THE NATIONAL QUALITY FORUM

+ + + + +

MENTAL HEALTH OUTCOMES STEERING COMMITTEE

+ + + + +

TUESDAY,
NOVEMBER 17, 2009

+ + + + +

The Committee met in the Columbia A room in the Hyatt Regency Washington D.C. Hotel, 400 New Jersey Avenue N.W., Washington, D.C., at 9:00 a.m., Tricia Leddy and Jeffrey Susman, Co-Chairs, presiding.

MEMBERS PRESENT:

TRICIA LEDDY, M.S., Co-Chair
JEFFREY SUSMAN, M.D., Co-Chair
SHEILA R. BOTTS, PharmD, BCPP
RICHARD J. GOLDBERG, M.D., MS
ERIC D. GOPLERUD, M.D.
MAUREEN HENNESSEY, Ph.D., CPCC
DARCY JAFFE, ARNP
DANIEL I. KAUFER, M.D., FAAN (via telephone)
ANNE P. MANTON, Ph.D., APRN, FAAN
KATIE MASLOW, MSW
LUC R. PELLETIER, MSN, APRN, FAAN
HAROLD A. PINCUS, M.D.
ROBERT ROCA, M.D., MBA, MPH
JOEL E. STREIM, M.D.
GEORGE J. WAN, Ph.D., MPH
CAROL WILKINS, MPP

NQF STAFF PRESENT:

IAN CORBRIDGE
ASHLEY MORSELL
REVA WINKLER
BONNIE ZELL

A G E N D A

P R O C E E D I N G S

9:06 a.m.

Welcome, Introductions and Brief Review

CO-CHAIR SUSMAN: So get your last minute coffee. I think we were tremendously productive yesterday, and I appreciate everybody being here on time.

After the battle, it's just showing up. We have a new participant today, Carol Wilkins. Carol, thank you for joining us. Do you want to introduce yourself and tell us about your experiences in this arena?

MS. WILKINS: Sure. I'm Carol Wilkins. I was participating by phone for most of the day yesterday, so some of you might have heard my voice once or twice. I am working now independently, but I was until very, very recently the Director of Policy and Research for the Corporation for Supportive Housing.

I think I probably said on the phone my work is really focused on the

integration of housing, health care, behavioral health services for people with very complex co-occurring disorders, who cycle often between homelessness or incarceration and crisis health services.

I guess that that's part of the perspective that I bring. I managed a lot of the research work that we did, as well as a synthesis of research for a major HUD/HHS research symposium on homelessness.

So I guess I'm the expert on chronic homelessness here at the table, though I think Darcy shares some of that expertise, and really focus on those folks who often are not engaged in the mainstream mental health system.

CO-CHAIR SUSMAN: Thank you very much.

CO-CHAIR LEDDY: So this morning, we're going to first hear from Bonnie, and following that, Ian is going to give us his summary of what all his work last night after

our extended discussion yesterday, putting our ideas together on a call for measure discussion.

Then we'll talk about how we're going to target our response for measures, how we will, you know, get as many participants and responses as we can, and then have a discussion of the measure evaluation criteria, where we'll hear from Reva about how it's not just a call for anybody's ideas; the measures have certain criteria and testing requirements, et cetera. So we'll hear about that last.

So we'll open the meeting with Bonnie, who is going to talk about population health.

CO-CHAIR SUSMAN: And we're going to do this all very promptly, so we can catch those earlier planes home. Unfortunately, remember to use your mic.

Health Care for Populations

MS. ZELL: Okay. I really

appreciate having the opportunity to talk with all of you today, and I have to say listening to your conversation yesterday, I realized, and I thought that those of you that are addressing the mental health needs of individuals in health care systems and in communities really do have an understanding of the complexity, and that's what we're going to be talking about.

Carol's comments about homelessness lead right into this. So basically what I'm going to be talking about is just a population health perspective, as you think through your mental health outcome measures.

I think that clearly, as I said, this group really understands how to think about this, both from an individual standpoint and a population standpoint. So I'd like to make this more of a conversation. If at any point somebody wants to make a comment or ask a question or pose something to the group, please feel free.

So I think it's always really important, and again I'm not so sure this group needs this reminder. But to really understand where health care sits in the big picture, ultimately what we're trying to achieve is health, and I think it's important for us to understand how population health and health has been defined.

WHO talks about it as merely the absence of disease or infirmity. The IOM talks about a state of well-being, a capacity to function, a lot of things we talked about yesterday in the face of changing circumstances. A positive concept, emphasizing social and personal resources as well as physical capabilities.

I think what's really important, and a lot of this was discussed yesterday as well, is where are the boundaries? This is a shared responsibility of health care, governmental public health and a variety of other community stakeholders, and that came up

multiple times in the conversation yesterday.

When we're talking about looking at health care measures and accountability, where exactly do we draw the line? And how do we address the complexity of the reality that in fact the things that we do in health care, although important, we can sometimes reduce them down to something measurable.

That actually has a lot of complexity when you think about the actual execution of what it is we're trying to do in the community. There's, I think, an opportunity to think about that boundary. Next.

So how does health happen? Again, a lot of this discussion yesterday, the recognition that we need to start with the individual. Health does happen one person at a time, one day at a time, one decision at a time. But that's really within the context of where and how people live.

These terms were even brought up

yesterday, the sites, the work, where you work, where you learn, where you play, where you shop, influenced by level of education, income and employment, the SES that we talk about, and determined also by access to healthy food, safe environments, available transportation, and health care services.

So we really need to have, I think, a very explicit recognition in this group especially, that health itself and mental health, although the mental health community from a medical standpoint certainly plays an important role, so much of what you're addressing happens outside of health care and outside the realm of health care, and we need to deal with that tension.

As well as the context, the preferences that people have, their cultural, social and economic frameworks, et cetera, also have a very significant influence on health. These individuals then aggregate the populations.

Next. So there was a lot of discussion yesterday that is this individual, is this population? I think it's important to remember that we're talking about the same thing, that individuals just aggregate into populations, and those populations are just wherever we decide to draw those boundaries.

So those boundaries can be around disease-specific things, those people with depression. It can be around those with site-specific things such as homelessness. I can be around racial groups, ethnic groups, life stage.

You talk about mental health challenges of children versus adolescents versus adults, which are certainly different, poverty.

We could look at a health systems' population of patients, or a health insurer's population across health systems. So we can do this any way we want, and it's really important to understand that is all we're

doing. It's the same individuals end up in different groups, depending on how we decide to aggregate those individuals.

But the importance of understanding that things don't happen in a cloud formation to populations; they happen on an individual basis, and there are certainly exposures and circumstances that exist within populations that then do cause things to happen in a population way versus an individual way, and that requires different approaches and we'll talk about that in a moment.

Next. So a reminder. I'm sure all of you have seen this. This is looking at the determinants of health and the proportional contribution to premature death. But what's important again for us to really remind ourselves of is the important but limited role that health care plays, and certainly in mental health.

Because there are so many individuals that suffer from mental health

symptoms such as anxiety and depression that do not rise to the level of necessarily meeting and intersecting with health care a lot to address those issues, it's really important for us to understand the role we do play, and the need to work with other sectors of our communities because of the importance of the behavioral patterns, as we've talked about, which are choice but limited by circumstance, the social circumstances, the environment, et cetera.

Next. This, I thought, is important because this was done by the Institute of Medicine and it talks again about healthy people and healthy communities, and really provides a broad view of the public health system, which includes the health care delivery system but a lot of other sectors of the community, and again highlights the importance of ensuring the conditions that we need for health in populations.

Next. I don't know how many of you

are familiar with the chronic care model. Is this something people are familiar with? Yes, okay.

This is just the expanded chronic care model, which just demonstrates the need for proactive communities and community partners, as well as the health care system, and just really highlights that the health care system sits within the context of each community that it's in.

I myself come from health care. I was a nurse for six years, an OB/GYN physician for 14 at Kaiser in Northern California, and was serving a very under-served community. It was really remarkable to me how isolated we were from that community, how disconnected we were from the services and the needs of a lot of our, the people that we were there to care for.

We really were very much in a bubble, and I think that even though this is obvious, it's important to sometimes make it

explicit.

Next. I don't know how many of you are familiar with David Kindig's work in Wisconsin. The University of Wisconsin has a Population Health Institute, but he is now emeritus, but he ran.

David did a lot of work on looking at the determinants of health, and this driver diagram is what they use for the measures that they use for county level for all the counties in Wisconsin.

Again, they use the Evans and Stoddart model in that diagram that you just saw previously, that pie shape that uses the ten percent for health care, 40 percent for health behaviors, et cetera.

What they have done is looked at every county in Wisconsin, and provided these statistics to each one of the counties. Now what they've done is looked at things like health care. They've said it's access to care and quality of outpatient care, and then you

see that there are some specific measures to the right.

What's important about this is those things that they chose were those things where they could get the data, so that limited somewhat what they could do, and I'm going to show you another driver diagram in a second that goes into a lot more detail, that's being used by another community based on this.

But what's important about this is that even though it was at a county level, which makes it hard to know what to do in specific neighborhoods, which is really where we need to go, since everything is local when you're talking about these issues.

But what this did do is drive a tremendous amount of conversation; it got a lot of press and caused a lot of counties and boards of health, et cetera, to look at what they were doing and to think differently about what they were doing and to have a much broader view.

It also motivated a lot of coalition-building, when it was explicit and clear to everybody that not one sector could manage these issues alone, and that there needed to be multi-sector activities.

Next. What I thought I would share with you is this driver diagram that is being used by the Vermont Blueprint up in Vermont, who's working the improve the health of their entire population of the state.

I just thought that this was really a good example of how communities are now taking this down to a community level, and looking at the specific issues that they think are important for their community.

I don't know if all of you can see it clearly, but when they talked about health care, they talked about immunizations, access to care, ER use and overuse and ambulatory care-sensitive conditions, and then they break that down and include mental health.

What I thought was interesting

about looking at this driver diagram and why I thought I would share it was because when you look at the health behaviors and you look at the socio-economic factors, there's almost nothing there that isn't pertinent to what all of you are discussing in terms of mental health.

High risk teen sexual behavior, violent crime, domestic violence, tobacco use, alcohol, homelessness, social isolation, single parent households, unemployment, education, on and on. And so I think it's -- although I know that this group is really struggling with where are the boundaries, I think it's really important to also understand that the boundaries are somewhat false.

As we try to make this simpler and simpler and more linear, so that we can measure in health care for accountability, which I understand we do need to do, we also need to think about who else to work with, who else to have shared accountability with,

because in fact it's much more complex than we'd like it to be, as the homelessness issue that Carol illustrated is, and the importance of us not siloing what we think about doing, but understanding we need to make that connection and make it very explicit again.

Next slide. This was just what they've done with the determinants of heart health in Vermont, and again I thought it was interesting because again, when we talk about something disease-specific, not only is it important for us to think about the psychological issues that occur when somebody's got a chronic illness, acute or chronic illness, but also the importance of thinking about family and the impact this has psychologically on families and caregivers, as well and the need for that support.

That's something else I think you might want to think about as you think about the measures. And holding health care accountable, because it may not be that health

care could actually directly cause something to happen, but health care can be held accountable to working with others in a community, to make sure that certain things are addressed.

Next slide, please. So bringing population health in relationship to health care. So one way to think about this when we're talking about individuals versus populations is the things that a lot of you already talked about, which is the bringing population level assessments into health care.

One of the things that I'm involved with, which has been a really powerful thing to do, is working with a health system to just query their own data, just ask questions that we don't normally ask, and it's amazing the things that you learn.

What we're doing down in Atlanta is I'm working with a health system that we're looking at congestive heart failure, only because it's one of the number one reasons for

admission. It's costly. Readmissions are probably not going to be paid for in the future, and there's a lot of readmissions that happen, and it's something that needs to be managed at a community level.

So I think that anyway, so I can tell you a little bit about that. What we did is we just asked, this was very simple. This was not costly. They already have the data. They're already sitting on their own data. It's real time data, and it was how many patients do you have with CHF; what percent of them are getting readmitted in 30, 60 or 90 days. We looked at a three year span and we said how many times are individuals readmitted?

We found out that there are individuals who could be readmitted 20 times in a three year span, but we didn't know it, because we hadn't asked the question. So it's just something to think about, is what information could you get that might really

inform your interventions, and better inform your interventions, and how can you use the data you already have to do that?

Another is to utilize GIS mapping. What we've done is we've taken those CHF patients and we've put them on a geographic map, and the patterns are quite amazing. Then you start overlaying that with things like when you're looking at CHF, and where people have access to healthy food, where people actually buy their food.

Do people have transportation to get to the healthy food that's three miles way or not, and is that realistic and et cetera. We've found some just really quite phenomenal things.

What this leads us to is when you look at the CHF measures of did we give comprehensive discharge instructions and let me get 100 percent on that let's say, and did we tell them to eat the right food? Yes. Did we tell them to get exercise? Yes.

But if in the context of their environments that's not realistic, even though from a health care perspective we may be getting 100 percent, if we're not really addressing the context and the realities out in the community, are we really doing what it is we're trying to do, and are we going to be able to do it by just focusing on what we do within the walls of health care? As I said, we've learned a tremendous amount by mapping out this data.

Next please. So that's the assessment. Then there's, you can bring population level strategies. Before I get to what's on the slide, again thinking about what we need to do out in the community is a population level strategy.

So yes, we should tell people to eat the right foods, get exercise. But then what we do out in the community to make sure that's possible becomes a population level strategy. So for instance, let's look at

something simple like smoking.

Yes, when we do intersect with somebody in health care, we should certainly tell them not to smoke, offer the quit lines, et cetera. But then raising -- and that's an individual strategy.

Raising taxes on cigarettes is a population-level strategy, and it has worked. So we can beat ourselves to a pulp telling people to quit smoking, and maybe we're successful and maybe we're not.

The other thing is how often do we intersect with these individuals versus the amount of opportunities that we have if we think about working with the places that people spend their time -- schools, businesses, et cetera, and opportunities for health care to go outside the walls of health care and work in those institutions through community benefit dollars, et cetera. We can talk about that.

