National Quality Forum

Moderator: Suzanne Theberge
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Operator: This is Conference #: 16880742.

Operator: Welcome everyone. The webcast is about to begin. Please note, today's call is being recorded. Please standby.

Suzanne Theberge: Hello everybody. This is Suzanne Theberge with NQF. Welcome to the Pediatric Performance Measures Projects Post Comment Call. We are here today to discuss the comments received on the side of Pediatric Measures.

Thank you everybody for joining us.

We're going to start first very briefly with the usual or housekeeping items. As you all know, this is both streaming and on the phone. So committee members if you wish to speak, please make sure that you are dialed into the phone so that we can hear you and if folks are on the phone and the Webinar, please do turn the sound off on your computer so we don't get feedback.

We also do request that, folks, do not put us on hold so we don't hear your hold music and also if you're not speaking if you could unmute that would be appreciated as well.

So, that's all of our general housekeeping and I'm now going to a quick roll call so we know who is on the call. And then I will (test) the agenda.

All right, next slide please.

- All right. Next slide to the committee listings. (Lauren Agoratus), are you here?

(Lauren Agoratus): Yes.

- Suzanne Theberge: Great. And (Martha Bergren)? James Bost?

(Off-Mic)

- Suzanne Theberge: (Tara Bristol-Rouse) there?

- (Tara Bristol-Rouse): Present.

Suzanne Theberge: Thank you. (John Brookey)?

(John Brookey): I'm here.

Suzanne Theberge: Great. (Karen Dorsey)?

(Karen Dorsey): I'm here.

Suzanne Theberge: Thank you. James Duncan?

James Duncan: I'm here.

Suzanne Theberge: Thank you. (Maureen Ediger)?

(Maureen Ediger): I'm here.

Suzanne Theberge: Thank you. David Einzig? Deborah Fattori?

Deborah Fattori: I'm here.

Suzanne Theberge: Thank you. (Kerri Fei)? (Jonathan Finkelstein)?

(Jonathan Finkelstein): I'm here.

Suzanne Theberge: Thanks. Karen Harpster?

Karen Harpster: I'm here.

Suzanne Theberge: Thank you. (Amy Houtrow)? (David Keller)?

(David Keller): Present.

Suzanne Theberge: Thank you. (Kraig Knudsen)?

(Kraig Knudsen): I'm here.

Suzanne Theberge: Thank you. (Susan Konek)? (Marlene Miller)?

(Marlene Miller): Here.

Suzanne Theberge: Thank you. (Jill Morrow-Gorton)? Virginia Moyer?

Virginia Moyer: I'm here and I cannot see anything on my screen.

Suzanne Theberge: OK. We've got a slide hold up with the committee list. (John), can you take a look on the back end?

(Crosstalk)

(John Brookey): Someone can just e-mail me the slides.

Suzanne Theberge: OK, we'll do that. OK. Ricardo Quinonez?

Ricardo Quinonez: I'm here.

Suzanne Theberge: Great. (Jeff Schiff)?

(Jeff Schiff): Here.

Suzanne Theberge: Thank you. (Kevin Slavin)?

(Kevin Slavin): I'm here for as long as I can.

Suzanne Theberge: Great. Thank you. Carol Stanley.

Carol Stanley: I'm here.

Suzanne Theberge: Thank you. (Jeff Susman)?

(Jeff Susman): Present.

Suzanne Theberge: Thank you. (Jonathan Thackeray)?

(Jonathan Thackeray): I'm here.

Suzanne Theberge: Great. (Kit White)? OK. And did I miss anyone?

James Bost: James Bost.

Suzanne Theberge: OK, great. So the good news ...

(Jill Morrow-Gorton): And this is (Jill Morrow-Gorton). I was not connected to the (inaudible) and so – after you went by my name.

Suzanne Theberge: OK, great. OK. So, the good news is that we are at (forums), which means that we will do voting on this call today and we will be going over how to do that in a couple of minutes.

But first, I want to just quickly go over the call agenda for the day. So, we have three items to accomplish today. And the first is to discuss the comments that we received. The second is to revisit the measure, which is consensus with not reached during the committee call or the committee in-person meeting. And finally, to review to request for reconsideration.

And next slide please.

Before we go over the voting software, I wanted to just briefly highlight what we did receive during the comment period. We received 45 comments from three different organizations. In general, the comments that we received were supportive of the committee's recommendations. The comments generally agreed with what you had version on about the measure measures. And so, in those cases, what we are proposing, as a committee response, is just thank you for your comment.

Several of the comments were directed towards particular questions about the specifications and we have asked the developers to address those comments

and they have done so in the comment in response table that we sent last – earlier this week.

And the developers are on the line today, so if you do have any questions either about their responses or something else that came up in a comment that you'd like them to address, please let us know and we'll direct those questions to them.

Staffs have identified three comments in particular that we felt needed to the committee's discussion because the comments specifically ask for the committee to discuss further. But other than that, we work by exceptions, so we didn't pull out any of the other comments in particular to discuss.

So, if you have a comment that you would like us to address, we will a section for that and please do bring it up and we'll discuss it.

So next, I will turn it over to (John) and (Severa) to talk us through how we're going to be voting on today's call.

(Severa): Thank you so much, Suzanne.

Carol Stanley: So, (Severa), do you have some specific information before we (test out) the voting software?

(Severa): (Sorry), I'm not really. We just want to make sure that every committee member is on the web because that's how we would be voting today. (Sorry), it will to help Dr. (Mauer) with her slides.

Carol Stanley: We can certainly double-check on some other things in just a minute with Dr. (Mauer).

(Severa): Thank you.

Carol Stanley: Perfect. So, as we approach our vote today, you will see – initially, the question will appear in a static image on the slide as you see it here.

Ones we get to the point for committee members only that are voting, we will (advance) to the voting slides. You'll see those options appear with a small

box next to each of the letter options. Voting members only will click in the box next to the answer of their chose and the NQF staff (wealth) and project team will see those numbers populate in real time and be able to give feedback on the vote.

You'll have, obviously, an opportunity for several seconds to click the box. Should you need to make a change in your response, you can simply click the other box and it will take a second and move your vote over.

So, if we could have all committee members, click in the box next to the answer of their choice now.

Suzanne Theberge: And do we have any committee members who are on the phone only? Who are not connected via webinar?

(Mauer): I can't see the voting. This Dr. (Mauer).

Carol Stanley: OK. Dr. (Mauer), we're going to get you some assistance here privately in just a second once we get through the housekeeping. You may want to try to refresh your session and same thing goes for other committee members. If the (boxes) ever failed to appear for you, you can simply refresh you session by pressing F5 or Command-R for a Mac.

And it looks like we are right on with our numbers, we have 21 right now and of course Dr. (Mauer) can't see that, so that would be our 20th vote, so we're good so far with what we have (members) on the screen (for).

Suzanne Theberge: OK. Do we have any other questions or anything before we dive into the call content?

Carol Stanley: Excellent. We're going to pull Dr. (Mauer) out privately and troubleshoot with her and then she'll be back in the conference.

(John Brookey): This is (John). Is there a way for people to raise their hand electronically? Or how are we going to sort of recognize people that want to talk?

Suzanne Theberge: There is a way to raise your hand.

(John Brookey): I see it. It's on the upper-left.

Suzanne Theberge: Yes. (Roden did you) see it?

(John Brookey): Yes.

Suzanne Theberge: I've just raised my hand. OK.

