NATIONAL QUALITY FORUM

Moderator: Pediatric Performance Measures
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OPERATOR: This is Conference #: 16736748

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

Suzanne Theberge: Good afternoon, everyone. And welcome to the first workgroup call for the Pediatric Performance Measures project. This is Suzanne Theberge. I'm the senior project manager on the team. And on behalf of the team, I'd like to welcome you.

We are going to start off with a committee roll call. But before we do that, I will just do our usual quick housekeeping notes, one of which you may already be aware of. We are streaming audio on the webinar so if you are dialed in on both the phone and the webinar, please turn the volume off on your computer so we don't get that feedback from having the audio from your speakers.

We do also request that you not put us on hold during the call since we'll get your hold music. And also if you could use your mute line when you're not speaking, that tends to help produce interference as well.

So, with those notes said, I think we can go right into introductions.

So, we have about half a dozen members of our committee on this workgroup and I'll just do a quick roll call and then introduce the team.

Maureen Ediger, are you here? And I thought I saw Maureen on the webinar. Maybe not.

David Einzig?

David Einzig: Yes, I'm here.

Suzanne Theberge: Great. Jonathan Finkelstein?

And, just a quick reminder that you do need to be dialed in to the phone line to speak. We can't take audio input to the speaker.

And it sounds like – if someone could turn off their speakers, thanks.

Kraig Knudsen?

Kraig Knudsen: Yes, I am here.

Suzanne Theberge: Great. Sue Konek? Carol Stanley?

Carol Stanley: I'm here.

Suzanne Theberge: Great. Jonathan Thackeray?

Jonathan Thackeray: Good afternoon. I'm here.

Suzanne Theberge: Great. Thank you. All right, it sounds like someone's got their speakers on, if they could turn those off.

That would help and reduce interference. Thank you.

OK. So we also have the NQF team on the line. As I mentioned, I'm Suzanne Theberge, the senior project manager. And I'll turn it over to my colleagues at NQF to introduce themselves.

Nadine, why don't you start?

Nadine Allen: Hi, I'm Nadine Allen, project manager for this project. I'm also involved in the MAP Medicaid Child project and the Perinatal project at NQF.

Severa Chavez: Good afternoon. This is Severa Chavez, I'm the project analyst. And like Nadine, I'm also in the Medicaid – in the MAP Medicaid Task Forces project, and the MAP Clinician Workgroup Pre-rulemaking project. Thank you.

Robyn?

Robyn Nishimi: Robyn Nishimi, I'm senior consultant for the team. I consult across a few NQF projects. I was the founding chief operating officer back in the early days of NQF, but since 2007, have moved more to sort of project-based consulting with NQF and some other clients.

Appreciate everyone's willingness to help us with this project.

Suzanne Theberge: All right, thank you, everybody.

Do we have any committee members who joined the line while the NQF staff were introducing themselves?

Jonathan Finkelstein: Hi, it's John Finkelstein, I'm here. I wasn't able to say so on the computer.

Suzanne Theberge: Great. We also do have the team from NCQA, the measure developers whose measures we're discussing on the phone, so they are available if you have questions for them specifically. So …

Female: OK, that's great.

Maureen Ediger: This is Maureen Ediger. I'm also on the call.

Suzanne Theberge: Great. Welcome.

Maureen Ediger: Great.

Suzanne Theberge: So, we are – before we get started, I want to go over the agenda and talk about process and then we'll just dive right into the measure discussions.

So, on today's call, we're going to walk through the criteria for each of the four measures that we're going to be looking at. We are not going to be voting on any of the measures, there's not going to be any decisions made today. It's

just kind of a time to discuss what the developers have submitted and I will be focusing that conversation on particular areas where workgroup members, staff have raised questions about this submission.

So we'll be using the input that you gave us on your surveys last week and this week. So we're not going to spend a lot of time on a section if everybody agreed that a measure seemed feasible and there were no concerns raised. We won't really spend much time on that. But we'll focus more on the areas where folks have questions.

And as I mentioned, NCQA is on the line, if you have a specific question you'd like them to answer, then they can do so.

After we have discussed all of the measures, we will do a brief member and public comment. So if anybody from the public or is on the line and which is to make a comment, we'll take those and then we'll just do our quick wrap up and next steps to let you all know what's coming down the pike for this project.

So, the – we're going to be looking through the measure worksheets that are on the SharePoint page and that have been shared with the developers by e-mail. We'll be pulling those up and kind of going through as we discuss so you have something to refer, you may also wish to pull it up and look at it on your own computer.

And, I wanted to note that what we've got on SharePoint right now and what we sent to you was just a stat preliminary analysis but after the workgroup call surveys are done, we'll be updating those and putting in that survey information. And then once the public comment period is over on November 20th, we'll also be updating the forms with that information if we get any public comments on the measures before the meeting. So, prior to the meeting, you'll have some more input on all of the measures.

So, with that said, does anybody have any questions before we start talking about the measures?

Robyn Nishimi: I just wanted to call, this is Robyn, the committee's attention to the spreadsheet that you received that I color coded into the four groups of measures. That might be useful for you to also have called up because it will have not only your input in the survey, but also your colleague's input.

Suzanne Theberge: Thanks, Robyn.

OK. So, we're going to through these four measures. They are all from NCQA. We have three measures on antipsychotic use and then one on tobacco use and help with quitting. And we're just going to do them in numerical order of measure number. And I'm going to add that on this call, we're going to go through and discuss each of the criteria for each measure. But if we were at the in-person meeting and the committee voted that a measure did not pass, say, the evidence criteria, we would stop the discussion there and we would not continue on, but that's not going to be the case on today's call.

So, with that said, Severa, if you could pull up 2799, that would be great. And we can start taking a look at that one.

So, 2799, use of multiple concurrent antipsychotics in children and adolescents. This is a measure that addresses inappropriate prescribing patterns for children and adolescents, ages one to 17. So, children who are on two or more concurrent antipsychotic medications.

And, the developer – this is a process measure. The developer provided evidence to support the measure. And, the staff had identified a couple of questions in a preliminary analysis and also our committee members had identified a few questions.

So, I'm going to pause here and see if anybody wants to kick off the discussion or if you would like me to start off. Does anybody want to dive right in or would you like me to summarize what was submitted?

OK. So, one of the – there were some concerns raised by the committee on the evidence. The – a couple of the things that I noted was that this – you know, this is a process measure and somebody raised the issue that there's not

clear evidence that describes that links concomitant use directly to poor outcomes for a child that there's – maybe we need more evidence, there's not much evidence about whether one high dose of one medication might be better than or safer than low doses of two medications. There were some thoughts that, you know, there are a lot of guidelines, but – and the expert opinion of professional consensus appears to be quite strong, but there is less strong direct evidence.

What do you folks think? Are there – how would you look at this using the NQF algorithm, what – do you have concerns or do you really sense here as pretty strong?

David Einzig: So this is David Einzig. I can jump in first here.

So just to give my background, I'm trained as both the pediatrician and the child psychiatrist. So, the population of kids at (ICD) are highly medically complex, you know, kind of (inaudible) cases.

My – you know, clinically, you know, I don't – I don't think I saw that coming that this happens. And if it does happen, you know, I – generally psychotic medications upfront. But probably well down the line after having failed other more conventional routes.

And then my second point would be, and I think we can kind of keep the global focus on the purpose of treatment and the purpose of medications just to improve functioning.

And so, well, there can be risk for polypharmacy, that was my comment that was – that had to do with these low doses of two medications truly more dangerous than high doses of one medic loss of evidence, I can say that that is the case.