But there's different strategies

that we could take to have much greater impact. We could target outreach for screening and follow-up by understanding our populations inside of health care, suggest available community-level mental health and health promotion resources to a community, to highlight for a community what they need, based on what we're learning from our health care experiences and health care data, disseminate targeted newsletters and partner with community stakeholders, as I've already mentioned, in places where people spend their time, where have an opportunity to have tremendous influence.

Next slide. So in addition to assessing did Alissa complete her depression assessment and leave her appointment with symptom management plan, counseling appointments and her Zoloft prescription, can we also ask how many individuals that we care for in a practice have completed a mental health assessment in the past 12 months, and

what percent of our patients who do have depression have completed a mental health assessment in the last 12 months so we know whether or not they're getting better or worse, have a symptom management plan, counseling or community support and indicate a medications order which could be a composite measure that has been talked about already.

Next slide. I just pulled some data. This is certainly information that all of you are familiar with, I'm sure. But I think it's again important, because I really believe that there are a couple of places in health care that really have an opportunity to stretch across all life stages and all diseases.

One is mental health and addressing mental health, and the other is nursing. Nurses are everywhere, and there's a real opportunity to utilize the nursing work force, because nurses are medical assistants in hospitals, to CEOs, to out in public health

departments, school nurses, et cetera.

But it's important to look at the leading causes of death, for instance, among adolescents; unintentional injury, which I'm sure has a huge mental health component to it, in terms of drinking and alcohol, in terms of anxiety and all those types of things; homicide and suicide.

Next slide. And looking at death due to injury among these adolescents. Again, it's motor vehicle, as I've talked about, but firearms and poisoning, which I'm sure a lot of it is substance abuse. So these are all issues all of you are intimately involved with, and I think again an opportunity for you to really span and lead in a lot of these discussions about working in a collaborative fashion within health care.

I understand that one of the struggles that the mental health community has is even being included in the medical model, which I think is a really important first

step. But it's also the opportunity that I think you have to think much more broadly, because of the perspective that you bring.

Next slide. This again was discussed yesterday. The aging of the population, the obvious increase that we're going to have in diseases such as Alzheimer's disease.

The reason that I put this in here was just to remind me to say how important it is that we think about, I think in this group as well, families and caregivers in the accountability for health care.

Next slide. This was just again looking at the 15 leading causes of death, and when you look down this list, whether it's an acute issue or a chronic issue, there's really no place that mental health issues aren't paramount.

Next slide. So this brings us to the question that I've already posed, and that I think all of you brought up yesterday.

Should other sectors in the community that significantly influence health status and mental health, in addition to health care, have accountability for health in their communities, and how might you think about connecting performance measures and health care with activities in other sectors?

Next slide. So can we expand our frame from why does this patient have this disease or condition at this time, to include what population circumstances are the underlying causes of the disease or condition incidence in this population?

Next slide. This is a diagram that just emphasizes that health care and the public health network, which is governmental public health, as well as all the social services and non-profits in a community, that we do overlap tremendously, that we need to understand there are certain things that happen in the health care delivery system that will never happen in public health, such as

going to an operating room.

There are certain things that happen in public health that will certainly not happen in health care, such as evaluating restaurants for safety. But there is a tremendous area of overlap and opportunity, and that we tend to think about think about where we are on the far right.

But what we're really, we keep talking about, that we have to operationalize, is the concepts of prevention, which move us over to the left.

Next slide. I have provided some references. The first one, I think, is a really powerful tool. It was put together, it says "Steering Committee Report on Hospitals and the Public's Health," put together by the American Hospital Association's Association for Community Health Improvement, which explicitly talks about how to use community benefit dollars to benefit the community.

A lot of community benefit dollars

are used for things like health fairs, which unfortunately usually don't connect to much anywhere in the health care system or within the community.

A lot of money is spent on community benefit dollars, and it's a real opportunity for us to rethink how we spend those dollars. That's one place where health care could start today, to think about how to move out into the community and partner out in the community in very substantial ways.

Then the other resources are just there. There's resources about the Guide to Community Preventive Services that provides the evidence base for community level interventions, and then several tools that talk about how to actually work within the community, the community toolbox and the MAPP resource. Thanks very much.

CO-CHAIR SUSMAN: Why don't we open it up for some comments, questions, discussion?

DR. PINCUS: Yeah. It's interesting that a number of the points you made are all -- I mean the points you made were all valid, but the question is who's really accountable for a lot of that, and who's going to pay for a lot of that is sort of the key issue.

But in terms of our task here, there are two things that came up, I thought. The one that you had about sort of population level factors, the slide that you had up there, that talked about, you know, like for example for you mentioned for cardiovascular diseases. You give somebody a diet and an exercise regimen and so forth. It depends upon the built-in environment.

Is there any possibility of incorporating any of those variables into risk adjustment models, and should it be? I mean it gets to the point of, you know, how does one fix accountability? Is it for, you know, a patient that gets discharged from the

hospital with congestive heart failure, to what extent is the hospital being penalized if there's no decent grocery stores in their neighborhood?

MS. ZELL: Absolutely.

DR. PINCUS: And does that get adjusted for or should it get adjusted for, and are there things that -- and I don't know if we're supposed to make recommendations on our list of sort of how does one deal with some of the risk adjustment issues for the various outcomes that we're dealing with?

The second point is your example of Alissa. Were you suggesting that those items that you suggested were potential measures to be incorporated measures? So the kinds of treatment that Alissa would get subsequently, should be incorporated, those kinds of things should be incorporated as outcome measures in our list?

MS. ZELL: I think that's for you to discuss and decide. I mean I think that --

did you want to say something Reva? Okay. You know, to answer your first question, I think that payors are looking at how to extend outside of health care.

I don't know if you've heard much about accountable care organizations and the discussions about that. That is a first step. But I think there's great recognition.

As I said at the beginning, and as you all discussed yesterday, that this is actually more complex than we'd like it to be. I think that the first step is how do we take payment and have shared accountability between hospitals and physicians' offices, and that there is no doubt that that's going to move to home health, et cetera.

And I think maybe in the distant future, we can think about how are we going to hold communities accountable and what is that going to look like and how will we have shared accountability? But I do think that potentially that is going to happen.

I think that we're doing a lot of demonstration projects to try to figure out how would we do that and how will attribution actually -- how will it be used and how will it be shared?

But I do think that if in fact what we're trying to do, which we say we're trying to do, is actually move the dots and look at outcomes, that we're going to have to deal with the reality that even if what we do in health care, as I said, checks off all the boxes, if in fact that doesn't move the dot, what are we going to do about that?

You know, I think obesity is a good example, and so we're talking about BMI and should health care be held accountable for doing BMI, okay? Yes. Should schools? Perhaps. That's also being discussed, because that's where kids are.

I think that what we have to really understand from a health care perspective and I come from health care, with over 30 years,

is how little intersection we actually have with people. That's just the truth.

Even when people are chronically ill, if you add up how many minutes they actually spend in health care, versus where they actually live and where they make their decisions and where their health actually manifests and happens, we have to understand that it's not as simple as we'd like it to be, and we have to start thinking about how to deal with the complexity across these boundaries.

CO-CHAIR SUSMAN: I have a question that may be more directed to Ian and Reva. As you were discussing, I was really reminded of the power of GIS and mapping outcomes, and it seems like one of the potential beyond just measures is technologies and applications that allow us to look at the underlying determinants of health, and that calling for the research community to really start exploring the development of tools that allow

us to understand better the underlying social determinants, really might be something very valuable.

Now that may well be beyond the scope of what we're trying to accomplish here. But also, it starts to integrate and look at the total outcomes for populations, rather than looking at it one by one by one.

MS. ZELL: If I could also just say that David Kindig's model, where it was done on a county level, has been funded by Robert Wood Johnson Foundation, to do this for every county in the United States.

So the information is going to be available. It is fairly high level information, but it will spur some discussions within communities. So I think there is going to be more and more discussion about the social determinants and how we need to start addressing that.

One of the things in the National Priorities Partnership that we're going to be

doing is developing a health index, and one of the things that we're talking about is can we consider the using the Kindig model, which will be at the county level, in figuring out how to take that down to a county level.

That is going to force the discussion of what we do from a multi-sector standpoint.

MS. WINKLER: Just to respond to Jeff's question, one of the things that's always part of NQF projects, even though our focus is evaluating and endorsing measures, is the rich discussion that happens. It's the creative thinking, the collective building on each other's energy and thoughts.

So that certainly making recommendations that would accompany the measures, to help see if we can capture some of these ideas to put out there, is certainly part of it.

And we certainly can start drafting some of these recommendations and try and

capture this, so that these wonderful thoughts don't get lost, even though the focus is on the endorsement of the measures. Some of these other things certainly can be captured.

The creative thinking that goes on in these conversations is a valuable part of what we're doing here. So don't feel that it's not. It's a little bit hard to operationalize downstream.

But frankly, more than a few of the recommendations that come out of the committee don't immediately get picked up, but subsequently things start to coalesce and advancements are made. So we'll be trying to capture those things for you and include in your work.

CO-CHAIR SUSMAN: Well, thank you. I heard Harold raise the issue of more robust and more integrated risk adjustment as another idea that we probably should capture, and I see Robert and Eric and perhaps others. So Robert?

DR. ROCA: As a practical matter, although it's clear that all the things that Bonnie mentioned have very substantial impact on health. When it comes to developing the call for measures, what really is the scope? What are the boundaries we're going to putting around the invitation?

Because most of us in health care can't have discernible impact on some of these larger questions, and the people who are going to be using the measures are going to be asking how can we -- you know, what measures can we pick that are really going to be within our power to influence.

MS. WINKLER: I think a certain amount of that is for you to determine around the scope, in terms of usefulness, usability, feasibility of the criteria. But I do think some of the -- there are some very specific things that Bonnie brought up around populations.

For instance, measures that look at

an entire population belonging to a system, a plan, a practice, whatever, as opposed to just the patients that walk through the door. You know, that's something that's part of this, those measures being perhaps more desirable, having more utility, especially perhaps in this population where a lot of the issues are just getting them in the door or having contact with them.

So I think you do -- there are some of these issues can brought to what you're actually doing now, you know. Dealing with these in the complex area that Bonnie's going to try and tackle, is clearly probably not going to come across the measures that we're likely to get, deal with, that will be useful for measuring accountability.

But at the same time, I think there are elements of it that you can consider in evaluating your measures.

CO-CHAIR SUSMAN: Eric?

DR. GOPLERUD: Yeah. Kind of going

along this way, I think that Bonnie's presentation, I thought, was very intriguing and that we've been looking at what is the individual outcome and then trying to aggregate upwards.

Whereas if we looked at the other way and said well, what are we trying to accomplish at a population level, maybe the accountable entity is the public health or maybe the governor or maybe somebody else.

I'm thinking in terms of things like, you know, what is the alcohol excise tax amount in the community, or gallons of alcohol sold or consumed, traffic crashes, drug mentions in the ED, anti-depressant scripts per population, suicide rate, homicide rate, measures from BRFSS or YRBS on binge drinking or drinking/driving, domestic violence and child abuse rates.

There are a whole variety of things where if you take seriously that pie chart, there are a lot of environmental things that

may be far more potent than whatever we do inside the clinical system.

If we don't look at what are outcomes that are at a population level, we're going to miss some very important levers. Plus why not give some assignment to the ASTHO/NAACHO types.

MS. ZELL: Can I respond to that?

DR. GOPLERUD: Sure.

MS. ZELL: My response is absolutely, and I think again, I think that the health care, those of us in health care have not really understood the power of us just stepping outside of health care, and going to a city council meeting and talking about these issues.

So and is that something we want to hold health care accountable for down the line, that you know, what kind of involvement do we have in the community? That is something we could be accountable for.

We may not be able to be

accountable for all the suicides or the fact that there's poor neighborhoods. But we certainly have a very strong voice if we stepped outside of our offices and we're very well respected. We understand data. We understand how to talk about the data.

So again, I think there's an opportunity for us to have some accountability there, and absolutely to talk to public health and to -- but what this requires, which I never did in 30 years of practice, was sit down with the public health department and talk about these issues.

You know, I stayed -- I was in a Kaiser system, which one would think we'd be much more involved in the community, and I tried and it just didn't happen. So my experience of health care, and I've done it from being a nurse's aide in a community hospital to a methadone clinic to home health, to hospital care, to head nurse to practicing as an OB/GYN physician for 14 years at Kaiser

to being chief of a department there, medical director to facility.

I understand health care. I understand what we can't do. But I understand the opportunities and my frustration was how little impact I was really able to have on what really mattered, which to me was often the anxiety, the depression and the circumstances.

It motivated me to leave practice and do what I'm doing.

CO-CHAIR SUSMAN: I think I have Tricia and then Maureen and then Harold.

CO-CHAIR LEDDY: I was just going to say that this broader view that Eric described and Bonnie, might not be, as someone else said, what we can influence as health care providers. Not that I'm a health care provider, but all of you.

But this is an opportunity, though, for health care providers to make a difference in policy. Like if you go back to that taxing

cigarettes example that Bonnie used, that you know, if you increase the tax on cigarettes it can have a huge impact on -- that is far beyond what a doctor can do or anything else.

If there are things like that that you all wish the government would do or whatever, whether it's, you know, the mental health insurance issues like that Patrick Kennedy has worked on, or alcohol excise taxes, what hospitals or community health centers or public health departments in states do around community benefits and public health issues.

If we can set measures to say well where such things are happening that you think would have a huge impact, and really support and help what you're trying to do for the population, if we can set measures that met, you know, for those kinds of things, and have outcomes and be able to say look at the outcome that can happen when such and such happens, then you have the power to go to, you

know, and influence government policy and public policy and change those kinds of things that otherwise wouldn't be able to be changed.

Because outcomes really speak, you know. If can show that something happens, then you can go and really influence it. So I think that this is an opportunity for this committee to have a broader impact on measuring outcomes than just what health care providers doing it, just providing a service to an individual can do.

DR. HENNESSEY: Yeah, those are great comments, and just sort of extending on that, one of the committees that I'm involved in my state of residence, Missouri, is a suicide prevention advisory commission. There's a number of states that have those, and we look at data all the time.

So I would think that there may be some opportunities to get some measures from them, and it made me think of the means/matters project at Harvard School of

Public Health, where they look at educating folks, particularly who work in emergency rooms, about informing families about means and limiting access to means when you have someone who's suicidal.