(John Brookey): Great.

Suzanne Theberge: Excellent. All right, great. So, (John), I will turn it over to you to begin the discussion about the comments we received.

(John Brookey): OK, with a lot of help from the staff.

So, I thought it would be helpful if we just refresh our memory up the measure. I wonder if we can pull up the actual measure and just review it together just briefly.

Suzanne Theberge: This is measure 2803 to (buckle), use and help with (pretty among at present). And we'll just pull that out there.

(Severa): Suzanne, we want to pull out 2803.

Suzanne Theberge: Yes, the measures (forum).

(Severa): OK. We're just pulling it up right now.

Suzanne Theberge: OK.

(John Brookey): And maybe while we're waiting for that, we can just quickly go over the eligibility for endorsement. So, if one of you, Suzanne, can talk about which ones are absolutely required for passing, starting with essence and so forth.

Suzanne Theberge: Sure. So, this measure was recommended during the committee meeting and just as a committee reminder, the criteria there must pass our (importance and try the) acceptability, which is the reliability and validity piece. (Use) in usability and case ability are not must-have criterion and there's the overall recommendation for endorsements.

As you all might recall, we do have consensus not reached status, so a measure must reach 60 – greater than 60, so 60.01 of the committee must vote to recommend or must vote yes or higher moderate for a measure to advance any vote percentage between 60 and 40 inclusive of both 60 and 40 if the consensus is not reached, which we (didn't) have one measure with that status and then anything below 40 with inclusive of 40 is not recommended.

(John Brookey): Great. OK. So, we have the measure on the screen now so people can review that quickly and this was one that we did recommend to move forward.

(David Keller): This is (David Keller). I'm sorry, I'm a little confused. We did recommend it but we didn't have consensus. Is that what I'm hearing?

Suzanne Theberge: I'm sorry that it is confusing. No, you or the committee did recommend this measure. I was just going over the different statuses. There was another measure that was consensus not reached, which we'll be discussing in a little while.

(David Keller): OK.

Suzanne Theberge: The reason – yes, the ...

(David Keller): I'm sorry. Got it.

Suzanne Theberge: Yes, sorry for the confusion. The reason that we're bringing this one up is that there was a comment raising some concerns about the measure and the comments are requested that the committee will re-discuss some of these issues. And we do have a slide with that comment, which we can also pull up.

(Crosstalk)

(John Brookey): Right. So, if everybody says take a quick look at the brief description, we can just go through the comment number 5532 and we can read that finally as supposed.

And remind you, for the developer, do we (have) that the (e-cigarettes) added into the measure?

Suzanne Theberge: I believe it was not a – go ahead (Roden).

(Lauren Agoratus): You have suggested that going forward, they consider doing that.

(John Brookey): OK. But it was not added to – we did not change the measure. Is that correct?

(Lauren Agoratus): No, the committee can't change the measure.

(John Brookey): Right.

(Lauren Agoratus): But you did recommend in future (alterations) and the developer indicated verbally that, you know, that was something that they would look as the measure moves forward and (fill the advances).

(John Brookey): Right.

Suzanne Theberge: Yes, I think they were waiting. They proceed not doing anything until there're clear clinical guidelines regarding (e-cigarettes).

(Lauren Agoratus): Right.

(John Brookey): Right.

(Lauren Agoratus): Their question for the committee really is whether you want to just stand by your position having considered the comments or not.

(John Brookey): Right. Now, I can't see the whole listed names, there's somebody going to be watching for people who are raising their hands because I can't see everyone's names or maybe you can pull that down so we can see the whole list, consolidate if you have that.

Suzanne Theberge: But I think if someone raises their hand, they should pop up to the top list.

(John Brookey): They pop up.

Suzanne Theberge: Yes, it's right though.

(John Brookey): OK. Very good.

(Crosstalk)

Suzanne Theberge: (Karen Dorsey) has raised her hand. (Karen), go ahead.

(Karen Dorsey): I was actually just testing but I did have, well, just one point of clarification which is that (my question) on conversation was that we did talk about (cognitive) measure in the context of the measure that's already in meaningful use and so we consider that and discuss it in prior to our – to recommend the measure.

Suzanne Theberge: Yes.

(John Brookey): Did I see another hand? Was that (Jonathan) who raised a hand?

(Jonathan Thackeray): That was me, you caught me testing as well. I'm sorry.

(John Brookey): Do you want to make a comment?

(Jonathan Thackeray): I don't, sorry.

(John Brookey): OK. Right. So we did this discussion and I think that we all felt it with an (important) enough measure to move it forward as is.

So, I guess the question will be, "Is there any discussion about pulling back on our recommendation or if there are any discussion about going ahead with our recommendation to endorse?"

(Jeff Susman): I have moved – this is (Jeff Susman) – that we just endorse it as we could formally decide it. I will not change our decision.

(John Brookey): OK. Any other comments, (David)?

(David Keller): Only that I'll second that motion. I can't see that this comment means we should change it.

(John Brookey): OK. Any other comments before we go to – I guess, we're going to vote. Is that right, Suzanne?

Suzanne Theberge: We actually don't need to vote on this kind of question. We just tackled this draft – the response based on what you've said and we'll have a final response for that comment there.

(John Brookey): OK. So, is there any objection to maintaining our position of recommendation?

So, there's no objection, so I guess it will stand.

The next measure is 2802 over (ES) for damaging for the evaluation of children with posttraumatic headache and we had a lot of robust discussion about this measure if we can just pull off the measurement description.

I believe this was the issue of being too specific for headache and not just all of head trauma in general, where we know that there's a lot of overuse of imaging and I think that was probably primarily the reason this didn't get recommended.

Suzanne Theberge: So the comment in which folks should be seeing on the screen had just raised some concerns about the lack of testing and whether the measure get up or should continue to work on their measure, and so we just wanted to bring that issue to the committee and see if you had any further comment as they've requested.

(David Keller): So, I guess – this is (David Keller) again. I'm sorry, I'm not clear. I think that's what we said that this measure needed work.

(John Brookey): Right.

(David Keller): So, either decision that we need or anything else we need to say besides, I mean, that was one of the options for the vote that I recall. I think it was, you know, accept or not accept. We didn't vote meeting continued work.

Suzanne Theberge: That's correct. Yes, you know, the comment said, you know, we request further committee discussion so, you know, we're bringing it back to you all. And you are correct that, you know, the measure needs more work, it's not an

option for voting but you, as I recall, correctly did make some recommendations for changes to the measure.

(John Brookey): Right so ...

(Crosstalk)

(David Keller): Well, go ahead.

(John Brookey): Yes, so – we're able to actually bring up the measure so we can all read it just to make sure that we know what we're looking at 2802. We're looking at the comments not the measure.

I can't tell if somebody is looking that up or Suzanne.

Suzanne Theberge: (Severa), are you pulling that up?

(Severa): Yes, we're pulling that up.

(John Brookey): OK. I just want to make sure before we move on that (we are all just) crystal-clear.

(Severa): I did see a couple of raised hands.

(John Brookey): Is that (Jonathan)?

(Jonathan Thackeray): Yes, I'm going back to my recollection of our meetings and there were two kinds of concerns as I was sharing the conversation. One would technical concerns about the numerator and denominator. So, I personally felt you were being too hard on the measure and maybe not quite understanding the map and (inaudible) the concerns that carried the day, that day (was that proceed). It applied to the very, very small and maybe somewhat (does our) population that is people with head trauma who didn't complain it's headache, which is tiny and the developers (inaudible) to do a measure about headache and that's why we ended it up here.