So for example, high dose of Risperdals can be more likely to kind of more likely to cause appetite, weight gain issues, dystonic reactions, elevated prolactin, where if you throw in a low dose of Abilify in combination that they recommended but, you know, in more severe cases, that can lower prolactin, it

can lower the dose of the Risperdal, it can actually contribute to less side effects.

So, well, it's not the norm, it's not necessarily all that uncommon and it's fairly – considered to be a fairly reasonable thing to do in complex difficult cases.

Suzanne Theberge: We have another comment that was talking about how – so there may be overlap due to transition times between medications and what's going off of one and onto another, for example. Or it could be there are case-by-case basis where this could be actually the right treatment for children with significant conditions.

(Safeen): Hi, Suzanne, this is (Safeen) from NCQA. Can you let me know when a good time to respond to some of these issues might be? I don't want to interrupt the workgroup discussion, but I just want to let you know we are here to respond.

Suzanne Theberge: Great. Thank you, (Safeen). I think, you know, committee members, you know, this is really your time to discuss the measures. And, so if you have specific questions at any time that you would like the developers to address, you know, please reach out to them.

Jonathan Finkelstein: So, this is Jon Finkelstein. I think there are – you know, there are these kind of technical issues, I wouldn't call them problems that come from – as I understand it, it's been measured through dispensing data that shows up in pharmacy claims and there's a little bit of misclassification. I just know that I would dispense the prescription for 30 days (inaudible) prove that I took it for 30 days.

But, I think those aren't the big issues here, I think the big issues, and I'm new to this process, is the first one you raised, kind of by the algorithm, where do we have evidence of harm and where do we have case reports and a lot of professional consensus that it's not a good thing to do. But that's short as the kind of evidence in the algorithm. And well, I was coming to – as I was working through it, was whether this rises to level of importance where this should be that box at the end that says rate is inefficient, that insufficient evidence but with exception, because it's hard for me to get to an evidence body that this is directly on point.

Suzanne Theberge: Anyone else from the committee?

Carol Stanley: This is Carol. Could NCQA talk about the findings they've had from the HEDIS 2015 members and feedback on the measure?

(Safeen): Yes, this is (Safeen) from NCQA. So, let me talk to a few of the things that I've been hearing. So, we did list out the guidelines on which this measure is based, and I think the reasoning here is that, you know, and medication is very powerful and you can use one medication at a time. You do see, you know, the immediate and dangerous effects in children. And so, many of these guidelines say that the simultaneous use of multiple concurrent antipsychotic is not recommended.

There was an issue raised about whether or not you might be – I think it was really around titrating and putting, you know, maybe starting a new medication and therefore the child may beyond two medications concurrently for good reason. And the measure actually specifies 90 days of concurrent use for that reason to allow for titration. And in testing and according to advisory panels, they felt that 90 days was the right place to specify the measure to not inadvertently count kids who are being appropriately titrated.

Molly, I don't know if you're on the call, but if you want to speak more to the evidence around the measure. I think I saw you on the webinar.

Molly Finnerty: Microphone is off.

(Safeen): Yes, we can hear you.

Molly Finnerty: Oh, you hear me?

(Safeen): Yes.

Molly Finnerty: Great, OK.

So, just – you know, just to speak to the evidence, I think the – part of the reason for these recommendations against polypharmacy are based on the evidence that suggest that the metabolic impacts are greater for the combined.

So, in terms of their weight gain and in terms of new onset of diabetes, and other cardiometabolic disturbance in children, and part of the concern there is that these – you know, these issues in children can create lifelong health problems.

So, I think that's sort of the case for harm.

(Crosstalk)

Male: I'm sorry.

Female: I'm sorry, I – go ahead.

Jonathan Finkelstein: It would be great if – so I still didn't get through in the staff submitted whether – where that evidence is. So I understand the guidelines say generally it's not a good thing to do or not a good thing to do initially, and I don't question that it's not a good thing to do.

And I understand the theoretical risk of harm of these medicines, but if there's evidence, if there's, you know, a randomized trial that showed in the people getting two drugs instead of one, there was a doubling of the risk of metabolic issues. I didn't see that and I would love to make it easier if we could see that.

Female: Was there …

Robyn Nishimi: So that's something the developer could try and address, I'm not sure they'll be able to address, we wouldn't expect them to do that on the phone, but are there any other request of – for clarification of evidence from the developer before we sort of start moving on?

David Einzig: Yes, just to – David Einzig here again. Just to clarify, so, each of the atypical antipsychotic medications had their own profile in terms of risk of metabolic syndrome. So just to, you know, emphasize the point of evidence to say that to medications together post greater harm than one alone, I don't think there's evidence to support that, it depends on the medication. Risperdal plus (Zyprexa) certainly, Risperdal plus Abilify, it – yes, I don't think that holds water.

Molly Finnerty: So, we can …

Female: Go ahead.

Molly Finnerty: Yes, I was just going to say, so it sounds like there was a request to see the articles that suggest that polypharmacy is more harmful than monotherapy.

Robyn Nishimi: That's what I heard, I also heard that even in the absence of that, there was some notion the committee may be able to get to the box on insufficient with exceptions. So, I think those are some of the take homes and in the broader discussion with the full committee, we'll try and focus the discussion there.

Suzanne, do you want to move on?

Suzanne Theberge: Sure, thank you.

All right. So, the next …

(Off-mike)

Female: Suzanne?

Suzanne Theberge: … that we consider …

Female: Suzanne.

Female: Suzanne.

Suzanne Theberge: Yes.

Female: You're breaking up.

Female: Suzanne, sorry, you're breaking up.

Suzanne Theberge: Is this better?

Female: It's OK now. Yes.

Male: That's better.

Suzanne Theberge: OK. Sorry about that.

So, this is performance gap, this is the place where we look at whether there is an opportunity for improvement, whether there is a gap in care, whether a measure might be disparity sensitive.

And I think that there was fairly – a fair amount of agreement across the committee members that there is a gap in care here. Folks noted that there appears to be higher utilization of multiple (inaudible) and minority use in children in foster care that there are racial disparities that, you know, that there does seem to be some gaps in care here. And, is there anything here that folks wish to discuss or are there any questions that the committee has for the developers?

OK. I did want to mention that one committee member noted that the mean rate is not zero, but it's not clear what the right number actually is. So, that was just a point that I wanted to mention.

So, if there are no other questions about importance to measure and report, you know, at this point, we would have voted on the two sub-criteria and then on the overall criteria. So, you know, if there's no other questions, we can move on. Yes?

Jonathan Thackeray: This is Jonathan. I do have one question. Somebody had raised it in the comments and I think it's a good question. There's not data specifically provided for the disparities issue. So the developers reference the rates being higher in Black children and adolescents than Hispanic and White children, but there's not data given to support that. So that might be useful.

(Safeen): Hi …

Suzanne Theberge: Is that something that you could …

(Safeen): Yes, we actually – this is (Safeen). So, in our firm, we referenced both literature and actually our own testing. In our submission form, we did list some measure rates from testing where we looked at rates ethnicity, foster

care status and rurality, urbanicity. And overall – and our – we're just using max data and did find some higher rates of multiple concurrent antipsychotic use in the foster care population compared to the general Medicaid population.

And then we also found it was slightly higher among non-Hispanic Black's use compared to the Hispanic and then compared to White non-Hispanic children.

David Einzig: Would this be a good place for me to give my clinical perspective on that?

Suzanne Theberge: Yes.

David Einzig: Great. So, you know, again, having the psychiatry background, so if you look at – I think it goes beyond races not as simple as it's a race issue. Kids in foster care, I mean, it's trauma, so if you look at it from an attachment perspective, there's been some dramatic experiences going on with these kids for a very young age. Lack of attachment with the primary caregiver, perhaps being placed in multiple home settings, which can be traumatic in the brain and it completely alters, you know, what a kid's sense of reality is, their scheme of life and what – you know, what is "normal".