It's had some nice outcomes. We may want to look at what kinds of measures are available there, and make sure they're aware of this project.

CO-CHAIR SUSMAN: Great. Harold?

DR. PINCUS: Now I completely agree with, you know, David Kindig's and Mike McGinnis' models. The question I'm having is how do we sort of translate that and operationalize it into our task? That and it relates to, I guess, what does NQF do with, since they have a list of 600 measures, what do they do with the use of those measures? How do they monitor, how do they get people to use it?

Because it's the kind of entities that we would be suggesting. We've been

talking about measuring these kinds of things, aren't necessarily the people represented in the membership of NQF, at least directly.

And what success has NQF had in promulgating their population measures, and is there a way that we should be thinking about specific target groups that should be incorporated to utilize whatever sort of mental health and substance use population-based measures we come up with?

MS. WINKLER: Essentially, I mean we're just starting to explore the whole population health issue within NQF. It's one of the six priorities from the National Priorities Partnership. That's why Bonnie's joined the staff.

I think that isn't a totally clear picture, and we're having to explore how that might happen. It seems that some of our projects may be more amenable to it. For instance, mental health is an area that does seem somewhat amenable to asking these

questions, how could we, how should we?

I think we're talking about looking at doing things potentially differently than we've done before, and that's why it's a little hard to envision what are we talking about.

But you know, as you start trying to look at measures that exist, you can say gee, you know, I wish it did this. I wish it did that in a very concrete way, or as you look at measures, you can develop ideas and concepts of the kind of measures you'd rather see or would like to see in addition, or by complement the ones you have, and start asking the questions within this larger context.

But in terms of your more specific question, Dr. Pincus, about use of the measures, you know, at this point NQF's monitoring of who uses the measures is fairly informal. We're actually going to be doing a formal survey to find out the degree.

But it's really rather amazing the

number of measures that do get picked up. Certainly, we're very aware of those are picked up on the national level by the federal government using those programs.

But I get messages all the time from health systems, hospitals, you know, various groups. There are lots of coalitions out there that are purchaser groups, you know, asking about the measures, where can I get more information about the measures?

Do you have -- I got an email last night. "Do you have measures for urgent care, outpatient urgent care? Do you have measures for this, do you have measures for that?" So people are looking for measures. So, you know, we are a resource.

So you know, there's this constant dialogue, but it's also a constant evolution, as people use measures more and more, the experience is greater. They want to be able to do more. We need measures that start really responding to what we're trying to get

to. What is it that's going to provide the best care and provide the best outcomes for people, and how do we get the right measures?

So the measures we're looking at and endorsing five and six years ago probably aren't meeting the needs of folks today. But what would those measures be, and then you start thinking about hmm, you know, where are we going to want to be and what kind of measures are we going to want in five years?

So that is part of this process as you're doing your evaluation. We have to stay grounded on what we can work with, but at the same time explore where do we want to go, how would we do it differently.

CO-CHAIR SUSMAN: So I mean from a practical standpoint, and then Darcy and Carol, I can tell you in Cincinnati, we have a health improvement collaborative. We have health coalitions that are working community-wide. I just gave a talk to Leadership Cincinnati, where you have community leaders

from all walks of life.

So they are interested in things like well, what is our community suicide rate? Well, what is our rate of incarceration, or what is our rate of things like homelessness. To me, those are measures that we could ask for, and do have a direct bearing, whether it's chicken or egg, on mental health outcomes.

So to me, while one might say well, come on, what does homelessness have to do with mental health, of curse this group all knows how deeply they're connected. So I for one think that this discussion and coming up with some concrete direction as we call for measures, would be very valuable.

It helps create dialogues at communities and there are an increasing number that are starting to look at health beyond the health care sector. I think that's increasingly where we're going to see things move. So Darcy?

MS. JAFFE: I just wanted to comment that I agree with Bonnie. I think if we look around the country, there are pockets where this is happening already. In Washington state, Harborview, for example, has been out in the community and really pushed for the government to set a mental health sales tax, and that passed.

We were able to give them data, looking at not only the reduction and service realization in the hospital, but extending it to the parts that really affect the economics of the government, the jails, the use of emergency medical systems that they pay for.

That's brought in millions of dollars to mental health that otherwise wouldn't be there, and Harborview has a seat at the table on how to use that money. So I think that there are good opportunities for hospitals and health care systems to step out there and have a good impact, not only on your own system, because it brings money into your

own system, but for the community as a whole.

I think, you know, as we were talking about, this is the opportunity to set those outcomes to move us towards that, to make it attractive to people that aren't thinking about it yet.

MS. WILKINS: Or to talk about gaps.

CO-CHAIR SUSMAN: Carol and then we have --

MS. WILKINS: I guess I just want to add to this. I really appreciate Bonnie's presentation, and I think one of the points early on really had to do with kind of looking at your data. I think perhaps part of the sort of transformation that needs to happen in the health care delivery system is to think about what kind of data needs to be collected or examined.

In San Francisco, they started about 15 years ago to create a homeless zip code, a kind of 99999 zip code, so that they

in their billing systems could gather really, really simple information about how many patients were homeless.

They were just startled to find that about one out of every four inpatient admissions, emergency room visits, hospital days was a patient who had that homeless zip code indicator.

That led to enormous changes in the San Francisco Department of Public Health's willingness to invest in supportive housing as a health intervention, because it produced better health outcomes, it kept people alive, it reduced use of hospitalization.

But until they had that data, they only had anecdotal experience and had no idea that it was such a big magnitude. Similarly in California, we had the Prop 63, our Mental Health Services Act, which is a tax on millionaires, and it generates a -- has generated -- it didn't do so well last year, but generated a lot of income for new mental

heath services.

When we were able to show county mental health directors that those consumers who were engaged, who were offered housing -- we didn't even look at it at the consumer level; we looked at it at the county level.

Those counties that had a significant capacity to deliver housing, supportive housing for their mental health consumers, had much higher levels of engagement and retention.

So they were showing great results for consumers who were retained in originally what were called the AB-34, the kind of integrated services models, the flexible models of services, the do whatever it takes models of services that were highlighted in the new Freedom Commission report.

But what we found was that to get those outcomes of reduced hospitalizations, reduced incarceration, increased employment, all the good signs of recovery, you had to

keep people engaged in services.

What we showed was that the counties that had very low levels of investment in supportive housing had very high rates of dropouts. So they were not retaining the consumers that they were engaging.

So again, we showed those connections at a population level or at a community level, and now in California, the Mental Health Services Oversight and Accountability Commission decided to recognize investments in supportive housing as a service intervention, as an intervention that could be funded out of mental health service dollars, because of that data that demonstrated that linkage and that connection.

But until health systems start to actually ask those questions, and shine the light on those connections, to say my gosh, if we give these folks this kind of -- I mean in the case of the work that I'm most familiar with, if we give folks a housing intervention,

it turns out we reduce their mortality. In the HIV world, we dramatically reduce both high risk behaviors; we reduce viral load; we increase survival with intact immunity; we reduce hospitalizations.

All of those are things that if it were a drug, we would of course say that this is something that the health care system should pay for. But until we look at that data and make that connection, it's hard to make the justification for the public policy changes.

CO-CHAIR SUSMAN: Joel?

DR. STREIM: Yeah, two thoughts that might be helpful to the steering committee in doing our task here. One is that I think the concept of usability as defined by NQF should help to guide us, and you know, when we're looking at candidate measures, we really have to think about to what extent the end user is going to understand the measure and how to apply it.

I know that's always a concern among stakeholders, you know. If we endorse a measure, ultimately is it going to get rammed down our throat at the other end. But if people understand the measure, how to interpret it, how to apply it, how to use it, that should be less of a concern.

So I think we should just keep that in mind. In terms of looking at population-based measures, sure, some of them aren't directly attributable to health care delivery systems or providers, but I think it's not just about attribution. It's about what variables are modifiable that ultimately can lead to better community health.

So I think mental health is in an extraordinary position to sort of model this for the rest of the health system, because one of the things we do -- take addiction as an example, where a provider or a health system is treating someone for an addiction and then they go back to their community, where there

are crack dealers on every corner.

If you did the mapping, you'd see the concentration of drug deals going on on the street corners, if you could image that.

Obviously, that kind of -- those kinds of data in terms of measurement become important, even to risk adjustment for that provider group. To say look, the recidivism rate in this addiction center in the inner city is awful, but we can't blame them entirely. Maybe they're accountable for ten percent of it because they do a lousy job of follow-up.

But in fact if you send someone out, you discharge them into this community, you know, you can't expect they're going to have the best outcomes. So you know, Harold was calling for, you know, better risk adjustment and doing due diligence there.

I think part of that is having measures. I mean, you do risk adjustment with measures, right? So having measures of

population and community health are necessary, actually, for appropriate risk adjustment of other measures that are more directly attributable to health care.

So I think in essence we have to have, open this up to measures of things that we can't hold health systems 100 percent accountable for. It's all about measuring broadly.

MS. ZELL: Exactly. If I could just -- I don't know if you're familiar, Jeff, with Cincinnati Initiative to Reduce Violence, because that is a great example of health care going outside and working across the community, trying to prevent homicides, gunshot-related homicides and mapping out neighborhoods of risk, just the way you're talking about, Joel, and demonstrating where the highest risk is, where the allegiances are and working with those individuals that are called violent groups.

Not gangs, but violent groups,

working with those leaders to totally change. They did it through its -- health care is still paying for it. It's a trauma surgeon that started the initiative.

It's across the community, and they worked with law enforcement to change policy, which is a population-level intervention.

What they did, instead of just working with the individuals, which they still do and putting them in jail, is now they put them in jail for 13 years instead of nine months, and totally turned around what's going on in the city.

There are multiple examples of this. So I appreciate what you were saying, and I think that it's absolutely true. There is a role for health care in it and there's a role for others.

CO-CHAIR SUSMAN: So let me see if I can summarize. I mean I hear a general consensus that we need to move beyond our noses in this arena, that we need to scale up

outcomes for both risk adjustment and for those communities that are moving towards an integration of health care with all the other social determinants of health, so that better tools to elucidate and understand the outcomes within communities -- so things like the GIS, mapping, the questioning of the outcomes that a defined population are achieving are important. Tools and ways to do risk adjustment beyond the traditional health care risk adjustment, the looking at global outcomes and population-based measures should be encouraged in our call for measures, recognizing that, yes, there are issues of attribution, but nonetheless, as we are moving toward community health as a goal, population health as a goal, Cincinnati health as a goal, if you will, that those measures are really where the puck is going to be, and not where it is today necessarily.

So the NQF can have an important role and Bonnie, I think, has very nicely led

us in this direction. Is that a reasonable summation of the group's thoughts about this important area? Any additions or things that I've left out that we definitely want to translate to Reva and Ian? Luc?

MR. PELLETIER: I just wonder what name or is there a name that we could put on these contributory outcomes, or these -- you know, I think you used the word complimentary?

But what are those things that we believe were responsible for and accountable for, and what are those things that we share accountability or need to work with?

CO-CHAIR SUSMAN: I mean there are a bunch of different models, but I like the social determinants of health, because it's a fairly robust model. It's well-accepted. People know what it means. I don't know if others have different models. I see a lot of head-shaking. So I think social determinants of health. Eric?

DR. GOPLERUD: Since the Healthy

People 2020 are working on social determinants of health, then that might be a useful, quick frame to go out and find out what their categories are and how they're describing those to get the -- and it aligns us better with what's going to be coming downstream anyway.

CO-CHAIR SUSMAN: Great idea.

MS. ZELL: And if I could just comment on that. We are going to be working HP 2020 to figure out how to align. They actually have 38 categories. They're calling them topic areas, and many of them are disease-focused, interestingly enough. I think the framework that we're talking about from NQF is the National Priorities Partnership framework, which, rather than being disease-specific, is very cross-cutting in its principles, and those principles need to be applied anywhere where there's an intersection that impacts health, which is in a lot of places.

So when you're talking about care coordination, you know, we're talking about not just between the doctors and the hospitals, but what about to home, what about to school, what about to business?

That's where we're hoping to go over time. That's where I'm hoping to go over time, maybe I should say, since I've only been here six weeks. It's where I'm hoping to go. But anyway, those are cross-cutting principles. I think that is actually a framework that works very well.

When you look at HP 2020, as I said, it's categorized. Primarily it's very disease-focused and there's some life-stage focus, as childhood and adolescent, and then there's an area now called social determinants with nothing under it yet, so and we're talking -- you know, I think there's a lot of discussion about should social determinants be the framework. So I just want you to know that things are in evolution and NQF is going

to be involved in those discussions.

CO-CHAIR SUSMAN: Well, I think NQF is in good hands with Bonnie pushing this agenda. I think the group is right along with you, if not behind you, and we appreciate this wonderful discussion. Thank you.

MS. ZELL: I appreciate you allowing me to be this provocative, because I realize that it is.

CO-CHAIR SUSMAN: You're preaching to the choir here, I think.

Measure Evaluation and Methodologic Issues

CO-CHAIR LEDDY: So the next thing that we're going to do is the Call for Measures discussion, which is going to incorporate a lot of the work we did yesterday; right, Ian? Then we're going to talk about who do we target.

I think, though, that it might come up about what we have left is the evaluation criteria. So it might be hard to determine what the call for measures, you know, how to

construct a call for measures if we're not all up on what the evaluation criteria are.

MR. CORBRIDGE: Yes. We can definitely go back and forth, if the group feels like that would be needed. I guess right here what we've done is just tried to take what was discussed yesterday, what was expressed and try to lay that out in a draft form of what the call for measures would look like, just trying to highlight some of the key issues that were expressed by the steering committee.

So we can definitely look through this. If we'd like to jump back and look at the measures, we can. We have that up here. Part of what we took was actual, I guess, the framework that we had was Version 1.0 yesterday, and you were able to work and kind of put a Version 2.0 together.

Then potentially after the discussion that we had this morning with Bonnie, we may want to revisit some of these

areas. It sounds like there was definitely social determinants of health, might be a category that you potentially would look at adding.

So this was just kind of a background document. We wanted to show you that what we'll be sending to you guys to hammer out a little bit more, to work with, we'll finalize it and this will eventually go out for the call of measures.

And actually I don't know, we didn't really ask really; is anyone on the phone right now?

DR. KAUFER: Yes. This is Dan.