So that consist my question, which if we thought technically the measure was OK, is the fact that it applies to a very small group of people at least not to

endorse it or do measures that applied to very small groups of people get endorsed and does not use very much.

(John Brookey): Right. And somebody has raised their hand up. I can't see who it is. Ricardo?

Ricardo Quinonez: Yes. So, my understanding is that the biggest concern with this was that this would be interpreted as the measure for overuse of imaging in kids with head trauma where it's clearly a problem in whether the developers we're trying to develop something that they were directed to develop, you know, is I think secondary to the fact that this would be interpreted as a head injury measure, where there's a bigger problem and this limits the population to the point that it would be meaningless.

So, I think that is still an overarching concern that we all had, and I know I certainly do, that makes it to me not want moving it forward.

(John Brookey): Right. (Jeff)?

(Jeff Susman): Yes, my concerns from before remain because the way this was (transitional to use) measure, it gets you into a very small denominator without adequate testing. I think the validity of this measure still remains in question and the training is something that just can't be fixed. I mean, it is what it is and it was in certain ways (dimmed) from the beginning because the way it was framed by the supporter of the measure but I still don't think we should be approving this measure, I still think it fills that validity level and that would uphold our – (I would agree that) it pulls our previous decision.

(John Brookey): Thank you. (James)?

(James Bost): I just wanted to (ask the reunite) our concern about this being a chart review and very intensive measure to do and that they were many comments that we might not adequately be able to capture denominator and numerator from the charts and that risk adjustment would also be challenging if needed from the charts and some (inaudible) also endorse not changing our decision.

(John Brookey): Right. And I think we may have some comments to the effect that they broaden the population to include all head trauma, which is a more likely coded diagnosis that you'd have a much larger denominator and probably could – to run the measure administratively as supposed to having a lot of chart review. So, I think our conversation is going to all coming back to us now.

Any other comments?

Any one who want to propose that we accept the measure as is or the recommendation to not recommend?

(Jeff Susman): I mean, I was moved again, like we pulled our previous decision.

(John Brookey): Any objection to that? Great. So, we will keep it as is, not recommended.

Could we pull up the next measure? The measurement description for 2805, which is, "Pediatric Psychosis timely inpatient psychiatric consultation"?

(Severa): We're pulling it up.

(John Brookey): OK. Here we go.

So, this was a measure that we did not recommend and actually I don't have in front of me – on (a lot) basis, do we not – which element that did not pass?

(Severa): This measure did not pass evidence.

(John Brookey): OK.

(Severa): I'm just pointing up the report here to analyze the committee's discussion.

(John Brookey): OK. You can leave that up and I'll just sort of read out loud the comments. (One), comments are more information about the committee's rationale that we support the committee's deliberation but encourage further committee discussion or clarification on a rationale provided, specifically, whether it could be operationalize in less specialized hospital setting such as general hospitals that are not pediatric specific.

The vulnerability of this population should be considered when applying assumptions that have the ability to (operation-lifetime) the consultation. Further, we would like the committee to revisit their rationale at not moving this measure forward because some hospital settings may not have electronic health record. This rationale could be irrelevant to whether previously endorsed measures.

So, we're being – excuse me.

Suzanne Theberge: We're getting some background noise.

(Crosstalk)

(John Brookey): Sorry. That's my phone going up.

(Severa): I like your ring.

(John Brookey): Yes. So, we're being asked to revisit this issue and if you want to go and pull that comment up it hopes to look at it.

(Severa): And while that's happening, I'll just refresh your memory. This measure did not cast evidence but it was – there was some interest in looking at the insufficient evidence with exception and then when you voted on the exception it didn't (pass) at that point.

(John Brookey): Right.

(Severa): It's marginally based on the consensus of experts and I think that was one of the concerns and there was some conversation about the set specifications as well.

(David Keller): Yes, this has got my hand up so...

(John Brookey): Hi, (David).

(Crosstalk)

(John Brookey): Go head.

(David Keller): Yes, the other thing I think we were also concerned about arbitrary time dimensions that there wasn't evidence connecting that time dimension, which I'm trying to remember was that 24 hours or 48 hours or something like that that they had to do the consultation within.

Suzanne Theberge: Yes, it was 24 hours.

(David Keller): Twenty-four hours. There wasn't evidence linking that to any kind of outcome and so it wasn't clear to us that this – what we all thought having a psychiatrist involved was a good idea that the arbitrary need nature of the time dimension seemed that it was something I remember discussing through anything (there).

(John Brookey): Any other comments, (Jill)?

(Jill Moro): So, I want then to kind of add on to what (David) said. Clearly, I think the time issue was an issue – I think the other issue is without the evidence that this actually makes a difference, it has the potential to add a huge amount of class and a huge amount of hardship to areas where child psychiatry is not as readily available and it seems unfair to do that when there's not an evidence-based that this actually makes a different in terms of outcome or treatment.

(John Brookey): Yes. And that actually is what the comment here is addressing, right? It's asking if whether or not that is a reasonable rationale and what I'm interpreting this to be as at, this should actually drive the smaller hospitals to have systems and place to accommodate the situations.

So, it's kind of the balance between those two and I hear what you're saying.

Somebody else has their and up but I can't see it.

Ricardo Quinonez: It's me Ricardo Quinonez.

So, this is the second comment that I'm kind of seeing where the association or the group commenting is addressing something that we secondarily or was not our overarching concern as to why not to move the measure forward, you

know, that the biggest issue with this measure I think was with the lack of evidence and they don't specifically address that in their comments.

If it that wasn't very clearly stated or I'm just kind of confused whether sort of hanging onto – through the secondary concerns and their comment doesn't really address our primary concern which was the lack of evidence.

(John Brookey): I agree.

(Severa): The comments are free to adjust as they will. I just want to clarify that.

(Off-Mic)

(John Brookey): (Kevin)?

(Kevin Slavin): Yes, my only other comment on this was in addition to the arbitrary time stamp or (di-seemingly) arbitrary time stamp. There's also a – it varied within the measure. There is an inclusion or an opportunity for some (wobble) around the 24 hours, around some (undefying) reason why somebody might not be able to complete the consolation within 24 hours to made me a little – that maybe a little bit problematic for the measuring part.

(John Brookey): (Jeff)?

(Jeff Susman): I would move that we uphold our previous decisions. It sounds to me like there's no real (substrative) new angle – and the committee, generally, doesn't see any change so I think we should just go ahead.

(John Brookey): Somebody else's (raised) hand by chance, so who it is?

(Kevin), do you have any comment or Ricardo?

(Crosstalk)

(Kevin Slavin): I'll put my hand down, sorry.

(Ricardo Quinonez): The only thing perhaps is just that in the feedback that we provide to the people who commented because I believe said that we do that is just to remind

them that that while they may raise some interesting that wasn't the overarching concern.

(John Brookey): I agree. (Jonathan)?

(Jonathan Thackeray): I'm not pushing hard to reconsider. We didn't move forward most of the mental health measures and I just have this concern that the evidence standard is just not going to be there for behavioral health in the same way. And that's why we went on the perception (road) and I'm also a little worried about the rationale that the fact that a measure will be hard for some people to meet is what you said, is motivation for health system to change and quality measures are supposed to call them as they seem and if you're at in institution that can't do this and by consensus if not evidence, this is considered the measure of quality, you have a lower score on that measure of quality.