And so I think it's a heck of a lot more complicated then to say that it's – it's just race discrepancies. I think it's important to point out that there's a lot more that goes behind it than simply race.

(Safeen): This is (Safeen). And I agree with that. And I definitely don't want to give up the impression that we think it's a simple issue.

We did run these measures. We actually had a panel dedicated to guiding us in terms of foster care, just because we know that these are relevant for a foster care population and that they did agree on is that among foster care kids, really, seeing multiple concurrent antipsychotic use was not something that is what we want to see. And, that many foster care kids are simply put on medications.

Unfortunately, it's sort of the clinical easy way to address some of the issues. Many of them are on for indications that are not recommended by the FDA

such as, you know, behavioral disruptive disorder, that sort of thing. And so, it's actually seen as a measure of high importance specifically for that population as well as Medicaid.

Jonathan Thackeray: So I guess the question for the NQF staff is, do we have enough there to decide that this is a disparity sensitive measure? Or do we need to see like actual – the data to make that determination?

Robyn Nishimi: The actual percentages are in further in the worksheet, what you had before you is just a summary. So …

Jonathan Thackeray: They're deeper in there. OK.

Robyn Nishimi: Yes. It's in there. And this is just something for you to think about and especially since someone will probably be a lead discussant at the meeting to note this. It's not something that you need to decide today.

Jonathan Thackeray: OK, thanks.

Suzanne Theberge: And I'll just pause here and add a kind of a process note. If you click – if you're looking at the worksheet and you click on that header in the blue box that says, "One B gap and care opportunity for improvement", and "One B disparities", those will pull you into – if you click on that, it's a bookmark placed in the measure submission form.

So you can see – I think that's where the data is.

So, if there are no other questions about importance, we can move onto scientific acceptability, the reliability and the validity of the measure.

And the first piece of that is the specifications, whether they – the measure as specified will produce consistent in care when implemented.

The numerator for this measure is children and adolescents who are on two or more antipsychotic medications concurrently for at least 90 days. And the denominator is children and adolescents who received 90 days or more of continuous antipsychotic medication treatment.

So, the questions that we looked at here are whether all appropriate medications are included, is the logic or calculation algorithm clear, is it likely that this measure can be consistently implemented.

The committee members who filled out the survey did flag a couple of questions here. And, would anyone like to start off the discussion?

We had some questions about whether things could be more precise. There was a question about a generic drug named ...

(Off-mike)

Male: You're breaking up again.

Female: Sorry, you're breaking up.

Female: Yes.

Male: Yes.

Suzanne Theberge: Sorry, I think they have a poor connection. Is that better?

Jonathan Thackeray: That is better.

Suzanne Theberge: OK. So, I think the – someone had a question about whether the language could be more precise. You know, the numerator and denominator are based on pharmacy dispensing over a 90-day period. And the – there's a question that was raised here is, are the gap days being counted. It says – and I think this might be a question for the developer team, it says that if the number of days between the end date of dispensing one and a start date of dispensing two equals 15 days, the gap day should be counted but should it be greater than or equal to 15 days.

Jonathan Finkelstein: Actually, less than or equal to 15 days.

Suzanne Theberge: Sorry, less than or equal to.

And did you want to expound on that question, or I'm not sure who that was that asked that?

Jonathan Finkelstein: Yes. So this is Jon. And so in claims data, we always have these gap things to deal with. But I think it's just that the measure developers to respond to that now or maybe I think they may be less than or equal to 15 days, and if it's short like that, they're going to count to.

And then, secondly, it wasn't clear there might be a good rationale why they're along the 15-day gap to constrain together dispensing and a 32-day gap is a lot than the denominator as I read it.

(Safeen): Yes, this is (Safeen) from NCQA and my colleagues probably going to help me out here. But, the way the specification is written out, it's – because of the way we structured it to use dates of dispensing and that's how you count. And so, that's why it says if – from the end of one day to the – you know, the beginning of another day. And, that's why we use equal 15 days.

And (Emily), feel free to jump in about that particular issue. But, I know that the specification is actually pretty tricky in terms of the way we've written it. But we've worked really closely with our measures team here at NCQA who filled all the questions about the HEDIS measures. And, I will just note that after its first year, we didn't – you know, with the implementation of the measure and with the auditors, we did not hear back any problems about the way the specification was written.

(Emily): And this is (Emily). I'll just jump in here as well because I just reviewed what we have in the submission form. And there is actually a typo under step three of the numerator where we say equals 15 days, that should be as you thought equal to or less than 15 days, then we count that with concurrent use.

Jonathan Finkelstein: Thank you.

Yes, that's what I think. I think the other question which is broader is, you know, if you read the guideline statements, they talk about people shouldn't be doing this for initial use. But, we don't know – and the specifications are written whether this is initial use or whether patient have failed many attempts

over many years to be treated with one medicine and this is where they are right now.

So, that's why I wrote earlier that the right answer might not be zero, in other words, people could be trying their best to avoid two agents. But after many trials in very severely effective kids, they end up here. And this may because there's no lookback, you don't know that these are new attempts of treatment or initial attempts of treatment.

I think – and that might be OK.

Molly Finnerty: This is Molly Finnerty. And, I don't think I've introduced myself before, but I'm a psychiatrist and also a staff at NYU Child and Adolescent Psychiatry as well as director of Bureau of Evidence-Based Services and Implementation Science for New York State Office in our health.

So, just to speak to the question about the difference between the numerator and the denominator. For the denominator, we're looking for this ongoing pattern so it's not that it happened one time because we would have a problem with cross-tapers and things like that.

So it's over 90-day period and allowing for that 32-day gap as sort of a way of constructing what we would mean by a continuous trial and in this case, we're saying only a 90-day trial. But, if they have a 32-day gap, you know, that is, you know, in general, we think of medication possession ratio of greater than even half if it was an ongoing and here, in the 90 days, you only have one of those in your 90 days. So it's higher than that.

And then the more conservative gap for the numerator to say that this really was this continuous pattern of prescribing multiple medications.

I don't know if that's helpful for explaining it. And, the speaker was right in that this is applied to all children with the idea that, you know, we do understand that kids can be, you know, some kids really have a lot of challenges and people work really hard to do their best by the kids that they're working with.

I think that the intent here is to really look very hard at those cases of polypharmacy particularly in light of some of the disparities that we see, for example, in the foster care population, is that, you know, are we – is multiple antipsychotics the next best thing, is it – you know, what more can we do for kids, are we sure they're even taking what we're giving and that kind of thing. So in (inaudible) issue with their psychosocial interventions, we can try.

So, that – there is some really tough complicated kids, I think we all can understand. But, the purpose of this measure is really to try and focus people on other possible options.

Suzanne Theberge: So I think, unless anybody has any further concerns, it would be the time to move on to reliability testing of the measure.

So, hearing none, the measure was test performance measure score using a beta-binomial signal-to-noise analysis.

And per the NQF algorithm, reliability testing of this type can be really rated high, moderate or low depending on the testing results.

One of the – the main thing that we saw in your comments was that folks felt that reliability testing at the state level was pretty strong. I did not see any concerns raised there. Does anybody have any questions about either the state level testing or the testing at other levels?

Health plan and Medicaid and commercial health plan levels.

Female: I'm just curious if anything has come up with the HEDIS 2015 results if you've seen anything that would change that.

(Safeen): Hi, this is (Safeen). And I believe that you were distributed a summary of results that we actually did just complete based on the HEDIS results. And I apologize that the HEDIS data were not available at this time of submission, so we had to do it afterwards.

