talk a little bit about this
3 particular scale, than that doesn't mean that
4 every single provider or insurer or government
5 program has to require this scale be done.
6 DR. GOLDEN: Yes, but in the
7 context of how this world is working, people
8 are looking for measures. You now have an NQF
9 endorsed measure of a scale, and there will be
10 many entities that will take that measure and
11 say, this is a simple - this is done - NQF
12 endorses it. Everybody should do this. So
13 you have locked into that scale. It's
14 basically done.
15 CO-CHAIR SUSMAN: At the end of the
16 day we are going to go through a process,
17 we're making a global judgment about whether
18 the world is a better place here and all the
19 criteria are going to be met. And I can
20 imagine we could come to a decision on the
21 basis of the psychometrics and all the data
22 presented here that the PHQ is a reasonable

1 tool, that there are good psychometrics, yada
2 yada, and so the world would be a better place
3 if we measured depression initially and
4 measured that patients achieve remission.
5 That's important, it has impact. Yada yada.
6 First Harold.
7 DR. PINCUS: A couple of points. I
8 really appreciate that. One, if this was
9 approved, it could potentially open the door
10 for other groups to come in and say, okay,
11 we've got a tool, we've got a tool, and that
12 is not a bad thing.
13 Number two is, I think if everybody
14 did PHQs I think that would be fine. I mean
15 the comparison is, we don't have a measure
16 that says, you must measure patient
17 perceptions of care. But CAHPS is endorsed so
18 everybody has to use it.
19 DR. GOLDEN: No, it's now a
20 requirement. CAHPS is now a requirement. I
21 mean if you want to be in Medicare --
22 DR. PINCUS: So what is the

1 problem? What is the problem with PHQ-9 being
2 a requirement?
3 DR. GOLDEN: I'm just pointing out
4 that you are endorsing a single scale that
5 would become the standard of care.
6 DR. PINCUS: What is the problem?
7 DR. GOLDEN: Well, that's for the
8 discussion.
9 DR. STREIM: It is true that we
10 would be endorsing a single measure that has
11 embedded in it a single tool that allows us to
12 do the measurement, but it is not exclusive.
13 I mean I think that is why this is okay to do.
14 It's not saying - well, Harold has already
15 said that other people can come forward and
16 say there are other ways to measure remission.
17 And all we are doing when we endorse is saying
18 that we vetted this, we believe it has
19 validity, it has utility, et cetera, and the
20 results will be interpretable. That's all
21 we're really saying. I understand your point
22 that it may be pushing the field in a certain

1 direction to have -- the availability of an
2 endorsed measure does move the field ahead.
3 DR. GOLDEN: But the measure says
4 to use this tool, it doesn't say, a tool such
5 as. If you are going to use the measure at
6 all. Nobody is obligated to use this measure.
7 DR. PINCUS: I don't see where the
8 issue you raise is embedded within the
9 criteria.
10 MS. BOSSLEY: This I think can go
11 down in the scientific acceptability
12 discussion, and perhaps feasibility. But it's
13 definitely there. So can I suggest because we
14 kind of skipped, allow me to sort of give a
15 little background of why they selected the
16 survey, why it is measured the way it is. I
17 mean I think they could try to give it for all
18 three because it's pretty much the same thing.
19 And then let's have an importance discussion,
20 have you vote on that, and then move down
21 through - because I think you are going to
22 address these issues when you get into the

1 different criteria for this.
2 MS. PITZEN: My name is Collette
3 Pitzen. I'm a staff member at Minnesota
4 Community Measurement. And these measures
5 were developed in concert with ICSI, around
6 the Diamond Project improving depression care
7 across Minnesota. A lot of the reasons why
8 the tool was selected is that it does have
9 validity and reliability. A lot of recent
10 articles are coming out, even in the
11 psychiatric community, that this can be used
12 in a psychiatric setting. It's easy to
13 administer and score, and the patients can
14 understand it. And I just wanted to share
15 that some of the discussion I'm hearing here
16 is actually playing out in our state. For
17 quite some time PHQ-9 has been used in the
18 primary care setting, and not hearing a lot of
19 gruff about that. But initially some of our
20 behavioral health providers were expressing
21 some of those same sentiments. I get emails
22 that it is insulting for me as a psychiatrist

1 to use this tool. I just wanted to share some
2 comments of some replies to that. A
3 psychologist who is leading up this effort in
4 the male health systems, but I was not
5 completely on board at first too, I will have
6 to admit. However after using the tool for
7 many months I find it an essential part of my
8 work with depression. My two favorite stories
9 consist of, one, a patient who stated, I still
10 feel depressed, but after showing her trend in
11 history, PHQ-9 scores, she was able to track
12 her progress and recognized her treatment
13 gains.
14 And secondly, the patient who
15 endorsed suicidal ideation in the PHQ-9 but
16 denied it with primary care and then with me,
17 but opened up about it after going through the
18 PHQ-9. I hope this helps encourage use of
19 this measure. This was actually a suicidal
20 patient that she would have missed.
21 In having all these discussions,
22 it's interesting, it didn't come up, oh we

1 should use the HAM-D or we should use the
2 Beck. It's like why - they didn't want to be
3 measured. They weren't applying measurement
4 on a routine basis. And I've seen a huge
5 acceptance over the last year and a half, and
6 many of our behavioral providers are coming on
7 board. This is still a voluntary measure for
8 a certain amount of time. Our state has
9 endorsed this going forward though.
10 Any other questions?
11 DR. STREIM: So when you say it's
12 endorsed but voluntary, that is saying that it
13 is not required by the state for reimbursement
14 purposes?
15 MS. MAYBERRY: It's just a matter
16 of time. In 2011 the provider groups are
17 going to have to all report this measure, and
18 it will be used in a quality incentive program
19 for the state. It's voluntary now in terms of
20 there is a provider coalition in town that
21 does have a payment for performance program
22 built around this measure, as well as all of

1 the health plans in the state are moving
2 towards payment for performance on this
3 measure.
4 DR. GOLDBERG: This measure has
5 some momentum. Now the issue of NQF
6 endorsement I think there are so many people
7 looking to mandate outcomes measurements for
8 depression that if they look in the NQF book
9 and they find one that is endorsed by NQF that
10 is likely to push this momentum forward. And
11 it's up to the other measure people to get a
12 measure adopted and endorsed by NQF. I know
13 there are other measures out there. This
14 measure is pretty good; not great, it's got
15 problems. But it's pretty good. And there
16 are other measures that are just as good,
17 maybe better. But they didn't submit them to
18 us. So the people that didn't submit them, I
19 think if this becomes an endorsed measure, if
20 it's going to further the momentum of this
21 measure, we're going to see it even more
22 widely, because people will say, well, we're

1 looking for something. Wait a minute, here is
2 one that is NQF endorsed, let's use that one.
3 There may be no stopping them after that. It
4 may become like the MMSE.
5 DR. HENNESSEY: Can I ask how did
6 you arrive at this particular measure?
7 MS. MAYBERRY: You know I think it
8 was that primary care is our initial audience,
9 and this is a tool used in Minnesota widely in
10 primary care.
11 DR. HENNESSEY: Thank you.
12 CO-CHAIR SUSMAN: As a primary care
13 clinician and mental health researcher, this
14 is widely disseminated. It has clear face
15 validity to people; it takes a very quick time
16 to administer; it's easy to incorporate if one
17 is so inclined into one's routine. I mean we
18 should go down and start considering the
19 points. And let's get down to the business
20 here, because I think we are really getting
21 into some of the weeds that will come out as
22 we go through the criteria.

1 DR. GOLDEN: Again, the question
2 though as we go through this, and this is
3 something for NQF staff, people say, okay,
4 other people could come forward with a
5 measure, the windows of opportunity for
6 further measurement tools to come forward to
7 be endorsed is fairly narrow. It's not like
8 this is a continuous process. So as we go
9 through this the question before us is
10 endorsement of a standardized measurement
11 process versus the endorsement of a
12 standardized measurement tool specifically.
13 And I think there is a nuance there, and I
14 fully - as opposed to the issue of not being
15 measured at all. And I just don't think it's
16 that easy for the iterative process if
17 suddenly, if we endorse one measure, to say,
18 oh yeah, there are five or six other things
19 that you could use as an acceptable
20 alternative.
21 CO-CHAIR SUSMAN: But the reality
22 is, we have the measure before us. This is

1 what was submitted, and I think we need to go
2 through the process. I hear what you are
3 saying, Bill, and I agree. On the other hand
4 this is our task for the day.
5 CO-CHAIR LEDDY: So could we start
6 with importance. And would anybody from the
7 workgroup that reviewed this measure like to
8 comment on this - on the importance issues,
9 impact, gap, and relation to outcome?
10 DR. PINCUS: From my point of view
11 this is clearly a major problem, for
12 importance. Actually there is some data that
13 if you look at people currently under
14 treatment, using Medicare and Medicaid
15 datasets and you do PHQs on them, a large
16 proportion of them are still highly
17 symptomatic and are not in remission. So that
18 is - there is clearly a gap. It's embedded
19 actually into a quality improvement process in
20 terms of how Minnesota is doing it so that it
21 is actually in the course of care that one
22 does this, so it's not just a measure, it's

1 actually a tool for monitoring treatment. And
2 it's one of the best performing measures of
3 outcome. So it clearly meets the importance
4 criteria.
5 CO-CHAIR LEDDY: Any comments on
6 the importance of this measure?
7 DR. GOLDBERG: Bill's point,
8 though, the importance - are we voting on the
9 importance of - look at the title: depression
10 remission at 12 months. Measuring that is
11 important. That is what we are talking about.
12 And we are not even mentioning any particular
13 way of doing it. Just that it is important to
14 measure depression remission at 12 months.
15 That's it. I would say yes. It's very
16 important.
17 (Simultaneous speaking)
18 DR. GOLDBERG: That's what we are
19 voting on. We don't have to worry about how
20 to do it.
21 DR. PINCUS: And the STAR*D part
22 clearly endorses the fact that if people don't

1 achieve remission that there is subsequent
2 significant problems in failure to achieve
3 remission.
4 CO-CHAIR LEDDY: So the vote on
5 importance.
6 DR. WINKLER: How many say yes?
7 (Show of hands)
8 DR. WINKLER: All right, does
9 anybody say no? Or abstain?
10 CO-CHAIR LEDDY: Okay, so the next
11 thing that we consider, and then vote on, is
12 scientific acceptability. Of the measure
13 properties. Now you are getting into
14 numerator, denominator, exclusion, all of
15 that.
16 DR. GOLDEN: I have a question for
17 the developers. I believe - am I correct that
18 the denominator includes MDD and dysthymia?
19 That's a pretty diverse audience, so tell me
20 about dysthymia being included with MDD.
21 MS. PITZEN: The decision was made
22 early on that this was a population that their

1 care could be improved. We did exclude 311,
2 depression not otherwise specified, from the
3 denominator.
4 DR. GOLDEN: And is there - in
5 terms of consistency of application in the
6 coding, you have to code for this to be
7 included, is that the deal?
8 MS. PITZEN: Correct.
9 CO-CHAIR LEDDY: Any other
10 questions or comments?
11 Did the workgroup want to talk about
12 your votes?
13 DR. PINCUS: One other question.
14 So you are defining remission as coming below
15 a threshold rather than 50 percent kind of
16 thing. So that is one reason why it would
17 apply to dysthymia as well. So it reduces the
18 heterogeneity because it is below a threshold.
19 DR. GOLDBERG: Can you tell us how
20 risk adjustment applies to this measure? That
21 seems to be the one weakness.
22 MS. PITZEN: We actually convened a

1 workgroup, a technical advisory workgroup,
2 that met March 22nd to start looking at the
3 risk adjustment methods for these measures,
4 and initially determined that we need to work
5 on getting our response rates a little better.
6 And I would speak more about the six-month
7 measure. We have a good full set of data. We
8 are getting ready to publicly report the 12-
9 month data. But going forward with severity
10 and risk adjustment we selected the severity
11 at the initial PHQ-9 score to be used for risk
12 adjustment in the future. We also did
13 consider other comorbidities like diabetes,
14 acute MI, double depression, chemical
15 dependency, substance abuse, and those will be
16 future considerations in our risk adjustment
17 model.
18 DR. HENNESSEY: I have a question,
19 are there any populations for which people are
20 concerned this may not be a valid concern at
21 this time?
22 MS. PITZEN: Pretty much as far as

1 the measure goes we are only including ICD-9
2 codes 296.2, 296.3 and dysthymia, 300.4. So
3 four that the instrument is valid in those
4 areas, and that the measurement is
5 appropriate.
6 DR. HENNESSEY: How about from a
7 demographic perspective, culture, gender, so
8 on?
9 MS. PITZEN: Going back to the risk
10 adjustment question, we did do some analysis
11 and literature search about the socioeconomic
12 impact. So for diabetes and vascular measures
13 we are risk adjusting based on insurance
14 product as a step towards that, but the
15 decision of the workgroup was that that was
16 not - that once patients who identified to
17 receive care that there were very little
18 difference based on type of product. The
19 differences were more in terms of access. So
20 for this measure that was kind of set aside as
21 a potential risk adjuster.
22 DR. GOPLERUD: Is it applied to

1 children?

2 MS. PITZEN: Eighteen and older.

3 DR. GOPLERUD: Is it available in

4 other languages?

5 DR. PINCUS: And what about this in

6 the geriatric population?

7 DR. STREIM: There is actually data

8 on its performance and actually Deb Saliba at

9 RAND, a group of people did a national

10 validity field study using it for MDS 3.0

11 which has been adopted by Medicare, will be

12 implemented next fall. So actually the PHQ

13 will be used in all 16,000 nursing homes

14 across the country.

15 DR. PINCUS: So that is a national

16 standard?

17 DR. STREIM: It is. So the horse

18 is already out of the barn.

19 DR. GOLDEN: I have no problem with

20 it being a national standard as long as it is

21 being accepted as a national standard. And

22 that was my first question: who else has

1 endorsed the measure.

2 CO-CHAIR LEDDY: So any other

3 comments about scientific acceptability?

4 DR. WINKLER: I just have one

5 question to clarify, the denominator statement

6 includes those with those diagnoses and a PHQ-

7 9. What about patients who haven't had the

8 PHQ-9 done? They wouldn't be included,

9 right?

10 DR. PINCUS: Right. That is

11 captured in the third measure. You wouldn't

12 be able to measure pre and post unless you had

13 that.

14 DR. STREIM: A question for NQF

15 staff on endorsements when things like risk

16 adjustment are still being developed. I

17 understand the stewards are supposed to update

18 these periodically, but at the point at which

19 it is endorsed, at one cross-section in time,

20 is it endorsed with caveats or explanations or

21 comments regarding the lack of risk adjustment

22 may limit the interpretation in certain

1 settings?

2 DR. WINKLER: The discussion around

3 that appears in the report, but doesn't

4 necessarily get tagged to the measure like in

5 the database. However, I think there is a

6 general understanding that measures have life

7 cycles and they evolve and they need to

8 evolve. So we do review them for maintenance

9 review every three years, or on an ad hoc

10 basis as needed if something changes or

11 becomes dramatically obvious that it needs a

12 sooner look.

13 DR. STREIM: If flaws are

14 discovered in later validity testing, can a

15 measure be un-endorsed or revoked?

16 DR. WINKLER: Yes, that would be

17 the purpose of an ad hoc review, is if in use

18 is usually where we are hearing the feedback

19 is somebody has tried to do it and something -

20 it did not work for any number of reasons,

21 and they tell us about it, then we would do an

22 ad hoc review to reevaluate that to determine

1 whether that needs to go away.

2 MS. BOSSLEY: I think the key

3 question for all of you is, do you feel

4 comfortable that this measure without risk

5 adjustment is appropriate to be put out for

6 public reporting right now. I think that is

7 your question, and that is what you all need

8 to grapple with.

9 DR. PINCUS: So, two questions.

10 One is, when a measure is endorsed, is it

11 endorsed with instructions to do risk

12 adjustment, or is it endorsed with

13 instructions saying, here is one way of doing

14 - what is the relationship of the endorsement

15 to the risk adjustment procedure?

16 DR. WINKLER: Well, the endorsement

17 is the measure as specified as it was

18 submitted. Now in the course of time until

19 the next maintenance review on an endorsed

20 measure there may be annual updates. Measure

21 developers have different schedules. It may

22 be every six months, who knows.

1 DR. PINCUS: If we endorse it and
2 there is a - not just for this one, for any of
3 them - and there is a statement in here about
4 risk adjustment, but as I read it it's more
5 like it's advisory than it is this measure
6 requires it. So what is the meaning of that
7 in terms of endorsement? Are we endorsing the
8 measure with the associated risk adjustment
9 procedure? Or are we endorsing the measure
10 with the option of a risk adjustment
11 procedure?
12 MS. BOSSLEY: This measure before
13 you, you would be endorsing without any risk
14 adjustment because there is no model include
15 and there is no specification, they haven't
16 tested it, so they are in the process of
17 doing that now. So this is where it gets fun
18 again. There are three criteria right now for
19 time limited; this was just approved by the
20 board in December. It needs to be - there is
21 no other measure within the NQF portfolio
22 which I think there isn't a measure within

1 addressing this. There needs to be a need for
2 it, so either a legislative mandate, that type
3 of thing, I think that one we'd have to think
4 through.
5 The last one though is that the
6 measure isn't complex, and it doesn't require
7 risk adjustment, isn't an outcome measure,
8 isn't a composite measure, and that's where I
9 think this is hard to apply time limited to
10 because it is an outcome measure and it is
11 complex and you are talking about risk
12 adjustment. So I think that is where it gets
13 a little difficult to say within one year you
14 need to come back to us and tell us whether or
15 not it should have been risk adjusted.
16 DR. PINCUS: If we wait until all
17 the risk adjustment issues are solved for
18 these measures, we - it's going to be three
19 years.
20 DR. WINKLER: At this point, the
21 measure you are evaluating is not risk
22 adjusted. It is looking like they are

1 considering it and thinking about it, and
2 maybe another iteration in a couple of years
3 will be modified and we can look at that at
4 that point in time. But today's issue is the
5 way it is.
6 DR. GOLDBERG: Any competent user
7 group, if they are going to use this as a
8 comparison across settings, is going to bring
9 up risk adjustment immediately.
10 MS. JAFFE: And actually we are
11 involved in a similar project in Washington,
12 and the risk adjustment issue is a big problem
13 right now. It's not the use of the tool so
14 much as determining what the score should be.
15 DR. GOLDEN: To follow up on I
16 guess with the developers, how is this
17 performed with comorbidities such as stroke or
18 heart attack or substance abuse? Has that
19 been an issue?
20 MS. PITZEN: The comorbidities were
21 considered by the group looking at risk
22 adjustment, and they will consider them in the

1 future, not for the first go round.

2 DR. GOLDEN: No, I guess my

3 question was, is there any track record in

4 notes or what have you about do those

5 comorbidities affect the response rate over

6 time and the score?

7 MS. PITZEN: I do have some

8 literature that talks about that, Unutzer and

9 Katon. So yes, and that has been discussed

10 within our workgroups. Right now we are not

11 excluding patients based on risk

12 comorbidities; they are included.

13 DR. GOLDEN: But it does - does it

14 affect the score over time?

15 MS. PITZEN: I think that it can.

16 I guess I don't have any hard evidence to give

17 you today.

18 CO-CHAIR SUSMAN: I think the group

19 that Wayne Katon and the group up in

20 Washington has done, there's been a lot around

21 comorbidities, and they have used tools like

22 PHQ and patients with diabetes, asthma, and

1 multiple comorbidities, and the importance of
2 monitoring to remission and the use of the PHQ
3 in doing so has been pretty well validated.
4 DR. PINCUS: Yes, the fact that it
5 is threshold kind of - so it reduces that
6 issue. I mean the fact that there is fairly
7 good evidence that the threshold as suggested
8 is - failure to achieve that is associated
9 with negative outcomes.
10 CO-CHAIR LEDDY: Robert is next.
11 DR. ROCA: This may be a usability
12 question, but I'm wondering how one handles
13 the fact that over the course of 12 months
14 somebody is likely to have passed through the
15 hands of several caregivers, especially if the
16 initial ascertainment occurs in an in-patient
17 setting. How is it determined whose care is
18 being evaluated over the course of 12 months?
19 How is that being handled?
20 MS. PITZEN: I can answer that, and
21 it's kind of a technical question. Groups
22 submit data to us, actually at a visit level

1 detail. So every contact that the patient has
2 gets submitted as a record with their clinic.
3 And we are attributing it to the location
4 where the patient first met that diagnostic
5 criteria. But then all of the information
6 within that medical group then comes forward
7 for that patient, so we have all the scores
8 and can see their history.
9 DR. ROCA: So for instance if
10 someone is in the hospital and the hospital is
11 reporting PHQ scores, somebody may very well
12 have a very high PHQ score at that point
13 because they are in the hospital. Twelve
14 months later they may or may not have stayed
15 in treatment with who knows which provider
16 down the road. Is the hospital then
17 responsible for that outcome?
18 MS. PITZEN: I can answer that
19 question for you. It's an ambulatory care
20 based measure, so the identification of
21 patients is starting in the ambulatory care
22 center. However we do have some systems who

1 have an integrated hospital and clinical
2 record, and they are submitting those
3 patients' PHQ-9 scores as well, but we are not
4 going after inpatients with depression.
5 DR. ROCA: So what we are looking
6 at here is an ambulatory process?
7 MS. PITZEN: Correct.
8 DR. STREIM: So the score from the
9 index episode would be whatever is available
10 from the current provider.
11 MS. PITZEN: That is correct.
12 DR. WINKLER: George had a
13 question?
14 DR. WAN: Just a general
15 observation. When looking at Minnesota's
16 submission they actually summarized their
17 results of 17,000 patients with data from 123
18 clinics. And I was amazed to see the average
19 scores. So they had the scores of 4.6 percent
20 from a population based level. So that seems
21 to me very low in this setting, so then the
22 question would be, I understand from an

1 assessment point of view this will help, once
2 you assess that and identify that gap, you
3 want to have target improvement interventional
4 programs to achieve a much higher rate. But
5 I'm just very surprised to see that very low
6 rate.
7 MS. PITZEN: Can I make a comment
8 on that? I think I mentioned earlier that
9 part of our problem in this initial go round
10 is that groups are not getting that six-month
11 PHQ-9 score or that 12-month PHQ-9 score as
12 much as we'd like. In the Diamond project
13 they are hitting that compliance rate at about
14 60 percent. In the full population, general
15 public, usual care, we are at about 20
16 percent.
17 If I look at just the patients that
18 we do have a PHQ-9 score on, and I will have
19 to give you six-month data, we are at about
20 24.6 percent are achieving remission. But we
21 don't want to promote - set that forward,
22 because that is usual care. Or we are only

1 going to measure the patients that we can
2 contact. That is not going to change.
3 DR. PINCUS: It's not so surprising
4 if you look at the existing process measures,
5 you know, depending on which measures you look
6 at, they are in the sort of 20 to 45 percent
7 range. And this is outcomes which are much
8 harder to achieve.
9 CO-CHAIR LEDDY: So are we ready
10 to vote on usability for this measure?
11 Sorry, scientific acceptability.
12 DR. WINKLER: The voting for this
13 one is along the same categories of completely
14 meeting, partially meeting, minimally or not
15 at all.
16 So how many of you think that the
17 measure specs and information meets all the
18 criteria completely?
19 (Show of hands)
20 DR. WINKLER: Partially?
21 (Show of hands)
22 DR. WINKLER: Okay, how many

1 minimally. That's a zero.

2 DR. GOLDEN: I am partial.

3 DR. WINKLER: Got you as partial.

4 (Off the record comments)

5 MR. CORBRIDGE: So 18 partial, is

6 the denominator.

7 DR. GOLDEN: I am partial, but I

8 would like to make a comment about the

9 reliability just for your own notes. If you

10 took 300 of these patients and you put them

11 through Clinic A and you put them through

12 Clinic B, the ones that take the test would

13 probably have similar results. However,

14 Clinic A and Clinic B may code grossly

15 differently, so you may have very different

16 numbers of patients receiving the test, so

17 there is a reliability issue about coding, and

18 entry into the assessment process.

19 DR. PINCUS: To the extent to which

20 they use - not everyone is specified.

21 DR. GOLDEN: Or the fact that many

22 primary care practices don't code depression

1 or dysthymia. I certainly don't, because it's
2 a payment problem, and it's also a stigma
3 problem. So it's a coding avoidance issue.
4 CO-CHAIR LEDDY: Okay, with that
5 comment we are ready to move onto a discussion
6 of usability of the measure. So that
7 includes is it understandable, harmonization
8 issue, does it add added value. Would anybody
9 from the workgroup like to comment on their
10 votes on that or how they found the measure?
11 Any discussion or questions?
12 DR. PINCUS: Yes, I have not sure
13 what partial means with regard to
14 harmonization.
15 DR. WINKLER: The ratings are, does
16 it meet the criteria as laid out in your
17 measure evaluation criteria. So it completely
18 meets them all, partially meets them all,
19 minimally meets them all, that kind of spread
20 out scale. So harmonization I think, I think
21 in this particular case the harmonization that
22 might be applicable would be the capturing of

1 the patients with depression compared to other
2 measures of depression.
3 CO-CHAIR LEDDY: Or the various
4 settings it's used in. The definition of
5 harmonization says, could this measure be used
6 not just in an outpatient setting but also
7 inpatient or nursing home.
8 DR. PINCUS: It's not just could be
9 used, no, it's a question of whether it's
10 related to measures that are already endorsed
11 by NQF in other settings.
12 CO-CHAIR LEDDY: Yes, yes, you are
13 absolutely right.
14 DR. PINCUS: So looking at other
15 depression measures at NQF they utilize very
16 similar criteria.
17 CO-CHAIR SUSMAN: There is an
18 effective continuation phase measure that
19 we've come up with.
20 DR. PINCUS: I think that - I
21 didn't look at the specific details, but my
22 sense was, they were well harmonized.

1 Somebody may want to look at the specifics of
2 that. But that's why I didn't understand the
3 "partial" in harmonization.
4 CO-CHAIR SUSMAN: I think the
5 longest is the six-month continuation phase.
6 But this is getting at longer term remission.
7 DR. PINCUS: The inclusionary suite
8 and criteria seems pretty similar.
9 CO-CHAIR LEDDY: Any other
10 discussion on usability? Or are we ready to
11 entertain a vote?
12 DR. WINKLER: Okay, so who all
13 believes it meets the usability criteria
14 completely?
15 (Show of hands)
16 DR. WINKLER: Seven.
17 Partially?
18 (Show of hands)
19 DR. WINKLER: Okay, nine.
20 Minimal?
21 One.
22 Not at all?

1 Thank you.
2 MS. BOSSLEY: We are missing one?
3 DR. WINKLER: Luc is out.
4 MS. BOSSLEY: That's it.
5 DR. WINKLER: Okay, a flexible
6 denominator.
7 CO-CHAIR LEDDY: Okay,
8 feasibility.
9 DR. GOLDEN: What is the status of
10 this as an electronic tool to query. Is it a
11 single score? I haven't used it.
12 CO-CHAIR SUSMAN: Yes. A lot of
13 PHRs now bake it in.
14 DR. GOLDEN: So it'd be sort of
15 like putting in the cardiac - the New York
16 State, New York Heart Association risk for
17 heart failure.
18 CO-CHAIR LEDDY: Yep.
19 DR. GOLDBERG: Sort of a widespread
20 ad hoc option of this says something about its
21 feasibility. People are finding it feasible.
22 DR. PINCUS: I had a question about

1 the criterion of data generally is a byproduct
2 of care processes. Is it - what do you mean
3 by that? Is it a byproduct of how care should
4 be, or how they are?
5 DR. WINKLER: Let's put it this
6 way. I can tell you what we meant it isn't -
7 we do not mean - and that is where someone has
8 to go in and abstract the blood pressure
9 recording from a chart in order to generate
10 the data to go do the performance measure. So
11 in this case the fact that you were doing the
12 PHQ-9 as part of the care of the patient and
13 it's in your records, if it's in your
14 electronic records so that the end result
15 number is readily extractable electronically -
16 -
17 DR. PINCUS: Is that a separate
18 criterion, electronic source? I thought just
19 in terms of 4(a) it - the - that it is sort of
20 a byproduct in the sense that if you are
21 providing care irrespective of where it is
22 located that you are doing it. So that if you

1 are doing blood pressures and typically
2 reporting it is a byproduct of care, then it
3 would be there whether it was electronic or
4 not. But it seems to me if you are treating
5 somebody with depression and you are
6 monitoring their response to treatment, this
7 would be a natural byproduct of care.
8 DR. WINKLER: Correct.
9 DR. ROCA: It might be, but you may
10 not do that scale routinely, though. Wouldn't
11 you have to do the scale routinely in your
12 regular practice?
13 (Simultaneous speaking)
14 DR. GOLDEN: I think the question
15 is, as currently constituted. You can provide
16 these - a glucose measure is a byproduct of
17 care. If he came for depression this score
18 may or may not be a byproduct of care at this
19 point in time.
20 DR. PINCUS: I am not sure I
21 understand the distinction, what makes glucose
22 a byproduct of care as a pressure measure or

1 not.