So, I understand all of the (counter billing) opinion here and I'm not pushing hard but I just want to make sure for mental health measures the kind of evidence we'll have will always be different.

(John Brookey): Yes, and I don't recall maybe the developers on the line. Did they allow for virtual consults – I forgot whether that concluded in the specs.

(Severa): Hi. This is the developer, yes we did allow for (inaudible) healht.

(John Brookey): OK. So that kind of give to the system's issue that the question would be – you're right, we didn't pass an evidence by getting to the (actual) comment, which maybe was not addressing that we need to move forward. Still that's asking the question of whether a measure should push every hospital on the country to be able to provide some level of support here and it can be done virtually. (Jill)?

(Jill Moro): I actually would like to disagree with that. I think yes, absolutely. If there's a measure that there's some evidence that is in fact the quality thing to do then absolutely we should push people to do it.

I think a measure that has – the only evidence is consensus guideline. Consensus is the weakest form of evidence. And something that has to do

with sort of virtually changed the system completely without evidence that it is in fact going to improve care.

I think they need to go back and do the research and identify whether or not this does in fact improve care.

(John Brookey): OK. (Jeff)?

(Jeff Susman): Yes, I think that it is important, whether it's a mental health standard or not in having – (come from) behavioral (inaudible) side to this committee.

I believe we have to do just what's suggested. We have to demonstrate that any given intervention as an (inputs) on important outcomes that matter to the patients and this wonder wasn't (that) underlying evidence, so without that, if you're going to face everything on a hunch or expert opinion, I think we're getting away from what the standard should be particularly when we have the ability frankly to influence the entire healthcare measurement of systems nationally.

So, we have a (storage) of responsibility to make sure that we're resourcing and supporting measures that truly affect patient outcomes, without that I believe (inaudible) this situation (you'd meet the) right decision.

Ricardo Quinonez: This is Ricardo. Just a point of clarification at the – if I heard correctly, feasibility which is this sort of idea that if it's hard we shouldn't stop the measure, that's not a must-passed. Isn't that correct?

Suzanne Theberge: Yes, that's correct.

(Jeff Susman): So then, it really shouldn't be a concern. It's not a must-passed, we can't pass measures that are hard to measure to try to make systems better. But the corollary to that is that by not passing measures that have weak evidence, we're also encouraging the developers to develop better evidence and pushing in that way.

So, I think that's right decision.

(Janine): This is (Janine). I can't raise my hand because I can't get on the webinar. But I would like to add that it's not just that we're encouraging research anytime we set about requiring something for which we have only weak evidence. We ran a very real risk of requiring something that's the wrong thing to do.

(John Brookey): OK. (David)?

(David Chellar): Yes. So, I guess, I was going to echo (Jonathan's) comment earlier, though, that this going to be an ongoing challenge in mental health world, is that the evidence for much of what we do (inaudible) that is I'm wondering and I was wondering, every member wondering this at the time whether this is, you know, is this a reasonable standard that would encourage people to think about standardizing their methodology around the treatment of children with mental health problems.

And, you know, it might got level where I remember when I first look at it, I thought that it was – I think I was persuaded that the evidence for outcomes was weak but the evidence for outcomes of much of what we do is no stronger than this.

So, then it becomes a question in my mind about whether encourage (you) to measure is worth it. And that's where I think I was one of the people (who's) pushed to the exception (inaudible) so little as being measured in mental health. And it's a big (trunk) of pediatric admissions.

So, I'm concern that if we don't pass it then nothing is getting measured and that's – it gets own set of problem.

(John Brookey): Suzanne, do we have the (inaudible) what we're talking. Look at the list of the measures if any of the mental health measures move forward. I don't have them in front of me. And what ...

Suzanne Theberge: Yes, that one of the slides, if we could pull out slide five has the list of recommended measures.

(John Brookey): So the first line type of special care. Is it the total list?

Suzanne Theberge: This is all the recommended measures, yes. The next slide has the consensus not reached and not recommended. So, why don't we go to the next slide?

(John Brookey): So (Jill) you have another comment?

00:40:34 (Jill Moro): So, I would just like to address what (David) said. I make bad data worth the no data. But I also want to suggest that a conversation we having up this measure which I understand, only measured kids with mental health disorders. But there are that subset of kids who have a medical cause for psychosis that might or might not be identified within the first 24 hours. And there would be that expectation that you would do with a child site consult for those kids who maybe have Benadryl toxicity or something like that.

So again, I think, you know, we look at the list of other measures I think there maybe other measures that are stronger if we feel really strongly that we need to have a psychiatric measure. And I just think this one is a really – I think it has the potential to harm where we don't really understand whether or not it's a quality activity.

41:43 (David): Right. And I recall the discussion about sort of, temporary psychosis or medication induced psychosis. For the developer, were those children excluded from the specs or are they in?

Suzanne Theberge: So, we provided the list of ICD-9 codes that are used to get into this measure. And they were vetted by psychiatrists on our mental health working group and were deemed to be diagnosis that would be given to children who truly had psychosis. So, but that's all we can say about that. That's how the population is selected for the measure, is using ICD-9 discharge diagnosis.

(Crosstalk)

(David): Yes, so does it help? Because an overdose, it may or may not be coded that way, right, so.

(Jill): Right but those – if you're going to meet that measure, you have a kid who presents to the E.R. with psychosis, you're going to get a psych consult in the first 24 hours.

(David): Yes.

(Jill): So, that your measure measures after discharge is irrelevant. You are still going to drive getting a child psych consult for that segment of children.

(David): Right, right, that's how it's part of our ...

(Jill): You don't know it upfront that it's a medical cause or a psychiatric cause.

Suzanne Theberge: That's true, and I think our mental health working groups sought that the benefits of this measure outweighed the risks of that possible misclassifications.

(David): (Merlyn).

(Merlyn): I just want to say, I think we're on a slippery slope because I (sew) some conversation at some of conversation at some of the (leaning), and though we haven't had a psych measure, maybe we should do it. And that wasn't our job. Our job was to evaluate the measures that we think are worthy of moving forward, not necessarily just to make a psych measure. So, I think, you know, we still need a lot of evidence here and I just don't want to have to go down that path which is not what I was tasked for.

(David): Is there anybody in the call that is feeling like we should reverse the decision here, if you're willing to speak up. OK, (Ricardo).

(Ricardo): I forgot the lower man.

(David): So, if I'm not hearing anybody that's wanting to reverse the decision, we, I think are in agreement that we would like to have mental health measures but this is not the one that wee would endorse. So, I'm hearing perhaps a consensus that we leave it as is, any disagreement with that? OK. I think I'm passing the baton the (Jeff).

(Jeff): OK, so – yes, go ahead.

Suzanne Theberge: Just before we move on, we'll just pause here and make sure. Were there any other comments that committee numbers noted in the spreadsheet on any of the measures that you would wish to discuss at this time? Or were you fine with just a general, thank you for your comment response?

(David): I think they're fine.

Suzanne Theberge: OK. Carry on ...

(Off-Mic)

(Jeff): OK. This (Jeff) and we're going to first consider a measure where the consensus was not reached. And then we have two requests for reconsiderations. So, lets begin with 2807, Seattle Children's Pediatric Danger to Self Discharge Communication with Outpatient Provider.

And as nicely summarized by the NQF staff, we're getting materials. We have a number of concerns including identifying the primary provider, different types of communication that might be appropriate at the validity of this measure was in question. And really boiled down to, was it measuring the communication was undocumented or did not happen?