But, we did some additional reliability based on health plan to reporting the new measures. And found that the measures were highly reliable, most of

them. And, I'm sorry, I'm talking across all the antipsychotic measures at this point. And we also did some – oh, yes, there it is up on the screen.

Yes, so you can see here that the psychosocial care metabolic monitoring measure with you all will discuss after this one were reliable.

For the multiple concurrent measure, it was reliable in Medicaid but in commercial, so below the 0.7 threshold that we tend to set and this is probably due to small denominators for commercial plans in terms of use who are continuously on in antipsychotic. And, also there was none as much variation in the performance rates.

Suzanne Theberge: Are there anymore questions?

OK. So, the next piece that we look at is the validity. Excuse me, the measure – whether the measure specifications are consistent with the evidence. And did folks have any concerns here?

One of the questions that staff highlighted for the committee are whether the appropriate medications are included in the specifications.

OK. Any thoughts on that, or?

Jonathan Thackeray: This is Jonathan. I – you know, I'm not an expert in antipsychotic prescribing but I did take this list and compared it to, you know, some other statewide and regional collaborative we've been doing working the antipsychotic use and didn't find any gaps in their medication list.

But, you know, there's probably more scientific way to say that that's OK.

Suzanne Theberge: OK.

So the next piece that we would look at is the validity testing. And that's where we ask the developers to demonstrate that the measure data elements are correct and/or that the measure score correctly reflects the quality of care provided.

Does the measure adequately identify differences in quality?

So we had – this measure, we have testing at the performance measure score, using both empirical testing and face validity.

This means per the NQF algorithm that the testing could be really rated high, moderate or low depending on the testing results.

Do folks have questions or concerns they'd like to discuss or address here?

David Einzig: David Einzig here. Just to reemphasize the question of, well, what's recommended to avoid polypharmacy and it's not what we desire, you know, is that accurate, is it valid to say that it does contribute to poor outcome. I know the guidelines are there but the evidence is missing, I believe.

Jonathan Finkelstein: This is a question for kind of the NQF folks. You know, the validity algorithm (syndrome) to kind of considered face validity and then other kinds of validity. And I think that face validity is relatively high because of the process the developers have gone through in terms of stakeholder engagement and comment and all those things giving very strong face validity and how are we supposed to categorize it if the face validity is very strong, but the empirical validity because of the data issues is not quite strong.

Robyn Nishimi: You're allowed to weigh them one against the other and reach your own conclusion there.

Jonathan Finkelstein: OK, thanks.

Robyn Nishimi: You're asked, you know, will this really – does the benefit outweigh the harm, I guess, is one of the ways that it's put in the algorithm.

So when it gets time for voting, that would be your focus.

Suzanne, you want to move us along? I know we're lagging a little bit. It always takes a little bit longer with the first measure, but we still have three more.

Suzanne? Well, since Suzanne is not on, let's move on then.

The next thing we ask the committee to weigh in on were exclusions. There were no exclusions for the measure, claims based, so there are …

(Crosstalk)

Robyn Nishimi: … there's no missing data. Did anyone have any concerns about in general about the threats to validity whether there needed to be risk adjustment, missing data for if developers says there are none and then the exclusions for which there are none?

Jonathan Thackeray: No concerns.

Suzanne Theberge: Hi, everyone, it's Suzanne, I apologize.

Robyn Nishimi: OK …

(Crosstalk)

Robyn Nishimi: We're on feasibility.

Suzanne Theberge: OK. Great.

So, I think this was one area where, you know, we, on the committee, raised any serious concerns about feasibility during their survey, the measures as part of HEDIS, it's not an eMeasure. The elements are generated through care. Do folks have any questions or concerns that they didn't raise earlier that they wanted to address now?

I did note – one question was marked on a survey during feasibility. Somebody asked for the developers to provide perspective on the HEDIS 2015 analysis. Are the rates cited in the results from the testing, has the measure rate per 1,000 or per 100?

(Safeen): The rates are actually just the numerator over the denominator and it's a percentage of proportions.

Suzanne Theberge: OK.

(Safeen): So, it's – I could say you take per 100.

Suzanne Theberge: All right, if there's no concerns about capability, we can discuss usability.

And I think this was another area where there were no major concerns rated was noted that the measure is currently in use.

Jonathan Finkelstein: So one of the problems was before we had – or at least I had didn't have a number for, so that may be one of the reasons why they're all blank. That's at least where mine was blank.

I don't think there are no feasibility concerns and it's useful. I think one thing to think about is you – whether it's reliable and valid at the level at which it's actionable. So, at the state level, I don't – I personally don't see it as very actionable. At the plan level, it might be actionable. At – and it's not reliable or valid as far as we know down to the practice clinical or provider level where it would be really actionable. So, I don't know if that isn't usability or not.

Suzanne Theberge: Can the developers wish to address that?

Molly Finnerty: Well, this is Molly Finnerty. I just wanted to say that as a state employee, you know, we actually have undertaken a number of initiatives to reduce and improve the quality of antipsychotic prescribing for children with Medicaid insurance that have been effective.

So, we actually think states are an important place to look for quality improvement support and performance measurements.

(Safeen): Yes, and this is (Safeen). I'll just add that as part of development, we also – we consulted with representatives from the state. We created a state advisory panel and we also work with MEDNET that's running out of Rutgers University that runs the state collaborative and focuses on antipsychotics among other issues.

And, states actually are the – one of the loudest stakeholders in terms of requesting measures that look into antipsychotic use, in particular for Medicaid.

And, so, you know, I – health plans also in terms of leaning on the providers who are prescribing these medications, so these are specified at the health plan or the state level and we do feel that there are things that those STs can do working with providers to improve their rates.

Jonathan Finkelstein: Yes, I actually – that's fair enough. I think I understand that, but thank you for that.

(Safeen): Thanks.

Suzanne Theberge: OK. So, we've now gone through the criteria for this measure and this measure does have a related measure, but I don't think that we'll address that now, that we'll discuss related in competing measures during the in-person meeting and the process for that.

So, I think – well, we – unless anybody have any other questions, we can move onto the next measure, 2800, the – this was pretty standard with all NQF meetings. We always find that the first measure takes the longest and, you know, as folks get more familiar with the criteria, that things will move along more quickly.

So, with that said, we can get started on measure 2800. So, this measure is metabolic monitoring for children and adolescents on antipsychotics. And it looks at the percentage of children and adolescents ages one to 17 who had two or more antibiotics – anti – sorry, antipsychotics prescriptions and has metabolic testing.

So, the – again, this is a process measure, and is based on guidelines from a number of organizations. And, we identified some questions on the evidence and the committee also identified some questions on the evidence.

One of the points that was raised was that the evidence is similar, I think, to the – a similar issue of the prior measure, it's on the link. The evidence is the

link between the medications and the metabolic issues, but is not necessarily directly linking the outcome, although it was – it is a credible link, it's just not a direct link.

Does anybody wish to discuss that on the committee?

Know that the guideline recommendations are strong, but again, it's expert opinion.

Any thoughts or shall we move onto the gap and care?

Jonathan Finkelstein: Just to say, I just want to know people who said the evidence was indirect. I think we need to say that I consider that a big barrier here. It's very, very credible that – it's clear that these medications can produce metabolic arrangements and it's not a big leap to say we should monitor for those and prevent them. But, it's just one more step to outcome.

Female: I'm curious why such low age limit, with the newborn – why our newborns and infants included.

(Safeen): So the age range – yes, the age range does go down to age one and, you know, while we don't see a lot of antipsychotic use in this lower age ranges, we do see some and that's why we included all of children and adolescents in the measure.