2 DR. GOLDEN: Only because not

3 everyone's doing it.

4 DR. PINCUS: But there should be.

5 DR. GOLDEN: But that's the point.

6 DR. ROCA: But it is certainly not

7 a standard of care. To use the scale. A lot

8 of us would say it should be but it isn't. So

9 in that case --

10 DR. PINCUS: That is why I was kind

11 of getting at the sense of, what do you mean

12 when you designed this thing as a byproduct of

13 care?

14 MS. BOSSLEY: The goal is that you

15 are not putting forward a measure that

16 requires this additional data collection or

17 going to somewhere else --

18 DR. PINCUS: That is irrelevant to

19 the care you are providing.

20 MS. BOSSLEY: Right, so we are

21 asking you to rate just this measure.

22 DR. PINCUS: Clearly this measure

1 is not irrelevant to the care being provided.
2 It ought to constitute a key feature of your
3 decision making with regard to the care you
4 are providing.
5 MS. BOSSLEY: The goal is to not
6 have any measures out that require a huge
7 additional piece of data unless it is
8 absolutely critical. I don't know that this
9 measure is a good example of that.
10 (Simultaneous speaking)
11 MS. BOSSLEY: We are trying to
12 look at the burden of data collection and the
13 feasibility -
14 CO-CHAIR SUSMAN: If this took an
15 hour to administer it'd be a very high burden.
16 In point of fact it's much much shorter.
17 DR. GOPLERUD: Two pieces. One is
18 that there are CPT II codes that could be used
19 for this, so it's built in and those were
20 adopted two years ago. The other is that it's
21 baked into the VA/DoD electronic medical
22 record, and it's the PHQ-9.

1 CO-CHAIR LEDDY: So are we ready to
2 vote on -- oh no, Robert, I'm sorry.
3 DR. ROCA: I was just going to say
4 that I completely agree this is a reasonable
5 thing to do and feasible, and what we ought to
6 be doing, and it really depends on what this
7 criterion means. Because clearly if you are
8 treating diabetes there is nobody who treats
9 diabetes without getting a glucose clearly.
10 But there are - most clinicians I dare say
11 treat depression without using a scale, so it
12 is going to be something extra to do, and I
13 can agree that it ought to be done, that we
14 ought to be doing it, it ought to be the
15 standard, but it would require something
16 additional for clinicians than they are
17 already routinely doing. And I thought that
18 was Harold's question, but maybe it wasn't.
19 DR. PINCUS: Well, my question was,
20 what do you mean by a byproduct of care. It
21 seems to me like I said it's certainly not
22 something that is irrelevant to the decision

1 making process of the clinician providing
2 care. It's very relevant to that. So in that
3 sense it is a byproduct of care.
4 DR. WINKLER: And certainly in its
5 most simple form, this is about burden of data
6 collection to do the measure.
7 DR. PINCUS: It is burden versus
8 benefit too, or critical benefit, not
9 performance measurement benefit.
10 CO-CHAIR LEDDY: Are we ready to
11 vote on feasibility?
12 DR. WINKLER: How many think it
13 meets the feasibility criteria completely?
14 (Show of hands)
15 Fourteen is what I get.
16 How about partially?
17 (Show of hands)
18 Four.
19 DR. WINKLER: All right. So then
20 the final vote of the day.
21 (Simultaneous speaking)
22 DR. WINKLER: Is to recommend that

1 it go forward for endorsement or not.
2 CO-CHAIR LEDDY: So it is just a
3 yes or no. This is a yes or no question.
4 MR. CORBRIDGE: Before we do that,
5 we would like to open it up for public
6 comment. Are the lines open? Anyone on the
7 line want to comment?
8 (Telephone dialing)
9 DR. GOPLERUD: We are voting on the
10 12-month measure. We will do this again for
11 the six-month measure?
12 CO-CHAIR LEDDY: Correct.
13 (Off the record comments)
14 CO-CHAIR LEDDY: Did you have a
15 comment?
16 MS. GALBREATH: I just wanted to
17 say, at the national council we do a lot of
18 work in terms of working with primary care on
19 PHQ-9 and doing this kind of screening
20 measuring, so we are very supportive of this
21 measure. We think there are questions
22 regarding implementation in terms of primary

1 care versus community and nursing home
2 patients to some of the things that are down
3 the road, but we are very supportive of this
4 measure.
5 DR. HENNESSEY: What do you see as
6 the challenges for -
7 DR. WINKLER: Can you use the
8 microphone?
9 DR. HENNESSEY: Oh, sorry about
10 that. Where is a microphone?
11 What do you see as the major
12 challenge for community mental health centers
13 moving forward?
14 MS. GALBREATH: We are working,
15 there are community mental health centers that
16 are working to use the PHQ-9 as a tool as was
17 explained in terms of using that as a
18 beginning place for further assessment. But
19 I think the cultural shifts for the
20 professionals, the time, data, how they list
21 PHQ-9 in an electronic medical records, if
22 centers are at that point. So some of the key

1 issues in terms of primary care in terms of
2 measurement and it means a piece of the puzzle
3 to start the conversation.
4 DR. PHILLIPS: I also have a
5 question. So the PHQ-9 I understand, but the
6 concept of remission at 12 months, could you
7 comment on that?
8 MS. GALBREATH: I have more of a
9 policy background than clinical. But I
10 imagine a lot of our centers are doing
11 measurement of best practice. I'm not really
12 sure in terms of the measure. I think that
13 that would be supportive of that.
14 CO-CHAIR LEDDY: All right, are we
15 ready to vote?
16 DR. WINKLER: How many vote to
17 recommend this measure?
18 (Show of hands)
19 DR. WINKLER: I get 17 yeses.
20 Any nos? Abstention? Oh, one
21 abstention, okay.
22 CO-CHAIR LEDDY: Now, hopefully

1 the next measure will be a little speedier,
2 because it is at least similar. So Ian, are
3 you going to introduce the next measure?
4 MEASURE OT3-012: DEPRESSION REMISSION
5 AT SIX MONTHS
6 MR. CORBRIDGE: So we are on
7 measure #12, entitled depression remission at
8 six months. So still from Minnesota Community
9 Measurement.
10 Just a brief description of the
11 measure. Once again, adult patients aged 18
12 or older, major depression or dysthymia.
13 Initial PHQ-9 score greater than nine, who
14 demonstrate remission at six months defined as
15 a PHQ-9 score of less than five.
16 This measure applies to both
17 patients with newly diagnosed and existing
18 depression whose current PHQ-9 score indicates
19 a need for treatment. The patient health
20 questionnaire is a tool widely accepted, just
21 once again similar constructs as the last
22 measure that we read over, and once again the

1 numerator and denominator statement are the
2 same from the last measure that we discussed.
3 DR. STREIM: Actually I just
4 realized, the word current PHQ score, in that
5 second sentence, implies current at what point
6 in time?
7 MS. PITZEN: If I can address that,
8 it's the process where - I mean you have a
9 starting point for measurement collection, and
10 it's the initial, the first PHQ-9 score that
11 is coming in that also we have the confirming
12 diagnosis that they do have major depression
13 or dysthymia.
14 So it's not newly diagnosed, the
15 very first PHQ-9 ever given. It's the very
16 first PHQ-9 when you are starting your
17 measurement process, going forward from that.
18 This is a longitudinal measure, so
19 patients can come into the population whenever
20 they are identified, so it's not like in this
21 last year, it's not like a snapshot; it's
22 whenever they are meeting the criteria for

1 that measurement then they come into the
2 population.
3 DR. GOLDBERG: What is the last
4 one, other than six for 12.
5 MS. PITZEN: There is absolutely no
6 difference technically, population, and
7 anything. The only difference is six months
8 and 12 months. We have a lot of data on six
9 months, and we'll actually be publishing 12-
10 month data in June of this year.
11 DR. GOLDBERG: So there is more
12 data on this?
13 MS. PITZEN: There is more data.
14 CO-CHAIR LEDDY: Eric.
15 DR. GOPLERUD: This may come in the
16 area of harmonization, but the NCQA measures
17 are typically a measurement within the year,
18 and so six months is an unusual length of
19 time.
20 DR. WINKLER: Eric, just one thing.
21 When you talk about a measurement year like
22 NCQA uses, they are talking about their data

1 collection stance at that time. The actual
2 specification of a measure may have other time
3 frames, because that is what the clinical
4 situation asks for.
5 DR. GOPLERUD: But if you look at
6 their asthma measures, their diabetes
7 measures, they - continuous care - has there
8 been a measure within a one-year interval
9 after --
10 DR. WINKLER: Right, but most of
11 those measures are usually a point in time,
12 something happened, yes or no, within the
13 measurement year, as opposed to here we've got
14 a change measure, and so the timeframe of
15 change is more about the measure than the
16 measurement program. You can put whatever
17 parameters you want to your window of data
18 capture. So I think that is where there is a
19 difference.
20 DR. GOLDBERG: Why six instead of
21 four, five or seven.
22 MS. JAFFE: I also asked why six,

1 and if you are doing 12 why also six.
2 MR. CORBRIDGE: I guess I would
3 say the reverse of that. There was strong
4 evidence in studies in the literature that six
5 months was one of the cut points for
6 measurement and also 12 months. If I talk
7 about the importance of the two, the six month
8 measure is where the most of our efforts are
9 being focused.
10 CO-CHAIR SUSMAN: I think you tie
11 it back to the data about length of
12 continuation phase treatment, and the data are
13 not precise that it's exactly six or eight or
14 five or nine. You can take that cut where you
15 want, but it's a very reasonable cut based on
16 best evidence.
17 DR. STREIM: I think one thing to
18 consider is that there is an emerging
19 literature on stepped care for people who
20 don't respond to the first line treatment.
21 And if you look at time, expected time to
22 improvement or remission, response or

1 remission, I'm not sure we have really good
2 studies of that for stepped care. Even the
3 impact study and the prospect study didn't
4 really look at it that way.
5 So I think that in some ways it's
6 almost arbitrary to say let's take a look at
7 six months because it's an awfully long time
8 to be suffering but I'm not sure we have a
9 scientific rationale in terms of time to
10 improvement, sort of as a survival analysis,
11 that would guide us to what is a reasonable
12 time interval for expecting remission.
13 MS. PITZEN: Initially with a lot
14 of our providers they were like, well why
15 don't you take an earlier score? And I think
16 oftentimes that that is just not enough to say
17 that that patient is better or in remission if
18 you are going to take a score at one month or
19 three months.
20 DR. STREIM: I think given that
21 treatment studies have clearly shown that
22 people can continue to improve on treatment up

1 to 12 weeks, as probably less than three
2 months wouldn't make sense.
3 CO-CHAIR SUSMAN: And there are
4 other NQF-endorsed measures that look at the
5 12 week milestone. So I look at this as a
6 family of measures that we are trying to
7 develop for the use of improving care of
8 depression. And there is a certain
9 arbitrariness here, and there are patients who
10 are going to fall out and will need further
11 steps here perhaps to get to remission. But
12 given where we are and the state of the art,
13 I think overall this makes a lot of sense.
14 DR. WINKLER: One comment, I would
15 ask you, they are very similar measures; the
16 timeframe is different. Do we need both
17 measures, or conversely, if you want to see
18 these measures widely used, should you expect
19 to use both measures?
20 CO-CHAIR SUSMAN: I guess I see
21 this as not making that decision for people
22 but giving people a set of options where there

1 is sufficient rigor, where there is sufficient
2 importance and so on. And some organizations
3 might choose to focus on initial 12 week of
4 therapy and choose the NQF measure in that
5 family. Others might choose six months
6 because of issues of tracking and getting
7 patients back into the longer course of
8 therapy, while others are really going to be
9 pushing for full-year follow up. So I don't
10 see this as an either/or or in some way
11 specifying. I see it giving more tools to the
12 field to help improve care. That is my own
13 personal belief on it.
14 DR. PHILLIPS: I think also if I
15 were a provider, the shorter timeframe I would
16 want because it's more likelihood I'm still
17 seeing this person, whereas at a year who
18 knows. They could have gone through three
19 other centers by that time.
20 DR. WINKLER: Is there any
21 information about the lack of follow up for 12
22 months versus six months in terms of what

1 experience you've had with the measure?
2 MS. PITZEN: It's about the same.
3 About 20 percent in achieving that follow up
4 PHQ-9 score at 12 months, and the remission
5 rates are similar as well; a little bit
6 better.
7 CO-CHAIR LEDDY: So are we ready
8 to look at importance and we've just had a
9 pretty long discussion about really the
10 importance of this measure at six months
11 measurement. And the scores of the group were
12 pretty consistent. So --
13 DR. GOLDEN: Just to comment. It
14 would seem to me in doing comparison is the
15 six month measure more important than the 12
16 month measure, and I could argue the answer is
17 yes.
18 MS. BOSSLEY: Maybe the best thing
19 to do is to vote. You've got three measures
20 to discuss. You've got another one coming up.
21 And then go back and revisit.
22 DR. PINCUS: Are we supposed to be

1 there, or are each one standing on its own?
2 Or is it a nested thing?
3 DR. WINKLER: It's a two-step kind
4 of thing. Each measure needs to be evaluated
5 on its own, but at the end of the day you want
6 to look at your group and say, does this make
7 sense as a group?
8 CO-CHAIR LEDDY: Okay, so let's vote
9 on importance. How many people think it meets
10 the completely definition for importance?
11 (Show of hands)
12 DR. WINKLER: Are three any nos?
13 CO-CHAIR LEDDY: You mean any not
14 at all?
15 DR. WINKLER: Let's go back so we're
16 consistent straight across.
17 DR. WINKLER: Completely, going
18 back to completely?
19 (Show of hands)
20 DR. WINKLER: Any not at alls,
21 minimally or partially? Oh, we have 18
22 people. Okay. Scientific acceptability?

1 Completely, I see none.
2 Partially. Is there anyone without
3 their hand up? Okay, 18. Any minimals.
4 Usability, completely? One, two,
5 three, four, five, six, seven, eight.
6 Partial? One, two, three, four,
7 five, six, seven, eight, nine.
8 And is there someone with a minimal
9 amount - okay.
10 Feasible, completely? Twelve.
11 Partials. Six. That's it.
12 And to recommend the measure or not.
13 CO-CHAIR LEDDY: So now to
14 recommend or not recommend. So all that would
15 recommend this measure?
16 (Show of hands)
17 DR. WINKLER: That's seventeen.
18 CO-CHAIR LEDDY: Anyone who would
19 not recommend. Any abstentions? Okay.
20 We are ready to move on to the
21 fourth in this group which is also submitted
22 by Minnesota, right?

1 MEASURE OT3-022: DEPRESSION UTILIZATION
2 OF THE PHQ-9 TOOL
3 MR. CORBRIDGE: Correct, yes, so we
4 will be moving on to Measure #22, as Trish
5 indicated, also submitted by Minnesota. The
6 title of the measure is, Depression
7 Utilization of the PHQ-9 Tool.
8 All right, so just a brief
9 description of the measure, very much similar
10 to a degree with what we have been talking
11 about. Adult patients aged 18 or older with
12 a diagnosis of major depression or dysthymia.
13 ICD-9 - go over the ICD-9 codes who have PHQ-9
14 tools administered at least once during a
15 four-month measurement period. The patient
16 PHQ-9 tool is widely accepted, which we have
17 gone over.
18 A little bit further down, the
19 process measure is related to they outcome
20 measure of depression remission at six months
21 and depression remission at 12 months. This
22 measure was selected by stakeholders for

1 public reporting to promote the implementation
2 of processes within a provider's office to
3 ensure that the patient is being assessed on
4 a routine basis with a standardized tool that
5 supports the outcome measure for depression.
6 Looking at the numerator statement
7 for the measure, would be adult patients aged
8 18 and older with a diagnosis of major
9 depression or dysthymia. They provide the
10 codes who have a PHQ-9 score administered at
11 least once during the four-month measurement
12 period. The denominator statement reads as
13 follows: Adult patients aged 18 and older with
14 a diagnosis of major depression or dysthymia
15 and they provide the codes there.
16 So that is just a brief overview of
17 the measure.
18 CO-CHAIR SUSMAN: Just to clarify,
19 it could be just one initial measurement with
20 the PHQ? This does not imply response,
21 remission, is that correct?
22 MS. PITZEN: Yes, correct. It's a

1 process measure, and it's applied to a whole
2 population with that diagnosis. It doesn't
3 matter what their PHQ-9 score is. Did the
4 patient have administered at least one time in
5 the last four months, and there is the
6 implication that they were in for a visit in
7 that timeframe, did they have a PHQ-9 test
8 administered or not?
9 DR. GOLDBERG: If you were
10 following at six and 12 months, you had to
11 have a measure at the beginning?
12 DR. WINKLER: If you didn't have the
13 test done you weren't captured in the measure.
14 CO-CHAIR SUSMAN: That was the
15 entrance criteria.
16 DR. HENNESSEY: So this is, as I
17 understand this then, this would be a uniform
18 administration of the test regardless of the
19 presenting problem to the PCP's office?
20 MS. PITZEN: Let me clarify: it's
21 for patients that have major depression or
22 dysthymia.

1 DR. GOLDBERG: Yes, it's not
2 screening.
3 DR. WINKLER: Bill.
4 DR. GOLDEN: A question on the
5 operation of this measure. You have a patient
6 being seen by a psychiatrist for major
7 depression and managing the depression. The
8 patient sees a PCP for their urinary tract
9 infection or their bronchitis. The question
10 is, it's not necessarily coded for the visit.
11 Is there an expectation that the PCP
12 administers this? Because the patient does
13 carry a diagnosis of depression? Or does that
14 have to be coded at the visit?
15 MS. PITZEN: It has to be coded at
16 the visit, but it is related to that patient.
17 So if that patient is being seen in primary
18 care for a variety of reasons and they also
19 have ICD-9 codes that support the depression
20 diagnosis, the expectation is that they have
21 a PHQ-9 also.
22 DR. GOLDEN: But if the depression

1 codes are in a separate office with the
2 psychiatrist as opposed to the primary care
3 office.
4 MS. PITZEN: I can answer that.
5 Technically we only have the ability to
6 capture information at the level of the
7 medical group, and when I talk medical group
8 that can be a broad health care system that
9 has a common patient identifier. Even a
10 chart, we have some clinics that have paper-
11 based charts that are participating. But you
12 can't know what you don't know. So in a
13 separate psychiatry office seeing that patient
14 we don't have a way to put that data together.
15 DR. GOLDEN: So you would expect the
16 psychiatrist to report but not the office that
17 didn't code?
18 MS. PITZEN: No, if both of those
19 offices are coding major depression for that
20 patient I would expect them both.
21 DR. GOLDEN: I understand, but if
22 only one is reporting major depression and the

1 other one is not, you would be expecting the
2 one who's reporting it.
3 MS. PITZEN: Correct.
4 MS. JAFFE: I have a question about
5 the scope of this one. It sounds like a
6 process as opposed to an outcome, and maybe we
7 need to talk about that first?
8 DR. STREIM: Agreed. I had the
9 same determination on first pass. So can you
10 suggest any way in which this might be
11 construed as an outcome measure, indirectly
12 related to measuring outcomes?
13 MS. PITZEN: Part of the reason why
14 we put this measure forward, our groups
15 initially were publicly reporting the six
16 month remission measure, and our first data
17 results, of course, were dismal, and a
18 decision was made immediately that we also
19 need to - we also have a set of 10 measures
20 that we need to get this out in a transparent
21 way because it is going to lead us to our
22 outcome.

1 Currently, groups are at about 70
2 percent overall for many thousands of patients
3 for having at least one PHQ-9. We still have
4 a ways to go to get our six month and 12 month
5 response.
6 CO-CHAIR LEDDY: So this sounds like
7 clearly a process measure.
8 DR. MANTON: The other thing, if I'm
9 correct, it's post-diagnosis. So the person
10 would already have had to have been diagnosed.
11 So in some ways it's measuring - I'm assuming
12 that if they had been diagnosed they're being
13 treated. So it's in some ways a kind of -
14 kind of quantifying that, too, in terms of
15 where they are. And it also is getting back
16 to the earlier discussion, it really is
17 pushing that particular tool, as opposed to
18 others.
19 DR. WINKLER: In terms of your
20 question on process outcome, one of the
21 reasons I asked the question about how
22 patients who didn't have a PHQ-9 done were

1 handled in the remission measures, there are
2 several different approaches to measurement
3 for dealing with getting the whole thing
4 started in the first place.
5 One of the things you could do is
6 pair this with one of your outcome measures.
7 To make - so that you've got the process
8 measure that says, yeah, you do it, and we'll
9 figure out to get a number on the
10 participation - or the use of the tool is, and
11 then you pair it with the measure that is the
12 remission measure, which is the true outcome
13 measure. But the two go hand in hand.
14 It's tied to it, exactly. You can -
15 one of your recommendations could be to tie
16 the two together, which would sort of take
17 care of your scope issue if you'd like. You
18 can tie all three.
19 MS. BOSSLEY: And what that means
20 is, anytime anyone went to use one, they
21 actually need to use all three and publicly
22 report all three measures together. We're

1 throwing it out there.

2 (Laughter)

3 DR. PINCUS: My view, while on the

4 face of it, it would seem sort of by itself

5 out of scope as a process measure, the reality

6 is, we've sort of enlarged the domain slightly

7 when we put out the call, and looking across

8 many of the other measures that are submitted

9 that are process-like, this is actually one of

10 the better ones. And so I would come down on

11 the side of including it, because I think it's

12 actually typical. At least it allows people

13 to have a way to demonstrate that they are

14 actually looking at outcomes.

15 DR. HENNESSEY: I have a question

16 for clarification. We talked about six

17 months, we've talked about 12 months. Now I

18 see here they are talking about administering

19 it at least once during the four month

20 measurement period. That seems a little out

21 of synch. Am I missing something here?

22 MS. PITZEN: I can try to answer

1 that. It is a little bit arbitrary. We are
2 having groups submit to us three times a year
3 in four-month segments. And part of the
4 questions, as they submit their outcome, their
5 denominator data to us is, how many patients
6 are you seeing in your clinic? How many have
7 the diagnosis of major depression or
8 dysthymia? And how many of those patients
9 received the PHQ-9? It is a counting-type
10 measure. The four months his just how we
11 happen to have it.
12 DR. HENNESSEY: So the denominator
13 is the patients seen in that four month period
14 --
15 MS. PITZEN: Correct.
16 DR. HENNESSEY: So it could be any
17 increment?
18 MS. PITZEN: Right. We had a
19 historical catch up period of actually three
20 quarters, and it's very easy to achieve on
21 PHQ-9 in three quarters. So the time frame is
22 a little bit arbitrary. If the group said oh

1 we are going to look in 12 months did you
2 receive a PHQ-9 your rates are probably going
3 to be much higher.
4 DR. GOLDBERG: There are a couple
5 of issues here. Now I hear you say it's a
6 counting measure, I'm more concerned about not
7 including it in the scope. You could start
8 counting a lot of things. But I am concerned
9 about the other two that we voted on, yes,
10 that unless we link the other two with some
11 initial measure, the other two are going to be
12 a problem.
13 CO-CHAIR SUSMAN: But the other two
14 do have an initial PHQ embedded in and then
15 measuring their effort, is that correct?
16 MS. BOSSLEY: It is correct, but
17 what you will not capture, the ones who do not
18 have a PHQ-9. It won't capture those patients
19 in the other two measures.
20 CO-CHAIR SUSMAN: I mean, you know if
21 you look at the existing NQF measure on acute
22 phase or practitioner contacts, it's usually

1 your typical 12 week, number of visits.
2 Ideally you would tie the PHQ within that
3 period and you'd have some harmonization here
4 that makes sense from a process point of view.
5 As it stands now, as a simple counting
6 measure, I agree with Harold, and I'm okay
7 with including this. It, in many ways, is not
8 at all an outcome measure per se.
9 CO-CHAIR LEDDY: Isn't it
10 informing you of the validity of the
11 denominator of the other two measures, so it
12 is linked.
13 MS. PITZEN: We did start publicly
14 reporting this information, and the groups
15 that are at 20 percent or below, they aren't
16 very happy, because they know that their
17 efforts to embed this process in their care
18 haven't been too successful so far.
19 CO-CHAIR SUSMAN: Well, if you are
20 going to take this a step further you don't
21 have any idea about all the patients that were
22 not recognized and therefore did not have a

1 PHQ, so it just depends on how far --
2 DR. PINCUS: I think standing on
3 itself, it is one of the better process
4 measures, one of the better process measures.
5 And it's one of the better process measures
6 that have been submitted to us as a quasi-
7 outcome measures. It certainly is justified
8 in terms of being linked to the other two
9 measures, although I think we should make sure
10 we separate them. Because the others let you
11 know who they didn't - how many people they
12 didn't get to.
13 DR. WINKLER: Bill.
14 DR. GOLDEN: I am confused. To me,
15 this measure becomes irrelevant with the other
16 two being passed.
17 MS. BOSSLEY: The only way that we
18 can do it, which is why NTQA does it, anytime
19 their PHQ score does not exist, it counts
20 against them in the remission measures. That
21 is the only other, I think, way you could do
22 it without this measure. And capture

1 everything. So if you didn't have a PHQ-9
2 score it would be the same as using diabetes
3 as an example or if they had an A1C test done
4 but you didn't have the level, that counts
5 against them in meeting the performance of
6 that measure.
7 DR. GOLDEN: I just assumed that
8 would be --
9 MS. BOSSLEY: But that is not the
10 case here, correct?
11 DR. WINKLER: Yes, I mean one of
12 the ways to get around the remission measures
13 is to never do a PHQ-9. And that's what this
14 measure is trying to --
15 CO-CHAIR SUSMAN: If you don't
16 diagnose depression you don't have to do any
17 of this. Right.
18 MS. BOSSLEY: So you guys have a
19 couple options. You can always request,
20 develop, or consider some changes to the
21 measures and have conditions on the
22 recommendations asking for that type of change

1 on remission. Or you can accept this as
2 paired with the --
3 DR. GOLDEN: That weakens the
4 integrity of the other two measures, but
5 that's all right.
6 MS. BOSSLEY: You have a few options
7 before you,
8 CO-CHAIR SUSMAN: I guess I don't
9 see why we would link this to the other two
10 measures, since the other two measures embed
11 an initial PHQ in there. I see this going
12 after a different population, a different set
13 of issues, and I basically agree with what
14 Harold has been saying, but I think it's
15 clearly process right now.
16 DR. MANTON: The other two have a
17 PHQ score that people would be entered into.
18 This has none. So is the assumption that if
19 their PHQ score wasn't nine, it was less than
20 nine, that they wouldn't be part of this
21 follow up, the six month/12 month?
22 MS. PITZEN: Correct.

1 DR. STREIM: I would argue that
2 linking these is essential because it goes to
3 the issue of usability of the outcome
4 measures. We have enough problems with
5 lacking risk adjustment, but at least if you
6 can look at the measures, the outcome measures
7 we just endorsed, and make a determination
8 about the denominator, and whether you are
9 actually getting at a substantial part of the
10 population with depression or you are missing
11 most of them. This will allow you to
12 interpret what you have captured in your
13 outcomes measures, and I think that it really
14 is anything we can do to help improve
15 interpretability of a publicly reported
16 measure is a good thing.
17 CO-CHAIR SUSMAN: But Joel, I am
18 not following. If I understand this, if you
19 are going to rely on the initial measures,
20 doing an initial PHQ and then a follow up to
21 demonstrate remission - pardon me?
22 DR. PINCUS: It doesn't require that.