In other words, this whole issue of there could be a variety of thought, means of communications. Some of which would be captured and others which would not be and in fact that in the most advanced systems that had robust electronic communications but that we may not capture that probably wouldn't capture this in the review processes. Best occasion is noted currently.

There's concerns also about the ability. It required training to abstract triggers and the use of the (would in) use because of elevation concerns. So in the end, we voted for the overall suitability and we had a 10 yes and 14 no and because of that, (luck) was a 42 percent at 58 percent vote nos slightly out-winning the yeses. And we came down to this consensus not reached.

There was one with substitute comment from the (AAT) and they actually supported the concerns then went on to say, "Was not ready for prime time." The developer did respond with this comment and this is in quotes, "We appreciate the reviewer's acknowledgement that this is an important area and it should be a goal for all discharges. Well there may be limitations in the current form's documentation, fringe, the lacked inclusion and clinical document architecture CDA in forms of communication happened in client direct messaging systems that are not likely available."

Our end prints, the timeline seemed to be on these systems is not clear. Any severity illness in this (low) level population consensus regarding the importance that equipped communication for all populations, this measure is important stoop gap while we wait for improvement in documentation and communication systems. In the sensor is saying, "Well, there might be some limitations that was a stop gap or (reviews) to get enough measure that would get us looking at this important issue."

So, we have our prior deliberations and this comment. And we need to strictly reconsider these comments and response and to ask ourselves if there's any change. And we will again, vote on the final question suitability after that discussion and there's consensus one way or the other. So, bend and if not, we'll go forward for the member vote of consensus not reached. And we'll have voting as we were summed before on this particular Webinar.

So, with that frame, the question is, are we in some way (ex-craved) from some of the previous discussion? There's a close vote for any new or other ways to look at things and we'll try to look at people will brace their hands or you can just tell them right in.

(Jim Bost): So, this is (Jim Bost). So ...

(Jeff): Yes.

(Jim Bost): Reading this, the developers chose not to respond to our concerns that we presented. Is that correct?

(Jeff): Basically, they said that yes, there are newer forms of communication and there's some concerns about (HIPAA) compliance. But they thought that given that this is a serious issue, that this measure is quote, "An important stop gap while we wait for improvements in documentation communications systems." So, whether you consider that responsive or not, I'll leave that to you.

(Jim Bost): So, it's specifics about feasibility and validity based on what I read in that paragraph don't seem to have been addressed. So, I don't see anything for me that developed or made a case for it to move forward with this.

(Jeff): Yes. I would say that the developer concern extent with acknowledging that there's something to the concerns that were raised. But they didn't present any new information testing. There is information about the feasibility, usability, and any of the other things that were raised. Other times requested.

(John): So this is (John). I had a question. This was – remind me about the actual measure if it's curled back up, I think, is that – are we on the actual measure (Dave)?

(David): I don't get anything on my actual Webinar screen.

(John) Right so, remind me on any of the developer. They may be in here. But in terms of the patient-outpatient provider, does that include primary care as well as behavioral health provider?

Female: Yes it does.

(John): So, it could either be a psychiatrist, could it be a therapist? Or does it have to be a physician?

Female: No, it could also be a therapist.

(John): OK.

(Jeff): Is it possibly NQF staff to get the brief summary of this specification up? At this point, at least on light Webinar, I don't have anything, basically a blank screen.

(John): Yes. I found the screen right now. If the percentage of children or adolescent's age greater than 5 to less than 19 years old admitted to the hospital with dangerous self harm or suicidality, should have document patient in the hospital record of discussion between the hospital provider and the patient's outpatient provider regarding the plan for follow up.

Discussion can be by phone or e-mail. So, again here in the comments with really be part of the issue is that you'd have to really mind the record to find this documentation. You wouldn't be able to pull this administratively. And this failed on what basis? It didn't fail we just hit recent consensus, right?

(Jeff): That didn't fail until the final suitability through endorsement. And we had 10 yes and 14 no.

Suzanne Theberge: So, it was just on the edge of consensus being reached there. It was consensus not reached on a scientific acceptability. So, the committee kept discussing. Although feasibility and usability are not a task criteria and the committee did not achieve consensus on either of those. And then again, there was no consensus on the overall recommendation.

Male: And that the percent, is that correct?

Suzanne Theberge: I'm sorry.

Male: It has to be 60 percent to reach consensus.

Suzanne Theberge: Greater than 60 for less than 40. So, the consensus not reached percentages are 40 to 60 included of votes 40 and 60 percent.

Male: Right. So, we had 42 versus 58 originally.

Suzanne Theberge: So, it was close but it ...

(Off-Mic)

(John): So I'm inferring then that while feasibility is usability of not, must pass. They can influence your decision to vote for overall suitability ....

Male: Yes.

(John): ... which is a must have.

Suzanne Theberge: That's correct. Yes.

(Sean): Do you have any other, I guess, new angles or substitute comments? And if not, I guess we should revote. Last call for further comments.

(John): Then, are just going to revote on the overall suitability?

Suzanne Theberge: Yes, that's current.

(John): OK.

(Jeff) Yes. OK. Then I will ask our NQF colleagues to prepare to and this is a vote on the overall measure – overall suitability for endorsement. And it'll be either yes or no vote. One is yes, two is no. And I ...

Suzanne Theberge: And (Sean), can you confirm that we have 22 committee members on the phone? Has there been any change?

(Jeff) We are 22.

Suzanne Theberge: OK.

(Jeff) So, we're going to be voting. Does the measure meet the criteria overall for endorsement? One is yes, two is no. And what it you're seeing in the moment, we're going to have a voting option once we figure out the denominator.

Suzanne Theberge: OK. I think we can go to the next slide. That's the voting slide. I would like to confirm first that we have 23. So, we should be expecting 23 votes. Dr. Moyer will be voting via e-mail. She'll be e-mailing the project team her vote. OK. (Sean), can you confirm please that we have counted the committee members who are present today eligible to vote?

(Sean): Currently, what I have counted as live in the meeting, actually of the 23rd did. It looks like (Carry Stay's) connection may have been blinking in and out. So, please (Carrie) if you're having difficulty seeing things, let us know. I do see it again now. So, that would put as at 23.

Suzanne Theberge: Thank you. OK. So, we are not voting. Measure 2807, pediatric danger dissolve discharge communication with outpatient provider on it's overall suitability for endorsement. As soon as I click to the next slide, everyone should be able to vote right away.

Male: OK. Make sure you point your clicker toward her computer desktop.

(John): Got to say, this is much easier than holding the things up in the air and clicking it 500 times.

Male: Yes, exactly.

Male: Are we supposed to see the vote yet there or not yet?

Male: No, you're just voting.

Suzanne Theberge: We're still missing a few votes, I think.

Male: Yes. It didn't work for me. Command R, is that what you said?

(Sean): Yes. If you're using the Mac to refresh, it will be command R.

Male: OK. Let me try that. OK. That worked. Thank you.

(Sean): And there should be little boxes to the right of the A and B option. That's where you'll want to click.

Male: Yes. I'm in now.

(Sean): OK. We're still missing a few votes.

(Jeff): Tell everybody who is on, please vote.

(Carrie): Hi this is, (Clarissa). I'm so sorry. I just joined. I'll abstain since I missed the discussion.

(Jeff): So, we should have 22.