CO-CHAIR LEDDY: Hi, Dan.

MR. CORBRIDGE: I apologize. This information was just created yesterday, so it's not something that --

MS. WINKLER: This morning.

MR. CORBRIDGE: Actually, this morning. So it's not something that's in the actual documentation that you were given, and

I apologize. We don't have Internet here, so I couldn't email it to you.

But I will get this out to your shortly. So you're at a disadvantage, because you're not looking at exactly what we have right now, but we'll try to keep you informed as we go through.

DR. KAUFER: Okay, thanks.

MS. WINKLER: Yes. Essentially, just to help the Committee understand, what we've done is taken a fairly standard format for a call for measures which, you know, the call is the title announces it. There's a background description that's usually very similar to what the project background description is. In the call for measures, we are soliciting measures for, dot-dot. Here it is.

And so Ian, very much more skillfully than I ever could, has created this into a nice little chart, the things you talked about yesterday. This is kind of how

we'll convey your wishes out into the world.

When NQF announces a call for measures, it is a 30-day call. That is part of the formal process. We announce it both on our website. We send it to all of our members, and I think we've got another list of folks who signed up, you know, registered on the website kind of thing. So we have that list.

In addition, you know, we try and use every avenue that we can think of, and that's one of the advantages of enlisting your assistance, you know, before we do the call for measures, because we'll certainly send it to you and then you are welcomed and encouraged to send it to whoever else you think of, as well as any other folks you direct us to send it to.

So we do want this to be well understood, what you're looking for in terms of the kinds of measures are, you know, understood by the audience you think is going

to be receptive to it. So, but this is where ended up pretty much from the work you did yesterday. How do you think it's coming together?

CO-CHAIR SUSMAN: Harold.

MR. CORBRIDGE: Definitely after the meeting, we can send it to you.

DR. PINCUS: We can't get it during the meeting? It's not possible?

MR. CORBRIDGE: Unfortunately, I can give you on a laptop, but we don't have printers here. So we were unable --

DR. PINCUS: Isn't there a business office here or something that --

MR. CORBRIDGE: I guess, yes. We can put it on a pen drive if you feel --

MS. WINKLER: Well, we can have Ashley go do it. We'll see.

(Simultaneous discussion.)

DR. PINCUS: Because it's hard to sort of grapple with this much text. I mean, two points that I just wanted to make.

One is this actually looks reasonable, but it needs a lot of cosmetic work. There are some things that I can see that just looked at it sort of that are over-emphasized by the placement where it is and, you know, with sort of not the best examples sometimes.

But it's sort of looks actually quite reasonable in terms of the overall structure. But it needs looking at.

The one concern I have -- there are two concerns. One is not getting very good measures coming in or like, you know, huge gaps on this. The second is getting too many, that I could see there are literally thousands of psychological tests that are published, that I could see a test publisher submitting all of them, you know, with all the reams of data that they have for all the psychological tests.

CO-CHAIR SUSMAN: I guess my understanding from previous, and Reva can

correct me if I'm wrong, that it's challenging getting measures in this arena. Outcomes measures may be relatively difficult. If you have process measures, we probably could come up with gazoodles. But, Reva, what is your sense?

MS. WINKLER: Our experiences in all the topic areas is there are not a plethora of outcome measures out there. Again, from a project perspective, too few measures is unsatisfactory for everybody. If they don't exist, they don't exist. We can't make something that doesn't happen.

But we do want to make sure that we at least looked everywhere that's possible. So that's the one end. The other end, too many measures. Couple of things, and this is why we're going to go through the measure evaluation criteria and the conditions.

When someone submits a measure, it's not a quick email to me saying, hey, you know, you need to consider this. We actually

need a formal submission by the measure owner, steward, person, the entity who will sort of enter into a relationship with NQF and maintain that measure, and have responsibility for it going forward.

So it's not a casual thing. It's a bit of an investment and their willingness to do so. So that, I think, will but down on the casual tools, if you will.

DR. PINCUS: No, I'm not talking about casual tools. I'm talking about there are literally thousands of psychological tests that are not casual, that have data behind them that that publishers publish and make a lot of money on.

I can see getting them into an NQF list would make them more money, or at least they would perceive that. I don't know if that's what's intended or is that how one sort of thinks about it in terms of outside measures. There are gazillions of these.

DR. GOPLERUD: And there's a

complement to that which is that those measures who don't have an owner but are out there in the public domain, whether that's homelessness, for example, or housing first or the rates of homelessness in a community or something that is like the AUDIT which is owned by the World Health Organization. It's very unlikely the World Health Organization's going to write into NQF.

SAMHSA has all of these God-awful measures that they require people to write on. If they're paying attention and have somebody who will write on your measure, you might get something. But it seems like it is potentially haphazard when there are good measures that we probably would want to have in here, and there are others that we wouldn't want to waste our time on.

So I'm concerned about sort of the haphazardness, especially for the non-proprietary measures that are out there, that are maybe more of the public health.

DR. PINCUS: Also, just to add to what Eric said, so that the two probably worldwide most-used measures is the disability scales developed by WHO and there's the HONOS, the Health of the Nation Outcomes Scale, developed in the U.K., which are probably the two worldwide, the most commonly used outcome measures. I don't know who would submit those.

MS. WINKLER: I think that is a limitation. This has been a process that's evolved due to -- in the early years, we actually would pick up a lot of public measures, but the ongoing maintenance, the being able to manage those measures just became relatively untenable, without having a relationship with someone who had an ownership aspect to the measures.

So we can acknowledge that that will be a limitation. In terms of the flip side, the proprietary side, it's not -- NQF does have -- has considered proprietary

measures and certainly in other realms there are lots of them, people who this is their business line.

We do have a policy and we do have a formal agreement that folks who would like us to consider their proprietary measures must agree to, and we'll let the lawyers duke that out. We find that not that many folks are willing to follow through with the agreement.

So there's no guarantee that that puts limits, but I certainly have observed that it limits it in many ways on the proprietary side.

DR. PINCUS: What about international people? Does that come up in terms of whether an international group submits measures or --

MS. WINKLER: There's no limit on international. We have seen several, but it is not the usual thing.

CO-CHAIR SUSMAN: I've got Carol and then Eric.

MS. WILKINS: Just a quick question. I just want to follow up on this kind of comment, that the social determinants that we've just been talking about.

I'm not sure. What does it mean to be the owner or a steward of a measurement? I'm just not clear about what that responsibility is, even where I know of non-profit organizations or non-profit intermediaries that might want to propose something. I don't understand what that responsibility sounds like.

MS. WINKLER: Yeah. I mean I can give you the references to detailed information from NQF. But measures, in our experience, are not -- they need management.

Many of them need to evolve. They need to be revised. They need to be looked at in terms of the evidence, looked at the coding, looked at whatever their specifications are on an ongoing basis.

Someone needs to take the

responsibility for doing that. That is every measure that comes into NQF for consideration, with the exception of those that are owned by the federal government, which puts them in a public domain, they still agree to maintain them.

The others have to enter into a measure steward agreement with us, saying that they will take responsibility for it, they will update it, they will maintain it. They will be someone we can contact for information. When it's time to review and maintain the measure in three years, you know, who knows about it.

Who knows what's happened to it? Who knows its history, its foibles, you know, all of the issues around it? So performance measures that NQF evaluates for endorsement are fairly robust and well-developed and owned measures.

CO-CHAIR SUSMAN: Eric and then Robert and then --

DR. GOPLERUD: Yes. Just taking the first condition in the list: depression, I could probably come up with eight or ten off the top of my head measure sets that are out there that are roughly equivalent, you know, the Beck, the Hamilton, the Zung, the CIDI, the DISC, the SCID, the PHQ-9.

Some of them likely would submit; others would not. One question would be how would you determine among the list of six or eight that are submitted, is there one or are they are all first among equals? Is there -- what do we do for --

You know, Hamilton will sign the agreement but not Beck. It sounds very --

DR. GOLDBERG: I hope we don't get those. They're all useless.

DR. GOPLERUD: Well, I'm just saying that they're all out there in the general parlance of depression scales, and you have the same with anxiety or you have the same for alcohol.

MS. WINKLER: All right, and the question is, and we've certainly seen this in other areas, the usefulness of those measures for getting information about quality or performance, you know, they're tools to be used in clinical care perhaps, but are they measures of performance?

Do they tell you something about the quality of care provided by whomever within the health care system? You know, are they -- yes. Are they --

DR. GOPLERUD: They would be measures of outcome.

MS. WINKLER: Right. Are they appropriate and suitable for public reporting of the results?

DR. STREIM: It occurs to me that -- oh, I'm sorry.

DR. HENNESSEY: Go ahead.

CO-CHAIR SUSMAN: I think we have Robert, Katie and then we'll get Joel.

DR. ROCA: My question was whether

the NQF was aware of any potential measure stewards out there lying in wait of this opportunity to submit their favorite measures. I mean has there been any initial inquiry into this or --

MS. WINKLER: Not at this particular time. I'm not sure that the word has gotten out. Certainly in the past, when we have done others, we get that as typical. It usually starts -- we usually get contacted when that call, the announcement, kind of goes out.

So it's a little bit early, but we certainly have had measures from SAMSHA. We've had measures from, you know, various agencies within the federal government. All of those happen on an ongoing basis. So most of those folks are pretty familiar with this activity.

MS. MASLOW: I'm changing the topic a little. So Joel, do you want to go first or --

DR. STREIM: Well, my only point was that I think when we have candidate measures, if there are two that measure similar things, that both meet all the criteria, there's nothing that says they can't both be in the library of measures that are endorsed and available for use in different situations. Is that a fair statement?

(Off mic comment.)

DR. STREIM: Oh, I know. I mean I think I was looking at Katie and thinking, you know, for measuring cognition, there also are a slew of tools for measuring depression, and some are proprietary, some are not.

Some are good for research purposes, some have their applications in more practical and clinical settings. But I think that will be a challenge on the dementia front as well.

MS. MASLOW: So I wanted to ask about some measures or areas of measures that I can think of that would be possible for

people with Alzheimer's and other dementias, but also for anyone with cognition impairment. I want to know whether you think that these are in here, and if they're not, could we add them.

So a first one is, does the family or other responsible caregiver understand changes in treatment, including medications in transitions? So I think this is a measure, Reva, that you have for hospitals now, something about understanding. But is that there, all kinds of transitions?

MS. WINKLER: We have endorsed a measure; it's a transition-of-care measure. It is a three-question survey measure, and it is for patients being discharged from the hospital.

MS. MASLOW: Does it say for caregivers, too?

MS. WINKLER: I can't remember off the top of my head actually.

MS. MASLOW: I think it might not.

Okay, so would we elicit what I'm talking about if we send this out?

DR. HENNESSEY: Would it make sense, maybe in an area where we say patient caregiver, to also add another one which is called transition of care understanding or something like that? In some ways I see it as part health literacy, but we could make it very clear. Where it says patient caregiver experience, we could put in transition of care comprehension or understanding.

MS. MASLOW: It's a change, yes. So for people with dementia, the message has to get to someone else about any change like that. So it's different from health literacy, but it's the same. It requires -- yes, right.

CO-CHAIR SUSMAN: Sounds like we want to add something a bit more specific about coordination of care, transitions of care.

MS. MASLOW: That the information -- someone knows. So, good.

CO-CHAIR SUSMAN: Make sure we're using the microphones. I'm going to give Katie the privilege to continue, and then Richard.

MS. MASLOW: So a second one, does the caregiver/responsible party understand that risks wandering, driving, guns in the house? So this, we have something abut that person, but what about that? Would we elicit that with what we have up here? Oh maybe --

CO-CHAIR SUSMAN: Patient safety and adverse events. Wandering. I mean we could add additional measures. Is that sufficient, or do you think --

MS. MASLOW: I'm talking about whether that caregiver. The measure is does the caregiver understand, whoever the caregiver is.

CO-CHAIR SUSMAN: So patient safety and adverse events are not only the adverse events themselves but prevention or understanding of potential adverse events on

behalf of the caregiver.

MS. MASLOW: Yes, and could you add guns, too, in the things that can go wrong?

CO-CHAIR SUSMAN: Sure. I think in the end, we probably could spend a lot of time making very specific specifications here. But we also need to make sure that the important things are called out. So thank you.

MS. MASLOW: So another one, in terms of what you were saying, is the caregiving status of the patient known to whoever's being measured? So mainly this is physicians, but other people don't know -- other providers don't know that the person is a caregiver. There's huge risks to caregiver health of caregiver problems.

CO-CHAIR SUSMAN: So is this an outcome or is it a proximal process that leads to an outcome of caregiver burden, stress, et cetera.

MS. MASLOW: It could be either. You could say that it's process, so it can't

be --

DR. HENNESSEY: But you could take a look at measures of caregiver distress, and there's probably some measures out there.

CO-CHAIR SUSMAN: I thought we had captured that somewhere, but let's make sure it's there. Caregiver burden and distress is certainly important.

DR. STREIM: Well, I think generally caregiver health status as an outcome of dementia care is really -- yes. It's not just stress and burden. It's their actual health outcomes of the caregiver.

MS. MASLOW: I think that also, but I think that physicians particularly don't ask and no one knows that the person is a caregiver. So it's sort of -- maybe it's a proximal thing. Then I also, as you know, am wishing that we could have something about the identification of people with dementia.

So I want to read you the three existing measures and see if any of them could

be in what we're asking for. These are measures. They're not from the U.S. So the percentage of patients diagnosed with dementia whose care has been reviewed in the previous 15 months.

CO-CHAIR SUSMAN: That seems to me to be a process measure, but do people agree? I mean I don't want to monopolize this conversation.

MS. MASLOW: This is extremely important. So the latest data from Indianapolis are in physician medical records in the University of Indiana, this medical system. In 2003, 19 percent of people with dementia had anything in their medical record. So 81 percent did not. That's the most recent thing.

So it's extremely important. I understand we're talking about process things here, but I'm looking for a way -- if there's some way that we -- this is probably to me the most important indicator for dementia, which

is not recognized -- it isn't recognized. So anything else that you add on is --

The other one's from Australia, so it's a process measure, probably. Medical patients, 65 years of age and older, who had their cognition assessed using a validated tool, blah blah blah, during this six-month time period. That's a process measure.