1 CO-CHAIR SUSMAN: Yes, it does.
2 The last two measures did.
3 (Simultaneous speaking)
4 DR. PINCUS: Again, you get into
5 the denominator by having had it. It's not
6 based upon the initial score; is that correct?
7 DR. GOLDEN: Right. All you have
8 to do is look at put that at the end of the
9 six months.
10 DR. STREIM: No. You have to have a
11 PHQ to be in that denominator.
12 So for this measure that is under
13 consideration before us right now, you don't
14 have to have a PHQ to be in the denominator.
15 All you need is an ICD-9 diagnosis of
16 depression. So it's a wider - it's
17 potentially a larger denominator, and what
18 this really tells you is, if only 20 percent
19 of people are getting a PHQ, then when you
20 look at your other out comes, the true outcome
21 measures, you are really only capturing 20
22 percent of people who have an ICD-9 diagnosis,

1 and that is still not the whole universe of
2 depressed people, but it's getting at a larger
3 denominator.
4 DR. PINCUS: If you are looking for
5 people who are currently depressed by PHQ
6 measure, the best place to look for that is
7 people who have a current diagnosis of
8 depression by ICD-9 diagnosis.
9 MS. JAFFE: So I am a little
10 confused. This standing by itself, not linked
11 to the other outcomes, just the fact that you
12 are just collecting this information once
13 every four months; that's all that's required,
14 right? So I guess I'm a little bit of: so
15 what, I mean if it stands by itself.
16 CO-CHAIR SUSMAN: I see this as a
17 process improvement measure. It's to get the
18 adoption of PHQ out into user care in
19 evaluating patients with a diagnosis of
20 depression, and I think it's wonderful for
21 that reason. But I still don't see this as an
22 outcome measure, and I still - I mean I

1 understand what you are saying.
2 DR. STREIM: It's not an outcome
3 measure, but it helps you incorporate the
4 other outcome measures, and so it becomes an
5 important part of the toolkit where the end
6 user is going online and looking at a publicly
7 reported measure and wants to know who are
8 these people in the denominator. It doesn't
9 answer all those questions, but it helps you
10 along to know whether you are only capturing
11 a small proportion - that is what I'm arguing
12 that it should be approved not because it is
13 in scope, but because it adds to the usability
14 of the other two measures.
15 DR. GOLDBERG: That is the only
16 reason I see to support it. Standing by
17 itself. So why have the complication of
18 another one? Why not simply change the others
19 to say, your first measure is, how many had a
20 baseline, rather than having this other thing
21 floating around out there.
22 DR. PHILLIPS: Then you are

1 radically changing the measure because you
2 have a new denominator.
3 DR. GOLDBERG: Right, but when you
4 start up eventually it's the same thing. I
5 mean, essentially you are changing the
6 denominator. If you link this, you are
7 changing the denominator.
8 DR. STREIM: No, I think what
9 you're suggesting would require a whole new
10 measure, set of outcome measures where the
11 denominator is ICD-9 diagnosis, and that is --
12 DR. PHILLIPS: But that is what this
13 requires, right?
14 DR. STREIM: No. No, this does
15 require it for this measure.
16 DR. PHILLIPS: Right. So it's not
17 different. If you are linking it you are
18 doing the same thing.
19 DR. WINKLER: Right. There are
20 multiple approaches to get to the same thing.
21 One of the reasons people like to keep them
22 separate is because they become more

1 actionable. If all you have is a low score
2 on the outcome measure, you don't know without
3 being able to break it down how many just
4 never had the test in the first place versus
5 how many had - did not, you know, change over
6 the timeframe, whereas if you break them down.
7 But we've seen both kinds of measures.
8 DR. PHILLIPS: Then this isn't just
9 process.
10 CO-CHAIR LEDDY: Why couldn't you
11 just change the first two measures, to measure
12 the first two measures, but then using the
13 current database use the same numerators for
14 the first two measures and come up with some
15 other measures that use the ICD diagnosis,
16 ICD-9 diagnosis population as the denominator.
17 Wouldn't you get to the same thing? Too
18 confusing?
19 DR. STREIM: But nobody has done
20 that, and nobody has submitted a measure like
21 that, so we don't have an option to work with
22 that right now, somebody unless next year

1 somebody or the year after does that.

2 CO-CHAIR SUSMAN: The other concern

3 I have about this is that patients have a

4 diagnosis of depression, and at least in

5 primary care, it is not uncommon to carry that

6 diagnosis forward for a long time. So if I

7 documented a PHQ and the person's remission,

8 then the question becomes, well, how

9 frequently should I surveil patients with

10 treated depression for recurrence? And

11 frankly the data are not, I don't think, very

12 robust. So we are adding a substantial burden

13 since depression is an extremely common

14 diagnosis in primary care. Now, we could

15 argue whether that would be on the whole a

16 good thing or not, but the question I would

17 say is, gee, is that burden, which is getting

18 down here a little bit. And I see both Harold

19 and Bob.

20 DR. PINCUS: One question: What is

21 the current U.S. Preventive Health Services

22 Task Force recommendations with regard to

1 depression screening?

2 (Simultaneous speaking)

3 CO-CHAIR SUSMAN: Once a year.

4 DR. PINCUS: Is it once a year? So

5 that's in the general primary care population,

6 and this is likely to be an enriched source of

7 people, it actually is good evidence, and it's

8 an enriched source of people who currently

9 have depression symptoms above threshold. So

10 one could easily say that certainly once a

11 year would be a reasonable amount to do that,

12 certainly if somebody is still carrying a

13 depression diagnosis.

14 CO-CHAIR SUSMAN: This is a four

15 month, not a year measure.

16 (Simultaneous speaking)

17 DR. PINCUS: I'm just trying to say -

18 DR. ROCA: Can I make a comment

19 here? This is a very interesting discussion,

20 and I don't suppose we're following Roberts

21 Rules of Order, but I feel an urge to call the

22 question right now. Because I think some of

1 us are going to think this is a process
2 measure and shouldn't - isn't within scope.
3 I think some people would think it ought to be
4 within scope. I think we are just going to
5 have to at some point vote on it, because I am
6 not sure we are going to come to consensus.
7 DR. STREIM: Just one other
8 question about - or clarification, the four-
9 month measurement period that you refer to
10 here, that begins in someone who is first seen
11 in a health system and gets a diagnosis, an
12 ICD-9 diagnosis of depression?
13 MS. PITZEN: Correct. They would
14 have to have a visit with that diagnosis in
15 that timeframe that you are measuring.
16 DR. STREIM: So it is possible to
17 have somebody who has been depressed for 20
18 years, but what would define the measurement
19 period is - it has to start with the
20 availability of an electronic record that has
21 an ICD-9 code in it, correct?
22 MS. PITZEN: Correct.

1 MS. JAFFE: You wouldn't - building
2 off what Joel was saying, if they are not
3 scheduled to come in every four months, you
4 wouldn't have them come in simply the screen,
5 would you?
6 MS. PITZEN: No, they actually
7 couldn't be counted, because the
8 identification of those patients are, you have
9 to have a visit with a diagnosis of major
10 depression or dysthymia in that time frame.
11 If you don't have a visit during that
12 timeframe you are not even in the denominator.
13 CO-CHAIR SUSMAN: I think we ought
14 to take a vote. I want to make a comment
15 though. As much as I like to improve care,
16 and you said this is a good process measure,
17 this is in preparation for the vote, of all
18 the process measures this is a good process
19 measure. It would help improve care. I don't
20 think that's what we are here for. I think we
21 are here to identify measures that are outcome
22 measures, that's why I think we need to have

1 a vote.

2 CO-CHAIR LEDDY: Okay, how about if

3 we call - okay, you have a question or

4 comment.

5 DR. HENNESSEY: Is there a way we

6 can vote on this as linked?

7 CO-CHAIR LEDDY: Maybe Reva could

8 explain - I thought that what we were going to

9 do is vote whether it's in or out of scope as

10 an outcome measure, and then or now I want

11 Reva to explain more clearly what you mean by

12 a process measure is linked. Where does that

13 vote go?

14 (Laughter)

15 DR. WINKLER: These are

16 cumulatively, and that's why sometimes we can

17 put ourselves in a box. But one of the

18 alternatives if you are concerned about it not

19 being an outcome measure and out of scope but

20 you still feel there is something valuable

21 about it and you would like to maintain it in

22 some way is, you do have the option of linking

1 it or pairing it is what we say so that you
2 would have the paired process measure paired
3 with, say, the six month outcome measure such
4 that if you did one you did both, the two
5 travel together. They are really two parts of
6 the whole recommendation. And so that is
7 always an option. And that is a way of
8 getting around, you have a dangling process
9 measure. But for those of you who feel it has
10 value to the outcome measures, this is a way
11 of using it.
12 DR. PINCUS: Separate votes?
13 DR. HENNESSEY: So, okay, I'm just
14 trying to clarify. I'm on The Price is Right,
15 I'm on the TV show, I've got Door # 1 saying
16 doesn't meet scope, not important. Door #2
17 says, does meet scope, important, and we can
18 go down the complete partial.
19 DR. WINKLER: We got a bunch of
20 doors. We've got the Winchester Mystery
21 House, actually.
22 DR. HENNESSEY: So we got more

1 doors.

2 DR. WINKLER: Well you are talking
3 about two measures at a time is what is going
4 on. So I think the question probably first
5 off is, is there strong enough feeling by the
6 majority that this measure is out of scope
7 under all potential eventualities, linked or
8 not linked, separate, or whatever. So should
9 we just take all potential eventualities,
10 linked or not linked, separate, or whatever?
11 So should we just take it off the board
12 altogether because it is just out of scope for
13 the project.

14 Do that, and then we can do the ones
15 that follow. Does everybody get that?

16 DR. ROCA: Can I just - I would
17 vote that it is out of scope, but if there
18 were an option saying that if you were going
19 to use either of the other two then you are
20 also having to report this, then the other two
21 are the primary measures and this is just sort
22 of a hanger on and I would vote for that.

1 (Simultaneous speaking)
2 DR. WINKLER: Yes, you have three
3 votes. So can we vote three options?
4 DR. STREIM: So if the initial vote
5 is on in or out of scope, up or down, that
6 doesn't preclude further votes. It's not like
7 the Senate where discussion is ended, you will
8 never hear about this again, right?
9 DR. WINKLER: Right.
10 DR. STREIM: Okay, thank you.
11 DR. WINKLER: Let's try it in kind
12 of two steps. The first one is in or out of
13 scope. So if you vote that it is out of scope
14 it does not come back; it's gone, goodbye,
15 keep that in mind.
16 CO-CHAIR LEDDY: So this is not in
17 or out of scope as an outcome measure. No,
18 this is in or out of scope of whether you ever
19 want to hear about it again. That's what
20 you're saying, Reva. That's different.
21 DR. WINKLER: If you say it's out of
22 scope it's because it's a stand alone process

1 measure you feel does not have any role in the
2 outcomes work you are doing. Is that fair?
3 (Simultaneous speaking)
4 CO-CHAIR LEDDY: So what I'm putting
5 up here, does this make sense, out of scope,
6 in scope, and then in scope would be - as a
7 stand alone. I think you would definitely
8 have to break it down.
9 MS. MASLOW: What if we vote on
10 what we want first?
11 DR. WINKLER: I'm hearing we want
12 something totally different.
13 MS. MASLOW: So what if we vote on
14 that instead of making us make an illogical
15 statement.
16 DR. WINKLER: Okay, what do you
17 want?
18 MS. MASLOW: We want it to be tied
19 to one of the other measures, and it is in
20 scope in that context.
21 MS. BOSSLEY: So we can switch it,
22 so if for some reason it doesn't pass as

1 paired with one of them, then we'll go back to
2 the out of scope. So I think that is what you
3 are getting at right? Does that make sense?
4 DR. KAUFER: We have already
5 endorsed this.
6 DR. WINKLER: We have?
7 DR. KAUFER: Well, logically we
8 have by approving the other two outcome
9 measures, we have tacitly approved this
10 measure as part of - as part of that outcome
11 measure.
12 DR. WINKLER: No. There is a four
13 months window.
14 (Simultaneous speaking)
15 CO-CHAIR LEDDY: I think the group
16 is saying that they - we don't want to say
17 this is an outcome measure, because it would
18 be silly to say that. But we would like to
19 consider it as a hanger on, but clearly
20 process. Is that what we are saying, because
21 it will help the other outcome measures.
22 (Simultaneous speaking)

1 CO-CHAIR LEDDY: Joel?
2 DR. STREIM: I will just restate. I
3 believe that this is a process measure by
4 itself. As a stand alone, it is not an
5 outcome measure. However I think it's
6 important to measure because it helps improve
7 and enhance the usability and interpretability
8 of the two other measures we just voted to
9 endorse.
10 CO-CHAIR LEDDY: So how about if we
11 have a motion, and we vote. That is very well
12 stated, and why don't we say whether we agree
13 with that statement or not, and that is what
14 we will be voting on. Is that okay, Reva?
15 DR. WINKLER: Yes.
16 CO-CHAIR LEDDY: No?
17 DR. ROCA: But does this mean, is
18 this voting to say that this would be a stand
19 alone measure? Or that it would have to be -
20 because Joel, what you implied is that it was
21 not really an independent measure or a stand
22 alone measure.

1 DR. STREIM: I don't think it meets
2 the criteria as a stand alone outcome measure.
3 It certainly could be a stand alone process
4 measure, but that is out of the scope of this
5 committee's - scope definitions from last
6 November. So maybe, I don't know if we need
7 to disaggregate those statements and vote on
8 them separately or you want to do the package.
9 That is really the chair's prerogative.
10 DR. GOPLERUD: I'd like to suggest,
11 based on what we did last November, developing
12 an incredibly broad definition of outcomes,
13 which included population health, the social
14 determinants of health, you know, we basically
15 voted on climate change as health outcomes.
16 DR. STREIM: As health outcomes,
17 though, not as processes of care. Not
18 processes of care.
19 DR. GOPLERUD: Okay, but given the
20 incredible breadth that you all accepted, or
21 we all accepted as being outcomes, why not
22 just define that we like this measure and know

1 that it is a process measure, and say that we
2 endorse it anyway?
3 DR. STREIM: Well, because I think
4 we have a process here that allows us to
5 endorse this as a linked measure that enhances
6 the usability and interpretability of the
7 other two outcome measures we endorsed. I
8 know I'm being redundant, but I think that is
9 really the legitimate reason for this
10 committee's - within the scope of what this
11 committee really did lay out last fall.
12 CO-CHAIR LEDDY: So that latter
13 little bit shorter statement, can we vote on
14 that? That was very good. Would anybody like
15 it repeated?
16 DR. PINCUS: I missed it.
17 CO-CHAIR LEDDY: Can you repeat
18 that latter statement, Joel?
19 DR. STREIM: You want the latter,
20 not the former. Well, the former was the
21 aggregate statement, let me do that, and then
22 if you want a shortened version I will try and

1 reiterate. As a stand alone measure this
2 really is not an outcome measure, it's a
3 process measure, so technically out of scope.
4 However, I think it is a measure that enhances
5 the usability and interpretability of the
6 other outcome measures we just endorsed, and
7 therefore, I believe it should be endorsed as
8 a linked measure to each of the other two.
9 CO-CHAIR LEDDY: Are there any
10 questions about Joel's statement?
11 DR. GOLDEN: The comment is that I
12 think we have before us that we have endorsed
13 a concept, the concept of the measurement of
14 status through this tool. The problem we have
15 is, I think is the measures themselves could
16 be made stronger, and we are now cleaning up
17 imperfect measures that unfortunately that is
18 not the rules of the game. But I think that
19 we are taking measures from a community that
20 I think, if we had more time to work with,
21 there would be a better numerator and a better
22 denominator.

1 CO-CHAIR SUSMAN: So just a point of
2 clarification from the measure developer. If
3 I had depression diagnosed at time zero, and
4 let's say I come in at five months, and I have
5 depression diagnosed at five months, and there
6 wasn't a PHQ in the first five month interval
7 -
8 MS. PITZEN: You weren't seen in the
9 office.
10 CO-CHAIR SUSMAN: Well, let's say I
11 was seen in the office.
12 MS. PITZEN: If you were seen in the
13 office in that first five-month interval --
14 DR. WINKLER: Could you use your
15 mike, please.
16 MS. PITZEN: If you were seen in
17 the office in that first five-month interval,
18 had the ICD-9 codes applied to one of your
19 visits and then if you had a PHQ-9, that would
20 be counted. But if you were not seen in the
21 office during that time with the depression
22 diagnosis you would not be in the denominator

1 for this process measure.
2 CO-CHAIR SUSMAN: That seems pretty
3 much garbage in garbage out in the sense that
4 it is implying that there is a follow up and
5 then there is rediagnosis. I understand from
6 a community adoption spread of diffusion of
7 the technology if you will why this is being
8 used. I still am worried about this as an
9 accountability measure, even when linked to
10 the other two. I also wonder then, to just
11 take my question one step further, then I'll
12 let the vote occur, is if I had that first
13 five months, and let's say I didn't come in,
14 and then let's say at the six month I get
15 another diagnosis of depression, it starts
16 over again, or are you excluded? Or what
17 happens?
18 MS. PITZEN: Let me see if I can
19 try and explain without being too confusing.
20 The denominator is different for the remission
21 measures and this process measure.
22 CO-CHAIR SUSMAN: Right.

1 MS. PITZEN: So going back to the
2 remission measures, if you are diagnosed with
3 major depression or dysthymia and your score
4 is ten or above, you are in.
5 CO-CHAIR SUSMAN: Right.
6 MS. PITZEN: And if you never see
7 your provider again over the next seven
8 months, because we do allow a plus or minus,
9 grace window, then you fail.
10 CO-CHAIR SUSMAN: Right, got it.
11 But now for this current measure --
12 MS. PITZEN: Right, for this
13 current measure it doesn't matter what your
14 PHQ-9 scores are, you are in the denominator
15 if you have depression or dysthymia.
16 CO-CHAIR SUSMAN: And is that a
17 denominator that lasts just four months?
18 MS. PITZEN: Four months. Right.
19 CO-CHAIR SUSMAN: So if I came in
20 at time zero and had the diagnosis, you would
21 have one to get the PHQ within the four month
22 period. If I came in at five months time

1 frame with depression that would be a new
2 episode of measurement.
3 MS. PITZEN: Correct.
4 CO-CHAIR SUSMAN: If I came in at
5 eight months or nine months it would be yet
6 another episode of measurement; is that
7 correct?
8 CO-CHAIR SUSMAN: Correct.
9 CO-CHAIR SUSMAN: Okay.
10 DR. STREIM: Can I also comment on
11 the issue of unintended consequences, which
12 will always be our concern here. If this is
13 endorsed linked to the two other outcome
14 measures and it is not endorsed to be used as
15 a stand alone process measure, then there
16 wouldn't even be a situation where someone
17 would get dinged for not doing a PHQ in the
18 first four months, because - let me finish -
19 because it would only be used in conjunction
20 with the outcome measures, and - that we just
21 recommended for endorsement, and therefore to
22 get in those denominators you have to have a

1 PHQ. So nobody is going to get dinged for not
2 having a PHQ as a result of endorsing this as
3 linked.
4 DR. PINCUS: But linking it does
5 not require that they have the same
6 denominator, correct?
7 DR. STREIM: No, not at all. All
8 I'm saying is, I'm just addressing the concern
9 or potential concern that people may have that
10 if we endorse this in any way that failure to
11 have a PHQ, in particular that tool on the
12 chart, is going to result in health care
13 provider or system getting dinged. That won't
14 happen the way I last stated it in the
15 proposal to endorse.
16 DR. WINKLER: Just as a
17 clarification, when we talk about linking
18 them, what we are doing is saying that when
19 these are implemented the expectation is that
20 they will be used together so that you will
21 get a report of the results of this measure
22 and the results of the outcome measure.

1 It's not a composite, it's just that
2 the two travel together. So it's not a
3 cafeteria; you don't get to choose one and not
4 the other. We're saying do them both.
5 DR. PINCUS: The current sort of
6 set of the three depression measures that you
7 have endorsed are there? They are? So this
8 must be a reasonable thing. So just one point
9 about this being - could it also be done,
10 could it be also as a separate measure, too?
11 Could it be linked and also separate?
12 CO-CHAIR LEDDY: Not by our group;
13 we don't do process.
14 DR. PINCUS: Well, no, in that
15 case, as I looked at the list of measures,
16 only four processes - definite outcome
17 measures on our list. I'm just saying that
18 when we actually sent out a call, we enlarged
19 the notion of outcomes.
20 (Simultaneous speaking)
21 CO-CHAIR LEDDY: We redefined
22 outcomes sort of broadly?

1 DR. PINCUS: Right, so what I'm
2 saying is, that is a question I have is if
3 this is - you know if we are taking a very
4 strict - if now we are taking a very strict
5 notion of what is outcome versus process --
6 DR. WINKLER: I would hope you are
7 internally consistent in your notion of
8 outcomes.
9 DR. PINCUS: My view is that this is
10 one of the better process measures that
11 actually has pretty good evidence linking it
12 to outcomes so that that is why - so from my
13 point of view, I think that as an outcomes-
14 related process measure, whatever you want to
15 call this sort of enlarged Venn diagram, it
16 has significant value. But also I think it
17 helps to interpret those other two measures,
18 because you get a sense of what they didn't
19 capture.
20 CO-CHAIR LEDDY: So you would like
21 to amend the statement that Joel made that
22 where you said that it would be useful in

1 coordination with these measures to interpret
2 the other outcome measures, and it sounds like
3 Harold is saying that it also should be
4 considered as a separate, as a stand alone
5 vote. So we could --
6 DR. PINCUS: You need two votes,
7 and a stand alone vote, that is correct.
8 CO-CHAIR LEDDY: Right.
9 (Simultaneous speaking)
10 DR. PINCUS: And the rationale for
11 that is that I think there may be
12 organizations that choose to only do the
13 remission measures, and it would be important
14 for them to have that information linked if
15 that is what they are going to do so they can
16 interpret them better. And on the other hand
17 there may be organizations that don't want to
18 use the remission measures but want to have a
19 sort of outcome-related process measure.
20 DR. STREIM: I could be convinced
21 that it should be recommended as a stand
22 alone. I could be convinced, but I have a

1 question based on Reva's last clarification
2 about harmonization, whether we could even
3 link these because if I could wrap my brain
4 around this part, it looks like if you link
5 them and they are traveling together and you
6 have to do them all, if you have an ICG - no
7 I guess I've answered the question, it doesn't
8 matter.
9 MR. PELLETIER: The four months,
10 how did you decide that? That's when you
11 kind of report things in your organization?
12 MS. PITZEN: Correct, it aligns
13 with the data submission.
14 MR. PELLETIER: Right, so I don't
15 think we should be getting hung up on four
16 months because it's the way they are reporting
17 compliance with getting a PHQ for someone with
18 three diagnoses. That's all that is. You can
19 do that in two months; you can do that in
20 eight months. You can do that yearly, you can
21 do that every two years.
22 DR. BOTTS: I think the idea is

1 that what you are getting is a cross section
2 of how many people are doing measurement based
3 care. So it just gives you a figure of how
4 frequently are we getting those, and that is
5 important in terms of interpreting the
6 outcome. As a process measure, even as a
7 stand alone, it's not necessarily tied to, you
8 are getting a clinical assessment that is
9 applied temporally with the initiation or
10 management of treatment. It just says, you
11 have been seen, you have an active diagnosis,
12 and we have assessed you with this tool. You
13 could be eight months out; you could two weeks
14 out; you don't know in that process. So even
15 as a process measure I would say that it needs
16 work. As an add on to our outcomes, I think
17 it makes a lot of sense.
18 CO-CHAIR LEDDY: So why don't we
19 take a vote, then. Joel put on the table
20 about the add on that this is the add-on to
21 help interpret the first two that we
22 recommended.

1 DR. PINCUS: So this is a paired or
2 linked measure? Is that correct?
3 DR. STREIM: And just again to be
4 really clear, by doing that, and I am still
5 struggling with the unintended consequence
6 thing, it means when they are performed they
7 will all be performed together, meaning all
8 three?
9 DR. WINKLER: You've got again more
10 options. Which ones are you linking? Are you
11 going to link the process measure with both
12 outcomes as a triad or link the process
13 measure with each outcome independently?
14 DR. STREIM: But even if you do it
15 with each of them independently, it means that
16 everyone with an ICD-9 diagnosis will be
17 included in the denominator at a minimum.
18 DR. WINKLER: At the first measure.
19 DR. STREIM: Right, and then the
20 second measures would be applied to those, but
21 that is where the harmonization problem is;
22 you couldn't do it unless you had a PHQ score.

1 DR. WINKLER: Exactly.
2 DR. STREIM: So that is the
3 harmonization issue; it doesn't matter.
4 DR. WINKLER: It doesn't matter.
5 That isn't so much harmonization. The
6 numerator of the first one --
7 DR. STREIM: It doesn't preclude
8 you from doing that.
9 (Simultaneous speaking)
10 CO-CHAIR LEDDY: Does everyone agree,
11 then? So the recommendation that we are going
12 to vote on, yes or no, is going to be Joel's
13 statement with the linking with Richard's
14 caveat about linking independently, and - did
15 you have another caveat Rich? That's it.
16 Okay. So we are going to vote yes or no.
17 How many vote yes to recommend that?
18 (Show of hands)
19 DR. WINKLER: Fourteen.
20 CO-CHAIR LEDDY: And how many vote
21 no?
22 DR. WINKLER: One.

1 CO-CHAIR LEDDY: And how many vote,
2 abstain?
3 DR. WINKLER: None.
4 MR. CORBRIDGE: Eric is out of the
5 room.
6 DR. WINKLER: Eric is out of the
7 room and Carol is out of the room.
8 CO-CHAIR LEDDY: Okay, and Harold's
9 back, so he voted. So this is whether we
10 would like to recommend this as a process
11 measure or as - as a stand alone measure. As
12 a recommended measure.
13 MS. BOSSLEY: You would be
14 recommending this measure in the NQF portfolio
15 that would be used by itself by anyone and
16 everyone as long as they report it.
17 CO-CHAIR LEDDY: Within our scope.
18 (Simultaneous speaking)
19 MS. MASLOW: So this is
20 recommending it as an outcome measure?
21 (Simultaneous speaking)
22 DR. WINKLER: One of the issues

1 around scope is it helps us limit what we - we
2 could bring you guys 200 measures to play with
3 if we didn't put some boundaries around what
4 we wanted to talk about. It also provides the
5 field when we ask for the call for measures,
6 and submissions, to tell what we want to
7 consider. So that is all the scope does.
8 Once they go through the process, these could
9 end up in the portfolio to be used.
10 DR. HENNESSEY: Sheila, you had a
11 comment about this measure from a process
12 perspective.
13 DR. BOTTS: Well, my comments were
14 related, I think what this measure, this
15 process to me just says, are we using
16 measurement-based care or not. Are you
17 getting that tool? It doesn't tell you about
18 the meaningfulness of when you are doing the
19 assessment or how that might relate to
20 treatment decisions. Just that when you see
21 a patient with a diagnosis of depression using
22 a measurement based tool to assess. And so

1 that is probably acceptable as one process
2 measure. I would like to see other process
3 measures that said you would have this within
4 X time from the initial diagnosis or the
5 initiation of treatment. But this at least
6 says, are you doing it, and I think that is an
7 important measurement, but we could go a step
8 further in terms of where it falls in
9 treatment.
10 DR. PINCUS: Or we could actually
11 say that when we get into what our
12 recommendations are for further development.
13 CO-CHAIR LEDDY: But that is not
14 right now. Are we ready to vote on this
15 measure recommending it as an independent
16 measure by this board? All in favor?
17 (Show of hands)
18 DR. WINKLER: Six.
19 CO-CHAIR LEDDY: Should we do it
20 again?
21 MR. CORBRIDGE: Seven.
22 CO-CHAIR LEDDY: Okay, and then -

1 or opposed to recommending this as an
2 independent measure?
3 (Show of hands)
4 DR. WINKLER: Seven, it is a push.
5 Did everyone vote?
6 CO-CHAIR LEDDY: Oh, I'm sorry, I
7 didn't ask for abstentions. One abstains.
8 You want to change your vote?
9 DR. GOPLERUD: Yes, for independent.
10 CO-CHAIR LEDDY: So it's eight and
11 six then, eight, six and one.
12 (Off the record comments)
13 CO-CHAIR LEDDY: So this is - do we
14 have anything else to do before lunch, Ian?
15 MR. CORBRIDGE: No, at this point
16 this concludes the first section of workgroup
17 number one. So at this point in time we had
18 planned -
19 (Simultaneous speaking)
20 MS. BOSSLEY: We need to know if
21 you feel - again I think well you are actually
22 evaluating it both ways, stand alone and

1 linked. Does it meet the importance criteria?
2 Does it meet scientific acceptability,
3 usability, feasibility? You have now
4 determined it would be used alone and linked.
5 So as a measure itself.
6 CO-CHAIR LEDDY: Okay, so are we
7 ready to vote? We've had a lot of discussion
8 on this measure. Can we vote on importance?
9 DR. WINKLER: Does anybody think
10 it's not important?
11 Okay, great. What is the next one?
12 Scientific acceptability. Does anyone think
13 it completely meets the criteria?
14 Partially meets the criteria? One,
15 two, three.
16 MS. MASLOW: Did you assume
17 completely?
18 CO-CHAIR LEDDY: I saw no one vote.
19 Did you want to vote completely Katie?
20 DR. WINKLER: Shall we start over?
21 MS. MASLOW: I will vote partially.
22 (Laughter)

1 DR. WINKLER: Twelve.
2 How many minimally? I saw a couple
3 of no votes. Did you vote?
4 MR. PELLETIER: I didn't vote.
5 DR. WINKLER: How many abstain?
6 MR. PELLETIER: You know what it
7 is? When you develop a measure you want
8 people to do something, okay. You then
9 collect your data, but the implicit is that
10 they are doing it. That they are going to do
11 this, that what you have asked them to do they
12 are going to do, so that is going to be part
13 of the measure. It shouldn't be this add-on
14 later that says, oh let's check if they are
15 doing it the way we want them to be doing it.
16 So that's where this is very - someone said it
17 before, we are fixing a measure that is not
18 perfect.
19 DR. PINCUS: I don't agree with
20 that notion that you are fixing it. It just
21 gives a broader perspective. For the
22 denominator of the two remission measures,

1 it's a good measure for looking at remissions,
2 but what you don't know is with the population
3 that the organization is dealing with, you
4 don't know the extent to which the - you are
5 getting information about the broader
6 depressed population.
7 MR. PELLETIER: But don't you
8 always want to know that?
9 DR. PINCUS: No.
10 MR. PELLETIER: I think you do. I
11 disagree.
12 DR. PINCUS: I would say that for
13 the vast majority of NQF-endorsed measures
14 they are very specific to the very specific
15 denominator, and they don't give you a broad
16 perspective.
17 DR. WINKLER: We need to just sort
18 of finish this out.
19 CO-CHAIR LEDDY: So the next one
20 to vote on for this measure is - we voted on
21 scientific acceptability. Okay, usability?
22 MR. PELLETIER: And this is the

1 paired vote?