Suzanne Theberge: I see 20 votes and I know we're expecting one by e-mail.

(Jeff): So, there should be one missing.

Female: I already sent my vote by e-mail.

Suzanne Theberge: OK. Let's see.

Operator: And just a reminder to our voting committee members, if you do not see the boxes, you'll need to refresh your session by pressing command r for a Mac or F5 for a P.C.

(Sean): So, we're still missing one vote. (Susan Puff), I still don't have (Janice) either by e-mail.

Suzanne Theberge: I see – OK.

Female: I just sent it again. I sent it to the group e-mail address box.

Suzanne Theberge: Ok. So, we're still short one vote.

(Sean): On the screen?

Female: Correct.

Suzanne Theberge: On the screen, correct.

(Sean): I think we just have to call the question.

Suzanne Theberge: OK. So, by my count, we have 13 no and 8 yes and that would be a total of 22. And ...

Male: 21.

Suzanne Theberge: 21, I'm sorry. We have achieved consensus that it does not pass. 13, no out of 21 is ...

(David): What's 13 out of 22 though if you counted the one missing vote?

Suzanne Theberge: Let's see, 13 out of 22 is 59 and – 59 percent and 13 out of 21 is 62 percent.

(David): So, I think we're going to have to do a role call to find the missing vote because that one vote could make a difference.

Suzanne Theberge: Yes, that's correct. Can you see on the backend of anyone dropped off? Or shall we run through – quickly run through the committee again and just role call?

(Sean): It looks like the committee members are still connected. The count looks correct in the box of numbers connected. Let me just check and see if we're able to – so, the polling question is still open. I may not be able to pull the full results but bare with me one second, we're going to check it.

Suzanne Theberge: And if we can't – we can't get this started out immediately, what we can do is send out a survey after the call and do the voting online. Thanks for your patience, folks. Give another minute here.

(Sean): I was able to get a report. Checking it now.

(David): Great.

(Sean): OK. It looks like, is (Jeff Schiff) still with us? His connection dropped and then it came back for a moment. But we do not have a vote there.

Female: I think (Jeff Schiff) is conflicted because he was part of our center.

Suzanne Theberge: OK. So, we are not expecting a vote from (Jeff) which would leave us at 21 voting committee members and we have – so we have a ...

(Jeff): It achieves consensus, 13 have 21 or 62 percent now.

Suzanne Theberge: OK. So, this measure has now been not recommended by the committee. This is not recommended for endorsement.

(Jill): OK. Then, are ready to move on to the next?

Suzanne Theberge: Yes, I believe we are.

(Jeff): OK. So, this next one if you remembered, is 2806 which is the Seattle Children's Pediatric Psychosis Screening for Drugs that is in the E.D. We actually, I think, were quite (talented) about this measure except the gate range.

(David): Right.

(Jill): And we asked the developer if they could re-specify the measure and eliminate, if you will, the owner cohort. And so, what they have done is to submit the testing data. Now when they add to an older range, it's children ages 12 though 19. The – was one comment and it's the comment supported our decision not to recommend the measure and they had mentioned the issues including the (A-drinks) to testing definitions.

The developer has responded and has redlined the original submission with their changes. So, they add at this juncture, it is open for consideration of whether we should reconsider this measure. And we would vote on this in greater than 60 percent of our committee must vote in favor of reconsideration. And then, we would have to revote on validity where it had earlier failed. And remember, that is a must pass criterion and the overall recommendation where the measure failed.

So, at this point I'll open it up for discussion and further comment and ultimately, the recommendation of whether we would like to reconsider this and it's sellable ...

(Off-Mic)

And up on our screens now is some of the redlining. It goes from the pediatric and adolescent psychosis and instead of 5 to 19, it goes from 12 to

19 which I think is sort of, (at least some) of our major concerns that were raised during our previous discussion.

(John): Just to clarify, we're voting on which is the first question? It's about validity?

(Jeff): Yes. So, first of all we had to decide whether we'd reconsider. And there's a motion to reconsider in a second, we will vote on that and 60 percent of the committee will have to vote in favor of reconsideration which would be I assume 13 out of 21 of us. If that passes then we'll go through the process on voting on the validity and then the overall recommendation if it passes validity. Is that correct (Steph)?

(Steph): That's correct.

(Ginny): This is (Ginny). I'm remembering that the age was one of the major issues here but I can't remember whether this was an extremely close vote which would suggest that maybe we really should reconsider or whether this – whether age not withstanding, we didn't (tell) this is good. It would help me to remember that part of the discussion and I can't see if there's some of that on the screen.

Suzanne Theberge: I will pull up the vote but the committee did specifically request these changes to the measure and ask that they'd be brought back if possible. Normally, we would've stopped the validity – I'm sorry?

(Ginny): Well, if we asked for it – have done what we asked for then probably we should at least reconsider.

(David Keller): Yes, I think we should – so, I'm going to make a motion, this is (David Keller). I'll make a motion that we'd reconsider.

(Jeff): OK. Is there a second?

Male: I second motion.

(Ginny): Second.

(Jeff): OK. So, it's (inaudible) seconded that we reconsider this, any discussion on the motion? If there's none, we'll now vote on reconsideration with this measure. Do we need a voting slide to do so?

Suzanne Theberge: Should be pulling that out momentarily.

(Jeff): OK. So ...

Suzanne Theberge: There we go.

(Jeff): ... we're going to reconsider. One is yes and two is no. And presumably, a voting screen will come soon.

Suzanne Theberge: OK. We should see the vote. Yes, there we go.

(Jeff): OK. So, I'd ask you all to vote clearly but note often.

(David Keller): Let's not live in Chicago.

(Jeff): Unless you live in Chicago, you can place three votes.

Suzanne Theberge: I know we have lost someone from the committee, had to leave early and I think given the votes that I'm seeing ,we can call the question and say that right now, it looks like 90 percent of the committee is voting to reconsider. So, we can move forward with the next discussion.

(Jeff): OK. So, with the supreme majority, everybody voted essentially to reconsider. So now, were going to go back and discuss and vote on validity which had failed earlier and then the overall recommendation. So, the validity concerns, I think, last time at least as I remember, were really focused on the age and that younger age cohort.

Now that this has been re-specified because the committee believed that this is more valid and if so, we will have this opportunity here in the moment to vote. So, a discussion on the validity as a measure now is re-specified.

(David Keller): Well, I put up my hand so I'll start talking. So, the ...

(Jeff): No, I'm sorry. I'm not doing a good job.

(David Keller): Just wanted to be (recommend), (David Keller). The other concern I think I remember discussing was that it really had only been validated at four hospitals granted they were different kinds of hospitals. But the total number of charts audited for the validation was like, in the – new numbers is about 200, before it was about 257.

So, I guess our initial thought that there weren't very many young people in this were as correct. At the same time, 200 said a lot. And I think that's the real question. Is, while there seems to be some face validity to this thing, it really hasn't been used widely or by and large population.

(Jeff): OK. So, concerns about the number and the test 200 or so and presumably that might be at least some threat if whether this has robust build in validity. Other concerns or question or? Hearing none, I would entertain a motion to vote on validity. Are we ready to vote on validity? Would someone like to move on that, (Vincent)?

(Vincent): So, moved.

(Jeff): OK. So, it's been moved and second please?

Female: Second.