Molly, I don't know if you want to add to that.

Molly Finnerty: So I think it was more to the extent that states or plans who engage in monitoring focus on the parameters of the measure, although the instance is low in those ages as (Safeen) had said, certainly wouldn't want to overlook them. So, I think that's the rationale for inclusion.

Suzanne Theberge: OK. It doesn't sound like there are a lot of concerns, we can move onto gaps.

And again, there was a consensus across the committee that there is a gap and care here that there is room for improvement and that there are some disparities by race ethnicity and by age. Although it was noted that

adolescents are more likely retested so I don't know if that affects the age disparities. But, there are – I think the committee generally agrees that there is room for improvement here.

Are there any questions or thoughts, or shall we move onto the scientific acceptability?

Jonathan Thackeray: Move on.

Suzanne Theberge: All right. So, again, the first piece of scientific acceptably is the reliability of the specification, whether the measure will consistently and credibly report on a quality of care.

There – it seemed like there was mostly agreement that the data elements were pretty clearly defined, but there were some questions about – one of the questions I noted was that, whether children and adolescents who were previously identified is already having type one or two diabetes, whether they should be excluded, how that's accounted for.

Is that a major concern here?

Susan Konek: This is Sue Konek. I may have made that comment (inaudible), those folks should be looked at perhaps differently or noted, certainly this could make things worse for them, but certainly if somebody is – has diabetes to begin with, that that is something that should be a measure of how it should be separated, but it did – should be noted. Thanks.

Suzanne Theberge: OK. Are there any further concerns on the specs before we look at the testing?

Jonathan Finkelstein: So, don’t you degrade, it's just something I don't know if the developers have any information on the capture of individual blood tests in claims data and Susan raised the point (with you), you know, claims – claims data capture, I'm sure every MRI that's done because it's a big test and people need to get paid.

I don't know whether it's known, whether they capture every blood glucose measurement separately that was done. I especially don't think they capture it, it is done as part of the inpatient admission where things aren't billed separately and I bet claims-based researchers in NCQA might have some information on that.

(Safeen): Yes. This is (Safeen). You know, in terms of claims data and specific to the test here, we find that they tend to be very reliable. You know, I think in all of our measures development works we've done where we've looked at claims and medical records, we found that in most cases, the claims do a good job of capturing services, if they don't, we definitely hear about it or we find out during development, we hear about it through our advisory panels as well.

This measure, the metabolic monitoring measure, which looks at specifically the glucose test and the lipid test is actually aligned with the existing HEDIS measures that also look at those tests. So, we have a measure for schizophrenia and antipsychotic that looks at those tests.

And so, those are based on specifications of existing measures that have also been through testing and development and found that this is a good way to specify those particular labs. Does that answer your question?

Jonathan Finkelstein: Yes. So it does, but even (inaudible) about those other things if there's – if there, in the past, has been some validation that these things weren't done up here in 98 percent of time and claims, that would be great. But I'll take your word for because I know this particular labs are using other measures, so I don't think it's a big concern.

(Safeen): Great. Thanks.

Suzanne Theberge: OK. So, moving onto the testing, this was similar to the previous measure.

Tested on the same data, and again, using a signal-to-noise analysis at the performance measure score level. And again, had similar results in at the state level, which fairly reliable and would maybe less reliable at the plan level.

Do folks have questions or thoughts about that?

(Safeen): This is (Safeen) and I just like to add that – and I know you guys didn't have this information earlier, but we did look at this with the recent HEDIS first year results and found that it was – this measure is highly reliable at the health plan level.

Suzanne Theberge: OK. And (Safeen), we can maybe talk about how we can offline about getting that after to the committee at large in a timely fashion, we did share it with the workgroup but that was just a couple of hours ago. So, we'll make sure the rest of the committee has that information prior to the full review ...

(Crosstalk)

(Safeen): Right. Thank you. And I apologize for such late breaking information.

Suzanne Theberge: Better to send it late than not have it at all for sure.

So, if there are no further concerns about reliability, we can look at validity. So again, first section here is whether the specifications are consistent with the evidence. Is there anything that folks want to discuss here?

We don't see any major concerns based in the preliminary survey. So I think we can probably just move right on to validity testing.

And did folks want to discuss anything here? Anyone? Any thoughts?

The next piece is threats to validity. There are no exclusions for this measure, so there would be any exclusions. We – I think we discussed that briefly previously when we talk a little bit about whether patients who have diabetes should be excluded or are there other patients maybe should be excluded.

Anybody wish to discuss that now? Any other exclusions or anything?

And all right. And the next piece here would be missing data.

Now, as we, I think, have mentioned, this is collected from administrative data source because I think this was touched on previously on whether, you know,

there would be necessarily a claim for every blood test. But, do folks have any other concerns they want to address here?

OK. Hearing none, if there are no other concerns on testing, we can move onto feasibility.

And again, much like the last measure, I didn't know if you've any concerns here given that the measure is in HEDIS and that the data elements are generally routinely regenerated. And similar with feasibility, it's – it is currently in use so there were no concerns raised.

But does folks want to raise anything else on any other criteria or most probably on feasibility or usability?

OK.

Well, hearing none, I think we can move onto the next measure, which is 2801. And it's the third in this set of measures on – about children and adolescents on antipsychotics.

This one is use of first-line psychosocial care for children and adolescents on antipsychotic. And, the – it looks at the percentage of children and adolescents one to 17 with a new prescription for an antipsychotic, but no indication for antipsychotics who had documented documentation of psychosocial care as a first-line treatment.

And this is also a process measure.

And, again, much like the other – the previous two we looked at, it's based on guidelines of professional society based on a general expert consensus. And, I think, again, similar to the other two measures, there were some similar concerns raised about the evidence.

Do folks have specific questions they'd like to discuss?

Carol Stanley: This is Carol. And just recently, we met with our managed care plans. And, the topic of this measure came up because were doing a study with – on our foster care population in using this measure. But, there were some concerns

about especially those kids who need trauma informed care and/or immediately put on antipsychotics that just the timing of it and the need for it may not enable kindly adherence to this measure especially in areas, in rural areas where it's a real challenge to find this type of care for adolescents and children.

Suzanne Theberge: Yes, I think – I don't know if it was you who submitted this comment, but someone noted that, you know, there are – there's a role here for early intervention services. I'll say that that was not addressed.

There were a number of concerns raised, does anybody else wish to discuss anything?

(Safeen): This is (Safeen). Can I – so actually, I think that's a very helpful comment for us to hear. I know we tried to address that specific issue of timing by allowing for antipsychotics – or, I'm sorry, psychosocial care 30 days after the antipsychotic in those cases where, you know, exactly as you described, children may need to be stabilized first before going – having psychosocial services.

So we did allow even those that are first-line psychosocial care and we recognized that having it first is ideal that there may be instances where you have to put children on medication more immediately in. So we do allow for that to occur 30 days after the antipsychotic as well.

Jonathan Finkelstein: So, it's Jon. I don't know if the developers can provide it, but it would be great if there are – if there are any studies that show that (inaudible) psychosocial approaches first have better outcomes, that would be great.

But, in the submission, it's all – it said that, you know, that there are guidelines, there are consensus guidelines and they're informed by evidence and/or opinion. But it doesn't tell us where that – like if you are – you're informed mostly by opinion, but I'm – I'd love to be wrong about that and just because they're my opinion doesn't mean that's not the right opinion. But if there is evidence, it would be great to have that.

Sarah Scholle: This is Sarah Scholle from NCQA. And I just – I'm sorry, I'm in a very noisy place. But I wonder if Molly would want to comment on this.