2 MS. BOSSLEY: No, this is the

3 process measure. We are evaluating this

4 measure on its own. Not linked.

5 MR. PELLETIER: No, either way.

6 DR. WINKLER: It's either usable or

7 it's not.

8 MS. BOSSLEY: I think because you

9 have determined that you feel this measure

10 could be used alone, you need to evaluate this

11 measure on its own face value, on whether it

12 meets the criteria or not.

13 MR. PELLETIER: I don't think that

14 was understood when you had the last two

15 votes.

16 MS. BOSSLEY: Well, that is what I

17 am wondering, was that understood or not?

18 CO-CHAIR LEDDY: Okay, so let's go

19 back and redo importance as an independent

20 measure. Importance is the first. Importance

21 to measure and report, completely.

22 DR. WINKLER: Anyone disagree?

1 That's almost easier.
2 CO-CHAIR LEDDY: As this measure,
3 evaluating it without thinking about the other
4 two. On its own face value, does it meet the
5 importance criteria, completely, partially,
6 minimally, or not at all?
7 (Simultaneous speaking)
8 DR. PINCUS: The thing that is
9 disarming is that this is so far superior to
10 every existing NQF depression measure that it
11 is not even funny.
12 CO-CHAIR LEDDY: So does it
13 completely meet the importance in your mind?
14 MS. MASLOW: Assuming it is a process
15 measure.
16 CO-CHAIR LEDDY: It is a process
17 measure.
18 (Simultaneous speaking)
19 CO-CHAIR LEDDY: Okay, so how many
20 are completely?
21 (Show of hands)
22 I have 13. Okay, how many are

1 partially?

2 Two.

3 MS. BOSSLEY: Any others? I think

4 we've got minimum.

5 CO-CHAIR LEDDY: Minimally. So the

6 next category is scientific acceptability.

7 How many vote completely?

8 (Show of hands)

9 CO-CHAIR LEDDY: How many vote

10 partially?

11 MS. CORBRIDGE: I have 13.

12 MS. BOSSLEY: Late hand. 14.

13 CO-CHAIR LEDDY: Okay, any minimally?

14 Any abstentions? Okay.

15 Next category is usability. How

16 many vote completely?

17 MR. CORBRIDGE: Got seven.

18 CO-CHAIR LEDDY: How many vote

19 partially?

20 MR. CORBRIDGE: Six.

21 CO-CHAIR LEDDY: Is that everybody?

22 Any minimally? And any abstentions or not at

1 alls?

2 MS. BOSSLEY: We are missing

3 someone.

4 CO-CHAIR LEDDY: Okay, let's do

5 completely again. We are missing someone in

6 one category.

7 MS. BOSSLEY: Eight, nine of

8 eight, okay we are good.

9 CO-CHAIR LEDDY: Now we are on to

10 feasibility. So how many people would like to

11 vote that this is completely on the

12 feasibility measurement?

13 MS. BOSSLEY: Ten.

14 CO-CHAIR LEDDY: How many

15 partially?

16 MR. CORBRIDGE: Four.

17 CO-CHAIR LEDDY: And how many

18 minimally? Two? And any abstentions? No?

19 Okay, now we have to vote on - oh we

20 did it. backwards. So we already recommended

21 - and do we have anything else to do before

22 lunch? Are you going to tell us about lunch,

1 Ian?

2 MR. CORBRIDGE: I guess at that

3 point we do conclude with that section. We

4 have lunch right out here for the Steering

5 Committee Members. We are hoping if we can do

6 it quickly, I know we are a little bit over

7 schedule, so if you don't mind take a half

8 hour or 15-minute break to have lunch, make

9 some phone calls, and if you would come back

10 and start on the major process here again,

11 that would be wonderful.

12 (Whereupon at 12:42 p.m. the

13 proceeding in the above-entitled matter went

14 off the record to return on the record at 1:15

15 p.m.)

16 CO-CHAIR SUSMAN: So we are going

17 to go ahead and get started. I appreciate

18 everybody's good participation during the last

19 session, and I will try to facilitate this

20 with the able assistance of Tricia and the

21 rest of the NQF staff.

22 So we are going to do readmission

1 and mortality. This is suicide deaths, and
2 then a bunch of readmission criteria.
3 READMISSION & MORTALITY MEASURES
4 CO-CHAIR SUSMAN: The group is Ann,
5 Darcy, Joel and Glenn. And I guess you are
6 somewhat grouped over on the end here. So we
7 will look forward to your thoughts about each
8 of these. Just to review the process, we'll
9 first decide whether it's in or out of scope,
10 make sure that we are doing this as an outcome
11 and not process measure; and then go through
12 the drill which, I think, everybody has
13 probably caught on to by now.
14 So the first measure I have up is
15 the suicide deaths, at-risk adult psychiatric
16 inpatients within 30 days of discharge.
17 MEASURE OT3-001: SUICIDE DEATHS OF "AT
18 RISK" ADULT PSYCHIATRIC INPATIENTS WITHIN 30
19 DAYS OF DISCHARGE
20 CO-CHAIR SUSMAN: And would you
21 like to give us the brief overview?
22 MR. CORBRIDGE: Sure. So as Jeff

1 started out, we have the title, which is
2 "Suicide Deaths of At-Risk Adult Psychiatric
3 Inpatients Within 30 Days of Discharge". The
4 description for this measure is rate of
5 suicide deaths within 30 days of discharge
6 from the inpatient psychiatric setting, adult
7 patients aged 18 and older, rated as "at
8 risk."
9 The numerator statement reads as
10 follows: suicide deaths of at-risk adult
11 patients within 30 days of discharge. The
12 denominator statement reads, adult inpatient
13 discharge with a pre-discharge suicide
14 assessment that affirms any of the at-risk
15 inclusion criteria and do not meet the
16 exclusion criteria.
17 And the information from that
18 measure, the subcriteria, is posted up there.
19 So from our group any concerns that this isn't
20 an outcome measure?
21 It is a terminal outcome -- I think
22 it's probably an outcome that matters to

1 patients. So I think we are all in agreement
2 there. Why don't we talk about importance?
3 I'll look to the group for some initial
4 comments.
5 DR. STREIM: High impact.
6 CO-CHAIR SUSMAN: Everybody agrees
7 this is a high impact outcome, probably self-
8 evident.
9 DR. PINCUS: So the incidence of
10 suicide post-hospitalization.
11 CO-CHAIR SUSMAN: So the question
12 is, what's the incidence of suicide post-
13 hospitalization? Is this an important issue,
14 one that's prevalent?
15 DR. PINCUS: It's obviously
16 important from the point of view of, it's a
17 catastrophic event. But if a hospital has one
18 of these every year, how stable is something
19 like that?
20 DR. STREIM: We know that
21 compared to other kinds of health outcomes
22 this is a low frequency event. But most of

1 our suicidology colleagues would probably say
2 that it's one of the hardest things to study
3 in terms of knowing what incidence rates are
4 reliably. I don't know that that adds
5 anything.
6 DR. PHILLIPS: I think that gets to
7 a point too, that if you look - our importance
8 ratings are very different from the rest of
9 our ratings of this measure, and it's that I
10 think - it's readily apparent that tracking
11 suicide is important, but we have lots of
12 questions about usability and feasibility of
13 this measure.
14 DR. GOLDBERG: Is this a Joint
15 Commission report?
16 DR. PHILLIPS: I don't know.
17 CO-CHAIR SUSMAN: So the question
18 is, is this a reportable joint commission -
19 does anybody know?
20 MS. JAFFE: No, it's not.
21 The reportable events are suicides
22 that happen during hospitalization.

1 CO-CHAIR SUSMAN: Thank you.
2 DR. GOLDEN: So the question in
3 terms of the importance of this measure on the
4 issue, I noticed, like, the last one you had
5 to have had a suicide risk assessment process,
6 with about six or seven things, does that
7 limits the utility of this as opposed to just
8 saying hey, anybody who committed suicide
9 after discharge from psychiatric
10 hospitalization.
11 DR. STREIM: Do we address that in
12 scientific --
13 DR. GOLDEN: I guess my question
14 for you, since I'm not doing inpatient
15 psychiatric care, are these criteria used
16 commonly, or are they not particularly - this
17 happens to be somebody's list?
18 DR. STREIM: I'm not aware of
19 anybody who is using post-discharge suicide
20 to measure quality at this point, but I'm not
21 a suicidologist.
22 DR. GOLDEN: I'm talking about risk

1 assessment. Does that tell us --
2 DR. STREIM: I was just saying I
3 think we have addressed that under scientific
4 acceptability, right?
5 MS. JAFFE: I think one of the
6 issues about, is this an important thing to
7 measure or not is, I think nobody will
8 disagree that measuring suicide is important,
9 but measuring it 30 days after discharge is
10 another question. And I'm not convinced that
11 it's all that important to measure at 30 days
12 out. Number one, because it hardly ever
13 happens, so it's not clear what we'd be
14 measuring, but there are just so many things
15 that can happen within 30 days after discharge
16 from a hospital. It's not clear to me that
17 this is the important thing to measure about
18 suicide.
19 CO-CHAIR SUSMAN: So part of the
20 discussion we are starting to get into it
21 sounds like, perhaps, is the scientific
22 acceptability sort of issues, and maybe

1 usability issues.

2 DR. STREIM: Well, I think even if

3 we just stick with the three, impact, gap, and

4 relationship to outcome items, maybe just do

5 this systematically as we've laid out the

6 process. In terms of the gaps, one of the

7 things we are looking for is disparities

8 across population groups, variability across

9 provider groups, and I'm not, again, a

10 suicidologist, but I couldn't find anything

11 published on post-discharge suicide rates

12 across health systems, anything that does

13 anything comparing performance, whether there

14 are health systems that do that internally I

15 don't know. I didn't look at that myself as

16 part of my review. I don't know if colleagues

17 did. But those of you who are health system

18 administrators, maybe, can comment on that.

19 DR. ROCA: We certainly, and I'll

20 try to get some specificity here, but there is

21 a reporting practice, if not a reporting

22 requirement, for suicides that occur within a

1 certain time period after discharge, and it
2 may be 72 hours, I can't recall exactly, and
3 I'll try to get that number, but certainly 30
4 days is outside that window. And of course
5 you don't always know if a suicide has
6 occurred within 30 days, there are certain
7 practical problems with ascertainment. And it
8 certainly is a rare event fortunately, but
9 it's obviously a high impact outcome that we
10 would all strive to avoid.
11 DR. GOLDBERG: On this issue of 72
12 hours versus 30 days partly is an artifact of
13 we have balkanized our health care system to
14 inpatient, outpatient, and diverse care, and
15 what we are really interested in I think is
16 how people do over an episode of care of their
17 illness. And at some point it may be that
18 suicide is 30 days after inpatient, the
19 inpatient phase of the episode of their
20 illness, would be an important outcome. So I
21 have that feeling which makes me think it's
22 important. I don't know if our system is

1 quite ready for that. What our system is
2 ready for is some - maybe not this, but
3 engagement and follow-up treatment, which a
4 number of people are trying to get at, either
5 by communicating discharge plans or outpatient
6 appointment being made and kept, that's our
7 system creeping towards taking care of the
8 person across the episode of their illness.
9 So what we are doing is make sure at least you
10 tell somebody that they left the hospital, and
11 you get a report to them, and they get a
12 follow-up appointment, and you give them
13 medication. But that's not this measure, so
14 as important and striking as this is I have
15 questions of whether this is the right time
16 for this measure.
17 DR. STREIM: Well, one of the
18 things that is not specified at least in the
19 materials we had access to from the measure
20 developer here -- is the measure developer
21 here on the phone, do you know? Sometimes we
22 can ask for a clarification.

1 MR. CORBRIDGE: It's Psychiatric
2 Solutions, and they are not here. I haven't
3 heard them on the phone.
4 DR. STREIM: One of the questions
5 is, if we are measuring the quality of an
6 inpatient stay, which is when the patient is
7 identified as being at risk in the way this
8 measure is proposed, then looking at the 30-
9 day period after the hospital stay depends --
10 you know, the outcomes depend heavily on the
11 transitions in care, what part of the system
12 is the patient being cared for. And again,
13 that goes to the scientific acceptability
14 which we haven't even gotten to yet.
15 DR. WINKLER: Just for context,
16 because this is sounding like a very similar
17 discussion, over the last couple of years NQF
18 has in other topic areas, notably around AMIs
19 and pneumonias and heart failures, moved in
20 the direction of 30-day post-hospitalization
21 mortalities readmission. So the idea that
22 transition of care, that the hospital has a

1 role to play in sort of setting and assisting
2 the trajectory of this patient to a successful
3 transition into the outpatient world it's
4 challenging, the data collection can be quite
5 difficult. But that is a direction that
6 measurement is moving in at a fairly rapid
7 clip, so we are certainly seeing in the main
8 outcomes, historically a lot of the measures
9 are, the data can be coming from both
10 inpatient and outpatient, coordination between
11 those two different settings of care is very
12 very much trying to get at this whole episode
13 of care.
14 So don't, I really would caution you
15 against, don't let that stop, because you are
16 going to find that this idea of that follow-up
17 after hospitalization is really of significant
18 importance in measurement that we are seeing
19 now.
20 DR. HENNESSEY: So mortality,
21 within 30 days of hospitalization discharge,
22 is becoming more prevalent within NQF

1 especially.

2 CO-CHAIR SUSMAN: So I am hearing

3 that everybody acknowledges that suicide is a

4 high impact condition, that while there is

5 probably a gap in overall care, the gap

6 demonstrated here isn't really very well

7 articulated, and the relationship to outcomes

8 obviously is there. So are we ready to vote

9 on importance here? Are there any new

10 concepts or questions?

11 So how many people would say that we

12 have completely met the importance? Raise your

13 hands please.

14 (Show of hands)

15 CO-CHAIR SUSMAN: How about

16 partially?

17 (Show of hands)

18 CO-CHAIR SUSMAN: Okay, so we will

19 move on. The next part, and I think we

20 already started to talk about this a bit, was

21 scientific acceptability. Let me ask the

22 group if you can shed some light on this

1 further. You will see there are lots of
2 comments up there.
3 DR. MANTON: The denominator
4 statement I thought was complete. A lot of
5 what was there was to be determined, which is,
6 I think, why that whole section really is
7 blank. Just about every measure, reliability,
8 validity, said it was to be determined, to be
9 determined, to be determined. So we really
10 don't have anything to go by.
11 CO-CHAIR SUSMAN: Who is the
12 measure developer?
13 MR. CORBRIDGE: It is Psychiatric
14 Solutions, Inc. And I guess because they are
15 not here, I have discussed it with them, so
16 I'll just kind of help inform that
17 conversation. They submitted under the intent
18 call for measures for this project, and after
19 having a discussion with them they realized
20 that their original measure didn't really
21 target the outcomes project. It was more
22 process oriented. After that conversation

1 they went back and restructured their measure,
2 and this is I guess that second draft, and
3 they are currently, right now, testing that
4 measure, but that is why there is kind of a
5 lack of that information is because they are
6 now going through that process. The numerator
7 for this measure is suicide deaths of at-risk
8 adult patients within 30 days of discharge.
9 DR. STREIM: The devil is in the
10 details. If you look at there are six factors
11 that define at-risk.
12 DR. PINCUS: Do you look at death
13 certificates? Is it mortality reports, or
14 what's the --
15 MS. JAFFE: They do talk about that
16 in feasibility, but they expect that you would
17 try to contact these people.
18 DR. PINCUS: It is hard to do.
19 MS. JAFFE: That was one of the
20 comments. And if you don't contact them they
21 are not included.
22 DR. HENNESSEY: How do you

1 determine at-risk? How is that determined?
2 CO-CHAIR SUSMAN: It looks like
3 there is a sixth criteria, patient verbalizing
4 despair and anxiety, admitted for suicidal or
5 self-injurious behavior, history of post-
6 discharge suicide attempts, complete discharge
7 safety plan, admitted with significant
8 suicidal ideation, on suicide precautions,
9 yada yada yada.
10 DR. STREIM: The yada yada ya is
11 what matters here. So the last thing in the
12 list - I think it's the last one - is actually
13 that the patient has had a suicide - a
14 discharge safety plan. Now that basically
15 undermines in terms of the face validity of
16 the measure it basically undermines the whole
17 intent. If you have already done the safety
18 plan and responsible discharge planning, a la
19 what Reva was referring to, and make sure they
20 are connected to follow up care and monitored
21 properly, that should move us in the direction
22 of suicide prevention of the thing. But if

1 you exclude, systematically exclude anybody
2 who has not had a safety plan, then you have
3 excluded from your denominator the universe of
4 people who are truly at the most severe risk.
5 So I see a structural problem that really
6 undermines face validity. So that is my
7 biggest concern.
8 CO-CHAIR SUSMAN: Any of the six -
9 it isn't all six .
10 DR. HENNESSEY: Pre-discharge
11 suicide assessment that affirms any of the
12 following at-risk categories.
13 CO-CHAIR SUSMAN: So they might not
14 have had the --
15 DR. STREIM: But the point is still
16 that they built in an exclusion essentially.
17 CO-CHAIR SUSMAN: Is there other
18 comments about scientific acceptability or
19 questions from the group as a whole?
20 DR. PHILLIPS: One of the things
21 that we talked about earlier is that they
22 don't - they essentially have no plan for risk

1 adjustment. And there are certainly many
2 things that can affect this, case mix being
3 the one that most readily came to my mind.
4 And the fact that there is essentially no plan
5 to do that is a little concerning for this as
6 a measure.
7 DR. STREIM: The fact that they
8 actually indicated that that wasn't applicable
9 here was really - I mean, to have a measure
10 steward look at a measure like this one and
11 say, we don't need to worry about risk
12 adjustment is a concern. It's a concern about
13 the acceptability, scientific acceptability of
14 the measure, but it's also a concern going
15 forward about the stewardship.
16 CO-CHAIR SUSMAN: Those points are
17 good. Other points from the group? Or
18 questions from the committee?
19 DR. MANTON: Just overall I don't
20 see how you can make a determination on this
21 section, because there is so much that isn't
22 done.

1 (Simultaneous speaking)
2 DR. HENNESSEY: What is troubling
3 about this is that this is a very very
4 important issue but the way it is hammered out
5 is highly lacking, and when we talk about
6 topics to put on a parking lot, this would
7 certainly fit that.
8 CO-CHAIR SUSMAN: So I will ask
9 that Ian or staff capture this as one of our
10 important parking lot gaps.
11 Are we ready to vote? Okay, so how
12 many believe the scientific acceptability is
13 completely?
14 (Show of hands)
15 DR. WINKLER: Zero.
16 CO-CHAIR SUSMAN: Partially.
17 (Show of hands)
18 DR. WINKLER: Zero.
19 CO-CHAIR SUSMAN: Minimally.
20 (Show of hands)
21 DR. WINKLER: Eight. I got eight.
22 CO-CHAIR SUSMAN: And how about not

1 at all?

2 (Show of hands)

3 DR. WINKLER: Ten.

4 CO-CHAIR SUSMAN: All right, our

5 addition is correct.

6 DR. PINCUS: And I'm saying, how do

7 we think about -- this wasn't submitted as a

8 population-based measure, but does it require

9 that there be -- that they submit it in some

10 ways? I can imagine this as a population-

11 based measure.

12 DR. WINKLER: And that might be

13 something that you would want to couch in the

14 recommendation of the measures needed that

15 haven't come through. But we are certainly

16 not excluding population-based measures,

17 because particularly these low-incidence

18 measures, patient safety measures, they are

19 difficult to handle because they're low

20 frequency, so there are issues around that.

21 But if perhaps you are talking about, thinking

22 about the integration of mental health

1 services in your community, perhaps a
2 population-based measure would be more
3 appropriate to capture, especially some of
4 these low-frequency things. So we can put
5 that as part of the recommendation.
6 CO-CHAIR SUSMAN: If we could sort
7 of flag that. So that is additional cars in
8 the parking lot. Let's talk about usability.
9 I think we had some implications about
10 usability from your prior comments.
11 MS. JAFFE: I think there are a
12 couple of things about usability. Number one
13 is, so much of it is not done, it's hard to
14 know how it would be used if it were done. I
15 think the expectation that patients are
16 contacted at 30 days and after three attempts
17 you don't try any more puts a lot of questions
18 into its usability.
19 DR. STREIM: As with all
20 suicidology, as I was saying before,
21 ascertainment for the numerator is the most
22 challenging thing in that whole field, and

1 this doesn't really propose a method for
2 getting at that and a remedy. Not that it
3 would be easy, but it is not even attempted
4 here.
5 CO-CHAIR SUSMAN: Glen, any
6 additional comments?
7 DR. PHILLIPS: No, I'm fine.
8 DR. MANTON: All of 3A is to be
9 determined. Or not applicable.
10 CO-CHAIR SUSMAN: Any thoughts on
11 harmonization here?
12 DR. WINKLER: I don't think there
13 are really any other measures that
14 harmonization really applies to.
15 DR. STREIM: You raised the point,
16 Reva, about measures from other fields where
17 they look at post-discharge mortality, and I
18 don't know whether any of those would be
19 relevant, but --
20 DR. WINKLER: The 30 days, I think,
21 is arbitrary for those, but at least they have
22 all picked 30 days. I can see where you might

1 argue a different timeframe, if you have -- do
2 we know that the suicide rate post-discharge
3 is, going on a time line, where is the peak in
4 incidences or not, and frame your measure
5 based on data to say what the appropriate
6 interval for surveillance is. So I don't know
7 that you should be wedded to 30 days, but I
8 think it might be nice to see what the data
9 might show would be a good interval.
10 MR. PELLETIER: I'm pretty sure
11 that at least in hospitals and under the joint
12 commission that if someone suicides within
13 three days of discharge that is a sentinel
14 event. And just for context, suicide risk
15 assessment is something that the Joint
16 Commission is focusing on. It's a new
17 national safety goal both in psychiatric
18 settings and in non-psychiatric settings, so
19 people are really at this point putting
20 together their risk assessments, and those of
21 course are not standardized at all.
22 DR. HENNESSEY: And looking at

1 Google I am seeing a lot of one-year posts
2 popping up.
3 CO-CHAIR SUSMAN: I think again
4 there is a sentiment that this is headed in
5 the right direction but perhaps not ready for
6 prime time. Other comments about usability?
7 Are we ready to vote about usability?
8 Okay, how many completely?
9 (Show of hands)
10 CO-CHAIR SUSMAN: Partially?
11 (Show of hands)
12 CO-CHAIR SUSMAN: Minimally?
13 MR. CORBRIDGE: Five.
14 DR. WINKLER: I can't tell.
15 CO-CHAIR SUSMAN: Can we please,
16 minimally?
17 DR. WINKLER: Five.
18 CO-CHAIR SUSMAN: Okay, not at all?
19 (Show of hands)
20 MR. CORBRIDGE: Twelve.
21 DR. WINKLER: Yes. Did we lose
22 somebody?

1 CO-CHAIR SUSMAN: Oh, okay, Eric is
2 out.
3 Let's go to feasibility. I think we
4 have already alluded to some of the
5 feasibility issues here. Group, thoughts
6 further?
7 DR. PHILLIPS: Getting this data
8 from most facilities I think would be
9 impossible. So being from the Midwest, large
10 state hospitals that serve half a state, how
11 are they ever going to track this across those
12 patients when they send them back out to the
13 community? I mean, it's unusable, I think,
14 for many of the facilities.
15 DR. MANTON: I guess the only thing
16 would be, because I think the phone contact is
17 unlikely to work and I don't know if they have
18 a lot of time to do it. They could look at
19 death registries or something like that. But
20 I think that would probably be about the only
21 way they could do it.
22 DR. STREIM: I think we can say

1 it's not a byproduct of care.

2 CO-CHAIR SUSMAN: Other thoughts

3 around the exclusions, inaccuracies,

4 implementation? Was there any data?

5 Okay, I am hearing a theme here.

6 Any other comments before we vote?

7 CO-CHAIR LEDDY: It seems like on

8 death registries it wouldn't be that hard to

9 do. Like in Medicaid, that's how we take our

10 enrollment accurately is using death

11 registries, and most states find it pretty

12 easy to do.

13 MS. JAFFE: Actually we have looked

14 at death registries and looked at suicide. It

15 is not that easy to do because it doesn't

16 always come across as a suicide.

17 CO-CHAIR LEDDY: Right, okay.

18 CO-CHAIR SUSMAN: Okay, so let's

19 take a vote then on feasibility, then.

20 Completely?

21 (Show of hands)

22 CO-CHAIR SUSMAN: Partially?

1 (Show of hands)
2 CO-CHAIR SUSMAN: Minimally?
3 (Show of hands)
4 CO-CHAIR SUSMAN: Not at all?
5 (Show of hands)
6 MR. CORBRIDGE: Seventeen.
7 CO-CHAIR SUSMAN: So we are going
8 to vote to recommend this for adoption. All
9 those in favor of recommending this measure
10 for adoption please say yes, raise by hand.
11 (Show of hands)
12 CO-CHAIR SUSMAN: Thank you. And how
13 many nos?
14 (Show of hands)
15 CO-CHAIR SUSMAN: Anybody
16 abstaining?
17 Okay, so all nos. All right, thank
18 you.
19 Okay, so we are moving on to 30-day
20 readmissions. I'll give people a chance to
21 get to this.
22 DR. GOLDEN: Let me ask a question,

1 before you do that. You have several
2 readmission measures, and before we do each
3 one you may want to prioritize which one you
4 want to do, do you want to do all of them? Or
5 do you want to decide seven versus 30? That
6 might save you some time and energy.
7 CO-CHAIR SUSMAN: Let me ask the
8 group who actually considered these. We do
9 indeed have three readmission measures, 30-
10 day, seven-day, 48 hours.
11 DR. PHILLIPS: They're essentially
12 identical proposals with different timeframes,
13 and they're all as poorly put together.
14 CO-CHAIR SUSMAN: So I'm hearing a
15 telegraph about where we might be headed with
16 these, but is there any merit to discussing
17 the timeframe up front in your mind, or will
18 that just keep us from an inevitable decision?
19 DR. STREIM: No, I think probably
20 not. If we just go through the first one I
21 think that will get us through the next two
22 quickly.