CO-CHAIR SUSMAN: I would think so.

MS. MASLOW: If anyone can think of anything or any way that we could legitimately ask for this?

CO-CHAIR SUSMAN: Well, there's been a history in NQF, I think, of having sort of these two-stage measures, where there is an outcome measure but it depends on identification, and identification of a denominator population that's been appropriately screened or case-found. So I think there are ways that can be built into outcome measures.

Harold, and then go back to

Richard.

DR. PINCUS: Yes. I think that that, you know, by itself, if you look at people that are having an assessment tool used in the past six months, is pretty much a process measure.

But as Jeff was saying, you could embed it into people that have had x number of measures, you know, two measures over six months, and were either improved or, if not improved, some adjustment in care was made.

So that it becomes kind of a -- sort of a process/outcome measure that is looking that there was some action taken, based upon an initial and a follow-up measurement.

CO-CHAIR SUSMAN: I mean for example in the bipolar disorder treatment, it implies appropriate diagnosis, and then just with regard to our previous conversation, a whole bunch of tools are listed as part of a measure, but the tools themselves haven't all

been submitted. But the TAP suggested these were all the sorts of reasonable tools that would be part of this measure.

So I think in some ways, just to go back to our previous conversation and provide some reassurance there, there has been a history in NQF of sort of implying that certain validated tools could be embedded in measures.

So for example, the diagnosis of bipolar disorder or depression might imply that there's, you know, 15 different tools that would be appropriate.

MS. MASLOW: Just one other thing. I think that it's probably important for the Committee to think with respect to these things that are not what I was just talking about, the actual identification of dementia.

But outcomes that are important for people with cognitive impairment. Whether we would want to say cognitive impairment instead of dementia, so picking up other people with

cognitive impairment, where decision-making and dangerous -- all of those things are relevant.

CO-CHAIR SUSMAN: So maybe the phrase is dementia and other -- individuals with dementia and other cognitive impairments, or something along that line, so that it's inclusive.

MS. MASLOW: It could be.

CO-CHAIR SUSMAN: Rich?

DR. GOLDBERG: I don't know. I'm hoping to see some things that have to do with outcomes. I'm very concerned about a lot of measurements that could lead to micromanagement of practice, and won't necessarily influence outcomes.

So there's been, as far as I know, two papers in the literature that have looked at the use of outcome measures by clinicians over the last few years. One is Zimmerman's, one is Gilbody's.

They were done -- one was in the

U.K., one was in the U.S. So, no surprise; clinicians don't use outcome measures, you know. Ten percent or 12 percent of people use outcome measures of any kind in their practice.

When they ask clinicians, how come you're not using outcome measures, no surprise. They take too much time, and they don't understand them. If we're going to impact on people starting to look at outcomes on some macro level, we're not going to start using 30-minute instruments for this.

I thought, you know, I don't know if it's necessarily the NQF agenda but, doesn't this have something to do with eventually publicly reporting outcomes, and trying to influence the macro system without micromanaging people's practices?

I think it's going to be -- we'll have to sort through a lot of process outcomes. If I can get to this golf analogy of, you know, you've got to hit the golf ball

150 yards and get it in the fairway, where your right elbow is, where your head is, how wide your feet are apart; I mean there's lots of ways to get it there, and that what we want to see is which practices are getting the ball up the fairway 150 yards in the short grass, and not get caught into an industry of golf lessons for people, which they can spend millions of dollars on and still can't break 100.

So I don't know. Will people with the call understand that? If they do, we're not going to get the Beck depression scale and the Hamilton depression scale and all these lengthy kinds of things. I'm not sure what they are yet.

That's part of the challenge. I know some people are kind of working on these, you know, trying to validate much briefer outcomes measures that have some validation, with more lengthy kind of assessments. Am I on the right track? Could you comment on

that?

MS. WINKLER: Yes, you are. Yes, sure. One of the conditions actually when measures are submitted is there are, up front, four conditions, and we have them detailed in the documents that you have. But one of them is that they are suitable for public reporting and quality improvement.

I mean that's the whole point. That's sort of NQF's role in this world. So measures that are not about, you know, quality, not going to be useful for producing information that's important to public audiences, and that is not just sort of the general public, but could be any number of stakeholders out there.

So I mean that's the slice of the pie that NQF works on, in terms of driving quality improvement.

So I think, Richard, you do have the right assessment on it, that the difference between lots of tools, but are the

tools assessing, you know, patient status or whatever to assist in clinical care versus measures of quality that can be used to provide information to a wide variety of audiences, that represent the quality of care provided, and certainly could be used for comparative purposes, that sort of thing. That's NQF's focus.

CO-CHAIR LEDDY: Maureen, one comment?

DR. HENNESSEY: I actually had two questions for clarification. One is, what's going to be the role of current mental health measures that NQF has already endorsed in this process. How do those fit or not?

MS. WINKLER: Essentially, they provide context, because there are actually very few outcome measures. I think there are what, three? What this project is doing is helping to enlarge that number, add to it, to the degree that they're available and possible.

We provide the process measures that we've also endorsed for context. Again, many of them have been endorsed at different stages through NQF's history. Some have been around for a long time; some of them are relatively new; some are going through maintenance and may fall off the list. But again, provides the context.

But as the interest in moving towards outcome measures, our goal with this project is to try and increase the number in that category applicable to mental health.

DR. HENNESSEY: I believe that there's an NQF measure that was submitted by the VA relative to trauma and screening for trauma, isn't there?

MS. WINKLER: Not recently. I'd have to go back and really look through history.

DR. HENNESSEY: Well, that would be the interesting question. Do you view it as a process or outcome? Because what's up there

is not just outcome, is it? Is that just -- isn't that also process?

CO-CHAIR LEDDY: You mean what we did yesterday?

DR. HENNESSEY: What's up here right now.

DR. GOLDBERG: Could you scroll down to the bottom? I missed -- the top's been up a long time. Could I see the bottom one?

CO-CHAIR SUSMAN: So resonance with diversity, with depressed or anxious mood. I mean to me, you know, where your mood is would be a patient-oriented outcome, whether I'm happy or sad. I mean, you know, I think that's something that matters to patients.

CO-CHAIR LEDDY: It seems like at this point, what we need is a structured instruction almost, especially for those of us that have not been through NQF, a committee before.

We really need to know, what is the

definition of an outcome measure and how are we going to -- what is that, you know, what is going to be the evaluation criteria for outcome measures before we can go forward, I think, in trying to do the work we are trying to do. Can we move to that, or do you think that we need to take a break at this point? It's about quarter of eleven, I think.

CO-CHAIR SUSMAN: I think perhaps if we took a brief break and recognize that the material that Ian so nicely put together, we can wordsmith offline and add additional comments via email, and then move now to the evaluation after the break, which I think will help frame this in a broader context. Does that sound like a reasonable --

Let's take a break. It is now a quarter to. Let's say five of, which means I know that this group will be around eleven or so. But five of eleven.

(Whereupon, the above-entitled matter went off the record at 10:46 a.m. and

resumed at 11:10 p.m.)

CO-CHAIR SUSMAN: Is anybody still online?

DR. KAUFER: Yes.

CO-CHAIR SUSMAN: Hello. I hope you'll join us if there are questions or comments.

DR. KAUFER: Okay, thank you.

CO-CHAIR SUSMAN: Okay. Eric and Carol, I'm going to have to smack you over the head now. Okay. I'm going to turn it over to Tricia to lead us through to the next outcome.

Identifying Gaps in Outcomes Measures

CO-CHAIR LEDDY: Excellent. The next thing we're going to do is try and go back to defining the scope of our group a little bit, and ask Reva and Ian to take us through some of the parameters of what we're doing, so that we can then construct our call for measures and, you know, and utilize all of the work we've done appropriately.

So one thing that Reva had said she

was going to do was to take us through the evaluation, how we evaluate the measurement of -- how we would evaluate measures that come in. What are the criteria we use to measure whether or not something that's submitted is going to make it to the final list?

I think that also if we could also define, if going back to this Donabedian principle, because we've had a lot of different opinions and thoughts, I think, about number one, who -- there's three dimensions to this principle.

There is the population and individuals, there's health care, whatever that means, and then there's the change that happens as a result of the health care intervention to that defined population or individual.

So if you could also speak a bit, Reva, about what parameters we have, so that we know if it's our decision even to define or not. Is the population people with the

diagnosis that you've talked about in the beginning: SMI, depression and Alzheimer's and other cognitive disease, or is it the whole population?

You know, what are our parameters for defining the population? What are our parameters for defining what is health care, because we've talked about health care, provision of health care, like provision of mental health services to an individual. We've talked about public health interventions such as suicide education programs, suicide prevention programs, those kind of public health things.

We've also could go so far as to talk about public policy, which we did talk about, which is such thing as a tax on tobacco or alcohol.

So is that a kind of intervention that we can consider to be something that is considered a health care policy decision that would influence health outcomes, because

certainly that has been shown to influence health outcomes, such as tobacco tax?

And so if you could give us the parameters around that, and then also talk a bit about outcomes as opposed to structure and process, so that we know, you know, what are the kind of outcomes that we're talking about, versus things that you've already done in the structure-and-process world. That would be helpful, I think.

Anybody else think they need something around the parameters of our assignment?

MS. WINKLER: Okay. This is a review. Essentially, this project is around outcome measures, and I'll talk about that definition in a minute.

There are constraints around the contract and the resources we have to do this. So as much as we might like to do a whole lot of things, we do have to focus in on the things that we are expected to do.

In this particular aspect that we kind of clustered under the term mental health, there are two primary topic areas that is the focus, and that is depression and serious mental illness.

Now there's some wiggle room, because serious to one may not be serious to someone else and vice versa. Then the other is Alzheimer's disease and related conditions, okay. So that's really the subject matter of what we're doing, and that's pretty straightforward.

Both of those happen to come off the top 20 Medicare conditions list, and that's why HHS is giving us money to do that. So that's kind of the why and how did we get there and where are we.

Going too far outside of that, we run the risk of not doing the job that was asked of us, and kind of diverting energy and resources in a direction that doesn't meet our deliverables, the expectation of the funders.

So we do want to stay focused in on what this project is all about.

The second piece of that is we're talking about outcome measures. This is a distinctive project that is happening specifically about outcome measures. Prior projects have been either process measures, process outcome measures, but this is very focused on outcome measures.

There is a changing world out there in terms of desirable measures, the kinds of measures that audiences are looking for. We've certainly seen an upswing in demand for outcome measures. There's a lot of reasons for that. Richard alluded to some of that around, get out of the micromanagement process measures business, and just what matters is the outcomes, what matters to patients is the outcomes. What matters to many stakeholders is what happened, rather than how did you do it per se. So this project is deliberately focused in on that growing interest in

expanding available measures, outcome measures for a wide variety of topics.

Also as I mentioned, there is ongoing work to start to pair quality measures with cost measures, to ultimately achieve concepts around efficiency. So outcome measures is the focus of this project for a lot of reasons.

So we're talking about identifying, evaluating and endorsing, possibly endorsing outcome measures for depression and other serious mental illnesses and Alzheimer's and related conditions. So that's the box I've got to keep you in.

Within that is really kind of where your expertise plays into it. So when we spent a lot of time yesterday talking about what are outcome measures, what are type of outcome measures, what might outcome measures look like, realizing that we do want to stay within the concept of structure, process, outcome. It's a classic construct. It's

pretty well understood by most folks.

Structural measures describe the sort of physical capability, the things, maybe the people in place, the building in place, the equipment in place, those sorts of things. Process is, how did you do something. How was it done?

But the outcome is what happened. Good or bad, what happened? So it's really the more sophisticated type of measurement. It's more challenging as a measurement. But it does provide important information that's urgently needed for a lot of various reasons.

So I'll stop right there and just ask, do we need to clarify any further on any of those parameters.

DR. GOPLERUD: When you come out with the end of this process, do you have in mind a range of the number of measures that you expect NQF will endorse?

MS. WINKLER: No. There's no way of knowing at this point in time, because it's

one of the unknowns whenever we're managing a project is we don't know how many measures a call will encourage be submitted.

We've had some where it's a struggle, where there have only been a handful and we really do whatever we can to identify them. There's some areas, in particular outcomes and some topic areas, there just may not exist. On the other hand, we've had projects where we've had hundreds of measures.

So I mean there -- and that is one of the sort of open-ended aspects of the project management. I think this is an area you all know better than I do, to know what performance measures, quality measures that are outcome measures that could be out there in terms of volume.

Part of the role of these two days is to get you thinking about those, get you to understand the parameters, the criteria and the process for them, so that if they're out there, if they're the kind of measures that

will be appropriate for this project, we at least have identified them and done our best to get them involved.

A lot of times we don't get the measures because we just -- the communication, the message doesn't get there. We don't talk to the right people, we don't ask the right people, we don't get the message out effectively enough.

So that's one of the things we're trying to deal with today, is enlist your help and recruit your assistance and being sure that the message gets out, so that the measures are looking for, if they exist, do get submitted.

DR. STREIM: In terms of the method by which you disseminate out the call for measures, sort of two points about it. One is who -- do you have mailing lists that it's sent to? Do you have, like, are there organizations that it's sent to? How extensive is the -- and if so, how extensive

is your sort of list of mental health organizations and researchers and entities and so forth, and also how extensive is it internationally?

Secondly, when this call goes out, are there specific things that you're going to be saying about risk adjustment?

It's embedded within the measurement criteria, but clearly for outcome measurement, it's a special issue, and whether you're going to be calling attention to that issue in the context of the call for measures.

MS. WINKLER: The answer to your first question is, you know, we primarily utilize our members for communications and announcements, and folks who have, you know, registered on the website, been involved in activities with us. You know, we kind of have a list of those folks.

That's why particularly in some topic areas we know we are probably not engaging or involved with or even know about

all of the appropriate organizations and contacts and the people that we should be reaching out to.

That's a large part of what we're asking for your assistance with. That's a world that are you're part of that we probably don't have an awareness of the full extent.

So that's why the announcements, you know, are the kind of thing -- we put it on our website, but it's the kind of thing that's easily embedded in an email, and it can get forwarded, you know, to anybody and anywhere.

I'm not aware if we have any international folks on it or not. If we do, it's very, very few, as far as I'm aware. We have had some, especially in the patient safety realm, we have had working, we have had international representatives on some of our committees. But that's not -- it's the rare event, not the common event.