(Jeff): All right. So, this move's been seconded to beforehand vote on validity. One comment that seems (tops to this) is while we've changed the age here, there still is a relatively small number of cases tested on. So, we'll move on to the voting and we will have a one through four option with one equals high to moderate, three (will enforce) insufficient.

Suzanne Theberge: OK. We are now voting on validity for measure 2806 pediatric psychosis screening for drugs of abuse in the EDE. Voting is open.

Male: I just have a question. Last time we were only eligible for moderator low, I think. So we are eligible for a high now?

(Jeff): I'll have to refer to the NQ staff – NQF staff.

Suzanne Theberge: If I am recalling correctly, if there was only safe validity it would've only been eligible for moderator low.

Male: So, you weren't saying that it was only – this is only if we though it was ...

(Off-Mic)

(Sean): No.

Male: OK.

(Sean): They did chart review data element level validity I think what it was.

Male: Yes, I thought so too. I was a bit confused when I saw that.

(Sean): So that's – and they did face validity but that's still – you're correct, that's only eligible for a moderate rating. They would have to have done performance score to be eligible for a high.

(Jeff): So, just to clarify for everybody. Then, we cannot vote A, is that what you're suggesting?

(Sean): Well, for the algorithm, right. The highest eligible – I suppose you could still vote high but that's not really ...

(David): You're not following the algorithm.

(Sean): ... following the algorithm.

Male: OK.

(Jeff): So, please case your votes. If you believe in the algorithm, don't vote for A. If you want to ignore the algorithm, that would be choice A to D. And let's vote.

Suzanne Theberge: OK. And this measure now passes validity. We have 17 votes for moderate and four votes for low and we're at a total of 21, we have lost one committee member.

(Jeff): OK. So now having passed validity, we will go forward. We've already voted and discussed usability and feasibility. So now at this point, we're going to vote, as I understand, for the overall measure.

Suzanne Theberge: Yes.

(Jeff): So, I believe we can skip feasibility and usability, is that correct?

Suzanne Theberge: That's correct.

(Jeff): OK. So, this is an overall suitability for endorsement. Again, as prior, one is yes. It's suitable for endorsement. And two is no. It's not suitable. And voting will open up momentarily. Now is your time to caucus which your friends, neighbor, dog, or other related creatures and vote now, one, yes, two, no.

(David Keller): Caucuses are next week.

(Jeff): Oh, OK. Or if you're in Iowa, you missed them.

Suzanne Theberge: OK. And we have our final recommendation for endorsement. This measure is now endorsed by a vote of 18 to 3.

(Jeff): All right. Thank you very much.

Suzanne Theberge: Sorry, I misspoke. This measure is now recommended for endorsement. It is not officially endorsed yet.

(David Keller): Correct.

(Jeff): So, we're going and we're forwarding that to the (inaudible) in the (sky), (those of validity rate) and the final measure here that we're going to consider was 2799. And that was the use of multiple and current antipsychotic and children's and adult's. And if you remember, this failed on validity, left six moderates, 15 low, and three insufficient.

We also did not reach consensus on reliability because of a concern about the size in the plan and (mixed) with plans in terms of hair source and that the medicate population would probably give more liable results but it was very difficult given the small sample within the plan to produce and report that was built officially significant comparable and appropriate.

We also – we're concerned about the evidence. So, some of us at least who are treating such populations thought that there was little documentation based on actual case review that the use of two or more antipsychotics was inappropriate, didn't get to the specificity of an individual practitioner's problem to prescribing or the reality that there certainly are some children who require more than one antipsychotic at a time. So, that's the baseline.

The developer then submitted a response and said that the recent (AHA) test of Dr. (Carol) reported this summary of their response, reports that signs (chart), has showed many antipsychotic prescribing patterns in medicate were determined to be poor quality to psychiatric reviewers. The staff reviewed this and it states that 67 percent of claims had quality problems of those 37 percent which were (many) drugs.

So, 25 percent of the claims with a – and at 687 were affected. However, the definition of too many was three or more antipsychotic and psychotropic drugs. One of which was infecting generation antipsychotic drug. So, their differences in the specification or definition of (well), for (too many) drugs and whereas we used two or more, the (H.A.) test I.G. report was slightly more complicated, created more psychotropic drugs, one of the first and second generation antipsychotic.

Vote for comments supported the committee's decision not to recommend. One comment suggested we shouldn't even weigh in on whether using quantities of proxy to asses safe and (and do this) issues is in itself an incorrect measurement approach. The other comment echoed concerns by those (inaudible) down to difficulties using as measured were totaled (inaudible) difficulty finding psychiatrists patrolling on medicate and medication changes, it may incorrectly appear to be more (concurrent) medication usage even though they were actually sequential use.

So overall, at the end of the day, we're here to decide whether we should reconsider. And then if we do vote positively to reconsider at 60 percent total thresholds, we build on validity, feasibility, use and usability overall recommendation, we don't reach the 60 percent threshold, we won't reconsider this. So, let me stop there. It's somewhat complicated but essentially, I think this really hinges on whether really we, the specification of two or more anti psychotic medications is a good proxy to quality.

So, (inaudible) raise your hand or is that from before?

Male: I will try to log in.

(David Keller): That's old, sorry.

(Jeff): No problem.

Male: There it is.

(Jeff): (Inaudible) now you don't even want to be – OK. He (ticked).

(Off-Mic)

Male: Yes, hi. You know, they say that there's data on construct validity and reliability were not available at the time of our review but the information that they provided to us here was available at the time of review and we actually used that information as part of our decision making. So, they didn't provide, I don't think anything new for us to review regarding reliability and validity.

(Jeff): OK. Any other comments?

(Saphine): Hi this is (Saphine) from NCQA, can I just clarify that?

(Jeff): Yes sure, please.

(Saphine): OK. So yes, that is correct. What we wrote was that constant validity information was not available at the time of our submission and we did include it as a supplement. And what is new is the information with the

Health and Human Services office of inspector general reports. And what we are seeing here is that we feel we've met the validity criterion which does include (faith) validity. You know, we had faith validity and we did have empirical validity included as part of the submission, thanks.

(Jeff): Thank you. Thank you for that clarification. OK. Other comments from the committee members? Remember, the other question at hand is whether we should reconsider our vote. So, ultimately here, I'm going to be looking for a motion to reconsider when you feel it is time. OK, (Jim).

(Jim Bost): Yes, I think that I believe that the report they provided does show, go a long way to providing more information of face validity. So, I am pleased and consider that a great addition to face validity. The reliability data that we did see last time was very good except for that one situation where the beta binomial results were point 58 which just seemed very, you know, considerably low compared to the medicate one but not so low that I think we have concerns about reliability,

The validity, there was only one of the other measures that they assessed that correlated with multiple concurrent antipsychotic which was only for the commercial plan and it was moderately significant at point 01. But then I could also make the argument that this particular measure may be not should be as correlated with the others because it does look at a potentially different domain of assessments.

(Jeff): OK. So, we had some new data and we've discussed briefly the differences in the validity assessment and the actual measure specification. And we had the argument that this does or doe not (reap) the face validity test. I will like to entertain the motion to reconsider so that we can vote among this, is it a fair shake and any other discussion. Go ahead, is that (David)?

(David Keller): Yes, this is (David). I thought we had a motion to reconsider. I'm second, (that's) already out but if we don't, I'll make one.

(Jeff Susman): If we did, I didn't note that. So, shame on me. But let's go ahead and we have now a motion for sure to reconsider and a second please.

Female: I second.