1 CO-CHAIR SUSMAN: Okay, I'm going
2 to then --
3 DR. GOLDBERG: Well, I'd like to
4 say, the seven-day one, we're being asked to
5 report on that by somebody. All our payers
6 are asking us to report on seven-day
7 readmissions, and feeding that back to us and
8 giving us regional norms comparing how we are
9 doing.
10 DR. STREIM: I think that it's an
11 important issue in terms of what timeframe
12 would you look at, but the problem here lies
13 with the measure itself and the way it's been
14 proposed, and so if we want to just address
15 what was submitted we will be more efficient.
16 I think it's not that the timeframe is
17 irrelevant; it's very relevant. But in terms
18 of what is going to probably kill these it's
19 other issues.
20 CO-CHAIR SUSMAN: So I would assume
21 that this is indeed an outcome measure worthy
22 of our attention. Why don't we turn to then

1 importance, and get the thoughts of the group.
2 This is the 30 days of discharge. Do you want
3 to provide us the overview, Ian?
4 MEASURE OT3-003: 30-DAY READMISSIONS
5 MR. CORBRIDGE: Yes, just to bring
6 people up to where we are. So we are looking
7 at number three, 30-day readmission. This was
8 submitted by Presby Shadyside. Description as
9 stands, percent of patients readmitted within
10 30 days of discharge reported as percent of
11 discharge for an inpatient psychiatric
12 hospital or unit. The patient is admitted to
13 the hospital within 30 days after being
14 discharged from an earlier hospital stay.
15 The numerator statement reads as:
16 total number of patients readmitted within 30
17 days of discharge. The denominator statement:
18 total number of hospital discharges.
19 DR. HENNESSEY: So we are not
20 looking at a patient who discharges and then
21 readmits at another facility? Is that
22 correct?

1 DR. PHILLIPS: Correct.
2 DR. PINCUS: Are there existing NQF
3 measures on readmission that generic? Or are
4 they all condition-specific?
5 DR. WINKLER: They are condition-
6 specific in terms of capturing the
7 denominator. They are all causes of
8 readmission but they are for patients with an
9 AMI, for patients with history of heart
10 failure, whatever.
11 DR. PINCUS: And I guess, this
12 comes up in the context of harmonization, but
13 I think just going into this, is there a
14 typical or standardized way by which those
15 numerators and denominators are defined? And
16 to what extent?
17 MS. BOSSLEY: These are the same
18 measure developers, so I would assume so.
19 We'd have to go back and look, to be sure.
20 DR. WINKLER: Most --
21 DR. PINCUS: I don't think so, that
22 we've had it, for AMI. This is UPMC.

1 MS. BOSSLEY: For the other ones
2 that are endorsed, though, it's all the same
3 developer.
4 DR. PINCUS: For AMI?
5 DR. WINKLER: For AMI and -- no.
6 Not the same as for here, but the same ones,
7 the ones that are endorsed, are all the same.
8 So they are all specified very similarly.
9 DR. PINCUS: OK, so we know the
10 extent to which this one is like those?
11 DR. WINKLER: I don't think we've
12 done that in that great detail yet.
13 DR. PINCUS: It ought to be from
14 the point of view of general hospitals.
15 CO-CHAIR SUSMAN: So I am hearing
16 some interest, at least as a parking lot
17 issue, to provide that sort of feedback.
18 Okay, any other questions about the
19 specification of this measure itself, or
20 understanding the measure? Yes, George?
21 DR. WAN: I know that there was a
22 summary in the packet of materials, but I just

1 want to have that discussion on how this
2 particular measure compares with others, in
3 particular the NCQA, was it the HEDIS
4 measures, right? They have, they assess
5 readmissions after the 30-day window as well.
6 DR. HENNESSEY: Do they still do
7 that? Or did they stop doing that? I thought
8 that was archived. My impression was that
9 they determined that it did not have validity,
10 from a patient outcomes perspective, and so
11 they had archived it.
12 CO-CHAIR SUSMAN: So there is a
13 question of fact here, and there is a thought
14 that this might be an archived measure for
15 NCQA.
16 CO-CHAIR LEDDY: That is what is
17 so different about this one. There's no
18 database, you can't -- like, I've looked at
19 30-day readmission from a public reporting
20 point of view, and the issue is, if you are a
21 payer, such as Medicare, on Medicare Compare,
22 they have 30-day readmission. And you could

1 link it to diagnosis, if you wanted to, let's
2 say. But that is only for Medicare patients
3 because they have the claims database. Payers
4 can do this, because they have their own
5 claims database. So they can link it and they
6 could say, for psychiatric as the primary or
7 secondary diagnosis on the discharge. But for
8 the whole population there is no database.
9 The required hospital discharge databases in
10 each state that are aggregated at the national
11 level do not have unique identifiers, so a
12 hospital can't see who is admitted to another
13 hospital. There is no database.
14 DR. GOLDEN: But wait a minute,
15 though. If Blue Cross of Alabama said we are
16 going to, for our Blue Cross patients measure
17 this, would that be okay?
18 CO-CHAIR LEDDY: Yes.
19 DR. GOLDEN: So then this is an
20 acceptable measure scientifically?
21 CO-CHAIR LEDDY: This is across
22 all populations, isn't it? All discharges?

1 DR. GOLDEN: We are talking now,
2 let's go back to the earlier measures, this
3 would be implemented by one payer, or by one
4 enterprise. This would be fine, and you could
5 do it.
6 CO-CHAIR LEDDY: Okay, then you
7 could do it. You could do it by payer, or by
8 provider.
9 DR. HENNESSEY: Yes, I think the
10 big issue is that the way this is written
11 right now, if you are a payer, or rather, if
12 you are a provider, you are not counting
13 someone who gets admitted to another facility.
14 As a payer --
15 DR. GOLDEN: But somebody else will
16 get you the data. They can count it for you.
17 DR. STREIM: The back story is -
18 DR. HENNESSEY: That requires a
19 level of coordination.
20 DR. GOLDEN: No, they'll send you
21 the reports, easily, that's an accountability
22 measure, that's what it's all about.

1 DR. STREIM: Actually, it was
2 informative to read further on down, in the
3 submission, the reason they actually give for
4 the fact that they don't - they thought risk
5 adjustment here is not applicable, and the
6 reason they thought that was because they only
7 see this as a health resource utilization
8 measure. So they use it - that is how this
9 health system uses this information within
10 system, and that is how they are coming at the
11 measure.
12 DR. PHILLIPS: And so I think part
13 of what -- the discussion I think is, we're
14 drifting between, the idea of measuring this
15 is probably a good idea. Measuring it the way
16 they do, not. And so that is what I'm more
17 saying is, if we stick to the proposal, even
18 under the reason they don't defend it well.
19 If you didn't know anything and you read this,
20 you would say, oh, we shouldn't do this.
21 CO-CHAIR SUSMAN: I'm going to take
22 Bill's comment, and then I'm going to get us

1 back to focusing first of all on importance,
2 and going through. I think the comments that
3 are coming out certainly are going to be
4 important to consider as we work at this
5 measure.
6 WPI REPRESENTATIVE: Are we still
7 talking about importance, or where are we at?
8 CO-CHAIR SUSMAN: Well, I'm going
9 to bring us back to importance, the focus. We
10 had started out rather broad across the field.
11 But I think it is all going to be relevant to
12 our discussion in coming to a conclusion about
13 the focus.
14 DR. GOLDEN: I will make my comments
15 later.
16 CO-CHAIR SUSMAN: Okay. So let's
17 start with importance. The impact, it looks
18 like people felt were fairly completely -- is
19 there comment from the person who said
20 minimally, or some revised thought about that?
21 How about a gap?
22 DR. GOLDEN: That was my question.

1 You know we talked about 30 versus 7, and all
2 this, but I'll ask the psychiatric
3 practitioners here, is there an issue if
4 somebody gets rapidly readmitted after a
5 hospitalization that they may have been
6 discharged either too soon or they had
7 inadequate care or something?
8 DR. STREIM: Sure. I think that's
9 what makes it highly important to measure, and
10 that's highly relevant in that way.
11 DR. GOLDEN: So there could be
12 differences between providers?
13 DR. STREIM: Right, but as this
14 measure was submitted from a single health
15 system, they haven't addressed comparability
16 across health systems or providers, so there
17 is no - they haven't really helped us look at
18 that gap. We don't know how much variability
19 there is, so we don't have that from the
20 submission anyway.
21 DR. GOLDEN: But as a practitioner
22 you would assume or you would say there would

1 be differences or potential differences
2 between providers?
3 DR. PINCUS: Absolutely, I know
4 something about it, it's --
5 DR. GOLDEN: All right.
6 DR. PINCUS: Actually, now you're
7 talking about the development of this measure,
8 this was developed as kind of a pilot program
9 to incentivize reducing readmissions. And so
10 that that is actually how this evolved. You
11 know, reducing readmissions within their
12 system, because they also, they have a closely
13 affiliated payer as well as a health provider.
14 DR. HENNESSEY: I find this to be
15 a somewhat troubling metric because of the
16 timeframe which is only 30 days, and also
17 because one can only relate the measure if you
18 are being readmitted into your facility. I
19 will tell you as a payor, I have actually
20 developed a metric like this in the past, but
21 it was measuring community tenure, and it was
22 presence in the community and it was over a

1 one-year period of time, which to me is far
2 more meaningful than what this is.
3 DR. GOLDEN: I'm sorry, but that's
4 just not what the measure is. The measure
5 does not measure you within your facility. If
6 you get readmitted, you're readmitted. And
7 that would not be necessarily facility-
8 specific.
9 DR. STREIM: From my read of the
10 submission it looks like the rationale for
11 this, it was Pittsburgh that developed the
12 measure was to be able to monitor the rate of
13 service utilization and think about
14 improvements in care to reduce that rate. But
15 it was really a measure of the rate of service
16 utilization, and therefore there was not a lot
17 of interest in doing validation studies and
18 other things that might not apply in that
19 sense. But Harold was probably there when it
20 happened.
21 DR. PINCUS: Just to say something
22 about, you know, it depends on the focus for

1 NQF in terms of how this gets used. So if you
2 are talking about having a measure out there
3 that is sort of a handy-dandy easy-to-use
4 measure for a facility, an inpatient facility,
5 to assess itself, using its own data set,
6 without having to rely on external sources of
7 data, this could be a measure that might have
8 some utility. On the other hand, it's not as
9 good as the measure that would capture all
10 admissions across, for an individual patient.
11 CO-CHAIR SUSMAN: So for quality
12 improvement purposes, is that what you --
13 DR. GOLDEN: I am sorry, I'm
14 looking at the numerator, it says, people
15 readmitted. It doesn't say readmitted to the
16 same hospital.
17 MS. BOSSLEY: Also if you look at
18 that also, underneath it says, transferred to
19 another hospital or setting for specific care
20 who then returns would not count as a
21 readmission.
22 DR. GOLDEN: Correct.

1 MS. BOSSLEY: So anyone
2 transferred from another one and then comes
3 back to a facility doesn't count.
4 DR. GOLDEN: That is just a
5 transfer.
6 MS. BOSSLEY: There are no other
7 exclusions, and it's not clear where they pull
8 the data source from, it's management data.
9 I think we'd have to go back and ask them to
10 clarify what source of data it's from.
11 DR. ROCA: And this may be partly,
12 and other people may know the Pittsburgh
13 situation better than I do, but I think that
14 is a very large system, and they may have a
15 pretty good handle on who has been readmitted
16 in that whole market, just through the
17 Pittsburgh system. Joe, do you know, or have
18 you looked at this, did they look at
19 clinician-level readmission rates? Because
20 I'm thinking this may have been --
21 DR. STREIM: That is not proposed
22 as part of the measure at the individual

1 provider level. Whether they did that on the
2 side isn't clear, but in terms of this
3 proposal that we received it is not addressed.
4 CO-CHAIR SUSMAN: So let's focus
5 on importance. I think again we've looked at
6 a bunch of related issues, relationship to
7 outcomes, gap, impact. Any further comments
8 in that arena or relevant questions to those?
9 DR. PHILLIPS: So, again, part of
10 the gap is a good example of one of my
11 problems with this proposal, in that they
12 don't bother to cite the literature around
13 this that is out there. You know there are
14 differences between, and there is a literature
15 around that, that different providers,
16 different places, have these kinds of
17 differences, and they simply don't cite it.
18 It's a very incomplete proposal.
19 DR. STREIM: And that may reflect
20 the burden of the NQF process on would-be
21 stewards, and they wanted to get the quick and
22 dirty submission in in the timeframe. But I

1 think it doesn't mean that, again, that there
2 is not evidence of variability that makes this
3 an important thing to measure. I think one
4 question again for NQF staff is when we vote
5 on importance to measure we have to
6 distinguish, are we voting on the concept of
7 the importance to measure readmission rates,
8 or are we voting on the importance to use this
9 particular measure to get at it. Because if
10 the latter - no, not the latter.
11 DR. WINKLER: It's the former, it's
12 the concept of a 30-day readmission for
13 patients.
14 DR. STREIM: It's not about the
15 method. Okay. Because in this particular
16 case I think as we get further along here,
17 since I think we will see it's probably
18 important to measure, is that there is no
19 provision to measure readmission outside of
20 this health system, so if somebody goes to the
21 community hospital that is not part of the
22 health system three days after discharge, that

1 is not captured. So it's only capturing
2 within-system utilization.
3 DR. GOLDBERG: Wouldn't it come up
4 as a later issue, if Reva says? We're really
5 voting, if it's importance, about the generic
6 concept.
7 DR. STREIM: Right, and Harold's
8 point, I think, is a good one, that even if
9 it has utility for an individual payor and an
10 individual health system, just because it
11 doesn't generalize to the rest of the world,
12 the health system - well, we don't have a
13 health system at large - but if we did the
14 failure to generalize to all hospitals, all
15 payors doesn't mean it's not a useful measure
16 that could be adopted by an individual
17 hospital or health system for their own
18 purpose.
19 DR. WINKLER: However, remember one
20 of the basics for NQF in endorsement of
21 measures is sort of an overlying criteria that
22 these measures are suitable for public

1 reporting and accountability, and they are not
2 - we don't really want measures that are
3 simply for quality improvement, internal
4 quality improvement kind of thing. And there
5 are lots and lots of those measures, which is
6 pretty much what Harold was describing.
7 That's not what we are looking for. We are
8 looking for something a little more than that.
9 DR. HENNESSEY: As a general
10 comment, there are a number of these measures
11 that are just that, they are probably good for
12 a system from a QI perspective but whether or
13 not they can really generalize over national
14 exposure is very questionable.
15 DR. STREIM: Move to call the
16 question.
17 DR. PINCUS: Just a clarification.
18 When we decide about impact gaps, is it based
19 on what they put into their proposal, or is
20 based on what we know?
21 DR. WINKLER: Both.
22 DR. PINCUS: Okay.

1 DR. WINKLER: Both. I mean that's why
2 -- we don't have a bunch of pediatricians
3 sitting here looking at these measures.
4 CO-CHAIR SUSMAN: So I am generally
5 hearing a sense that this is important, that
6 there is a gap, that it may not have been
7 documented as well, there are some questions
8 about suited this particular measure might be
9 that are going to come up perhaps under the
10 other metrics that we are going to work at.
11 Is there anything new to discuss on this
12 topic? Why don't we go ahead and vote?
13 Importance, completely?
14 (Show of hands)
15 DR. WINKLER: Ten.
16 CO-CHAIR SUSMAN: Okay, 10.
17 Partially?
18 (Show of hands)
19 DR. WINKLER: Seven.
20 CO-CHAIR SUSMAN: Minimally.
21 (Show of hands)
22 CO-CHAIR SUSMAN: Not at all.

1 (Show of hands)

2 CO-CHAIR SUSMAN: Somebody out?

3 Okay, completely again, please. I'm

4 sorry. Completely.

5 MR. CORBRIDGE: I got 12 now.

6 DR. WINKLER: I got 12 too.

7 CO-CHAIR SUSMAN: How about

8 partially. That's six.

9 So 12 and six it is, that's 18.

10 Let's move forward. You don't want to learn

11 much about this process.

12 Okay, scientific acceptability, I've

13 heard a lot of qualms in this realm, perhaps

14 -- we're on this measure now. It's not the

15 global importance, not the concept, it's this

16 measure.

17 CO-CHAIR LEDDY: So for a health

18 system, a 30-day readmission rate. This is

19 just within a health system. Because

20 otherwise 30-day readmission rate is really

21 used a lot.

22 DR. STREIM: I think that is the

1 main limitation, and again it's not that - it
2 only is designed to measure utilization rates
3 within the health system.
4 DR. PHILLIPS: It says it later in
5 the proposal. It very clearly says, a gap is
6 we missed admissions to other hospitals within
7 the proposal.
8 CO-CHAIR SUSMAN: I think we are
9 trying to redo the measure for them. And I
10 don't think we have the time and resources to
11 do that.
12 DR. PINCUS: I just want to clarify
13 exactly what's in there, because there's a
14 discrepancy --
15 DR. STREIM: But just to summarize
16 a few of the other points about the scientific
17 properties and acceptability, the measure
18 developers stated explicitly that there was no
19 need for a validation, again, because they are
20 using it to determine a rate of service
21 utilization, and the second thing is really
22 they didn't think risk adjustment was

1 necessary beyond - they said we sometimes,
2 depending on our internal needs, adjust for
3 age, gender, zip code and diagnosis, but there
4 is nothing about disease severity, case mix,
5 et cetera. So there is -- the kinds of risk
6 adjustment that you would want for a public
7 measure to make it really interpretable isn't
8 part of this internally used measure. Those
9 were the main points I would make about the
10 science.
11 CO-CHAIR SUSMAN: Any questions
12 about the science or additional comments from
13 the group?
14 (No response)
15 Hearing none, let's go ahead and
16 vote on scientific acceptability. Completely?
17 (Show of hands)
18 CO-CHAIR SUSMAN: Partially.
19 (Show of hands)
20 WPI REPRESENTATIVE: There is
21 substantial evidence that this is a good
22 measure but not as they define it.

1 DR. WINKLER: No, no. Scientific
2 acceptability applies to this measure, as
3 specified, as written, in this piece of paper.
4 DR. STREIM: Unlike importance
5 which is the concept.
6 CO-CHAIR SUSMAN: Okay, partially
7 again, please, just to make sure we have the
8 count. Please raise your hands high.
9 (Show of hands)
10 MR. CORBRIDGE: Four.
11 CO-CHAIR SUSMAN: Okay, minimally.
12 (Show of hands)
13 CO-CHAIR SUSMAN: None at all?
14 Okay, one. Good, thank you.
15 So we are okay with that, let's move
16 on. This is usability. It looks like the
17 spread here in understandable harmonization
18 and added value. Comments from the group?
19 Questions from the committee?
20 DR. STREIM: I guess we should make
21 some comments here. Well, it's all written up
22 there, but for those who haven't been able to

1 read the small font as it's projected, I
2 thought one of the main concerns was the
3 understandability or meaningfulness of the
4 actual measures was pretty much anecdotal.
5 What they do is have monthly meetings and
6 focus groups which can be useful for these
7 sorts of things. But it was really more our
8 own experiences, it works for us. And, again,
9 there was nothing to convince me that this was
10 going to generalize to the wider group of
11 healthcare providers, whether others would
12 find it useful as defined. And I think if I
13 were speaking for my own health system I would
14 be concerned about the lack of risk adjustment
15 in there.
16 DR. PHILLIPS: Right, and about the
17 risk adjustment, the other measures that they
18 cite actually do use risk adjustment, so it's
19 not really lining up with the way some of the
20 other things are being measured.
21 CO-CHAIR SUSMAN: Okay, so from an
22 added value perspective I'm hearing maybe that

1 there doesn't seem to be as much added value
2 as suggested by the ratings.
3 MS. JAFFE: Well, I think, at least
4 when I scored it, it added value to the
5 system, but I don't know if it's added value
6 for the world. I think that, when I was
7 reading it, it was very clear that they have
8 a process that works well for their system,
9 but to me they hadn't put a lot of thought
10 into beyond their system and how this outcome
11 could impact beyond their borders.
12 CO-CHAIR SUSMAN: So at least the
13 definition says, review of existing endorsed
14 measures, measure sets demonstrate the
15 measure provides a distinctive or additive
16 value to existing NQF-endorsed measures.
17 DR. PHILLIPS: And because there is
18 not one for this population, I would say it is
19 added value. But not --
20 DR. STREIM: That was my rationale
21 for rating it completely, because if you
22 measure anything related to readmission it's

1 better than nothing, but if you can't
2 interpret it maybe it's not.
3 CO-CHAIR LEDDY: How about if this
4 measure was available for - in the same format
5 for each of the health systems in a large
6 area? In a region, let's say, or a state.
7 Then will it have value?
8 DR. STREIM: I would say yes.
9 CO-CHAIR LEDDY: In that the only
10 thing it would be missing is people going from
11 one to the other, which when I looked at it
12 for medical and psychiatric together it's
13 about 20 percent.
14 DR. MANTON: Usability comes into
15 that. I'm not sure they could really do
16 that.
17 MS. JAFFE: Are you saying that
18 they'd get together and they'd kind of compare
19 who got admitted?
20 CO-CHAIR LEDDY: No, no, no, I'm
21 saying that's impossible. I'm saying that if
22 you have four health systems in a large

1 region, each of the health systems did this
2 for themselves, then even though they were all
3 missing that, say, 20 percent that are going
4 across, you are measuring apples-to-apples
5 readmission rates to their own facilities, and
6 since readmission rates are going to be really
7 the up and coming thing in health care reform
8 with accountable care organizations, et
9 cetera, and it is already measured for
10 Medicare populations, that that could, I would
11 say, make it usable, if you did it hospital by
12 hospital or health system by health system, so
13 that they are comparing themselves to each
14 other, and the noise of people going to
15 different places is just, they just can't deal
16 with it, so you exclude it for all the
17 measurements.
18 DR. PHILLIPS: But all of those
19 hospitals would run some form of risk
20 adjustment, because they are all going to be
21 serving different populations, and this does
22 not account for that at all. So I would say

1 the way they've done it, no. I mean, you
2 would still have to account for that.
3 CO-CHAIR LEDDY: Hospitals have
4 risk adjustments.
5 DR. PHILLIPS: This measure
6 doesn't.
7 CO-CHAIR LEDDY: No, this measure
8 doesn't, you're right.
9 DR. GOLDEN: I would say - I would
10 put this in the parking lot, but you're still
11 focusing on the system. There are already
12 measures in place for readmissions for after
13 pneumonia and heart attacks.
14 But it doesn't matter if it's not through
15 your institution. It's in the institution,
16 and they collect the data, and they can do
17 that for Blue -- any insurer could track the
18 readmission rates. So it doesn't matter. My
19 academic center would be in a little bit of
20 difficulty because a lot of their discharges
21 get readmitted elsewhere in the community and
22 that is going to count against them. So that

1 is still fair game.

2 DR. STREIM: So based on what Bill

3 is saying is I think you have a better measure

4 coming out of a payor for something like this

5 than -- I think payors are in the best

6 position to get at this.

7 CO-CHAIR SUSMAN: So I'm hearing

8 some consistency of thought here. Are there

9 any other additional comments on usability?

10 Let's go ahead and vote.

11 Completely?

12 (Show of hands)

13 CO-CHAIR SUSMAN: Partially?

14 (Show of hands)

15 MR. CORBRIDGE: I got nine.

16 CO-CHAIR SUSMAN: How about

17 minimally?

18 (Show of hands)

19 CO-CHAIR SUSMAN: Okay, that should

20 be it. Let's go down to feasibility. It

21 looks like a relatively high feasibility

22 score. Comments from the group, and then

1 what's in the minuscule type.

2 MS. JAFFE: I think that we need --

3 feasibility, when I was thinking about it is,

4 feasibility for a particular system to do it

5 for themselves, and it's not feasibility as

6 we've sort of talked about it through the

7 course of this conversation.

8 DR. HENNESSEY: Are they defining

9 readmission as readmission to a psychiatric

10 unit, or can it be readmission to the hospital

11 at large?

12 MS. JAFFE: You know, they don't

13 really say that in their submittal, but this

14 is a psychiatric hospital, that's all they do,

15 so that was one of my comments too. When they

16 were talking about -- I made the assumption

17 that it was psychiatric.

18 DR. MANTON: There are places

19 earlier that they refer to psychiatric

20 patients, I forget which category it is.

21 CO-CHAIR SUSMAN: Psychiatric

22 hospital or psychiatric patients?

1 DR. MANTON: I just can't remember
2 which one. It might have been under number
3 one, but there was some place that they
4 indicated it was psychiatric patients and
5 psychiatric readmissions.
6 CO-CHAIR SUSMAN: So at least in
7 summary a psychiatric hospital or unit.
8 DR. HENNESSEY: So concretely, I'm
9 a suicidal patient, I leave the hospital, I
10 then inflict a gunshot wound and I'm now in
11 ICU for my gunshot wound, it wouldn't be
12 reflected.
13 CO-CHAIR LEDDY: According to the
14 summary it would be reflected, because it's
15 discharges from the psychiatric hospital or
16 unit and the patient is readmitted to the
17 hospital. It doesn't say to the unit, at
18 least in the summary. But I was not on the
19 workgroup. Maybe it specifies it more.
20 DR. PINCUS: I just think it's
21 worth pointing out to put this into context
22 that the current NQF approved readmission

1 measure for other conditions is all cause
2 readmission. So that if you treated somebody
3 with an acute MI and then, you know, two weeks
4 later they get hit by a bus and come to the
5 hospital then that gets counted.
6 MS. JAFFE: And actually looking
7 back on my comments, in the denominator and
8 numerator, it just says, all patients, so that
9 was one of my questions. It didn't say
10 psychiatric patients or what they were talking
11 about.
12 CO-CHAIR SUSMAN: So it sounds like
13 there are some issues perhaps of the title of
14 the measure and maybe the specifications maybe
15 not quite lining up. Other feasibility,
16 though, reflections?
17 DR. PINCUS: Caution is only if you
18 are a system, in this?
19 CO-CHAIR SUSMAN: It will be what
20 it is.
21 DR. WINKLER: It doesn't sound like
22 you are going to recommend it, so I don't

1 think we need to worry yet about that.
2 DR. PINCUS: There is a kind of
3 inverse relationship between feasibility and
4 some of the other criteria. Because this
5 actually is very feasible if you are doing it
6 all within your own database.
7 DR. MANTON: That is what I was
8 thinking, the data is there, it's accessible.
9 DR. GOLDBERG: But, for people on
10 that workgroup, did they specify that this was
11 a measure for a health care system? They
12 didn't propose this to be more broadly used?
13 MS. JAFFE: They talked about
14 straight from the hospital and readmission
15 back to the hospital.
16 DR. MANTON: But for instance, when
17 it talks about use in public reporting
18 initiative it talks about, within our multi-
19 system -- multi-hospital system this measure
20 will blah blah blah. I mean, throughout, they
21 tend to make references to within their
22 system.

1 DR. STREIM: They made it clear,
2 that - they made it clear that all this was
3 designed and used in their system, tested in
4 their system, they didn't really address how
5 it would translate into other --
6 DR. WINKLER: Well, they did, they
7 actually did. There is a section, question on
8 level of measurement or analysis. It's right
9 at the end of the specifications section. And
10 they said facility or agency or multi-site
11 corporate chain. So they really are talking
12 about something that's -- But it's not
13 individual providers.
14 CO-CHAIR LEDDY: Because that is the
15 data they have.
16 DR. WINKLER: Right, correct. But
17 not individual providers sort of thing.
18 CO-CHAIR LEDDY: Because that is
19 the data they have.
20 DR. GOLDBERG: So a facility-only
21 issue has feasibility problems.
22 DR. PINCUS: I find I am confused

1 by this discussion, and I think part of the
2 problem is, is this truly intended to be only
3 all-cause admissions to your facility? Or is
4 this clinicians' readmissions across whatever
5 we find for the broader database?
6 So it seems to me if it's only
7 within your facility then it's - the
8 feasibility is high, but the utility is lower.
9 On the other hand, if it's all sources, all
10 places of readmission, then it's feasible for
11 a payer but not for a facility.
12 DR. PHILLIPS: So if I may in
13 Section 4(d)(1) they specifically say, also
14 important to note the possibility that some
15 patients are or would be readmitted to a
16 different hospital and/or facility. As a
17 result the figures for a given
18 facility/operation would come with the caveat
19 that it may not be the true total figure for
20 the facility.
21 DR. PINCUS: That is something
22 worth noting. But when they specify the

1 numerator and denominator, who do they -

2 DR. PHILLIPS: They don't talk

3 about it, and I noted it that it was

4 specifically an issue that they didn't talk

5 about it.