CO-CHAIR SUSMAN: The NQF

equivalent in other countries?

DR. PINCUS: Do you know of one? Well, in the U.K., they have the Healthcare Commission, which is a governmental body. It both develops and applies measures. But there are sort of a number of equivalents.

I'm working with a group of sort of the chief clinical leaders or chief psychiatrists from 13 countries that are around the issue of quality measurement, and you know, if you could send it out to all of them.

MS. WINKLER: Yes.

CO-CHAIR SUSMAN: So let me ask a practical detail. As Harold has suggested, we all have our own circle of friends, colleagues. How do you want that information, or how will the information be disseminated to us?

MS. WINKLER: Well, we'll send you an email with an attachment that's going to look a whole lot like the draft of what Ian

showed you earlier. It's the announcement. It's the description of what we're looking for and the link to the submission, the link to the measure evaluation criteria, you know, a variety of --

So we sort of have it standardly packaged. If you think there's something addition that for this particular audience perhaps we need to include, we're certainly happy to hear that and make those adjustments.

Again, we're trying to facilitate communication with folks out there who are likely to be able and desire to participate in the project.

CO-CHAIR SUSMAN: It sounds to me, then, we will be the intermediary, and do we get paid on a case rate or not here? Okay, okay. Now Maureen and then Carol and then Harold.

DR. HENNESSEY: I have a question about definition of outcome measures. I had heard you talking earlier, Jeff, about case

finding. Now is case-finding or screening, as we say, for dementia or we were talking trauma earlier, post-traumatic stress, are those kinds of things considered to be an outcome or are they a process?

CO-CHAIR SUSMAN: I mean I would answer, and I'll see what Reva says, that those are process measures, but they ultimately are embedded in some of the outcome measures.

If you look at our existing measures within the NQF portfolio, a lot of them imply that there's a preliminary step around screening, case-finding, identification. Reva?

MS. WINKLER: Yes, and I'd agree. I mean those, I think, are -- it's a process. Doing the screening is a process. So they would not be considered outcome measures. But I think that Jeff is absolutely right, that we've seen measures where it's embedded within it or part of it, such that the case finding

is part of the measure specification aspect of it.

DR. HENNESSEY: Thank you.

CO-CHAIR SUSMAN: So Carol?

MS. WILKINS: Just a quick question and suggestion. Earlier, I think you said that it's a 30-day period that the call for measures is open. We've heard that there are actually very, at least right now, there's very few mental health outcome measures that folks have got.

I guess I'm wondering if we want -- if it would be feasible and appropriate to do some kind of early warning, early notice that would maybe not have the full packet of requirements and information, but would be more of a kind of heads-up, you know, we're heading into the holiday season and January people come back, and there's, you know, 8,000 emails.

I'm just really worried that folks may overlook this at a time that, maybe they

have other pressing priorities, and it just gets put to the back burner until somebody finds it in mid-February and says, oh gosh, I guess I missed that.

So a kind of early announcement might really help.

MS. WINKLER: It's actually part of the process too. Approximately, you know, in the weeks prior to the call going out, officially an opening, is to issue a preliminary, which is sort of a call for intent, you know, that describes the project, saying the call is coming up. Give us a heads up of what measures you might have out there and looking to submit, some opportunity for them to ask questions. So there actually is embedded in it, and we're looking to do that in early December.

CO-CHAIR SUSMAN: So it sounds like for us, we could try to make our contacts and say, hey, hold this date. This is going to be coming out very shortly. Please get ready to

submit your measures. Harold?

DR. PINCUS: A couple of things that I would say about the submission process. When I've spoken to people about sort of submitting NQF measures, most people in the field don't think of themselves as being professional measure developers, and the concept, and some of them may or are not even aware of NQF.

And so the concept of actually submitting a measure and then looking at the level of effort that's required can sometimes be daunting. On the other hand, many of them are motivated to do it. But the 30-day period may not -- you know, on the whole, may not be sufficient for somebody that's a total novice to this kind of thing.

I think that's something that you may want to look into. The second point is that there are a number of groups that probably should be alerted, but I don't know if I have access to them, but I could think of

them.

So for example, you know, members of the American Public Health Association, Mental Health Section, you know, would be people. I don't have that list. But maybe you could get that list. You know, members of Academy of Health, you know. NIMH, NIDA, NIAAA, PIs of health services research projects. You know, those are people that I could think of would -- you know, are not typical measure developers, but at least don't think of themselves as, but would be people that you might want to reach out to, but also may require more time to submit.

Just going back to the point about sort of screening as an issue. I guess screening would definitely not be an outcome measure, but what about as you move more into things like follow-up and engagement in care, like the Washington Circle measures. Is that considered sort of an intermediate outcome, since it's associated with better outcomes?

CO-CHAIR SUSMAN: Yes. My sense is that there's some clear boundaries or anchors on either end, and then there's a bunch of stuff in the middle. And you know, the litmus test should be, does it matter to patients, their families, the community, those outcomes. And if engagement matters, as Katie and I were discussing, does education, fully understanding a treatment plan, is that an outcome that matters to patients and their families?

I would argue probably it is. You know, we could debate that all day here, and that's not going to be very helpful. So I think there's going to be some gray area, and as we get to the task of measure evaluation criteria, we're going to come up with some rules, guidelines around that.

But ultimately, We're going to have to sit back down and say "Well yes, this one's clear, this one isn't. This is one is sort of in the middle and here's where we come out."

So that is why they have an expert group like ourselves. So Richard?

DR. GOLDBERG: I don't know. Unless I misheard it, calling for this at the beginning of December would be a problem. People pretty much disengage for a lot of December. If you're going to have a 30-day window, it's going to be a ten day window. So I don't know what that does for your time line, but I think it will be a problem.

MS. WINKLER: The actual call is in January.

DR. GOLDBERG: Okay, all right.

MS. WINKLER: The pre-announcement, the intent if you will, is in December, in early December.

DR. GOLDBERG: Calling for submission by when?

MS. WINKLER: No. The initial one is an announcement. The call for measures is open 30 days during the month of January.

DR. GOLDBERG: All right. That

might work, even though I'm not telling you anything you don't know. I mean -- and the other, I have one other comment, I mean around Harold's issue about are these out there?

I know a number, at least several people that are very psychometrically well-researched outcomes, brief use of outcomes tracking measures. I think one of the issues for them is they see them as proprietary, and I think that's a real disservice to our field, and I think hopefully they'll get to see that what's really proprietary about their work is their web-based platforms, that allow people to utilize them.

Because there's a variety of ways for people to implement these outcomes tracking across practices, that probably are going to need to be web-based. Those will have some creative people who figure out how to do that and engage, you know, and link patients and providers together.

But there are, I think it would be interesting in this first pass. I know there are some people out there who have this. If not, and Harold's right that people say, you know, "We need more time to do it." We'll learn that. But if we can, you know, search the trees for -- some of these are out there.

CO-CHAIR SUSMAN: I guess I would encourage everybody to twist arms, if you will, at least make people aware. This won't be the only call for these measures.

I mean I bet you 18 months, a couple of years from now, we're really back at the table or the staff at NQF is going to be back and say "Look, you know, we didn't get so much this first go-around, you know. Here are some other opportunities."

So this is a process. It's a marathon, not a sprint. Let's take it as that, and encourage this first go-around as many measure holders as we can think of to contribute.

DR. GOPLERUD: What about the bulk distributors of measures like the Joint Commission? There must be hundreds of ORYX-approved measures. Do they typically respond back?

MS. WINKLER: Yes. The Joint Commission is certainly -- we've endorsed many of Joint Commission's measures. So they are -- and to the degree they have outcome measures in these topic areas, I think we're likely to hear from them. And there are other kind of folks we'll touch base with, just like we do with NCQA and you know, kind of the usual players.

But there are often in specialty areas, if you will, folks that we're not aware of, that we may have not, you know, they're not aware of us, we're not aware of them, and trying to make those connections is an important part of what we're trying to do.

DR. WAN: I have a question, just because I joined later yesterday, is that when

you went over the NQF-endorsed outcome measures, you said that there were a few of them, that there were three. What were the three? I just want to get a flavor of what is currently endorsed.

MR. CORBRIDGE: I don't know if you have a copy of the background documents.

DR. WAN: They're in Appendix I there, and they're really not --

MR. CORBRIDGE: Yes, it's in Appendix I, and also they were the ones that we had up on the screen earlier in the actual chart, with the NQF number. So and if you need those, I can always get them to you later on.

MS. WINKLER: I think we've given you the list of the process measures as well as the outcome measures that we've dealt with in the past. That's just for context, and realizing that where we've gotten to these lists of measures have been through a variety of projects that may have had different goals

and focus.

So it does have a tendency to seem a bit random, and trying to understand what a bigger more comprehensive picture would be and where the gaps are is something we want to tackle as well.

So moving on from a discussion of outcome measures, starting with this definition, the list you guys you were working on yesterday that we'll want to embed in the call for measures is actually your description of types of outcome measures you're looking for.

Because if you just said outcome measures to, you know, ten different people, what they think of as outcome measures and what they think we would want to include is likely to be ten different things. So being explicit to the degree to say yes, we we're looking at outcome measures that assess symptom improvement relief, maintenance, whatever, you know, improvement in

functioning, change in behavior.

You all have said that those desirable types of outcome measures that you would want to see in a good set of measures around in this topic area. So that's what that list is all about. So your way of describing the outcome measures.

So that's why we spent the time we did yesterday. So I think those are the parameters. Some have been set by others and some have been sort of established by you all to move this forward.

CO-CHAIR SUSMAN: Just to name the three, there's residents with worsening of a depressed or anxious mood, experience of care and health outcomes using the ECHO and use and adherence to anti-psychotics for those with schizophrenia.

MS. WINKLER: We've got one more in the queue, which is follow up after mental health hospitalization, outpatient follow-up after mental health hospitalization, an NCQA

measure. That endorsement should occur somewhere around the end of the year. Yes, it is a use measure.

DR. WAN: So I know that we're going to eventually get into some of the criteria for evaluating these methods. But just looking at the current endorsed measures or the outcome measures for one was based on the ECHO survey, which is based on 52 questions.

So when we're looking at the relevance, the appropriateness, the feasibility and practicality, I'm hoping that we'll consider those issues when endorsing those types of measures.

CO-CHAIR SUSMAN: I think we have to remember that there's a wide variety of contexts in which NQF measures are going to be used or are currently used.

In some settings, having a 53 measure assessment is okay. I mean it's part of what's routine. In other settings, primary

care, you tell me I've got to ask nine, you know, questions and I'm sort of I can't do it.

I can't do anything more. So the reality is here NQF really has to be everything to all people in some ways. So that's a challenge that we'll have to balance as we look at this.

MS. WINKLER: In your handout after page, let's see what it is -- right after Appendix I, is about a five page document that talks about the evaluation criteria as it is revised, just a little over a year ago. You've got me doing things that I shouldn't be doing here. Okay.

There are, and these were established up front as part of the revision, are the conditions for consideration, and there are four conditions. As someone goes into the electronic submission process, they're asked to answer these questions. If they don't answer the right question, then they say thank you very much for your

interest, but it won't be appropriate for you to continue the submission.

So the first one is being in the public domain or we have an intellectual property agreement. So even measures that are open-sourced, that they still have an identified legal owner, we have to enter into an agreement with them, because we can't just arbitrarily run around using somebody else's property. Not a good thing.

The measure owner, steward, developer, whoever that person is, organization is really, verifies there's an identified responsible entity and process to maintain and update the measure on a schedule that is commensurate with the rate of clinical innovation, but at least every three years. So there's this ongoing relationship with us.

The intended use of the measure includes both public reporting and quality improvement. We've had people want, you know, say well, this measure's great, but it should

only be used by quality improvement, for interim quality improvement, and should not be used for any kind of accountability, public reporting or any of those other activities. That's not the space NQF works in.

So we are looking at measures that would be suitable for public reporting, and there's a large push by lots of our stakeholder members for at some point requiring that they all be publicly reporting somewhere down the road. So you know, we're starting to see that tension, not only suitable for, but that they are reported. So you can see that that's one of the major interests.

Then we need the information complete within the form. A title or a description and the rest of it left blank isn't going to provide you any information to evaluate it. So there we are. Okay.

So as we move into the actual evaluation criteria, we briefly touched on it

yesterday, that there are four major criteria. These are the importance to measurement for scientific acceptability of the measured properties, usability and feasibility.

Just note that they're not absolute. There's no absolute scoring system. It's not like you rate them and add up and you have to make at least so many points. It's not that kind of thing. There are no absolute thresholds.

But clearly measures that are strong in all of the categories are going to be better measures than measures that are weak in some important areas. So the assessment is a matter of degree, but one of the significant changes in the most recent criteria is the first criteria, importance to measure and report is a must-pass criteria.

So in your evaluation, you have to feel that it does pass the importance criteria. What you're going to find is the tool we will give you for doing your

evaluation is we take the information from the electronic submission and we put it into an evaluation form, and you have scales to go through each of the subcriteria that are completely meets the criteria, partially meets the criteria, minimally meets the criteria or doesn't meet the criteria at all. Kind of a scale.

So that you'll be looking at the subcriteria and then getting an overall rating to the main criteria. So the first one is important to measurement and report, the extent to which a specific measure focuses important making significant gains in health care quality, as defined by the IOM aims, if you will, and improving health outcomes for a specific high impact aspect of health care where there is variation or overall poor performance.

So there are three subcategories here, and the first one is it addresses a National Priorities Partners goal or priority.

Again, we're being good partners, or it's a demonstrated high impact aspect of health care, large numbers, severity, high use -- excuse me, cost, significant consequences.

So again, it's a value judgment in the eye of the beholder, and that's one of the elements the steering committee gets to opine upon and decide whether it meets the criteria.

The second one, 1(b), is demonstration of a quality problem and an opportunity for improvement. This is a data-driven subcriteria. What we have seen in the past is measures that are submitted where current use among say a dozen health plans shows that current performance is all about 98.5 percent.

So the idea is that it costs resources to, you know, collect that data, crunch the data and report the data, and there just isn't going to be much opportunity to do anything with that data, except pat yourself on the back and listen to the applause.

That's really not what we're here to do.