So I think the reason for the psychosocial – the evidence for the psychosocial intervention might be somewhat indirect. So, it's for – the measure is working at children in order to have diagnosis other than the ones where antipsychotics have a FDA indication and nearly all the time, those are going to be disruptive disorder ADHD. Other conditions for which psychosocial interventions are the recommended first step, so – or other medications but not antipsychotic.

So, Molly, did you want to – do I have that right …

Molly Finnerty: Sure. Yes. No, I think, you know, in contrast to adults for children, you know, the majority of children do not have a primary indication or, you know, have or better do not have – so the kind of diagnosis they would need to have to receive these agents as an adult like schizophrenia or bipolar disorder or some kind of psychotic condition.

So in children, they're often used to control behaviors and so whatever your diagnosis might be, you know, you would want first-line treatment for that condition. And – but if you also have some kind of aggression or, you know, maladaptive behaviors, rather than reaching for an antipsychotic, really the first-line treatment for aggression is psychosocial intervention.

So for behavioral issues in children are psychosocial interventions, not antipsychotics. And so, this is really trying to highlight that cross diagnosis, antipsychotics are really not indicated, you know, antipsychotic and bipolar disorders. And then if they're used for something like aggression, there shouldn't be first line.

And what first-line treatment and there is good evidence for it is psychosocial intervention.

David Einzig: This is David Einzig. I think there's several population groups that we're talking about here where people might consider using atypical antipsychotic medications. So there's a group where clearly psychosocial interventions will be preferred over jumping to medications, complicated ADHD with

aggression, for example. But then there's going to be other conditions, shaken baby syndrome, fetal alcohol, kids with neurodevelopmental syndrome, (Inaudible).

Other things where really maybe an organic brain as you where you can do all the psychosocial treatment since the first that you want, but the brain is just now wired, where it's missing something that's preventing that, stopping things part of the brain where the medications really truly are the go-to thing.

So, I think this is – this measure is well intended, but I think it's too broad with not being specific enough with subcategories of who we're intending the psychosocial intervention strategies to go to first.

(Safeen): And this is (Safeen). So just to – I hear your point. I do want to reemphasize that the measure does remove use who have a primary indication for antipsychotic.

So, specifically these are who have schizophrenia, bipolar disorder, tic disorder and there are couple other psychotic disorders, and these were aligned to FDA indications. So, really, I think what we had to do here would turn to the FDA indications to guide us and remove kids where they do have a reason to be on antipsychotic and really focus more on those kids where it is not indicated as a first-line treatment.

David Einzig: But that – just to add on to that, FDA non-indicated uses, they don't necessarily mean non-standard of care.

(Safeen): That is true. But I will say that during testing, we did look to see what conditions were most closely associated with it of antipsychotic use and found that most of it was ADHD and other conditions for which they are not indicated.

Suzanne Theberge: So I think at this point, maybe we can move onto gap and care, unless anybody has any major issues they want to discuss on the evidence. And just being conscious of the time.

So, I think generally, people seem to agree that there are gaps in care here. I didn't see too many concerns raised here. Although, there was the concern that there's a performance gap that it might be more related to lack of access to appropriate services.

And then there was another issue raised on whether behavioral interventions will always appear as distinct claims for health plans.

Do the person who made that comment want to address that a little bit further?

Jonathan Finkelstein: Yes, no, kind of. So I'm on thin ice because I'm not a mental health professional. I'm a general pediatrician. And, it depends what you include by psychosocial intervention, but were (high practiced).

There are salary social workers in definitely qualified health centers. There are school resources that sometimes kids get plugged into and those kinds of things if they count as psychosocial intervention, I think wouldn't end up (treatment) for health plan claim. That's one of the problems is they don't get paid for in the usual way.

So I'd differ to – I differed to the content experts on the call if that – if they think that would be an issue here in terms of incomplete capture.

(Safeen): Well, this is (Safeen). So, that's a really fair point. I think that – and this was raised when – during development in public comment, they're wondering if whether the (inaudible) psychosocial care services was captured.

And so, we did run that by our advisory panels. And, they felt that, you know, despite the fact that people do go outside to get this set, you know, the measure is specified for those plans that have a mental health benefit. And we added that benefit in order to address that issue.

So, you know, at least those plans that are covering a mental health plan services would probably be capturing enough of it to be able to report the measure. And I don't know, Molly, if you want to add anything to that.

Molly Finnerty: You know, I think it is a reasonable concern. I think that capture may vary a little bit by states.

But, in our analysis, you know, we had some concerns, for example, maybe schools were offering services that we wouldn't see, but interestingly, it was the kids who weren't in school, who were other – you know, who are older than high school, like young adults, and also younger than grade school who had lower rates of services.

So, it actually suggests that in fact schools were referring kids for services and that the school age kids are getting more attention and services. So, I think it's – I think in a way this measure is sort of the heart of the problem that many stakeholders are concerned about with over prescribing of antipyschotics for children, is that, you know, are we – when it's not primary indicated condition, are we really doing our best by children and giving them psychosocial interventions and other kinds of things? So I think this is in a way one of the measures that really speaks to the heart of this set.

David Einzig: So, I would – David Einzig here again. I would recommend that might be kind of jumping ahead here. But I would recommend that this is a good measure for certain conditions for things like ADHD or autism.

But I just think it's too broad applying all non-FDA indications. I think it'd be more specific where the specific populations where the medications may be over prescribed.

Molly Finnerty: And we definitely want to talk and highlight NQF team for the in-person meeting.

Female: OK.

Molly Finnerty: I think if I could just speak to it for a second, I think one of the challenges as you …

Female: I'm sorry, I'm going to have to cut you off.

Molly Finnerty: All right, all right.

Female: And it's – that are addressed to the full group.

Molly Finnerty: OK.

Female: Then why don't we take up scientific acceptability in total?

Suzanne Theberge: Sure, yes. So, yes, we're going to look at the reliability and validity whether the measure is consistently going to produce good results and whether the testing – testing was adequate for both reliability and validity.

I think there were a few concerns raised here. Does anybody want to jump by then with anything on validity or reliability before I summarize?

There was the concern raised again about whether the measure is – whether the specifications are clear enough. There was – and I know that there is a good broad definition of behavioral treatments. But, that it's not necessarily clear that you can ensure that the – this is a new prescription on the medications. That was one concern I saw raised.

I think we have the same, with the data that we had, it was good reliability at the state level. I think we probably have the good reliability at the health plan level now with the new results.

And then, again, we had similar consistent concerns raised on validity. I think that we've already discussed about whether that – they're – whether they're identifying their prescriptions, whether it's the right set of kids, whether it's linking to the right outcomes. Do folks want to discuss anything on testing or do you feel like we've covered it already?

Jonathan Finkelstein: Right. So, I think that would be a good question for the developers, maybe I misread it. But if the measurement here is January 1 to December 31st, and there's a prescription on January 15th, how do we know that was new, how do we know that the patient hasn't been on that medicine for the last years and how do we know that, you know, in October, November and December, they were getting psychosocial treatment that either did or didn’t work.

Did I misread the – is there any lookback or running period?

(Safeen): Hi, it's (Safeen). No, I'll just explain it. It does get a little confusing sometimes when you look at these measures and you're thinking throughout the date.

So, the intake period is actually January 1 through December 1 of the measurement year. And then we looked for the first prescription and we do this by looking 120 days or four months prior to this prescription, the first prescription in the year. And then look through 30 days after this prescription. And the continuous enrollment is 120 days prior.

So, just gives plans and opportunity to look back prerequisite number of months in order to verify that this is a new prescription. This aligns with the way we specify new prescriptions across all HEDIS measures. So we have several measures that look at new prescriptions and services that are associated with that. And we – so we have tested this 120-day negative medication history is what we call it in order to verify new prescriptions.