6 DR. PINCUS: Is there a way that we

7 can interact with them to know exactly what

8 they are talking about?

9 CO-CHAIR SUSMAN: I think what we

10 have here today is the data they provided is

11 from a health system or hospital perspective,

12 in a single entity, and we have to really vote

13 on what we have before us. I'm sure Ian and

14 staff did the best they could to clarify the

15 issues here and I think we should judge it on

16 what's been submitted.

17 DR. PINCUS: One thing that we did

18 with the medication management measures

19 steering committee is that we were

20 disappointed in a lot of what we got, I think

21 I mentioned this at the last meeting. And so

22 what we did was, we sort of did not approve

1 things or had sort of a - did not approve
2 things, but pending further discussions, might
3 approve it if the measure developer was
4 willing to make some changes. And is that
5 something that we can do now? So if they
6 clarify that the intention is that they would
7 have it be applicable for a payer.
8 CO-CHAIR LEDDY: They couldn't
9 maintain it. It would have to be a different
10 submitter.
11 DR. PINCUS: Why?
12 CO-CHAIR LEDDY: To me this is
13 completely logical, what's happening. This is
14 a health system. If a health system wants to
15 do internal monitoring of themselves on how
16 they are doing.
17 DR. PINCUS: No, no, I'm saying
18 that a health system can propose anything they
19 want. I mean a health system -
20 CO-CHAIR LEDDY: But they have to
21 be able to do what NQF wants them to do,
22 right?

1 DR. PINCUS: Right, if I have my
2 own little corporation I can propose anything
3 I want, and if I'm willing to do whatever the
4 stewardship requires -
5 CO-CHAIR LEDDY: Maintain the
6 measure. They can't maintain the measure
7 because they don't have the data.
8 DR. PINCUS: Well, how do you know?
9 You can't say they don't, because in fact they
10 do. They own a major payer.
11 CO-CHAIR SUSMAN: Okay, Reva.
12 DR. WINKLER: Yes, certainly there
13 are times when discussions with the measure
14 steward, there are suggestions that a steering
15 committee will make, that they are amenable to
16 making changes, that your approval is
17 conditional on them making that change. So
18 that is possible. However I would caution
19 you, one, with outcome measures, that's hard
20 to do; you don't turn those on a dime, so you
21 don't tweak around the edges very readily on
22 outcome measures as you might on certain

1 process measures. And two, the degree - one
2 of the reasons our measure developers have
3 been provided to participate, and I don't
4 known if the fact that they are not on the
5 phone is causing us a problem because they are
6 not participating.
7 CO-CHAIR SUSMAN: Oh, nobody is on
8 the phone?
9 DR. WINKLER: Anne?
10 MR. CORBRIDGE: I will ask.
11 (Simultaneous speaking)
12 MR. CORBRIDGE: So I guess we will
13 ask again if one of the measure developers is
14 on the phone? Because I know I had talked to
15 them and they were planning on it. I know we
16 have had some -
17 (Re-establishing telephone
18 connection)
19 CO-CHAIR SUSMAN: Okay, so I think
20 we are actually on your measure currently,
21 which is a readmission measure, and I think
22 there are some questions that people might

1 have. Let me ask the group if there are some
2 specific questions for the measure developer.
3 DR. PINCUS: I thought we had a
4 question about the specific of the numerator
5 with regard to whether the readmission had to
6 be at the specific facility or is it from any
7 facility within some sort of range of
8 location.
9 CO-CHAIR SUSMAN: Did you hear
10 that?
11 WPI REPRESENTATIVE: That is a good
12 question, because that is internally based on
13 what we are measuring ourselves. They are
14 only able to see people who are readmitted to
15 our facility because that's the data we have.
16 And I'm expecting that that is what we are
17 proposing as well. However on a much higher
18 level if it's possible to see readmission
19 across systems, that would be ideal.
20 CO-CHAIR SUSMAN: Thank you. Other
21 follow-up?
22 DR. PINCUS: What exactly are you

1 proposing?

2 CO-CHAIR SUSMAN: The question is,

3 what are you proposing?

4 DR. PINCUS: The question is, what

5 are you proposing? Is it at a single hospital

6 or health system or is it at a broader level?

7 WPI REPRESENTATIVE: I think in this

8 case, it's the hospital or system.

9 CO-CHAIR SUSMAN: Okay, thank you.

10 DR. MANTON: And are the

11 readmissions just psychiatric readmissions or

12 any readmissions?

13 WPI REPRESENTATIVE: Psychiatric

14 readmissions.

15 DR. STREIM: And is that determined

16 from a hospital administrative database or do

17 you have a payer database that you use for

18 that?

19 WPI REPRESENTATIVE: Hospital

20 administrative database.

21 CO-CHAIR SUSMAN: Okay, so I think

22 we have better clarity about the measure and

1 the intent from the measure developer. Are
2 there any other questions from the committee
3 about this measure for the measure developer?
4 DR. STREIM: Yes, do you have
5 access to a payer database to track
6 readmissions and if so, do you see a way that
7 you could use this measure more widely beyond
8 your own system? Or to be able to test it
9 beyond your own system?
10 WPI REPRESENTATIVE: Can you repeat
11 that?
12 DR. STREIM: You said that you have
13 obtained this data from your own hospital
14 administrative database. What I'm asking is,
15 do you have access to a payer database where
16 you could get the same readmission
17 information, not only for your own
18 institution, but for other perhaps regional
19 institutions, so that you could test this
20 measure more widely?
21 WPI REPRESENTATIVE: Currently we do
22 not have that information available to us

1 readily, and we are not measuring the exact
2 level of readmission rate; we are currently
3 just measuring the readmission within our
4 system.
5 (Simultaneous speaking)
6 WPI REPRESENTATIVE: It might be a
7 possibility if the payers are willing to pass
8 that information along. This would have to go
9 across multiple payers as well, so that is a
10 future measure. Currently this is just within
11 the hospital system.
12 CO-CHAIR SUSMAN: Okay, thank you
13 very much. Let's turn back, then, to
14 feasibility and see if there is any further
15 comments. And if not, why don't we go ahead
16 and vote. On feasibility completely.
17 (Show of hands)
18 CO-CHAIR SUSMAN: Partially.
19 (Show of hands)
20 DR. WINKLER: Nine.
21 CO-CHAIR SUSMAN: Minimally.
22 (Show of hands)

1 DR. WINKLER: Five.
2 CO-CHAIR SUSMAN: Not at all.
3 (Show of hands)
4 CO-CHAIR SUSMAN: And that gives us
5 15. Eric is gone.
6 MR. CORBRIDGE: I got 11 on the
7 partially.
8 CO-CHAIR SUSMAN: Okay, so we've
9 got the count correct. And let's move
10 forward. Any final questions that the
11 committee has for the measure developer or any
12 final comments the measure developer would
13 like to make prior to our vote? Or public
14 comments?
15 (No response)
16 CO-CHAIR SUSMAN: Hearing none,
17 let's go ahead and vote.
18 All those who would vote yes for the
19 recommendation, please raise your hand.
20 (Show of hands)
21 CO-CHAIR SUSMAN: All those who
22 vote no, please same sign.

1 (Show of hands)
2 CO-CHAIR SUSMAN: So the vote is 17
3 nos, zero yes. Thank you very much.
4 So let's go on to the next set,
5 which I think will probably go a little bit
6 quicker, given our conversation. And now we
7 are at the seven-day readmission measure. Was
8 this also submitted by Western?
9 MR. CORBRIDGE: Correct.
10 CO-CHAIR SUSMAN: Any additional
11 comments you would like to provide from
12 Western Psych? Please, Richard.
13 DR. GOLDBERG: As long as they are
14 on the phone I'd like to hear their thoughts
15 about the risk-adjustment efforts they made
16 and why or why not they made those comments.
17 CO-CHAIR SUSMAN: Hello, folks at
18 Western Psych. Are you still on? She hung up
19 after the vote. She was down, suicidal. Have
20 we done a care plan with her?
21 (Laughter)
22 CO-CHAIR SUSMAN: Okay, Dr.

1 Goldberg has a question for you.
2 DR. GOLDBERG: Could you comment on
3 what kind of thinking you did about risk or
4 severity adjustment in relation to this
5 measure and what you included in it, or what
6 you didn't include?
7 WPI REPRESENTATIVE: Currently we
8 have - we are vetting various risk adjustment
9 criteria. We are looking basically at
10 severity by unit of - within the hospital, our
11 different age groups. So we have not
12 completed the risk adjustment process. We are
13 doing it by trade-off currently.
14 CO-CHAIR SUSMAN: Okay, so I hear
15 that there is some risk adjustment activity in
16 process, thank you. From the group that
17 reviewed this, are there additional new
18 comments or let's focus first on importance?
19 DR. STREIM: Actually, it would be
20 helpful to me since I'm not an expert on all-
21 cause readmissions and I know NQF has had
22 experience with these, what is the current

1 thinking about the - this whole issue of risk
2 adjustment for causality?
3 DR. WINKLER: I thought you were
4 going to ask a different question.
5 DR. STREIM: You can answer the
6 other one first.
7 DR. WINKLER: Okay, the concept
8 around all-cause - because this discussion has
9 been ongoing - a couple of things. The idea
10 that you look at a patient's episode of care
11 and services from their perspective,
12 regardless of why a patient might be there,
13 especially with multiple comorbidities and
14 other things going on, that, to focus in on
15 whatever is the primary reason for diagnosis
16 and exclude all other things and let the
17 diabetes become problematic and not be
18 attended to during the course - or their
19 depression not be attended during the course
20 of their stay for heart failure or whatever
21 else is not appropriate, and certainly a way
22 we want to move to. So the idea is you really

1 do want to look at all aspects of a patient's
2 care, and that any lack of attention to some
3 of these other comorbidities might be the
4 reason for their readmission, and that is a
5 fair sort of thing.
6 Also what we've started having
7 conversations about is when you start looking
8 at a list of what is or isn't related, to the
9 primary readmission, it becomes very different
10 to sort them into black and white buckets.
11 You might think that a patient is being
12 discharged, and then you know has a car
13 accident. But what if they had an arrhythmia
14 episode as a result of a heart problem that
15 causes them to be in the accident. So you can
16 start having a real difficult time parsing
17 those out. And so the all-cause - and
18 realizing that that all-cause applies across
19 the board to everyone, so there is going to be
20 - you will never hit zero readmissions, but
21 the idea is to reduce them to as low as
22 possible. So that is the current sort of

1 dynamics of the discussion around the all-
2 cause readmission concept.
3 DR. STREIM: I will ask my second
4 question after.
5 DR. ROCA: To what extent, since
6 these measures have been out there for awhile,
7 have we actually found that hospitals or
8 systems have been able to reduce their
9 readmission rates?
10 DR. WINKLER: Considering it's one
11 of the biggest focuses for quality improvement
12 you are seeing a lot of particularly forward-
13 thinking hospitals, but a lot of systems
14 really trying to come up with some innovative
15 ways of doing patient follow up, of
16 facilitating that care transition, asking what
17 is it that is important about it, to keep them
18 from bouncing back into the hospital. So it
19 actually is a huge focus right now and I think
20 you are going to see in the literature reports
21 that are demonstrating a whole variety of
22 approaches that may be appropriate, which is

1 why then people say the outcome measure is
2 really the most useful tool, because however
3 you got there is fine as long as the
4 readmission itself is reduced. So that is
5 kind of the -
6 DR. ROCA: And are those data
7 appearing already? Have readmissions been
8 measured for awhile in this way?
9 DR. WINKLER: I don't think they've
10 been measured all that long. I think the
11 readmission rate has only been up for a year
12 maybe. So within the last year. So I don't
13 think we've got lots of longitudinal data yet,
14 but Medicare is the big push for this. But I
15 think we will shortly in a couple of years.
16 But there isn't a lot of longitudinal data
17 right yet.
18 CO-CHAIR LEDDY: But there are
19 some examples, not in mental health
20 specifically, but across - although there are
21 some evidence based practices that have been
22 found and replicated. So that is starting to

1 come out like in Colorado is one, mostly
2 around discharging care planning.
3 DR. ROCA: Certainly embedded in
4 this is the presumption that there has been
5 some failure leading to the readmission or a
6 quality problem leading to the readmission.
7 And certainly anecdotally you can discover
8 that in individual cases. But I'm wondering
9 if the data would bear that out.
10 DR. GOLDBERG: There was an article
11 in the New England Journal a few months ago
12 where the Congressional Budget Office reported
13 on what is likely to work to reduce costs. It
14 was a little unsettling, because they said
15 that electronic medical record, the primary
16 care medical home did not - it was hospital
17 readmissions they projected would only be of
18 the five or six items they reviewed, it was
19 only hospital readmissions that were likely to
20 reduce costs. It was surprising that some of
21 the other panaceas that we're holding up,
22 according to CBO.

1 CO-CHAIR SUSMAN: So PCMH rates
2 could potentially - who knows. Eric?
3 DR. GOPLERUD: There is some old
4 data and reports from the VA hospital that
5 used the seven-day readmit, and looked at
6 unforeseen consequences. And one of the
7 things they found when they had that
8 psychiatric-only readmit diagnosis is that you
9 got diagnostic fiddling. And so what you had
10 was they would get readmitted for a non-psych
11 diagnosis, or when they had a seven-day
12 readmit, they wouldn't readmit until after the
13 seventh day. People were being kept in 22-
14 hour holding, whole lot of things, because
15 there were some real consequences for their
16 incentive payments.
17 But so in support of what Reva was
18 saying about all-cause readmissions, if you
19 don't do it, you set it up for people to be
20 diagnostic fiddling.
21 CO-CHAIR SUSMAN: Joel, did you
22 have another question?

1 DR. STREIM: Yes, and again this is
2 for Reva or anyone else who is the expert
3 here. What do we know about the - I don't
4 know - the validity of seven-day - 48-hour,
5 seven-day, 30-day in terms of validity,
6 content validity?
7 DR. WINKLER: To me, what I would
8 say, and I am no expert on this, I think it
9 would be dependent on the reason for the
10 initial admission. And I would ask you all as
11 the mental health experts what is it about
12 that particular condition and the
13 hospitalization which does or doesn't happen
14 during that hospitalization and care
15 transition that - what is the timeframe that
16 would be the most useful for public reporting
17 and pushing and improving quality. The
18 arguments in favor for using more medical
19 conditions like heart failure, AMI, those are
20 sort of a traditional, everybody is
21 comfortable with looking at what is going on
22 for 30 days, but I'm not sure that is

1 necessarily applicable in the mental health
2 field. I think some conditions might be
3 different.
4 DR. STREIM: Yes, I think there is
5 a lot of heterogeneity across conditions in
6 terms of time to relapse, time to recurrence.
7 Even if you look at, take a simple example
8 like bipolar illness where you have
9 recurrences that are part of the chronic
10 illness, an expected part of the chronic
11 illness. And some people cycle rapidly and
12 some people cycle slowly. That is the
13 intrinsic nature of the illness itself. The
14 factors we are trying to get at with these
15 measures had to do with how we provide care
16 and how we can influence outcomes, and I think
17 it's very hard to come up with a time interval
18 that makes both clinical sense, but my
19 question was really about what time interval
20 makes sense in terms of quality measurement,
21 and I don't know whether anyone has really
22 been able to tease that apart. Again I don't

1 know that literature myself.

2 DR. MANTON: I wonder if they have

3 looked at it, if she is still on the phone.

4 CO-CHAIR SUSMAN: Is our measure

5 developer still on the phone at Western Psych?

6 There is a question here about the rationale

7 of 48-hour, seven-day, 30-day, and whether you

8 actually accumulated data that reflects these

9 readmission rates and how it might inform us

10 and sort of where the points of improvement

11 might be in the process.

12 WPI REPRESENTATIVE: I don't have

13 that data available with me offhand, right

14 now, but we can get that to you.

15 DR. STREIM: So are you saying that

16 you do have comparative data looking at the

17 readmission rates for 48 hours, seven days and

18 30 days?

19 WPI REPRESENTATIVE: Yes, we do have

20 seven-day, 30-day, 48-hour readmission rate

21 data, but I don't have that number currently

22 with me.

1 DR. STREIM: Even if you don't have
2 the numbers, can you tell us whether you think
3 the differences are informative about which
4 time interval is most helpful for measuring
5 quality?
6 WPI REPRESENTATIVE: We believe that
7 the shorter time interval is usually most
8 indicative of the quality of service delivered
9 as the hospital that is discharging, and as
10 the time interval becomes larger and larger,
11 less of the readmission rate can be attributed
12 directed to the discharging hospital. We
13 currently use this information as part of our
14 report cards we do for physicians as an
15 hospital-wide indicator.
16 CO-CHAIR SUSMAN: Okay, thank you.
17 If there are no other general questions, why
18 don't we go down the list here. This is on
19 the seven-day readmission. We are looking at
20 importance. How many believe completely on
21 importance?
22 (Show of hands)

1 DR. WINKLER: Zero.
2 CO-CHAIR SUSMAN: How about
3 partially?
4 (Show of hands)
5 DR. WINKLER: Eighteen. That
6 looks like everybody.
7 CO-CHAIR SUSMAN: Okay, let's go
8 down then to scientific acceptability. Any
9 new or differing information from the comments
10 of the past discussion?
11 DR. STREIM: I would just mention
12 that the submissions for all three time
13 intervals for measurement were identical
14 except for the difference in 48, seven and 30.
15 CO-CHAIR SUSMAN: Okay, then.
16 DR. PINCUS: For all of these
17 things we basically all agree that that our
18 votes for all of them apply so we can move on.
19 CO-CHAIR SUSMAN: Thank you very
20 much, Harold, for that suggestion.
21 Is it the wisdom of the group that
22 we replicate our findings here, and perhaps we

1 can move to a vote so we have that formal.
2 I'm seeing a lot of head-nodding.
3 How many would vote in favor of
4 recommending this measure for acceptance?
5 How many would vote against, let's
6 see hands please.
7 (Show of hands)
8 CO-CHAIR SUSMAN: Eighteen. So the
9 final count is eighteen against, zero for.
10 DR. PINCUS: Can I make a
11 suggestion that there be interaction with the
12 measure developers about potentially adapting
13 this measure to respond to some of the
14 concerns that we have.
15 CO-CHAIR SUSMAN: So I'm hearing
16 that one of our parking lot issues, here, is
17 that this general concept is obviously quite
18 important and that perhaps encouraging the
19 measure developer to do some further work
20 would be very beneficial to the field.
21 DR. PINCUS: It strikes me as a
22 natural thing. We told the Joint Commission

1 that we weren't going to approve it unless
2 they did X, and then they did X and we
3 approved it.
4 MS. BOSSLEY: Right, you could say
5 that you would like certain things completed
6 to these measures, and if those were met then
7 you would recommend it, and we can take that
8 to the developer and ask them. I think the
9 question is, you would have to go really
10 detailed and give them really explicit
11 information on this measure. I guess the
12 question is, for these three measures will you
13 be able to do that, and will they be able to
14 then respond back in the timeframe we have, or
15 is it too big.
16 DR. PINCUS: My question is - I'm
17 not sure. If they said that these measures
18 were to apply to all the readmissions whatever
19 reason, would that be acceptable?
20 DR. WINKLER: Some of those
21 questions I think we can get clarification on,
22 but one of the major things I heard from all

1 of you is the lack of risk adjustment as being
2 the sort of major downfall for these measures,
3 for this purpose, and that I don't think - I
4 think that is pretty big to try and get that
5 fixed too quickly.
6 DR. MANTON: It also sounds like
7 they are working on it.
8 DR. PHILLIPS: It almost sounds
9 like they just need to get farther along in
10 their development and come back to us.
11 CO-CHAIR SUSMAN: I think again,
12 since you are, I assume, still on the phone
13 the general sense of the group is that this is
14 great work but there are some elements
15 including looking carefully at the
16 numerator/denominator specifications and the
17 risk adjustment process that could make this
18 a very viable measure.
19 DR. STREIM: And the other factor
20 I would add to that list is the availability
21 of payer data so that you can look across
22 systems within a region.

1 CO-CHAIR SUSMAN: So now we are at
2 the 48-hour again. Is it okay - same thing.
3 I thought we'd have to for the safe, but if
4 not, same vote? Okay. Fine.
5 Well, then I'm going to declare
6 victory and ask if there is any NQF member or
7 public comments?
8 (No response)
9 Hearing none, it looks to me like it
10 is now 10 of 3:00. We are sort of ahead.
11 Would it be the wisdom of the group to launch
12 on to substance abuse or take a break? Short
13 break. How about at three o'clock more or
14 less. Thank you.
15 (Whereupon, the above-entitled
16 matter went off the record at 2:50 p.m. and
17 resumed at 3:04 p.m.)
18 CO-CHAIR SUSMAN: Tricia and I had
19 this great plan that we were going to
20 alternate facilitation but then we had the
21 workgroup order changed, so you will have to
22 put up with me through this next set of

1 measures. We will work until about quarter to
2 five and do as many as we can with the first
3 one up being substance abuse, patients,
4 clinical status, recovery and substance abuse
5 treatment.

6 SUBSTANCE ABUSE, PATIENTS CLINICAL STATUS,
7 RECOVERY AND SUBSTANCE ABUSE TREATMENT

8 CO-CHAIR SUSMAN: And that group,
9 if you were a member of that, myself, Eric,
10 who else was a member of the workgroup?
11 DR. WINKLER: It was workgroup
12 four.
13 CO-CHAIR SUSMAN: Okay, good, so we
14 are on, and the first one we're going to be
15 considering is the milestones of recovery
16 scale.

17 MEASURE OT3-001: MILESTONES OF
18 RECOVERY SCALE

19 CO-CHAIR SUSMAN: And I will ask
20 Ian to provide a brief review of that.
21 MR. CORBRIDGE: So we are working
22 right now on Measure #10: Milestone of

1 Recovery Scale. And, Heidi, I think is going
2 down to this at this point, so we'll be there
3 in a second.
4 Just a brief description of this
5 measure. The Milestone Recovery Scale is a
6 one-item self administered scale that
7 indicates when an individual is in the process
8 of recovery from a severe - and I'm sorry my -
9 does that cover it? I guess my page got
10 lost.
11 CO-CHAIR SUSMAN: Severe and
12 persistent mental illness, the scale is
13 designed for use with adults who have severe
14 or persistent mental illness, 18 years and
15 above, scale measures. We underlined
16 constructs, level of risk, level of
17 engagement, level of skills and supports,
18 combined to create the following eight
19 categories of extreme risk, high risk not
20 engaged, high risk engaged, poorly coping not
21 engaged, poorly coping engaged, coping,
22 rehabilitating, early recovery, advanced

1 recovery.

2 So that was the tag team there.

3 MR. CORBRIDGE: This is measure

4 #10.

5 CO-CHAIR LEDDY: It's in a

6 different order if you are looking at this

7 packet. If you are looking at this packet,

8 the decision table, it's in the second group

9 because we decided on the phone it wasn't an

10 outcome measure but we wanted to look at it

11 anyway. So it's like on the fourth or fifth

12 page.

13 CO-CHAIR SUSMAN: This is workgroup

14 four, so you will find that a little further

15 along if you are looking at these number of

16 ratings.

17 MR. CORBRIDGE: I believe on the

18 Word document that was sent out for what's

19 being projected up there, I believe he said it

20 was page 36, page 36 for those who are

21 following.

22 CO-CHAIR SUSMAN: Thirty-four, 36,

1 35. I mean this is an inexact process.
2 CO-CHAIR LEDDY: I have matched up
3 the pages.
4 CO-CHAIR SUSMAN: All right, so for
5 those of us who have had an opportunity to
6 look at this thoughts about whether, first of
7 all, this was an outcomes measure or a process
8 measure.
9 DR. GOPLERUD: I was one of the
10 publicly disappointed reviewers in that I did
11 not think that this was an outcomes measure.
12 It also really didn't show any change scores.
13 It - most of the measure was not filled in, so
14 it was very difficult to know what to make of
15 this measure because they didn't essentially
16 complete the form. But my sense was it was an
17 interesting area, but we have no idea of
18 reliability, validity, so it's an important
19 issue. Is it an outcome measure? I don't
20 think so.
21 CO-CHAIR SUSMAN: Luc and Sheila.
22 MR. PELLETIER: I would agree that

1 knowing where someone is in recovery is an
2 important thing, but I would agree that there
3 were not studies or evidence that the measure
4 is effective for reporting outcomes.
5 DR. BOTTS: Same here.
6 DR. GOPLERUD: And also this is a
7 staff reported measure without good anchors,
8 and that has incredible demand
9 characteristics.
10 CO-CHAIR SUSMAN: So the first
11 step, and then I'll get to Harold's comment or
12 question, is to decide whether this meets the
13 scope or not. And I think we should clarify
14 whether we believe we want to go through the
15 process if we think it's in-scope, so why
16 don't we take Harold and get back to that
17 issue?
18 DR. PINCUS: So I come back to
19 looking at the importance of scope, we are
20 evaluating the measure or the concept, and so
21 to try a potential understatement, what the
22 concept is behind this. The concept of

1 measuring recovery seems to be an important
2 concept, but I don't have a good idea of what
3 the intent of this, what - how they kind of
4 operationalize that concept in a meaningful
5 way.
6 MS. WILKINS: I can respond only
7 because I am somewhat familiar with the use of
8 the tool in California. It's been pretty
9 widely used in some really innovative and
10 strong programs that are addressing many of
11 the outcomes that, in our meeting last fall,
12 we said we really wanted to be looking at. So
13 even though I'm not in that group and didn't
14 actually see what they submitted to us. I am
15 somewhat familiar with the instrument and so
16 I brought a copy of it. The way they look at
17 poorly coping not engaged is, these are folks
18 who - so they are towards the middle of this.
19 It addresses their symptoms; they may have
20 moderate to high symptom distress. They may
21 use drugs or alcohol, which may be causing
22 moderate but intermittent disruption. It

1 talks about their thinking, they may not think
2 they have a mental illness, they are not
3 participating voluntarily in ongoing mental
4 health treatment. Some of the other measures
5 then get into details like how often are they
6 going to jail, are they in stable houses, so
7 to the extent to which in our discussion of
8 outcome measures last fall, we came up with
9 this really big list of things like are people
10 homeless, are they going to jail, are they
11 managing their symptoms, are they functioning
12 well bundled inside what looks like a really
13 simple list here is a lot of detail about -
14 detail meaning it won't fit on one page. But
15 it's more than just what you see there.
16 CO-CHAIR SUSMAN: So apart from the
17 issues of the usability, the psychometric
18 properties and so on, I'm hearing that this is
19 a multidimensional composite score which
20 embodies many of the dimensions of outcomes
21 that we talked about at our last meeting. And
22 I wonder you guys in the group have had some

1 time to look at this, recognizing that many of
2 us aren't familiar with the instrument itself,
3 does that meet the scope criteria?
4 To me, it seems to.
5 DR. GOLDBERG: I wasn't in the
6 group. But I was one of the people - I saw
7 this as an outcomes measure from the
8 beginning. I can't speak to the science. I
9 know we'll have discussion of that. But there
10 are people with severe persistent mental
11 illness who it distorts or cuts across many
12 categories of where they live and level of
13 function and co-morbidities and psychiatric
14 symptoms. It kind of bundles all those in a
15 way that allows you to say, what's their
16 outcome at this point. I mean is their
17 outcome at this point any better. So I thought
18 it was on track in some way as a category, and
19 it seems to me that it is within scope, and
20 that we ought to discuss the other dimensions
21 of it.
22 CO-CHAIR SUSMAN: Okay.