So that's what that subcriteria is addressing. There needs to be something that's actionable, something that we can anticipate some improvement in quality as a response to implementing the measure.

Then for 1(c), for us this actually becomes a lot easier than for some of our other projects, where the focus of the measure is an outcome. Outcomes in and of themselves, you know, are good things.

So what other types of outcomes -- it's relevant and we've already discussed why outcomes are really good things. In the absence of outcomes, you know, we look at process measures. God, I am just spastic at this.

CO-CHAIR SUSMAN: Not if you're a surgeon.

MS. WINKLER: Not anymore, and you can see why.

CO-CHAIR SUSMAN: Let's not go

there.

MS. WINKLER: Yes. I'm not really good at the glide path thing. So the second, under 1(c), the alternative is if it's a process measure, that there's clear, strong, compelling evidence that that process is related to an important patient outcome.

So doing things just for doing things is not what we're talking about. So this is also true to a certain degree of intermediate outcomes. I mean we need to know that the intermediate step also is related to ultimately the outcomes, and that there's evidence, you know, evidence base. We try and grade the strength of the evidence.

So not just a good idea, but something that's really grounded in science. So these are described in greater detail. But again, for this project, we're talking about outcomes, you know. Being an outcome measure tends to get you through this first criteria. Any questions?

CO-CHAIR LEDDY: So a utilization measure which is not really an outcome measure, might be considered an intermediate measure, such as decreased emergency room use or decreased rehospitalization?

MS. WINKLER: Typically, utilization measures are either structure or process measures. They aren't considered outcome measures.

CO-CHAIR SUSMAN: Although one might argue that from a patient's or family's perspective, if I've got Alzheimer's disease and I'm in the emergency room every other day or bipolar disorder, that that is an important outcome perspective.

MS. WINKLER: Well, under your types of outcome, service utilization. That tends to be more the, you know, appropriate use/inappropriate use of health care services. So any other questions?

CO-CHAIR SUSMAN: I want to make sure I got you, Alice, Katie.

MS. WINKLER: Okay. The second main criteria, scientific acceptability of the measured properties, and that's the extent to which the measure, as specified, okay. We've certainly seen multiple measures of the same thing, but all slightly different.

So we're really talking about the characteristics of an individual measure. Not the concept, which may be lovely, but the actual nitty-gritty details of the specifications, that that -- those, as specified, produces consistent and credible results about the quality of care when implemented.

Is the information, you know, is it reliable and is it valid, and is it accurate information? So the first of the subcriteria is about precise specifications, good definitions, can it be implemented consistently in a standardized fashion? We've seen measures that come in where a lot of the terms are not defined, so that they can be

interpreted any number of ways by any number of folks.

That leads to lack of standardization, and those measures should be rated a little bit lower.

High quality data elements. As we're looking to move into the electronic world, some of the work on our HIT activities, we've had the health information technology expert panel. They've started looking at quality of data elements, how reliable, how accurate are they, is the information of different types?

So they've rated things like diagnosis codes for inpatient, outpatient diagnosis codes, laboratory values. So there's actually a report where they start looking at data quality, and we will, as appropriate, look at that in the measure specifications as well.

Come on, come on. Show me where it is. There you go. That's what I want. Okay.

Lots of explanatory footnotes, so additional information to help you understand that.

So here, under the scientific acceptability aspect, reliability testing. What do we know about the reliability of the data? 2(c) is validity testing. What do we know about the meaningful and the meaning of the results? Does it really represent what it is you're trying to measure?

One area that's particularly received a lot of focus lately is around exclusions. Some measures become very complicated with lots and lots of exclusions, and that adds to the complexity of measurement, data collection and really from a measurement perspective, exclusions that don't contribute to the actual result, don't distort the outcome, don't add anything to the measure results, but do add complexity and cost to doing the measurement.

So, you know, met exclusions should be evidence-based and of sufficient frequency

that they would impact the results. They need to be clinically appropriate and precisely defined and specified.

One of the things we've seen is a certain number of measures that say, for instance, the numerator or denominator easily captured in electronic data, but the exclusions require a chart review. Those measures don't get implemented, you know. The feasibility just goes to pieces and they just don't.

So a real good assessment of the exclusions and be sure we don't have a situation that really impacts either the results or the feasibility of the measures.

Then Dr. Pincus, to address your issues, 2(e) is for outcome measures and other measures where indicated in evidence-based risk adjustment strategy, as specified and based on patient clinical factors that include, influence the measured outcome, and are present -- dah dah dah dah -- at the start

of care.

If there isn't a risk adjustment, why not? There may be a reason and it may be appropriate not to, but explain. Not just leave the whole thing blank as if you never thought about it.

2(f), you can see this has the greatest subdetails. This is where the real technical aspect is. Data analysis, demonstrate the methods for scoring the analysis for the measure, allow for identification of statistically significant and practical and meaningful differences about performance. I mean, I think that's pretty straightforward.

We've seen measures -- 2(g) is multiple data sources that demonstrate that they produce comparable results. We've certainly seen specifications where it measures that oh, you can do it in any EHR, you can do a manual chart review, you can do it, you know, electronic data. You can do it

all sorts of way, any way you want. Hmm. That prompts a lot of questions.

And then if disparities in care have been identified, specifications and analysis allow for identification of disparities through stratification of results.

This again is because it is one of NQF's focus areas. Unfortunately, lots of measures just -- that one just doesn't happen. So we're really trying to encourage that capability, so that we can get information about disparities.

Any questions about those criteria? Again, these are the technical aspects of the measure, but it's of the measure itself, as the coding, as the definition, as the terms of the numerator/denominator exclusion criteria.

DR. PINCUS: I have a question. Just, you know, if you look across the measures that are on the list, the -- list, I mean a lot of them, at least to my knowledge, don't really have much in the way of validity

testing.

MS. WINKLER: Yes. Most of the time what we see is face validity assessment, you know, and most measure developers will have some sort of expert panel. They will, you know, sort of systematically have them review it for both the evidence and face validity.

There are times, however, when you do get folks who do some construct validity assessments. It's always nice when you see it, but face validity tends to be the most common kind. So again, it would be very nice if every measure scored very highly on all those criteria.

But the fact of the matter is most of them won't score high on all of them. It would not be a great measure if it scored low on all of them either. So you do tend to get sort of a range. That will be ultimately your decision on whether it's good enough to recommend go forward.

That's why I say, there is no absolute thresholds or criteria, or absolutes or scoring system or minimum score to meet and that kind of thing.

Usability is the next criteria. The extent to which the intended audiences, and those can be a wide variety of audiences, can understand the results in the measure and are likely to find them useful.

I mean it's the "so what" factor. I mean you did it, now you have a result, so what? Is this, you know, is it anything anyone can use?

So demonstration that the information that's produced is meaningful and understandable. This is where -- 3(b), this is where harmonization comes in, because the usability for implementation, if you're trying to implement a group of measures around a certain topic, say diabetes, say asthma, and the denominators are all different, different age ranges for the inclusion criteria,

different codes, leave some out. Age tends to be one of the biggest ones.

You know, that's not going to facilitate implementation, because it's going to be very hard for an implementer to agree to retool and re, you know, set up their data collection mechanism for a completely different group, a population that's only really different at the margin to meet the specs for each measures.

So harmonizing them, so that if you're doing measures for asthma, asthma's defined pretty much the same. You can, you know, identify that patient population and then get the information you need for the numerators.

So harmonization is becoming a growing and very increasingly important aspect about it, merely because we're hearing from the field that implementation really depends on how well it's harmonized and aligned with other similar measures, perhaps ones that are

already in play, and to measure specs that are applicable to multiple levels and settings is highly desirable.

It's not a requirement, but highly desirable. We've often seen measures, certainly in the early years, that were targeted: hospital measure, nursing home measure, home health measure.

The fact that the patients move among them all and make it measured on the same thing, somewhat differently depending on bed they're laying in or, you know, chair they're sitting in. That just adds kind of chaos to the world, that we're hearing, you know, can you do something about that? Get them all the same.

We also want to review the existing endorsed measures and measure sets, to see how this new measure could add to it. Perhaps it's better than an existing one and should replace it. That's fine.

Is it a complement? Does it

provide additional information? Is it redundant, you know? Does it need to be evaluated head to head with an existing measure because it's similar? So we'll guide you through that assessment process.

But what we don't want is a library of multiple similar measures. That is not fostering standardization, which is certainly the goal around NQF endorsement. Questions around usability?

Okay. The last one is feasibility, and this is the extent to which required data are readily available, retrievable without undue burden and can be implemented readily. You know, feasibility is the bottom line, and nothing will happen unless these measures are feasible.

So you know, the subcriteria look at things like the data elements that are routinely generated with and as a byproduct of care during delivery. We're not there yet. That's one of the hopes of EHR implementation.

But having to either abstract data or use data collection tools just adds cost burden to measurement. So to increase the feasibility, we really want to encourage more efficient data collection.

Whether data elements are available in electronic sources. Measures that are now specified for manual chart review are really, I mean, except in maybe research settings or very narrow settings, just really are not being used. It's too costly and not where people are willing to invest their resources.

Again, just reiterating the exclusions, not requiring additional data sources that's required for scoring the measure, and then some assessment of the susceptibility of inaccuracies, errors or unintended consequences, and the ability to audit the data items.

I mean you need to be able to have some reassurance that the performance results are accurate, and some demonstration that the

data collection strategy can be implemented. Frankly in this one, if the measure's in use, that's a very nice proxy for feasibility. Somebody clearly has done it, is doing it and it's happening.

We see measures that are in just popping out of the development pipeline, and really aren't in use. So that opens the question to, you know, real feasability concerns and ratings.

So those are the criteria against which the measures will be evaluated, and you will be using these criteria. These are the same criteria we use for all NQF measure evaluations for measure for endorsement. So does that kind of clarify some of the questions you were having earlier perhaps, about our expectations for the kinds of measures that NQF is looking for, to add to our portfolio?

DR. GOLDBERG: As I hear them, it just reminds me how important this is.

There's so many cottage industries going on right now. There's -- that are growing up, and we have to get a way to start to be able to compare practices.

I think the world is looking for, I mean NQF has the gold standard of these measures, and the question is how fast are we going to be able to get there, what's there? But we've got to get past the cottage industry stage, and allow practices to be able to compare themselves on outcomes.

DR. PINCUS: On the other hand, it's also seeing this, you see how daunting it is for somebody to actually develop and submit a measure. You know, I think somebody's --

DR. GOLDBERG: Don't try this at home.

DR. PINCUS: Well, I think somebody's assessed that, I think it's close to like a minimum of $500,000 to develop a measure.

CO-CHAIR SUSMAN: And you think

about it. If we're going to use these for accountability, I want these to be robust measures.

If I'm going to held accountable, if I'm going to be judged, one health plan versus another, one practice versus another, et cetera, et cetera, there is a trade-off.

That means that the small cottage industries where maybe wonderful research has been done, but doesn't make it through all these hoops, it's a challenge. Do the criteria go out with the call, so that people that might be submitting have copies of this?

MS. WINKLER: Yes, the information about the criteria it's one of the measures. It's one of the standard evaluating criteria, here's the link, here's the information.

CO-CHAIR SUSMAN: Fame and glory.

DR. STREIM: Is it? Do people -- there's no names attached to it. Is it just part of somebody's professional commitment?

MS. WINKLER: The organizational

name the measure developer tags with the title, absolutely, because they're talking about their intellectual property that we are using for the purpose of identifying the best ones, if you will, and putting in a portfolio.

So when we talk about, when you do a search on our website, on our endorsed measures, the measure developer owners, call it whatever you want to, comes up with the title, absolutely. So yes.

DR. STREIM: But I think what you see, looking across the 16 -- how many? What's the total number?

MS. WINKLER: About 500, 566 is today's count. Ashley knows.

DR. STREIM: So if you're looking at disproportionate number, I mean most of them are either NCQA/HEDIS measures, or there is a whole chunk of them that are stable bipolar measures, which was basically submitted by a drug company to get more attention to bipolar disorder.

So it's organizations that have some capital to invest in measure development. One of the problems is that there's no entity out there that's actually paying for measure development and stewarding the whole process. It doesn't have skin in the game, so to speak.

DR. STREIM: So back to the question of how we get at people who don't think of themselves as measure developers, people who get NIH dollars or AHRQ dollars to actually do expensive projects to develop test feasibility, do the validation steps, but there are plenty of investigators out there, are there plenty of health systems, I guess, that adopt measures and start using them, find that, as you said, you know, they use them, they can collect them, we know it's feasible from that. But did somebody actually do more than face validity? Often not.

So it sounds like if measures like that met these criteria, we would consider

them. I think the question is how to get beyond, and I think Harold already raised this, how to get beyond people who think of themselves as their career identity is measure developer, because there's lots of measures in use.

CO-CHAIR SUSMAN: I don't think there's an easy answer to this. Really, that's why we're here in part, is to help make those connections, and nonetheless, it is a daunting task to submit and to, you know, meet all the criteria that NQF has outlined. Are there other questions, comments, concerns, issues that need to be raised? Carol?

MS. WILKINS: Maybe just as a follow-up to some of the last comments, do you envision that part of the outcome of this process might be to say that this group has identified a number of outcomes that are really important, for which good measures don't exist, and that this could help prioritize investment in the development of

appropriate measures?

CO-CHAIR SUSMAN: I think that's really probably the most impact of this group in the longer run. It's not so much to get the call for measures today, as to help spur measure development for tomorrow.

MS. WINKLER: Definitely this project has two major goals. One is endorsing additional measures, if we can find them and they meet the criteria. But the second one is trying to get a sense of what do you want, and get that concept out into the field.

Certainly, I know when I have my every other week calls with the Department of Health and Human Services about this project, they are interested in knowing the kinds of measures that should be developed, that would be useful, that they are in a position of, you know, looking to some of their constituent agencies as potential measure developers. So certainly that part of it is equally important, and there is an audience for that

information already in place.

CO-CHAIR SUSMAN: So to just sort of close this loop, Ian and Reva, in January there's going to be the formal call. There's 30 days. You get them all in. Staff will then try to look at the setting up of each of these measures vis-a-vis these criteria, and then we will wait them.