(Jeff Susman): OK. So, we have a motion a second to reconsider this measure and remember this is a motion to be considered if it's greater than 60 percent, we will go ahead and then go through the voting and in particulars, it doesn't need the 60 percent threshold that will remain where it is. So with that, let's go ahead and open the voting for reconsideration. One is yes to be consider the measure and two is no.

Female: OK. We're voting for reconsideration for measure 2799.

Female: Virginia Moyer will not be voting on this measure.

(Crosstalk)

Suzanne Theberge: And we now have 20 votes. We have 55 percent, 11 voting to reconsider and 9 voting not to reconsider.

Male: So we will not be (inaudible).

Female: For the motion staff.

(Crosstalk)

Male: If I understand it, if we had 60 percent or less, measure will stay not recommended and so – and will find incorrect in NQF staff for this way in, the measure will stay not recommended.

Female: That's correct.

Male: OK. So thank you everyone, for those three votes and very useful discussions and comments. And I think, they have thought and then look forward, I'm going to turn it back over to (John) and (the team).

Suzanne Theberge: I think we can talk here and see if any of the committee members have anything else they wish to discuss at this time. Any other topics that were raised in the comments that they would like to bring up.

(Jeff Susman): The only thing I would say, this is (Jeff Susman) and I hear is to continue to encourage the submission of behavioral health and psychiatric measures and that well they maybe difficult that these are very important domains to assess and I think clearly the committee is noted this such but continues to be have in related toward high quality evidence and considering such measures.

Carol Stanley: Hi this is Carol. I don't know its inappropriate question or not, but for this measure we just discussed regarding and current anti psychotics. I noticed that this measure it mentioned its on CMS's (triple a core set) now and I'm just wondering if we can ask the developers to tell us and it would – the cheaper measures are vetted heavily and I'm just curious and wondering what's the difference between our perspective on the measure and the cheaper panel. And like I said, I don't know if that's inappropriate question for this call but I just thought I'd ask.

Suzanne Theberge: Sure, this is Suzanne and I'm happy to answer that question if it's appropriate.

Carol Stanley: Go ahead Suzanne.

Suzanne Theberge: OK. So you are right, measures application partnership that makes recommendation for measures that should be considered for the – (of the adult) and the child core sets first voluntary (inaudible) reporting did recommend the multiple concurrent antipsychotic measure for the child core set and it has been added. You know, they thought that it was an important measure that highlighted the quality problem in particular from Medicaid.

You know, they saw, I would say much of the same information that you all seen regarding the testing results, the validity and the reliability, the usability, the feasibility, the work that our center had done to process or public comment and run it through our multiple advisory panels.

In addition to the process that the measure then underwent to be added to the HEDIS health plan measures that which is, you know, in additional vetting process that assesses the plans appropriateness for health plan level reporting. In this measure was submitted at both a health plan and a state level measure.

And the other thing that they appreciated was that this measure also is being used for electronic health care records that had been specified for eMeasures, and was – there were – there was work on the measure on that respect as well and so, they felt that it aligned across some different programs.

So, you know, that was the conversation from the developer's standpoint at the Measures Applications Partnership Medicaid Task Force. And so, it has been added to the child core set which we shut off that spoke to the measure's validity and faith validity.

Female: I would like to just step in and clarify that the measure was recommended to the core set of pending endorsement from the CDP process. So that endorsement is provisional, I believe, is not finalized.

Suzanne Theberge: It has been added to the core set how the panel with, you know, my understanding was that there was a general recommendation of endorsement across all of the measures because some of the measures had not been taken through the process yet. So, you're right, I'm not sure how that would be handled. But it has been added to the core set from my understanding. But, you know, I think that CMS may be the one's to speak to that.

Well, I think, you know, at this time the committee did both not to reconsider and, you know, I think that result did not made the criteria for – or did not make the cut-off for reconsideration. And so, that's the vote that we have landed on.

Female: Suzanne, I think we could move to next step unless there's any other additional committee question. Or do you have to go to public comment?

Suzanne Theberge: We do have to do a public comment period. So, at this time the operator could open the lines for public comment.

Operator: If you have a public comment, please press star and then the number "1" on your telephone keypad. That's star "1".

And your first comment comes from Sally Turbyville.

Sally Turbyville: Good afternoon this is Sally Turbyville with the Children's Hospital Association, can the committee hear me?

Suzanne Theberge: Yes, we can hear you.

Sally Turbyville: Great. First of all, thank you all for taking so much time to review the measures that were put forth for you for endorsement and to take the comments submitted seriously and to really revisit some of the deliberations.

I wanted to comment specifically on what one of the committee members said early on about some of the comments at that the association submitted. And that was some of the rationales were indeed not clear as you know they're not waited. So, it was not always apparent if there was a primary overarching rationale.

And what that really brings to mind is some concern on my part in capturing discussion points in rationales potentially inadvertently or minor rationale. And while in of itself it may not be a problem, I do think future implications whether it's a discussion of a rationale having been applied before and so it makes sense in another endorsement, a decision and I'm not necessarily focusing on the pediatrics subcommittee, I mean, in all of the (unkempt) subcommittees. As well as, if someone were to pick up their report what some of those rationales may mean and implicate in future measure development if it's not understood that those were – some of those or perhaps more discussion points than a rationale to not endorse.

That was my interpretation. I do think words in framing matters. So just something to think about and for you to do as you like and you work on the final report. Otherwise, just thank you again for all the time that you all spend committed to helping us sort through better measures for children.

Suzanne Theberge: Thank you. Operator do we have any other comments?

Operator: We do have a comment from Renee Fox.

Renee Fox: Good afternoon, this is Renee Fox from CMS and I just wanted to make a clarification about the core set addition. We did take all of that information

and in addition to, as Carol explained the work we run it through some of our stakeholders as well as internal stakeholders. And in fact, it is added to the child core set for Medicaid and shift for voluntary reporting from the state.

Thank you. And thank you for all your work.

Suzanne Theberge: Thank you. And so we have any other comments.

Operator: There are no further comments.

Suzanne Theberge: OK, (Nadine), would you like to take us into the next step?

(Nadine): Sure. So next step, we will be putting the report out in a memo to the NQF membership on March 15th and they will – at that time they will have a chance to vote from March 15 to March 29 on the measures before they go off to the (sit back) committee for review. At that time the CSAC will review the measures and the committee's decision voted and public comment. And then make a decision on whether or not they should move forward for endorsement by the executive committee which will be meeting in – on May 12.

After the board endorses the measures or not endorse the measure it moves forward for a 30 day appeals period from May 16 to June 14. And at that time, the public has the opportunity to submit appeals only on the recommended measures.

With that said, I would like to turn it over to our chairs to make final decision. So, thank you.

(John Brookey): This is (John), thank you everybody for calling in and participating. I think it's been a good process and we've made some good decisions. So, hope to see you again some time.

(Crosstalk)

(Jeff Susman): Thank you very much. I think everybody did a great job and I appreciate everybody's time and energy.

Female: On behalf of NQF, thank you very much, everyone, one the committee and to our developers and the members of the public who delved in as well. Thanks for your time this afternoon. And we will keep you informed throughout the next step for the process. I will – we'll keep updating our website and sending out messages to the – both the committees and the developers. And …

Female: Thank you.

Female: Thanks very much. And you all can have about 10 minutes back.

Female: Thank you. Thank you NQF.

Female: Thank you. Bye bye.

Male: Thank you.

Male: Bye bye all.

END