1 DR. GOPLERUD: I think there are
2 two parts of challenge to this. One is that
3 we didn't have the detail either; all we had
4 were the eight descriptors. Second is that
5 nobody submitted, say, the global functioning.
6 Global functioning is used a lot. You get a
7 gap score, but it's a measure, it's not an
8 outcome, or you could use the basis, or you
9 could use a whole lot of different measures.
10 The measure itself is not an outcome; it's the
11 use of the measure in a context, either change
12 score or - and so that's where I had the
13 difficulty with an outcome is it told us about
14 a measure which seemed to have some
15 difficulties, rather than its use in gauging
16 outcome.
17 CO-CHAIR SUSMAN: So if we look at
18 the underlying embodied behaviors that are in
19 each of these categories, would going to jail
20 a lot or being an abuser be patient-oriented
21 outcomes that would matter? And I would
22 submit they really are. Now it's hard to know

1 that from the summary staging, but knowing the
2 underlying constructs I think it sort of right
3 within the scope of what we should be doing.
4 But again that's just one person's opinion.
5 MS. JAFFE: To me I think the
6 confusion was part of it maybe was the
7 author's interpretation of what NQF wanted
8 was that if the measure shows improvement over
9 one year using the milestone recovery scale
10 then that's an outcome. And I think implicit
11 in the use of this recovery scale - my guess -
12 is the author's assumption that the outcome
13 is that they are improving. But they are not
14 writing it that way. And so it's a little
15 confusing to me.
16 MR. PELLETIER: The other confusing
17 part for me was even in the introduction they
18 say, it only takes 15 seconds to do this. And
19 I'm like, not having seen the tool at all,
20 really, wow.
21 CO-CHAIR SUSMAN: Maybe they meant
22 15 hours.

1 MR. PELLETIER: Because there is a
2 rich amount of information behind it,
3 supposedly.
4 DR. STREIM: It's like if you are
5 doing a clinical global impression of
6 severity, it only takes 15 seconds to score
7 it, but you know the patient's baseline, you
8 know a lot of information.
9 DR. PINCUS: I mean it seems to me
10 there is no question that is an outcome thing,
11 and I think the gap is an outcomes measure.
12 I mean it's not a good one. Anything,
13 obviously, but the intent is, I mean clearly
14 the intent is to do this.
15 DR. STREIM: Was there any attempt
16 to define baseline?
17 DR. PINCUS: At least what they
18 report here they have actually a fair amount -
19 they don't give any citations but they do
20 report a fair amount of research on this in
21 terms of inter-reliability coefficient of .85,
22 with test, retest reliability of .85, so they

1 have in - it was also strongly correlated with
2 the direction with the Multnomah Community
3 Ability Scale.
4 CO-CHAIR SUSMAN: I am going to get
5 Reva and then Bill.
6 DR. WINKLER: I just want to tell
7 you that Carol just pointed me in the
8 direction of where to find this document that
9 has all this information, and I'll be more
10 than happy to, when we're done here to go get
11 it and I'll send it out so everybody has it.
12 So that if you feel that you need that to go
13 get a good handle on this measure, we can go
14 get it for you.
15 DR. PINCUS: Although it doesn't
16 get the actual information about looking at
17 citations for it and actually how they
18 conducted those assessments.
19 DR. GOLDEN: One criteria for
20 assessing this measure which is not in your
21 master list is validation. I mean you have
22 basically a provider-generated measure, so the

1 person being evaluated is the person filling
2 out the assessment. So if you start to go to
3 an accountability measure, then it can be
4 gamed, and the question is, how does an
5 outside entity validate that the reporting is
6 actually reflective of the care. I think that
7 would be very tricky business, and could be an
8 issue for this particular measure.
9 CO-CHAIR SUSMAN: So let me
10 entertain a vote, if there are no other
11 discussions of whether this is in scope or out
12 of scope, because if it is out of scope then
13 we needn't go further. If it is in scope then
14 we need to do the rigorous work.
15 So would you please vote first if
16 you believe that it is out of scope. Out of
17 scope, a process measure not sufficiently
18 linked to outcomes.
19 (Show of hands)
20 CO-CHAIR SUSMAN: I'm just going by
21 the order up there.
22 How about in scope, raise your hand?

1 (Show of hands)
2 We are just trying to see if you are
3 aware. Abstentions?
4 (Show of hands)
5 One, okay. So let's then go on and
6 just go through our process and I think these
7 other issues will probably come up.
8 First of all, importance to measure
9 the report impact gap in relation to outcomes.
10 MR. PELLETIER: The same thing that
11 I said before, that the concept is in
12 alignment with the recovery model applied to
13 mental health but we found no studies or
14 evidence that the measure was effective.
15 It's an important concept.
16 CO-CHAIR SUSMAN: So remember this
17 is more the importance of the concept of the
18 dimensions being measured as opposed to the
19 measure itself. So I would - when I looked
20 at or now with the benefit of going through
21 these, it seems to me like this is an
22 important concept, that the recovery process,

1 recovery model as an outcome is pretty
2 important and the patients value that and
3 patient advocates value that highly.
4 CO-CHAIR LEDDY: So even though
5 the title of the measure says, milestone of
6 recovery scale, we are not voting on the scale
7 itself?
8 DR. WINKLER: For the importance
9 criteria, the question of measuring this using
10 a tool, perhaps, this one or others that they
11 happen to exist, is the concept of the
12 measure, then you look at the specific
13 characteristics of how the specs are for this
14 particular measure.
15 DR. STREIM: So we are voting on
16 milestones of recovery not with capital
17 letters but with lower case?
18 DR. WINKLER: Absolutely.
19 CO-CHAIR SUSMAN: Joel, you have a
20 wonderful way of distilling things down.
21 Sheila, any thoughts or comments
22 from any of you?

1 DR. BOTTS: I thought it met it.
2 I will talk louder. I felt like it met this
3 measure in terms of an impact and relationship
4 to outcomes. I think some of the other
5 discussion that comes up really comes up in
6 terms of scientific acceptability.
7 CO-CHAIR SUSMAN: Luc, any further
8 comments? Eric?
9 DR. GOPLERUD: I agree with Sheila
10 completely.
11 CO-CHAIR SUSMAN: Are we ready to
12 vote on importance then? Completely?
13 (Show of hands)
14 MR. CORBRIDGE: Thirteen.
15 CO-CHAIR SUSMAN: Partially.
16 (Show of hands)
17 MR. CORBRIDGE: Five.
18 CO-CHAIR SUSMAN: Okay, so we are
19 done with that part. Now let's go on to
20 scientific acceptability. I think this is an
21 area where there probably is some more
22 concerns, at least from my point of view.

1 DR. GOLDBERG: Based on the section
2 and what they submitted, not this addendum but
3 this one.
4 DR. WINKLER: We are on capital
5 letters, right.
6 DR. GOLDBERG: So what is your
7 guidance on that? Do we have to do more of
8 this.
9 DR. BOTTS: Part of what was in
10 the document were links to the PDF I think of
11 the criteria that were passed around, but they
12 weren't linkable in the PDF that we had, so
13 the PDF is incorporated there, so I'm guessing
14 that they were submitted, but when we reviewed
15 them we didn't have access to them.
16 MS. BOSSLEY: What we can do is
17 provide it to you, and then Ian, we are going
18 to have them come out on another call again,
19 most likely? You can discuss it then after
20 you have time to review it. That's fine to
21 table it now, if you like.
22 DR. BOTTS: I just wouldn't want

1 them to be penalized for us not reviewing what
2 they probably did submit.
3 DR. GOPLERUD: I think in this one
4 it would be useful for us to read the
5 numerator and denominator because it doesn't
6 come clearly in the description. The
7 numerator details is the sum of all clients
8 who have a higher MORS score at the end of a
9 specified time frame than they had at the
10 beginning of a time frame. And the
11 denominator is the number of all clients who
12 were given an admission MORS score at any time
13 during the specified time frame.
14 CO-CHAIR SUSMAN: So it is sort of
15 - imagine what you are going to measure at any
16 time and place, and we'll call it an outcome.
17 CO-CHAIR LEDDY: It was at
18 admission or at any time. Too bad it's not
19 at admission and another specified time.
20 DR. STREIM: So there is no
21 attention to speed of recovery, recovery
22 trajectory here. So if they come back two

1 weeks later and they get a MORS score and they
2 are no better, that would be actually excluded
3 from the numerator, right, because they are
4 not improved.
5 DR. GOPLERUD: This comes from the
6 Village, that's where it was developed, and
7 these are the most severely mentally ill,
8 severely mentally ill who are in prisons and
9 jails. So they are really looking at probably
10 a longer time frame of a year or a couple of
11 years and it probably wouldn't say work for
12 acute psychiatric.
13 DR. GOLDEN: Since we are on the
14 scientific piece right now, it would strike
15 me, people who looked at this, was there any
16 statement about inter-observer reliability.
17 I could see depending on who filled out the
18 tool, there could be great variation.
19 (Simultaneous speaking)
20 DR. GOLDEN: And a 15-second
21 assessment, that's interesting.
22 MR. CORBRIDGE: I'm sorry, just to

1 interject quickly, I know the measure
2 developer is on the line. He just sent me an
3 email. He's having a hard time hearing the
4 discussion. So if you are speaking just try
5 to make sure you use the mikes or something.
6 MR. PELLETIER: It was limited to a
7 regional sample. It's pretty much California
8 and they talked about working with someone in
9 Boston.
10 CO-CHAIR SUSMAN: So there is
11 discussion of the reliability testing, is it
12 primary and secondary rater blind to the other
13 raters, a total of 105 clients rated by two
14 individuals, test/retest reliability, two
15 points in time during a single month in
16 California, and 381 clients with the interval
17 ranging from 10 to 20 days. So there is
18 actually at least some inter-rater and
19 test/retest reliability, and the correlations
20 actually are pretty good. Inter-rater
21 reliability achieved using clients and staff
22 was .85; inter-rater reliability using clients

1 and staff, at another place, was R equals .86.
2 Test/retest reliability, R equals .85. So I
3 think, pretty robust, albeit it in a
4 relatively finite sample.
5 DR. PINCUS: We really don't have
6 the specific methodology that was used for
7 doing this, and has it been published?
8 DR. WINKLER: Since the developer
9 is on the phone, they could provide a little
10 background if that could help us.
11 CO-CHAIR SUSMAN: Is the developer
12 here on the phone, can you hear us?
13 MHA REPRESENTATIVE: I can hear some
14 of you, though I can't hear others.
15 CO-CHAIR SUSMAN: What we are
16 talking about right now is the reliability
17 testing and we wonder if you might be able to
18 describe a little bit further what sort of
19 reliability testing has been done, and where
20 and if that has been published.
21 MHA REPRESENTATIVE: Sure. First
22 of all there was somebody who described or

1 mentioned the fact that one of the sites that
2 this had been tested on mostly is at our
3 Village program here in Long Beach. We did
4 our major reliability study on that, and that
5 was the study where we did get about a .85
6 inter-rater reliability coefficient.
7 Basically as it mentions in the article, we
8 had all of our clients rated by up to five
9 different staff, and all staff were blind to
10 each other's ratings, so that was a fairly
11 large number of clients.
12 We also did another inter-rater
13 reliability where I went to Massachusetts and
14 trained the staff of a large mental health
15 provider in Massachusetts, and that was the
16 study with 105 clients who were rated by
17 various members of staff who were also blind
18 to each other's rating, and they got just
19 slightly higher; that was the .86 coefficient
20 that was mentioned.
21 So those are the two inter-rater
22 reliability studies that we did.

1 CO-CHAIR SUSMAN: Are there any
2 further questions about reliability testing?
3 Yes.
4 MHA REPRESENTATIVE: I'm sorry?
5 DR. GOLDBERG: We've had some
6 reaction to the fact that the test can be
7 given in 15 seconds. And what these raters -
8 is that true?
9 MHA REPRESENTATIVE: It's based on
10 the staff knowing their client that they are
11 rating. So fundamentally I think somebody
12 mentioned the fact that these are for folks
13 who are considered to have a severe and
14 persistent mental illness and who have been in
15 the system for quite some time. Here in
16 California these folks are primarily serve in
17 what are called full service partnerships, so
18 we have very low caseloads, above about one to
19 15, one to 17. So every month all of our
20 staff rate their consumers, clients on their
21 caseload, and literally takes about 15
22 seconds, because if you know the client you

1 know sort of what their risk factors are, what
2 their level of engagement is and what their
3 level of skills and supports are, so it
4 doesn't take long at all.
5 We work as a team on a team basis,
6 so it's not unusual for everybody in the team
7 to know everybody on everybody else's
8 caseload, and that's how we can do inter-rater
9 reliability that are so high, because the
10 staff do know members who aren't necessarily
11 on their caseload, but we are very familiar
12 with all of them.
13 DR. STREIM: So another way to put
14 that is that it only takes 15 seconds to
15 decide on a Likert scale rating and circle it.
16 MHA REPRESENTATIVE: That's
17 correct.
18 DR. STREIM: But can you estimate
19 how much time at any cross-sectional
20 assessment the caseworker or whoever is
21 following this client, how much assessment
22 time they actually take to find out how they

1 are doing, how they are behaving, how they are
2 functioning, how is their last two weeks been
3 going. Because they are interacting with that
4 person, making a clinical assessment, and that
5 clinical data then translates into the 15
6 seconds scoring.
7 MHA REPRESENTATIVE: Right.
8 DR. PINCUS: If you brought an
9 independent -
10 COURT REPORTER: Microphone please.
11 DR. PINCUS: If you brought in an
12 independent assessor to obtain the score, how
13 long would it take them to achieve a valid
14 ability to put down a valid score? Although
15 what I'm really asking is, in the real world
16 with the assigned caregiver how long does it
17 take that person who also knows enough of the
18 history that they don't have to reiterate it
19 at every subsequent measurement period.
20 They --
21 DR. PINCUS: What is the marginal
22 level of effort needed -

1 DR. STREIM: Exactly, because that
2 is really - in terms of the burden of the
3 instrument and what it takes to actually
4 accomplish this, that is the real measure.
5 MHA REPRESENTATIVE: Right. I
6 think I understand your question. As we
7 explain in our manual we actually encourage
8 people to use the MORS in one of two ways.
9 You could use it as an individual measure
10 where basically the case manager thinks about
11 how the person is doing, tries to assess them
12 on the three constructs of risk, engagement
13 and skills and support, and then butts up with
14 that. And because they are meeting with their
15 clients regularly, you know, you don't see
16 huge shifts in those underlying constructs
17 from day to day. So we've also done a lot of
18 looking at sort of the stability of ratings
19 over time. And so what I heard somebody
20 questioning well, what is the numerator and
21 denominator in terms of what is the time
22 frame, is that we are looking at periods of a

1 year to two years in terms of people who may
2 enter the program when they come off the
3 street. They may be high risk unengaged, so
4 they would be rated as a two. But over time
5 we would expect - and that is really the
6 question, we want to look at the trajectory of
7 recovery and see how can different programs do
8 in terms of moving people from a two to a
9 seven or eight, how long does it take on
10 average, those are the kinds of questions we
11 want to use the scale, and that's why we think
12 that it really should be considered at outcome
13 measure.
14 But the other thing about the way
15 that we have rated folks is that we often
16 encourage our own team to do the ratings as a
17 team, so our teams meet once a week, to
18 discuss how their members are doing, how their
19 clients are doing. So during that meeting,
20 during the discussion, people - different
21 people, different staff on the team, may have
22 different information about how the client is

1 doing. That is all kind of put together into
2 - and the client is given a rating based on
3 that discussion. So much of that team meeting
4 can be used in that way.
5 CO-CHAIR SUSMAN: A couple of
6 further questions.
7 We have an unusual placement of
8 microphones, and we have to wait until they
9 are shuffled around.
10 MHA REPRESENTATIVE: Sure, no
11 problem.
12 DR. HENNESSEY: Hi. Have you done
13 any reliability studies looking to see what
14 kind of inter-rater reliability there is when
15 you compare an individual rating versus a
16 group rating?
17 MHA REPRESENTATIVE: No, we have
18 not done that.
19 CO-CHAIR SUSMAN: Since these
20 measures are ultimately being proposed for
21 accountability purposes, do you have any
22 standardization timeframe or other

1 specification here that will make this a more
2 suitable measure for those purposes? In other
3 words if I measure it at one year and Eric
4 measures it at three years, and his population
5 is a little bit less sick because they are not
6 getting any patients who may have fallen into
7 the criminal justice system and yada yada, it
8 sounds like we might do well to say apples and
9 oranges, and that for accountability purposes
10 this measure wouldn't be appropriate. Am I
11 misunderstanding what you are proposing?
12 MHA REPRESENTATIVE: I think that
13 the common wisdom is that recovery takes a
14 long time, and we are talking in terms of half
15 a decade for a lot of people who come in as
16 high risk unengaged. But I have seen members
17 - we tend to use the term, members, as opposed
18 to clients or consumers - I have seen members
19 come in as high risk unengaged, and be able to
20 reach early recovery within a six-month
21 period, so I think the individual path of
22 recovery is going to be very different

1 depending on the individual. But I think that
2 we really want to use this to find and give an
3 idea of what are the typical trajectories of
4 recovery. I don't think that we really know
5 or can really speak to that question, because
6 we don't have a tool that actually has a way
7 of quantifying people's paths to recovery on
8 the aggregate. I mean there are a lot of
9 anecdotal stories out there about how people
10 recover, but we don't know how programs are at
11 actually helping people move through that
12 process. So this is our attempt to quantify
13 this to some extent and say, given the fact
14 that if we had a large group of people who
15 come in at these earlier stages of recovery
16 how long does it actually take us to boot them
17 to the higher stages of recovery? How long
18 does that process typically take? So we are
19 really trying to provide some information to
20 the field about that.
21 DR. STREIM: Are you collecting
22 data on the mean times that are spent at any

1 given level of recovery to know --
2 MHA REPRESENTATIVE: We in our
3 programs we collect this - the milestones
4 every month, and we strongly suggest that in
5 other programs that are started using it do
6 the same. So we really tell people that they
7 should do it less than quarterly so that they
8 can start getting the data points over time
9 and actually have a feel for what progress or
10 lack thereof that they are making. We have
11 also got some papers in press or under review
12 to sort of look at what are those average
13 times in our own program as well as others.
14 DR. STREIM: And the converse, time
15 to relapse or regression to a lower level, are
16 there data at this point that you have
17 collected on that as part of a recovery
18 trajectory where they may have bumps in the
19 road and setbacks and then advances, two steps
20 back, one step forward?
21 MHA REPRESENTATIVE: We are looking
22 at that as part of this paper, but I can tell

1 you that the one study that we have had going
2 on this, for example, the early data, for
3 example, the kinds of information that we are
4 hoping to get out of this is that for all the
5 people who come into our Village program for
6 example is that based on our Milestones to
7 Recovery data, what I can tell you is that
8 anybody who comes into the program at a
9 relatively high risk, that is they are a one,
10 two or three when they come in, is that within
11 one year if you look down the road one year at
12 their recovery, there is still about a 6
13 percent chance that they would be still at
14 that high risk category. So 94 percent of our
15 folks after one year are now above the high
16 risk category if they came in as a high risk
17 person. So that is the kind of information.
18 Now is that particularly good for a program or
19 particularly bad for a program? I don't have
20 any benchmarking data so I can't tell you
21 that. But those are the kinds of information
22 that we are trying to use the Milestones of

1 Recovery scale to help us to understand.

2 CO-CHAIR SUSMAN: Eric.

3 DR. GOPLERUD: I think we have here

4 a really good example of a field developed,

5 program developed measure which is maybe

6 jumping too quickly but is not ready for

7 nationwide implementation and prime time, but

8 not only needs to be encouraged at the local

9 level to develop it, but really to bring in

10 some of the technology of the folks to do the

11 - some of the critical issues around risk

12 adjustment and the questions that we have

13 asked about inter-rater reliability, if you

14 have an outside objective observer, some of

15 the validity testing using different

16 populations et cetera.

17 It's on a topic that is incredibly

18 important, and it is probably - it may be a

19 measure that could be ready for prime time at

20 some time in the future if developed. On the

21 other hand there are so many challenges right

22 there on the scientific acceptability that it

1 is very difficult at this point to go forward
2 I think at a national level and say, yes let's
3 support this.
4 CO-CHAIR SUSMAN: Eric and then
5 Harold.
6 DR. GOLDEN: Similar comments. I
7 think that it has great promise as a quality
8 improvement measure, but because of the
9 problem of validation I'm not sure it could
10 ever become an accountability measure. So I,
11 depending on how you propose the vote, I could
12 not endorse this or support this
13 scientifically as an accountability measure.
14 CO-CHAIR SUSMAN: Harold.
15 DR. PINCUS: I agree with both of
16 the previous comments, but also I think the
17 issues of usability in terms of understanding
18 sensitivity to change, and what are the
19 elements that actually influence that change.
20 So that if organizations are seeking to apply
21 this as a - it kind of goes to what you are
22 saying - seeking to use this as a quality

1 improvement strategy so how do they improve.
2 What are the mechanisms to do that? Would be
3 important to begin to elucidate.
4 CO-CHAIR SUSMAN: So I'm hearing
5 from the group a lot of excitement that this
6 type of measure is being developed, but
7 concerns about some of the basic scientific
8 acceptability currently, things like risk
9 adjustment, looking at disparities of care,
10 population differences, validity, reliability
11 when you have naive observers or objective
12 observers.
13 Are we ready to vote on scientific
14 acceptability? Let's go ahead then and
15 completely on scientific acceptability?
16 (Show of hands)
17 CO-CHAIR SUSMAN: Partially.
18 DR. WINKLER: Five.
19 CO-CHAIR SUSMAN: Minimally.
20 DR. WINKLER: Thirteen.
21 CO-CHAIR SUSMAN: Okay, let's move
22 on to usability. We have already had some

1 comments in this direction. Further
2 discussion of usability. Do you have
3 something, Sheila?
4 DR. BOTTS: I think that Harold's
5 comments addressed those, and part of this is
6 just an interpretation and meaningful. You
7 know you are going in a direction of
8 improvement, but what that improvement
9 actually means in terms of outcomes and being
10 able to apply that as an accountability
11 measure I think there is a huge gap still.
12 CO-CHAIR SUSMAN: Any further
13 thoughts from the group on usability before we
14 vote?
15 Okay, completely?
16 (Show of hands)
17 CO-CHAIR SUSMAN: So partially.
18 (Show of hands)
19 CO-CHAIR SUSMAN: Minimally.
20 DR. WINKLER: Sixteen.
21 CO-CHAIR SUSMAN: And then not at
22 all.

1 DR. WINKLER: Two.
2 CO-CHAIR SUSMAN: Okay, let's go
3 ahead to feasibility. Remember that this is
4 a byproduct of care, the issue of burden,
5 ability to electronically incorporate such
6 measurement, exclusions, looking at inaccuracy
7 in the implementation issues here.
8 Thoughts from the group, please.
9 MR. PELLETIER: It sounds like the
10 measure is embedded in a practice based on a
11 model, based on the recovery model. Certainly
12 it sounds like this is being talked about all
13 the time. And this is a framework that the
14 inter-disciplinary team uses to talk about
15 patients recovery. So I think those are
16 strengths.
17 DR. GOPLERUD: I think one of the
18 big limitations is in the material that we
19 were given it shows that this is something
20 that you said it was embedded in a program; in
21 fact it's one of the leading most reputable
22 recovery programs in the country. And the

1 replicability of it I think is fairly low
2 until we see some evidence that it is
3 replicated. That they don't mention at all
4 things like exclusions I think is really a
5 problem if a measure like this is - are
6 cognitively impaired individuals going to be
7 excluded? Patients with organic brain
8 syndrome, patients who are substance abusers.
9 I mean there are a whole lot of different
10 criteria. And then data collection strategy
11 I think reflects that this is part of the
12 program and hasn't been taken out to more
13 programs to test it. So I think those are
14 real limitations not that they couldn't be
15 overcome, but I don't think at this point that
16 it's ready for that.
17 CO-CHAIR SUSMAN: So I think the
18 sense that I had is that this is a great start
19 but we are not at the accountability stage
20 yet.
21 So any further comments on
22 feasibility?

1 Let's go ahead then and vote.
2 Completely.
3 (Show of hands)
4 CO-CHAIR SUSMAN: Partially.
5 (Show of hands)
6 CO-CHAIR SUSMAN: Minimally.
7 DR. WINKLER: Seventeen.
8 CO-CHAIR SUSMAN: Not at all.
9 (Show of hands)
10 DR. WINKLER: Bill left.
11 CO-CHAIR SUSMAN: Okay, I think we
12 had a robust discussion, have been impressed
13 by the work being done, but - pardon me? I'm
14 getting up to recommendation.
15 How many would vote in favor of
16 adopting this measure? Yes.
17 (Show of hands)
18 CO-CHAIR SUSMAN: And the nos?
19 DR. WINKLER: Seventeen, Bill left.
20 CO-CHAIR SUSMAN: So seventeen,
21 Bill do you vote yes or no? Okay thank you.
22 DR. WINKLER: Were there any

1 abstentions? Okay.
2 CO-CHAIR SUSMAN: Okay, so again
3 for the sake of our developer, I think the
4 committee is enthusiastic about the potential
5 of this concept and measure, but there are
6 many issues which the feedback from the group
7 and staff can be passed on, and we sure hope
8 that this will lead to a measure in the
9 future. So thank you very much for taking the
10 time today.
11 MHA REPRESENTATIVE: Sure, I look
12 forward to getting all of your feedback, and
13 to your guidance in terms of the meeting the
14 qualifications that you are looking for.
15 Appreciate it.
16 CO-CHAIR SUSMAN: Is there any
17 public comment?
18 Okay, yes, thank you very much for
19 taking time today. Let's go ahead then and
20 move on to our next which is time for first
21 face-to-face treatment.
22 MEASURE OT3:013: TIME FROM FIRST

1 FACE-TO-FACE TREATMENT ENCOUNTER
2 BUPRENORPHINE DOSING
3 CO-CHAIR SUSMAN: Medication
4 developers? Well, was it really
5 representative here.
6 MR. CORBRIDGE: Donald, have we
7 heard if Baltimore Substance Abuse is on the
8 line?
9 DR. OLSEN: We are right here.
10 MR. CORBRIDGE: They are here.
11 For those measure developers from
12 Baltimore Substance Abuse, can you just state
13 who is on the phone?
14 DR. OLSEN: Yes, I'm Yngvild Olsen,
15 vice president for clinical affairs, and the
16 medical director for bSAS
17 MS. KUHN: And I'm Vanessa Kuhn also
18 with bSAS.
19 CO-CHAIR SUSMAN: There are a
20 couple of questions around the table of just
21 briefly your organization, who you are, two
22 minutes or less?