MS. WINKLER: You know, part of unknown of how many measures ultimately will happen is why we have to leave things a little bit open-ended, and if we get two measures or if we get 20 measures, we'll have to handle them slightly differently.

Essentially, your meeting in April will to do the final evaluation against the criteria, and then recommend which measures should go forward for endorsement. We're planning on a two-day meeting. If we only have two measures, you know, we can probably handle that.

If indeed we've got, I don't know,

20, 40 measures, something I don't know, and I'm being deliberately absurd, but we may need to think about the amount of time it will take to do it, and you know, we may need to meet with you by conference call ahead of time to help, you know, formulate that work plan and assessment.

You know, I hear Eric grumbling over there about possibly 200. The likelihood that there will be 200 measures that we couldn't do some screening and filtering through, to really focus in on the ones that are going to meet the criteria I think is unlikely.

But you know, there is a certain amount of uncertainty in this. There's no doubt about it.

CO-CHAIR SUSMAN: So any further questions about the evaluation process, going out to colleagues, call for measures, what will be happening in April?

DR. GOPLERUD: I have a question

about whether we might take some measures that are submitted and expand them or distort them? For example, we've got a whole bunch of bipolar measures. Okay. It's a significant condition.

But if we had something that was submitted that might be a bipolar measure, specified et cetera, meets a lot of those criteria, is it likely or possible to expand it to say this should cover behavioral health conditions?

MS. WINKLER: Okay. Remember that we don't own the measures, and so one of the important aspects of evaluating measures is developing a good relationship with the measure steward, measure developer and having these ongoing conversations.

Minor tweaking of measures in conversation, as you're evaluating them can occur in the course of a project. But frankly, remaking the measure, such as you're suggesting, is a little bit greater

enterprise, such that your suggestion to do so probably cannot happen within the time frame of the project, but could happen such that we might be able to capture it down the road.

DR. PINCUS: Actually, just to give an example of how that worked, with the medication management development, Medication Management Measure Steering Committee that I was part of, we sort of had to deal with that issue, because the call for measures came up with a really disappointing lot across the board.

And this is relevant in two ways. Number one, there were huge gaps, and number two is similar concepts, like adherence for example, were being addressed with vastly different definitions. So what we did was, you know, as Reva said, you can't go the extent of just wholesale changing things. But what we did was we put down a fairly hard line of saying that we really weren't going to approve things unless they met some kind of

standard, and try to get the different measure developers to try to use a similar way of measuring adherence.

We actually had to put together a small work group that developed a statement about what we thought was sort of an appropriate way that sort of balanced all the various ways of measuring adherence, and got a number of the measure developers to accept modifications in their measures, to be able to do that.

But in terms of doing exactly what you said, I mean the best example of that was the Joint Commission submitted a measure for polypharmacy, which made -- in schizophrenia or people on anti-psychotics, which made a lot of sense.

But it was just for inpatient care, because that's what the Joint Commission focused on. You know in some ways it doesn't make a lot of sense, just for inpatient care, because that's the point at which people are

going to transition, and they're sort of reasonably on multiple medications.

Polypharmacy as a measure makes more sense for outpatient care, but nobody submitted that. So in our report, we had a long list. Actually, we had a much larger component of the report about where the gaps were and what, you know, and with some ideas about what ought to fill those gaps.

DR. GOPLERUD: One of the -- take a look at the history of the diabetes measures. The diabetes measures started out being entirely paper and pencil chart review, and then they moved to hybrid measures and then eventually they became, you know, they got Category 2 codes for levels and now it's primarily, I guess, electronic.

Many of the measures that I can imagine coming forward would be at the chart review level, and if what we do is penalize ourselves because we do not, have not yet reached the level of maturity of diabetes,

which actually did have a glide path that got them finally to electronic, I think we're going to end up being stuck with administrative data that don't cover this range of outcomes that we've spent the day on.

CO-CHAIR SUSMAN: I thought the analogy to diabetes is probably a good one, because I mean how many years has it been that diabetes has been a focus of measurement, and look at that evolution.

We're still in the midst of it, because many of the items that we'd like to measure are not yet codified within the typical EHR. So this is a journey, and you know, if we can start and identify the gaps as Harold did with the other group, and really en encourage the field to fill in those gaps and not be too impatient, that we've got to get it all the first go-around, which is probably not realistic, I think we will be making progress, and that's what it's all about. Eric?

DR. GOPLERUD: Yes. In the area of

alcohol use, we have the Joint Commission working on reduction in risky drinking for inpatients. We have emergency departments focused on reductions in risky drinking as a follow-up. We have primary care that's doing the same thing. We have EAPs doing the same thing.

If we have a single measure that comes in, where we know that in fact it's been applied in other areas, how -- so the Joint Commission submits one on inpatient reduction in risky drinking, but it's the same measure or applicable to other conditions. How do we handle that?

MS. WINKLER: You know, sometimes it can get very frustrating, because the logical answer is just there's one measure, and you apply it wherever. It's a tough one at this point to find the organization that's willing to kind of jump and own that. Everybody's still kind of carving out their piece of the real estate.

Our first step is harmonization, making sure that at least you're measuring the same thing, even if you're measuring it first in the hospital and then in the outpatient. A lot of it's driven by data, types of data availability, the type of coding, the type of data collection tools that may be available.

But again, this is a conversation that happens over and over and over and over again, and I think that you're seeing some progress. You're seeing some openness, but not as quickly as anybody would like, not as optimally, but we keep trying to hammer and push things.

We're at a much better place than we were five years ago, you know. Things are moving -- my nine-year perspective puts me in a position to watch, when I sit back. There has been a lot of change. It's just on a day-to-day basis, it seems monumentally slow.

So like I say, harmonization is one of those first steps. But again, the National

Priorities Partnership is trying to again, these concepts that aren't setting-specific, that they follow the patient and the goals are common to wherever the patient might be or receive care.

So there are a lot of different strategies to try and reach that point. We're not there yet.

CO-CHAIR SUSMAN: Harold?

DR. PINCUS: Just three points. One in response to that. If you look in the medication management thing, that it really depends, I think as Reva said, where the data's coming from.

So that in fact any number of the measures that were cited, even though they may have been intended for a particular setting, if those data are available in other settings, then they can be applied in other settings. So that's often a piece of it.

I guess a second point. You know, there are -- I mean the diabetes models are

the interesting thing. It also is an example of sometimes we can go too fast.

So in terms of, you know, looking at going from whether people got a foot exam and an eye exam in a year or over two, whether they got a hemoglobin A1C in a year and then into what the value of the hemoglobin A1C was, you know, was it below 9, is it below 8, is it below 7?

Then your core study comes out and shows that below 7 is associated with higher mortality. So you know, you have to be a little careful about how fast you go on some of these things, and that's where sort of understanding some of the segmentation issues in terms of some things make sense for some people, but not for others, to understand that.

But you know, there is a CPT-2 code for standardized assessment of depression, that using a standardized instrument that actually exists. But it's not being used in

any measure, to my knowledge.

DR. GOLDBERG: It's not being paid for. It exists, but --

(Simultaneous discussion.)

DR. PINCUS: Right, we haven't paid for it. Right. The CPT-2 code, no one got paid for CPT-2 codes no matter what, but except through PQRI. But you know, but it's sitting there waiting for a measure to be used, you know, to be promoted using that.

CO-CHAIR SUSMAN: So we're at a point where I think most of the content of the sessions have been taken care of. We're going to have an opportunity to take a look at Ian's compilation of all the material and provide feedback and refinement of that.

That will be done offline. If we need to have a conference call or something along that lines, I'm sure we can. But I suspect this will be pretty easy to do via email.

We've outlined the call for

measures and how that will occur. We've gone over the criteria. I think we're probably at a point where we could finish up in fairly short order, and then have lunch. Or if everybody's exhausted and can't go on, we could have lunch first and finish thereafter.

What's the will of the group? Try to push forward and finish and then have lunch? They tell me, Reva tells me very little to do. So why don't we push forward, get done and then people who have planes to catch can do so.

Work Plan/Time Table for Project

MS. WINKLER: Yes. I mean essentially we've gone over all of the topic areas, the kinds of things that we wanted to bring you all together, orient you to, explain, discuss and we've gone all over it I think fairly thoroughly. Certainly Ian and I are available to you for any questions going forward.

In terms of the process, we've

talked about it all along, but what happens next? Most immediately, we'll be sending out the draft for you to do your redlining suggestions to. We'll pull that together into a final document.

It will initially be embedded in sort of the announcement that's the call for intent to submit measures, which is early December, which is more an announcement, trying to get folks to be aware what's going on.

The actual formal call for measures will be posted in early January. In the meantime, we'll also do a summary of this meeting. It gets posted on our website. We'll circulate to you all for your input, approval, revisions, whatever.

We will be posting the recording of this meeting on the website, as well as the transcript when we get it. Transcripts now are no longer five inch documents landing on my desk but are electronic documents. So

we'll be able to share those with you, for all of you who want to relive the last two days.

I do that a lot, by the way. When I write reports and write documents, I quote you liberally. I go back into the transcript and pluck out wholesale phrases and sentences. So the entire point of the work that NQF does is meant to be highly transparent. You do represent a wider population of folks, and they need to have access to what you're working on.

Once we have a sense of how many measures are submitted after the call for measures, we'll be right back at you to say here they are, this is how many we got, however many it is, with a list, and here's the titles, as well as devising a work plan to prepare for our meeting in April.

Like I say, if it's two measures, it's a different prep than if it's, you know, 20 measures. So we'll kind of have to be a little bit flexible on that planning until we

have a handle on how many measures we're talking about.

DR. ROCA: Any idea about what the dates in April are likely to be?

MS. WINKLER: No. I think one of the important things that Ian needs to do relatively soon is get all of your availabilities, so we can figure out what that is. I can just tell you that all three of the steering committees for outcomes are going to be meeting over a relatively brief period of time. So you know, everything's all happening in concert.

So we'll get that and see if we can nailed down on your calendars so that it's clear. But that's a good reminder. Thanks Bob.

So anything else from anyone? Any questions? I can't tell you how much I appreciate the conversation, the discussion, the new ideas. This is not an area of my expertise. I'm a physician and I practiced

for 20 years, but I'm an obstetrician. So mental health it happened, but slightly differently in my personal clinical experience.

So I enjoyed very much listening to your ideas and your thoughts. It's always one of the best parts of my job is meeting people like you, people who are kind of working in different aspects of this, have really fun things to contribute. The sharing is fun, the relationships we build.

I've worked with some of you for many years and some of you are new, and I'm sure we'll work together as we go forward, not only on this project but perhaps in the future. Ian, what's it for you?

MR. CORBRIDGE: Yes. I just wanted to thank each individual here for the opportunity to meet you and work with you through this process. As Reva mentioned, I should be sending out shortly a set of deliverables from us to you guys.

I think we've probably talked about the framework that we're looking at for each of you to kind of wordsmith and go forward with that, and we'll circulate that document, and I'll try to provide some clarity within that as you guys add your advice or inputs and move forward.

The other, I guess, article that was expressed that individuals on this committee would like would be to look at the National Priorities Partnership. So I will send that document out to you for review, and if you have any questions, please feel free to send them my way.

I'm still trying to learn, I guess, what is in that document and how it fits into NQF as a whole. So I'm always more than welcome to field any questions, but I can also reach out to the other department that handles the National Priorities Partnership.

In addition, I guess what seems to have been expressed here, is that there is

-- each individual here has a lot of knowledge of where there may be some measures or potential people who might be willing to submit, or individuals that we might need to reach out to and touch.

Specifically in areas that NQF and this project might be advancing beyond their traditional realm that we functioned in, so as trying to look at some of these more global public health aspects.

If any of you have any individuals that we should contact, areas we should engage, maybe we should try to start -- if you can send those to me, I'll try to start compiling those. We can get a list going, and that way we know NQF is touching out to the right people, you know who we're actually engaging, and we can move forward from there.

So if that seems agreeable to people, I know that would be something very helpful for myself. Just listening to the comments that were expressed, it seems like

there's deep knowledge in areas that we should be engaging that we might not at this point. So with that, I want to thank each of you for participating, and we appreciate all your help.

CO-CHAIR SUSMAN: I just want add my appreciation as a co-chair of this process. It's tremendous that all you have to do is sit back and let you take the ball and run with it. I'm very impressed with the quality of discussion and the willingness to put yourselves out there and to contribute to a robust process.

So thank you. It's been a lot of fun, and I look forward to working with you throughout this in coming April.

CO-CHAIR LEDDY: Yes, and I also say thank you to everybody, including Reva and Ian, and especially also mentioning Bonnie's presentation.

I think it really broadened all of our minds, and I think that when we -- before

the call for announcement goes out in December, that when we review what we did the first day, I think we need to keep in mind that we heard Bonnie's presentation the second day.

So it may not reflect everything that we talked about afterwards, such as like some of the public policy or public health issues, and the fact that we have kind of agreed that in addition to -- or talked about that in addition to clinical outcome measures, we might be interested in hearing from people on outcome measures that might reflect more public health or public policy such as tax policy, and really stretch kind of in that direction.

So I think hopefully we can pay attention to that during the review process, and make sure we're expansive in that. I think that clinical measures are more typical, and very important obviously. But if we could also expand in the directions that Bonnie led

us in, I think it would be useful. So thank you.

MS. WINKLER: We do have lunch. It's on the buffet right outside the door. So please, you know, don't go away on empty stomach.

CO-CHAIR SUSMAN: I just want to say is the operator on the line?

OPERATOR: Yes sir.

NQF Member/Public Comment

CO-CHAIR SUSMAN: Do you know if there was anyone on the line for public comment?

OPERATOR: The only person on the line is Daniel Kaufer.

CO-CHAIR SUSMAN: Okay. Wonderful, thank you.

OPERATOR: And are we concluding today's call?

CO-CHAIR SUSMAN: Dan, did you have anything to add or are you --

CO-CHAIR LEDDY: He must have gone

off the line.

CO-CHAIR SUSMAN: Okay. I think we're concluding for the day. Thank you.

DR. KAUFER: Thank you.

OPERATOR: You're welcome. Have a great day.

CO-CHAIR LEDDY: I think she cut him off. Oh well.

CO-CHAIR SUSMAN: If anybody's going to the airport, I'll share a cab.

(Whereupon, at 12:27 p.m., the meeting was adjourned.)