Jonathan Finkelstein: So, that's perfect and that addresses that concern for me.

(Safeen): Right.

Suzanne Theberge: OK. I think, next, we're on feasibility. Again, not too many concerns raised here given that the measure is already in use. One – well, I did see one concern flagged here.

One of the committee members wanted to discuss balancing concerns of over prescribing antipsychotics and associated safety issues, balancing that with the issue that's potentially withholding effective treatments for targeted symptoms.

Is that something folks want to discuss now or just kind of flag to be aware of?

David Einzig: You know, common sense of, you know, with you. If they have severe symptoms in September and October and you withhold effective treatment

and they're in school, you know, potentially ruining the entire school years. But I think it's something that should not be taken lightly.

Suzanne Theberge: OK.

All right. And then, again, with feasibility or sorry with usability, there were no – nothing was raised by the committee.

Is there anything else on this measure folks would like to discuss before we move onto the last measure?

All right. I think we can jump ahead then to 2803. We've got about 20, 25 minutes left to discuss this measure. And then we'll have some wrap-up items in the public comment period before the end of the call. Just to let you all know how we're doing.

So, measure 2803 is a slightly different topic area. It's tobacco use and help with quitting among adolescents. And, you know, the measure looks at the percentage of adolescents ages 12 to 20 for whom tobacco use status was documented and who received help with quitting if identified as a tobacco user.

This is another process measure. And, the committee had kind of mixed comments on the evidence for the measure. It's – there was a comment that the evidence apply conventionally to the goal of decreasing tobacco use that there are insufficient evidence, and there are a number of recommendations by expert group, there's a limited evidence. And that is in the form of professional consensus guidelines.

So, would the committee like to discus this? I think there's a bit of disagreement here.

Female: So, I was able to sign on the preventive services task force where recommends interventions and education and counseling to prevent initiation of tobacco use.

But I couldn't – and that was B recommendation, but I could not find B or stronger for providing assistance or quitting.

Kraig Knudsen: And this is Kraig. I found the same thing and that's why I put that.

(Safeen): This is (Safeen). Would you like me to address that?

(Safeen): Yes.

(Safeen): OK, great.

So, you're right. So, there is a U.S. Preventive Services Task Force recommendation statement and it's very focused on preventing initiation, which is why we actually added the additional guidelines.

So, the U.S. Public Health Service, the American Academy of Pediatrics, and those are just based on studies that say that, you know, physicians advised to quit actually can be very helpful. And so we've listed some of this study there.

So, this measure really tried to take more of a holistic view which is, you know, assess them which is, you know, I think it is somewhat indirect but it's in the U.S. Preventive Services Task Force recommendation.

And if you do find that an adolescent is smoking, you know, based on studies that find that if physician is advised to quit can be effective, offers treatment advice. And then you can see the measure, you know, gives a couple of different ways to meet that criterion.

Suzanne Theberge: OK. Are there further questions?

Any further – any other thoughts on evidence before we move onto gap?

OK. Didn't see a lot of disagreement from the committee here. Folks generally agree that there is a performance gap.

So anybody have any questions or wish to discuss anything before we move onto the testing?

Jonathan Thackeray: I think the NQF staff had prompted a question about information since 2011. I have the same question. Is there any updated data? Or is that the most recent?

Female: Are you asking about our testing data?

Jonathan Thackeray: Well, the data from the …

Suzanne Theberge: The National Youth Tobacco Survey.

Jonathan Thackeray: Yes, the NYTS as well as the testing data. They're both, I guess, 2010 and 2011.

Female: Yes. We can look into the national youth testing data. But, for our data, it is based on care that was given in 2011 based on when we developed this measure, which was actually few years ago.

But we could look in the literature to see if there's more updated information that gets at the same issues that we were testing.

Jonathan Thackeray: I guess the reason I ask is more and more, you know, as meaningful use is becoming more prominent. And EHR is rolling out, sort of more widespread, I wonder if these numbers – if you're going to see higher numbers across the board.

Female: Right, that's a good point.

Suzanne Theberge: OK.

So, moving onto the reliability of the specification, the numerator is adolescents who are not smokers or adolescents who are smokers but are receiving cessation counseling.

And the denominator is adolescents who turned 12 or 20 during the measurement year and had documentation of a face-to-face visit with a primary care practice during the 12 months prior to the measurement year.

There were several concerned committee in this section, so I will just dive right into those. The first one that I wanted to highlight was someone asked why the – that the numerator statements (inaudible). Hello? Hello?

Female: We're here.

Suzanne Theberge: OK. Sorry, I got a weird bit of feedback on the line.

The numerator statement seems to include two separate and distinct groups, adolescents who don't smoke and adolescents who do smoke and had been counseled to quit. And, the person said, the numerator seems to have two intentions, tobacco use status and if a tobacco user, an advice to quit. Why are the two groups combined rather than having two separate measures?

Folks want to talk about that?

Jonathan Finkelstein: I think I made that comment. I'm not sure if it's a problem or not and maybe at the in-person meeting, the developers could help us wrestle with that.

If – I'm just trying to figure out how I could or how our health system could do well on that measure if they have a low rate of smoking – of smokers, they could get to me just by screening everybody and documenting not smoking even if they did a terrible job of referring and counseling kids who use tobacco just because their rate is low.

And so, part of me says we should be measuring people on the screening part. And then, for whoever screens positive, they should have a high rate of offering intervention to quit. I understand there might be weaknesses and I might be convinced that the logic of putting them together, but I can't quite get my brain around it.

Carol Stanley: Yes.

Jonathan Finkelstein: And maybe ...

(Crosstalk)

Jonathan Finkelstein: ... didn't have an issue.

Carol Stanley: Yes. This is Carol. Actually, I wrote this in – I was really confused about why those two groups would be combined into one numerator when an adolescent who doesn't smoke would require much less time during this visit with the physician then an adolescent who does smoke.

And, is this measure going to be use in some type of p for p or accountability type measure. And, it seems like it would put practitioners who see a higher proportion of smoking adolescents with – inadvertently be sort of penalized for that.

Sarah Scholle: That's a good point. This is Sarah Scholle.

We actually modeled this measure of separate measures that are – I believe the NQF endorsed are used in the adult population that look at screening and follow up, so the logic being that a screening measure alone without a follow-up step for people who are identified is kind of insufficient.

And so, there is an adult measure that is for tobacco use that has a similar construction, there's one for depression screening that is one – but maybe there is one for blood pressure as well. So, this logical problem is something that we've raised in our development that we were trying to line the measure with the existing adult measures that were NQF endorsed based on that preference so they're not being – did not have a screening measure that didn't indicate whether appropriate follow up at the screening result with Jon.

Female: Yes. So, I guess I was thinking about the measures, for example, for blood pressure where there's a measure for a blood pressure screening for people who are hypertensive. And then there's also a separate measure for a blood pressure control. But, I can see what you're saying.

(Safeen): Yes, and this is (Safeen). I'll just add that also, you know, I think that, you know, we were striving for a population-based measure in the sense and structure it this way. And, when we divided up and, you know, focused only on smokers, you may run into low denominators.

Female: OK. That makes …

Suzanne Theberge: And I think that gets at an issue that was raised by someone else that the comment was their – if a (chart) as non-smoker, will that be taken as evidence that the teen is not using tobacco in other way such as chewing tobacco or (snuff).

I think there was also some question here about the lookback period. The comment was, the other state lookback period of 18 months, I'm not sure if that's correct given that the measure could include anyone turning 12 to 20, and the measurement is about visits in the year prior. It seems at least 24 months of data is required.