1 DR. OLSEN: Sure. So Baltimore
2 Substance Abuse Systems is a quasi-
3 governmental agency that has the monitoring
4 and oversight and some funding
5 responsibilities for a wide range of treatment
6 services, prevention, intervention and
7 treatment services for substance abuse in
8 Baltimore City, and one of the innovative
9 areas that we have focused on is the adoption
10 of buprenorphine into what previously were
11 kind of drug-free outpatient substance abuse
12 treatment programs to help increase access to
13 effective substance abuse treatment for opiate
14 dependence which is a huge problem, I think as
15 probably most people know, in Baltimore. And
16 the model that we have adopted is to start
17 buprenorphine in outpatient substance abuse
18 treatment programs, and link that to ongoing
19 primary care outpatient medical care, both as
20 a way to continue the buprenorphine, but also
21 to integrate our medical care for individuals
22 with opiate dependence. So that is where

1 these measures originated, and we really
2 appreciate the opportunity to talk with you
3 today about the two measures we have submitted
4 and our happy to answer any questions.
5 CO-CHAIR SUSMAN: Thank you very
6 much. We appreciate your taking time. There
7 may be questions along the way. We have a
8 fairly structured approach here, but there may
9 be some issues which we wish to clarify.
10 Ian, did you just want to go over
11 the specifications overall?
12 MR. CORBRIDGE: Can do sir. Right
13 now we are currently looking at measure #13,
14 so it's time from first face-to-face treatment
15 encounter to buprenorphine dosing. Number of
16 hours of opiate dependent non-pregnant adults.
17 So the description is number of hours opiate
18 dependent non-pregnant adults aged 18 or older
19 have to wait between the first face-to-face
20 treatment encounter and receiving their first
21 dose of buprenorphine medication.
22 Numerator statement reads as

1 follows: opiate dependent patients receiving
2 a first dose of buprenorphine medication.
3 Denominator statement reads: the event of an
4 adult aged 18 or older, opiate dependent,
5 buprenorphine appropriate, and treatment
6 counseling patients received the first dose of
7 buprenorphine.
8 CO-CHAIR SUSMAN: Okay, so those
9 are the group. Would you care to address is
10 this an outcome measure or a process measure?
11 I was frankly pretty skeptical that this was
12 an outcome, an outcome that is relevant to
13 patients, and there may well be symptoms or
14 issues that result from a delay that I didn't
15 quite see this as a patient-oriented outcome
16 myself. At least I had some concerns about
17 that. So Richard.
18 DR. GOLDBERG: Can I make a comment
19 on the extent to which there is data, that
20 this time interval relates to an outcome.
21 Is this an intermediate outcome? Is there
22 good data that - you understand the question

1 I hope. I'll rephrase it if I need to.
2 CO-CHAIR SUSMAN: And maybe that's
3 a good thing to put to our measure developer,
4 but is this a causal pathway or intermediate
5 outcome to patient-oriented outcomes that
6 would matter?
7 DR. OLSEN: Yes, so thanks for that
8 question. This is actually a process measure.
9 It's intermediate outcomes to the ultimate
10 outcome of retention and treatment. So there
11 is some evidence that the sooner patients are
12 - receive medications and the sooner that they
13 are engaged in care, the better the retention
14 of the treatment will be. You are correct,
15 this is an intermediary outcome measure.
16 DR. GOLDBERG: What is the nature
17 of that data? You say there is some
18 evidence, or you have evidence that the time
19 to starting buprenorphine is tied to retention
20 and treatment? What is the nature of the
21 evidence that exists for that?
22 CO-CHAIR SUSMAN: Are you still

1 there?

2 DR. OLSEN: Can you hear us?

3 CO-CHAIR SUSMAN: No, did you hear

4 the question?

5 DR. OLSEN: No, can you repeat the

6 question?

7 DR. GOLDBERG: Just so you can

8 refresh us about the nature of the evidence

9 that ties the time to dose to your outcome

10 which is, you are saying retention of

11 treatment. What is the nature of that

12 evidence?

13 DR. OLSEN: There are a couple of

14 studies that we have cited that suggest that

15 the sooner a patient gets engaged in treatment

16 and if you wait three to five - longer than

17 three to five days to get people into

18 treatment that likelihood of dropping out of

19 treatment increases.

20 DR. GOLDBERG: And where is that -

21 is that published? Is that an accepted

22 scientific finding? That has been reported in

1 quite a few research studies looking at rates
2 of show dependent on length of time to first
3 appointment. It is not specific as far as I
4 know to buprenorphine dosing. It has more to
5 do with the length of time between initial
6 contact requesting service and the first
7 service, and that is extensively reported on
8 the NIATx website. Again, there is no reason
9 not to believe that the sooner you get
10 buprenorphine dosing that the greater is the
11 likelihood of retention. But I doubt that
12 there is any buprenorphine-specific data that
13 says some interval, at least better than
14 another, or that it is anywhere different for
15 buprenorhpine than for something else.
16 One the other hand we have a measure
17 that is before us which is specific to
18 buprenorphine dosing, even though perhaps the
19 committee might be interested in length of
20 time to first appointment more generally for
21 either substance use or for behavioral health.
22 DR. PINCUS: I guess my concern is

1 that this mere distance from outcomes than a
2 number of the processy things that we looked
3 at.
4 CO-CHAIR SUSMAN: Certainly my
5 sense in initially reading this is that this
6 was somewhat removed, and I think it's a
7 judgment call because clearly there is some
8 relationship. And how important you judge
9 that causal pathway to retention and treatment
10 in the Baltimore patient area outcomes is in
11 the eye of the beholder. Sheila, what did you
12 think about that?
13 DR. BOTTS: I had trouble
14 deciding. I mean I look at this as an
15 intermediary outcome that was important, and
16 it's important to look at where you draw the
17 line between what we want to include versus
18 exclude. The fact that there are no other
19 measures makes me inclined to say, perhaps we
20 should stretch on this issue. But again I'm
21 not --
22 CO-CHAIR SUSMAN: I am going to let

1 Luc, and then we will get --
2 MR. PELLETIER: I was stretching
3 too, especially with the developers'
4 discussion of TIP 40 as being evidence, and I
5 wondered whether this particular organization
6 is using that and then trying to get more data
7 about whether something was effective or not,
8 so they were developing a measure to prove
9 what may not have been really strong.
10 DR. GOPLERUD: It is fairly clear
11 FDA approved buprenorphine because it shows
12 reduction of craving and opiate use goes down
13 if a patient is taking buprenorphine compared
14 to placebo or to other medications. Therefore
15 it's not a stretch to say if you get a patient
16 started on a medication which is known well to
17 be effective in reducing opiate use but it
18 might be linked as a process towards an
19 outcome which is well known.
20 CO-CHAIR SUSMAN: Rich.
21 Okay, are there any members of the
22 committee who say this should be taken out

1 because of out of scope? Maybe we should go
2 ahead and take a vote then.
3 How many of you believe this is in
4 scope? That it is sufficient as an outcome
5 measure, or as we've stretched things a bit,
6 an intermediate outcome measure, how many of
7 you would vote yes.
8 (Show of hands)
9 CO-CHAIR SUSMAN: This is -- right
10 now we are looking sort of -- well, we're
11 going to get the conversation going, and we
12 are going to stop it right here. And against
13 - it doesn't really matter. I think we've got
14 enough. So we are going to go ahead. Too
15 bad. I want to be inclusive; come on.
16 Okay let's talk about the
17 importance. We've already had some
18 conversation toward that. You know, my
19 concern is for the accountability measure,
20 this was a very narrow focus. And that was my
21 comment up here. And there wasn't a lot of
22 supporting data, there was some. And I think

1 we have heard the nature of that data already.
2 So let me turn to Sheila and Luc and then open
3 it up.
4 MR. PELLETIER: I thought it was
5 important, I thought this was an important
6 topic and the framing of it using the evidence
7 from the TIP was substantial I thought.
8 CO-CHAIR SUSMAN: Other comments?
9 DR. PINCUS: As an accountability
10 measure I think it's very narrow. If this
11 were framed as something broader, Eric is
12 gone, but more like what Eric described as
13 something looking at a larger set of time,
14 engagement and treatment in some ways, for a
15 broader population, it would have more
16 utility. And so I just don't see this being
17 picked up a lot except as an internal quality
18 improvement measure. But not as a large scale
19 accountability measure.
20 MS. JAFFE: I have a question for
21 the staff given that this is a much more
22 narrow measure than anything that we have seen

1 before, are there other measures that are this
2 narrow?
3 DR. WINKLER: Definitely, I mean
4 there are over 600 measures in the portfolio
5 and some of them are very narrow. Your
6 question is, and this is more philosophical
7 than policy, is that appropriate? Is that
8 useful in the grand scheme of things? And we
9 put that to you and ask you to advise us.
10 DR. GOLDBERG: I find myself
11 thinking of like the term of antibiotics to
12 certain outcomes. But the data that ties that
13 intermediate outcome measure to be acceptable
14 is pretty robust data in terms of the outcomes
15 that they are talking about. And here it's by
16 implication. But it's not here. So there is
17 no reason not to believe that this wouldn't
18 have an impact on retention and treatment
19 which should have an impact on outcomes, but
20 it's not really at the same point of
21 antibiotics in the ER for pneumonia treatment.
22 DR. STREIM: I would argue though

1 that for substance abusers it's not a fair
2 comparison to infectious disease; that
3 engagement and retention and treatment may be
4 more challenging with that population and that
5 particular set of health problems. So I think
6 the argument made by the measure developer
7 that it could make a difference, and indeed is
8 an intermediate outcome measure I think is
9 persuasive enough.
10 CO-CHAIR SUSMAN: And I think the
11 relief of pain and suffering symptoms in and
12 of itself is pretty substantial patient
13 oriented outcome, and if one's suffering
14 longer --
15 DR. GOLDBERG: Right, but this is a
16 slippery slope. If you let this in the door
17 and you pick up thousands of measures like
18 this that could be submitted and presented for
19 --
20 CO-CHAIR SUSMAN: I don't disagree,
21 but I --
22 DR. PINCUS: -- retention and

1 treatment would be a more - have more proximal
2 benefit.
3 DR. STREIM: Well, under depression
4 you could argue time not to first dose but to
5 first appointment could be important. I mean
6 you can imagine similar things --
7 DR. PINCUS: Right, we almost
8 knocked out measuring base care as not being
9 processed - being too process-y.
10 CO-CHAIR SUSMAN: I think there is
11 a certain amount of behavior here. How about
12 gap in relationship to outcomes I think we
13 have already covered. Anything further?
14 MS. JAFFE: I guess I wonder if we
15 would have had more submissions of other sorts
16 of these where it was time from treatment to
17 prescription of anti-depressants, would we
18 have a different conversation? We just happen
19 to have only one of them, so I think that is
20 something to consider as well.
21 DR. MANTON: I also think that the
22 topic is important to consider. I mean we are

1 talking about importance to measure and
2 report, and I don't know that the rest of the
3 category will show that it's worth the
4 docking, but I do think that in terms of
5 importance, the measure and report, it's a
6 substantial problem, and I think that whatever
7 we can do to measure the differences that
8 occur because of prompt treatment would be
9 worth looking at. So in terms of importance
10 I think it should be considered.
11 DR. STREIM: For NQF staff, what do
12 we have in the library for measures of
13 substance abuse outcome? Just curious, I mean
14 this is a process measure, so looking at
15 process.
16 DR. WINKLER: There are like two or
17 three. Most of the work we've done on
18 substance abuse has been around practices.
19 I'd have to go back and look. But there are
20 very few, and they are process measures. The
21 Washington Circle measures, and I don't think
22 there is much beyond that.

1 DR. PINCUS: Maybe when we get to
2 the harmonization issues, it seems to me that
3 this is encompassed to some extent by the
4 Washington Circle measures.
5 DR. GOLDBERG: I'm a little
6 obsessed with the outcomes part. This is an
7 intermediate outcome towards some outcome.
8 Why don't we tell them, present the outcome?
9 What's the outcome that this is intermediate
10 towards, and I'd like to consider that
11 measure. You know the problem,
12 micromanagement, like thousands -
13 (Simultaneous speaking)
14 CO-CHAIR SUSMAN: So I hope the
15 measure developers hearing this conversation
16 about where the outcome is. Well, let's go
17 ahead and vote on importance here.
18 Completely?
19 (Show of hands)
20 CO-CHAIR SUSMAN: Partially.
21 (Show of hands)
22 CO-CHAIR SUSMAN: Minimal.

1 (Show of hands)
2 CO-CHAIR SUSMAN: So we are set on
3 that.
4 Let's move on then to scientific
5 acceptability. So I mean just to telegraph my
6 thoughts here I thought that the analysis the
7 analysis at least was presented around things
8 like reliability, validity, was very thin, if
9 at all. And I saw that as an important
10 weakness.
11 Sheila, what were your thoughts?
12 DR. BOTTS: I would probably echo
13 some of your comments in terms of testing.
14 Again it's looking at it as an intermediate
15 outcome, even the relationship to improve
16 their tension. I mean there's a large
17 suggestion, comes from a lot of clinical
18 trials, whether - I think it's whether we have
19 another process or outcome measure, but a
20 comfort level in terms of scientific validity.
21 MR. PELLETIER: The developer
22 actually stated that there was no formal

1 reliability --
2 CO-CHAIR SUSMAN: Likewise, risk
3 adjustment was not considered or suggested.
4 No risk adjustment necessary, which I guess
5 probably you could say there should be a
6 standard that is applicable across types of
7 patients. At least that would be maybe more
8 sellable. But if you are going to do
9 different populations across different
10 programs, that might have an impact.
11 Facts, comments, from the committee
12 as a whole on this?
13 Let's vote then. Completely?
14 (Show of hands)
15 CO-CHAIR SUSMAN: Partially.
16 (Show of hands)
17 CO-CHAIR SUSMAN: Minimally.
18 (Show of hands)
19 CO-CHAIR SUSMAN: And then not at
20 all.
21 (Show of hands)
22 CO-CHAIR SUSMAN: Okay. Let's move

1 on to usability.
2 Again I thought there was just a
3 relative dearth of data.
4 DR. PINCUS: I think there needs to
5 be some effort at harmonization with the
6 existing NQF measures, because I think they
7 may in fact encompass and be better than.
8 DR. BOTTS: The notes here say
9 that there are no similar or related endorsed
10 or submitted measures. Is that accurate?
11 DR. WINKLER: I would have to look
12 at the details of the Washington Circle
13 measures. Those have been endorsed. I'd have
14 to look at the details on them actually.
15 DR. PINCUS: Initially for those --
16 the initiation is essentially looking at going
17 from identification to risk assessment.
18 CO-CHAIR SUSMAN: Other thoughts in
19 this one looking at the Washington Circle?
20 MS. BOSSLEY: Let me read it out
21 loud. Because I don't think you can read
22 it.

1 CO-CHAIR SUSMAN: No.
2 MS. BOSSLEY: So it's the
3 percentage of adults aged 18 and over
4 diagnosed with AOD abuse or dependence and
5 receiving a related service to initiate
6 treatment, assessment of the degree to which
7 members engaged in treatment with two
8 additional AOD treatments within 30 days after
9 initiating treatment. So it's two pieces:
10 initiation and then within 30 days.
11 DR. BOTTS: So the second piece -
12 so the first piece is the number - anyone who
13 is diagnosed and received the related service
14 and initiates treatment, so just that, the
15 number. And then the second piece is how many
16 days to additional treatment within 30 days.
17 CO-CHAIR SUSMAN: Okay, so there is
18 at least some overlap at a broad level,
19 whether you think it's important for this
20 particular focused measure or not, I think, is
21 again up to the group. Any other comments on
22 usability?

1 Then let's move on to vote.
2 Completely?
3 (Show of hands)
4 CO-CHAIR SUSMAN: Partially.
5 (Show of hands)
6 CO-CHAIR SUSMAN: Minimally.
7 (Show of hands)
8 CO-CHAIR SUSMAN: Not at all.
9 (Show of hands)
10 Okay, let's move on then to
11 feasibility. Do you want to start off, Luc,
12 and tell us your thoughts about feasibility?
13 MR. PELLETIER: I think what I said
14 here is, performance is limited to a group in
15 a city. Current system features aren't well
16 described; didn't really get a good sense of
17 how burdensome this is.
18 CO-CHAIR SUSMAN: Sheila.
19 DR. BOTTS: I thought it seemed to
20 be fairly straightforward in terms of getting
21 the time to treatment within a system, so it
22 seemed that the data would be readily

1 accessible, the data in the lab, the
2 methodology.
3 CO-CHAIR SUSMAN: Yes, I guess from
4 a sort of face validity standpoint it sort of
5 made sense that this would be relatively
6 feasible to do, but there were no real data.
7 This is basically one system's ability to do
8 this, and whether it transfers to other
9 settings I think is unknown.
10 DR. PINCUS: I would think for the
11 most part it's a large system, it would be
12 very difficult, because you have to combine -
13 it's based on hours, and I don't know the time
14 for figuring out the hour of dosing from the
15 time - you know, you couldn't use claims --
16 CO-CHAIR SUSMAN: So issues of
17 confidentiality. Other concerns, questions,
18 comments.
19 DR. MANTON: I guess I would
20 suggest that they look at doing a research
21 study first, because it doesn't make sense to
22 me to look at the time to actual treatment

1 without knowing that it makes a difference.
2 So I think what I'd recommend is that they do
3 a research study, come back with what that
4 shows them, and then look at outcome measures.
5 CO-CHAIR SUSMAN: The measure
6 developer does note that data is easy to take
7 as long as data entry occurs in a timely
8 manner; data needs to be entered into the
9 database to do accurate tracking and efficient
10 workflow, which sounds to me like a separate
11 process; it does not occur as a routine part
12 of care if you will.
13 Okay, if there aren't any other
14 comments then let's vote.
15 Completely?
16 (Show of hands)
17 CO-CHAIR SUSMAN: Partially.
18 (Show of hands)
19 CO-CHAIR SUSMAN: Minimally.
20 (Show of hands)
21 CO-CHAIR SUSMAN: And then not at
22 all.

1 (Show of hands)

2 CO-CHAIR SUSMAN: Okay, then let's

3 go on and vote, how many of the group would

4 recommend yes, adoption of this.

5 (Show of hands)

6 CO-CHAIR SUSMAN: How many would

7 recommend no?

8 (Show of hands)

9 CO-CHAIR SUSMAN: Any abstentions?

10 Any public comments?

11 I want to thank the measure

12 developer. I think everybody is very

13 supportive of the concept here, I think there

14 are some suggestions about how to go from

15 where you are. It really would be possible,

16 I think, for us to move on to more of an

17 accountability measure by looking at ultimate

18 outcomes for tension and treatment.

19 Let's see the next one, same

20 developer, yes, well, let's go. Percent of

21 eligible patients who transfer.

22 MEASURE OT3-017:PERCENT OF ELIGIBLE PATIENTS

1 WHO TRANSFER FROM A SUBSTANCE ABUSE PROGRAM
2 TO A CONTINUING CARE PHYSICIAN FOR ONGOING
3 BUPRENORPHINE MAINTENANCE THERAPY
4 MR. CORBRIDGE: So we are moving on
5 down to #17, Percentage of Eligible Patients
6 Who Transfer From a Substance Abuse Treatment
7 Program to a Continuing Care Physician for
8 Ongoing Buprenorphine Maintenance Therapy.
9 The description reads as follows:
10 percent of adult patients aged 18 years or
11 older who meet eligibility criteria to
12 transfer from a substance abuse treatment
13 program where they have been induced,
14 stabilized on buprenorphine, and received
15 counseling services, to a continuing care
16 physician in the community who will continue
17 the patient's buprenorphine treatments and
18 will provide other mental health and
19 social/medical services.
20 Numerator statement reads: the
21 percent of adult patients who began
22 buprenorphine treatment at a substance abuse

1 treatment program who upon stabilization, on
2 buprenorphine, and upon meeting transfer
3 eligibility, ensured stable negative urine
4 drug screen, responsible with prescription
5 handling, transferred buprenorphine to health
6 care services to a continuing care physician
7 in the community.
8 The denominator statement reads: all
9 patients who were inducted and stabilized on
10 buprenorphine in a substance abuse program,
11 and to meet the transfer criteria. The
12 transfer criteria are stated as: ensured,
13 stabilize, negative urine drug screens,
14 responsible prescription handling. Regardless
15 of whether they ultimately transferred their
16 care to a continuing care physician in the
17 community or not.
18 CO-CHAIR SUSMAN: So again I guess
19 you could ask is this a patient related
20 outcome. Their tension and treatment, we
21 probably will have the same set of issues.
22 DR. PINCUS: transferred. Why is

1 somebody needing a transfer?

2 CO-CHAIR SUSMAN: Should we ask the

3 measure developer if they are on?

4 DR. HENNESSEY: Is what we are

5 talking about then is an outpatient substance

6 abuse treatment program where say someone who

7 is a nonþphysician has assessed someone as

8 potentially benefiting from this medication,

9 and so now the person is being referred to a

10 physician who has this expertise; is that what

11 we are talking about?

12 CO-CHAIR SUSMAN: And other

13 appropriate services is what I understand this

14 measure.

15 MS. JAFFE: I understand it that

16 they are in a specialty substance abuse

17 program, probably being treated by a

18 physician, and they met some criteria so that

19 they no longer need that level of care and can

20 return to primary care.

21 DR. HENNESSEY: Okay, thank you.

22 DR. PINCUS: -- necessarily a path

1 to outcomes for everyone.

2 MS. JAFFE: I would think that it

3 might be more a reflection on the comfort

4 level of the primary care physician and not

5 so much on the patient.

6 CO-CHAIR SUSMAN: Well, I mean the

7 description is patients able to continue and

8 receive maintenance therapy, convenient office

9 setting, other somatic and mental health

10 services, mitigating relapse, continuing care

11 physicians are able to take care of already

12 inducted and stabilized uninsured patients.

13 Their practice office settings do not need to

14 be altered to accommodate time consuming and

15 sometimes difficult and/or uncompensated

16 induction protocols, waiting room disruptions,

17 yada yada. And three, the stable patient

18 condition out of the publicly funded treatment

19 slot and substance abuse program, a new

20 patient in need of service is able to enter

21 the program.

22 DR. MANTON: It sounds like a

1 system as opposed to a provider outcome.
2 DR. HENNESSEY: It sounds like a
3 utilization outcome to me.
4 DR. ROCA: I could certainly see
5 that it could be a quality outcome if the
6 treatment program made the determination that
7 this is somebody who is appropriate for
8 maintenance treatment, then I think it would
9 be a responsibility of that program to do
10 whatever they could do to ensure that they got
11 into the next stage of treatment which would
12 include maintenance. Presumably not everybody
13 is a candidate for this, and I'd be interested
14 in what the eligibility criteria were. But
15 presumably the eligibility criteria would
16 include being appropriate for more of a long
17 term maintenance buprenorphine treatment that
18 might involve other treatments as well.
19 DR. GOLDBERG: But this has
20 something to do with getting out of a
21 specialized treatment system to a primary care
22 patient system -

1 (Simultaneous speaking)
2 DR. ROCA: But with an appropriate
3 provider.
4 DR. GOLDBERG: Even with the
5 appropriate provider, I mean conceivable to me
6 they may make their transition and then drop
7 out after a week. So I don't know what the
8 outcome is, just to say that we got rid of
9 some people, we transferred some people to the
10 primary care system, is an ambiguous outcome
11 to me.
12 DR. PINCUS: That's basically the
13 equivalent of saying that someone who is used
14 to being seen at special a mental health
15 center got transferred to a primary care
16 provider. It may be appropriate for some
17 people, but I don't see how it's relevant --
18 MR. PELLETIER: The way I read it
19 was that she was describing a community
20 standard that someone is inducted, they go to
21 maintenance to a person who is familiar with
22 this medication and has gone through the

1 training to medicate this person; that's how
2 I read it.
3 DR. PINCUS: Right, but what is the
4 counterfactual this person remains in the
5 substance abuse treatment program.
6 DR. ROCA: Or is lost to treatment.
7 DR. PINCUS: Right but that's --
8 MS. JAFFE: I thought I read
9 something in there that you move them out of
10 the specialty so you can make room for a new
11 person.
12 CO-CHAIR SUSMAN: I mean this is
13 from a perspective of a community health
14 service agency and what their goals are to get
15 patients induced and then get them into
16 ongoing care and a whole range of services.
17 Now whether that's an appropriate outcome
18 measure or not, I think, is the first point
19 here. Is this in scope or not.
20 DR. STREIM: I am not a substance
21 abuse subspecialist, but however, I would
22 wonder how many primary care physicians have

1 done the training, paperwork, have the special
2 DEA number which you need for this. I happen
3 to know this, because I actually got this
4 training. I have never actually prescribed
5 buprenorphine, because I do geriatrics, and we
6 don't have too many of those patients. But
7 the question is, how many primary care
8 physicians in the entire United States do you
9 think are actually eligible to prescribe, and
10 is that a common enough phenomenon in any
11 sector of our health system that this would be
12 an efficiency in health care utilization that
13 we would want to measure in a nationally
14 reported measure? I don't know the answer,
15 but I think that is an important question.
16 DR. MANTON: Actually I think a lot
17 of primary care physicians can prescribe
18 buprenorphine.
19 DR. ROCA: I don't know how
20 widespread the utilization of this would be,
21 but if you were a substance abuse treatment
22 program that might not be an unreasonable

1 thing to expect.
2 DR. BOTTS: I would agree, and I
3 think you kind of get at the heart of the
4 issue is that you have a drug treatment system
5 that is highly regulated both from the patient
6 standpoint and the provider standpoint, and
7 things can potentially get bottlenecked in
8 terms of the turnover. So what you are
9 looking at is efficiency for care, and the
10 numbers involved, the same as large as in my
11 population, no, but for that group it's
12 incredibly important that we do it well.
13 DR. GOLDBERG: I wonder what data
14 there is once they get transferred, how
15 effective the primary care providers who are
16 licensed and eligible, how effective are they
17 at maintaining these people in treatment. Do
18 we know that?
19 CO-CHAIR SUSMAN: I don't know that
20 this necessarily implied primary care. It
21 implied ongoing care, and requires ongoing
22 care.

1 DR. GOLDBERG: Some continuing care
2 providers that are not specialized --
3 CO-CHAIR SUSMAN: A continuing care
4 physician in the community. I think the
5 reality is that a very very small percentage
6 of PCPs are doing this type of treatment.
7 (Simultaneous speaking)
8 CO-CHAIR SUSMAN: In response to my
9 question Ann was saying not so.
10 DR. MANTON: I think that there is
11 a fairly large percentage, and I think
12 probably for just these reasons, that the drug
13 treatment centers are saying, it certainly
14 isn't 80 percent or anything like that. But
15 I bet just as a ballpark I bet there is maybe
16 30 to 40 percent. Maybe it's a regional kind
17 of thing.
18 DR. PINCUS: What evidence if any
19 is that this is proximal to outcomes?
20 CO-CHAIR SUSMAN: So we have about
21 15 minutes. Let's first of all vote is this
22 within scope. Is it in scope? Raise your

1 hand if you believe it's in scope, an outcomes
2 measure. Raise your hands high. Five.
3 Okay.
4 Out of scope.
5 (Show of hands)
6 DR. WINKLER: Eleven.
7 CO-CHAIR SUSMAN: Okay, thank you.
8 That helped catch us up. It is 4:30. We
9 have 15 minutes. I don't know if we want to
10 address the next one which is substance abuse
11 or begin that.
12 I don't know if you want to go on to
13 tomorrow morning's or do you want to stop
14 here?
15 CO-CHAIR LEDDY: This is workgroup
16 four, and Ian has evidently split it into
17 three and two because he thought this is about
18 where we would end, right? So the two that
19 you rated are first thing tomorrow morning we
20 continue with this workgroup, then we go on to
21 workgroup three.
22 CO-CHAIR SUSMAN: So what I'm

1 asking, and I think we are going to argue up
2 our time here, we've got about 15 minutes. Do
3 you want to spend that on the next measure, or
4 do you want to get out and enjoy the beautiful
5 Washington weather and see the cherry blossoms
6 or whatever else is on your agenda.
7 DR. STREIM: I think it is more
8 efficient to do it all at once, because we are
9 just going to have to reiterate tomorrow
10 morning what we discuss in the next 15
11 minutes.
12 MR. CORBRIDGE: Do we want to do it
13 now.
14 DR. STREIM: You mean extend and do
15 the whole thing? That's different if you want
16 to extend and do the whole thing.
17 CO-CHAIR SUSMAN: I think probably
18 starting tomorrow would be the most efficient
19 use of our time. I know if we can have
20 agreement on that we'll just wrap up today.
21 Some key things tomorrow, there is a good
22 overview of discussions today, where we stand

1 in terms of measures that we ended up with
2 moving forward to potential endorsement. Most
3 measures that we discussed recommended might
4 not go forward.
5 Wanted to make a brief note that we
6 will not be in the Brown Rudnick offices
7 tomorrow. We are actually going to be in our
8 offices, which is our meeting floor - I have
9 to send email to everyone, so if you do have
10 access to email. So it is on the 6th floor,
11 however you went to the south side today. Our
12 offices are on the north side. So what you
13 are going to do is, you are going to walk in
14 the building and go to your left, and then you
15 are going to go on the north side of the
16 building, go to the sixth floor, and as soon
17 as you open up the doors you will be right at
18 the NQF offices. We have a similar set up.
19 We are not a lawyer group and so we don't
20 quite have all the plushness of this room, but
21 it should be sufficient tomorrow. And I think
22 one of the main reasons we are moving is that

1 we do have access to a working phone which
2 will be much more helpful in facilitating the
3 process.
4 Just to clarify again, you will go
5 in the same entrance right on 13th Street, and
6 you will go to the north side, which will be
7 turning to your left. You can ask the
8 security guard or the concierge down there if
9 you need any help with that.
10 I want to thank everybody for their
11 hard work and forbearance, and look forward to
12 seeing everybody tomorrow morning.
13 (Whereupon at 4:34 p.m. the
14 proceeding in the above-entitled matter was
15 adjourned.)
16
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