Any thoughts on that?

Female: Hi …

Female: Maybe address that at the in-person meeting.

Suzanne Theberge: OK. I think we can move onto the testing.

This measure, there were some concerns raised here on the testing about the kappa being moderate and the chart review – the measure in the chart review measure was only tested in three clinical settings. There was some concern that that might be insufficient to understand the variation in how things are documented.

Some other – any thoughts on that folks want to discuss here?

Jonathan Finkelstein: I think at the in-person meeting, it'd be great that the developers think as EHRs evolved. This will be able to be more automated, or the difference between the chart kind of instruction, the manual instruction of the automated was striking. And I – that makes it a very expensive – a less – a more labor intensive measure and I wonder if we think we'll get to a place where EHRs will be better at doing this in an automated way.

Sarah Scholle: This is Sarah. We can definitely address that. I think this is early on in the meaningful use, but it's been our experience across a number of measure development activities that was extractable from the searchable coded fields in the EHR is limited and it's growing and actually probably the best way to get the field to use accurately would be to have a measure that require their use.

We got a chicken and egg problem here. I would expect that this has improved since meaningful use as require or has an effect of about the use of the – this – practically tobacco documentation.

Suzanne Theberge: OK.

I think probably want to move onto validity in the interest of time. There were, again, concerns raised here on the – whether the measure specifications are consistent with the evidence. There were some concerns raised here.

Again, the two pieces of the measure, the documentation of no tobacco use in counseling, that came up again here. There was another concern raised that regarding the most effective strategy to assist with quitting smoking. No mention with motivational interviewing strategies.

Any comments on that?

There's a lack of clarity it seems, perhaps for receiving cessation counseling, what that might actually mean.

Female: I had some questions about the use in terminology because it seemed like at times, the term receiving cessation counseling was used, which receiving to me means they are receiving it now before they got to the physician's office. Or did they receive it while they were there. And then other terms that were used, or things like received help and intervention and assistance quitting.

So, I wasn't really clear about what if an adolescent is smoking but is receiving counseling already or has received it. Because it seems like there are some just a little need to clear up some of the consistent terminology.

(Safeen): This is (Safeen). Thanks for that feedback.

We'll try to make sure we're consistent throughout all of the forms. I know that we probably talked about it throughout a little differently.

The numerator does detail – the way we've listed it here is documentation that the adolescent is – has any of the following. We say advice given to quit, counseling on the benefits of quitting, assistance with a referral to external program around smoking or tobacco use and current enrollment in tobacco or smoking sufficient program also would count towards the numerator.

So, we do – we've tried to align this to other ways that we look at this sort of thing, you know, I know it's always tricky when you are trying to capture all of the different ways that these sorts of things might be documented.

We have some other measures in HEDIS that look at, you know, well-child visits. And so we've tried to align our language to the way we try to capture assessment or counseling in those measures as well.

Female: OK. That makes sense.

David Einzig: And this is Dave. I'm sorry, I hit the wrong button. I got disconnected so this might have already been talked about. But that was my on the motivational interviewing strategies, and then using effective strategies.

Counseling is such a broad definition. And if you have a teenager, if you tell him up, they're going to think down. And if you tell the kid to quit smoking, you know, so sometimes, you know, the – I would encourage utilizing more specific language in terms of what is the gold standard in terms of what counseling strategies, what types of things should be done to assist with quitting smoking.

Suzanne Theberge: OK. We are running very short on time.

Anything else folks want to discuss on validity before we move on?

Moving onto feasibility, I think we've already discussed this briefly, but generally, there was some concern about the fact that the measure requires manual abstraction at this time. And that is a feasibility concern.

Does anyone want to say anything?

OK. Hearing nothing, I think we can move onto usability. And, I couldn't see much here regarding unintended consequences or other concerns with usability, so.

Anything else on this measure before we move to the next part of the call?

OK. Well, that finishes the measure discussion portion of the call. And we'll stop here. And, open the lines if there are any public comments before we move onto the next steps please.

So (Ann), can you see if there are any public comments?

And if you're on the phone, you can submit a comment verbally. You can also submit a comment via the chat box on the webinar.

Operator: At this time, if you have a comment, please press star then the number one on your telephone keypad.

We'll pause for just a moment to compile the roster.

And there are no public comments at this time.

Suzanne Theberge: OK. All right. So I think we can move onto next steps.

So, I want to thank the committee members for all your work thus far. Thank you for taking the time to review the measures.

And, the next step for you in your work on the committee is to review the rest of the measures, the other 11 measures under review in this project.

We do ask that folks have looked at everything prior to the in-person meeting. We'll be sharing the rest of the workgroup comments so we're going – we're going to be doing these calls, we've got one on Thursday and then two next week, on Monday and Wednesday.

And so we'll be collecting comments and input on those measures. And then we'll share that with everybody. As I mentioned, after those are compiled, we'll also be sharing the public comments with you.

In the next few days, we'll be assigning lead discussants for each measure. And so what we'll ask you to do rather than having staff lead the discussion on each measure, we'll be having a couple of committee members assigned to each measure to lead the discussion at the in-person meeting.

So, you'll be taking on the role of introducing the measure, flagging issue to discuss, summarizing comments received, et cetera. So, more coming soon on that. And we'll be getting that out to you soon.

And in terms of logistical information, you should have already received your travel arrangement e-mail from the NQF meeting's team that will allow you to make your flight and hotel reservation. So, if that hasn't – if you haven't gotten that, please do let us know right away. And we'll get that sorted out.

So, any questions on that?

Female: Suzanne, I just wanted to clarify. There's no expectation that they're filling out the survey for the other measures, correct?

Suzanne Theberge: Correct. And actually, Severa, if you could jump to the next slide. I'll go over the next set of calls.

So, as I've mentioned, we've got these other upcoming workgroup calls. You don't have to attend, although you are welcome to listen in if you would like to, but you are not – definitely don't have to attend. You don't have to fill out anymore surveys. Although again, you are welcome to if you find that a helpful guide. And, you know, if that helps you review the measures, please do but it's definitely not required.

Again, thank you for the work that you have done already. We know it's time consuming. And we appreciate it.

So, after – we've got a couple of workgroup calls, and then we will – everybody has their Thanksgiving Holiday and then we'll all be meeting in-person on December 1st and 2nd at NQF's office in D.C. And that's really when (inaudible). Is everyone still there?

Female: Yes.

Suzanne Theberge: Sorry, it was more feedback.

Everyone will be discussing and the committee will actually make their recommendation from the measure, or the measure set rather.

We do have a follow-up call, a time held on December 10th from 3:00 to 5:00 p.m. Eastern Time. And that's for if there are any issues that we don't get to at the in-person meeting. If anything runs over and we need more time, we'll discuss it then.

And if not, then we'll cancel that call, so. With that said, I think – and we did get a comment, and I will just – I see them in the chat box. I will just read that out and then we can conclude the call.

A comment was, just wanted to second the concern regarding 2799, use of multiple antipsychotics. In light of the black box warnings on suicide, risk benefits must be (weighed), there's now less prescribing resulting in increased suicide rate.

OK. So, if – does anybody have any questions? I'll pause here.

All right. Hearing none, if you – please do start looking at the rest of the measures. If you do have any questions, if you can pull up the next slide, Severa, please get in touch with us. You've got our e-mail address, that's the team e-mail address, you've got our phone number.

The SharePoint site is where all the measures are being posted, all that information is being – for the committee is being shared there. And then there's the public project page as well.

But don't hesitate to give as a call or an e-mail at any time. And, we are looking forward to seeing you all in December.

So, with that, I will conclude the call. Thanks very much everyone for your time this afternoon.

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