



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 2605

Corresponding Measures:

De.2. Measure Title: Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Co.1.1. Measure Steward: National Committee for Quality Assurance

De.3. Brief Description of Measure: The percentage of discharges for patients 18 years of age and older who had a visit to the emergency department with a primary diagnosis of mental health or alcohol or other drug dependence during the measurement year AND who had a follow-up visit with any provider with a corresponding primary diagnosis of mental health or alcohol or other drug dependence within 7- and 30-days of discharge.

Four rates are reported:

- The percentage of emergency department visits for mental health for which the patient received follow-up within 7 days of discharge.
- The percentage of emergency department visits for mental health for which the patient received follow-up within 30 days of discharge.
- The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 7 days of discharge.
- The percentage of emergency department visits for alcohol or other drug dependence for which the patient received follow-up within 30 days of discharge.

1b.1. Developer Rationale: This measure targets individuals with mental health or alcohol or other drug dependence who are discharged to the community from the emergency department as they may be particularly vulnerable to losing contact with health care system. High use of the emergency department may signal a lack of access to ongoing care or a gap in fulfilling urgent care needs. Therefore, this point of transition presents an opportunity to ensure that the patient is connected to care and receives follow-up. Health plans have access to information and care management processes to ensure that follow-up care occurs. Therefore, health plans have the ability to help connect patients into outpatient care after emergency department use.

Estimates suggest that about half of psychiatric patients discharged from the emergency room transitioned successfully to outpatient care (Bruffaerts, 2005). Low-intensity interventions that can be applied widely are typically implemented at periods of high risk for treatment dropout, such as following an emergency room discharge or the time of entry into outpatient treatment (Kreyenbuhl, 2009).

Individuals discharged from the emergency department face two main risks: (1) disengagement from treatment and (2) readmission to the emergency department. Treatment disengagement is a problem because individuals with the most serious mental health problems or alcohol or drug use disorders may require ongoing support and counseling to live independently in the community. Individuals who lose contact with outpatient care providers begin a vicious cycle of symptom deterioration (Kilaspay, 2007) that necessitates further crisis intervention in emergency settings (Fischer, 2008; Jencks, 2009). Preserving individuals' engagement with post-discharge treatment requires high quality handoffs between emergency settings and ambulatory care providers (Hartley, 2007; Wislar, 1998) as readmission is problematic because it involves further disruptions in life and becomes costly for health care systems, especially the emergency department setting.

Bruffaerts R, Sabbe M, Demyffenaere K. (2005) Predicting Community Tenure in Patients with Recurrent Utilization of a Psychiatric Emergency Service. *Gen Hosp Psychiatry*. 27:269-74.

Fischer, EP, McCarthy JF, Ignacio RV, et al. (2008) Longitudinal Patterns of Health System Retention Among Veterans with Schizophrenia or Bipolar Disorder. *Community Mental Health Journal*. 44:321-330.

Hartley, D, Ziller EC, Loux JA, et al. (2007) Use of Critical Access Hospital Emergency Rooms by Patients with Mental Health Symptoms. *Journal of Rural Health*. 23:108-115.

Jencks, SF, Williams MV, Coleman EA. (2009) Rehospitalizations Among Patients in the Medicare Fee-for-Service Program. *New England Journal of Medicine*. 360:1418-28.

Kreyenbuhl, J, Nossel, I, Dixon, L. (2009) Disengagement from Mental Health Treatment among Individuals with Schizophrenia and Strategies for Facilitating Connections to Care: A Review of the literature. *Schizophrenia Bulletin*. 35:696-703.

Killaspy, H. (2007) Why do psychiatrists have difficulty disengaging with the out-patient clinic? Invited commentary on: Why don't patients attend their appointments? *Advances in Psychiatric Treatment*. 13:435-437.

Wislar, JS, Grossman J, Kruesi MP, et al. (1998) Youth Suicide-Related Visits in an Emergency Department Serving Rural Counties: Implications for Means Restriction. *Annals of Suicide Research*. 4:75-87.

S.4. Numerator Statement: The numerator for each denominator population consists of two rates:

Mental Health

- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 7 days after emergency department discharge
- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 30 days after emergency department discharge

Alcohol or Other Drug Dependence

- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7 days after emergency department discharge
- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 30 days after emergency department discharge

S.6. Denominator Statement: Patients who were treated and discharged from an emergency department with a primary diagnosis of mental health or alcohol or other drug dependence on or between January 1 and December 1 of the measurement year.

S.8. Denominator Exclusions: The following are exclusions from the denominator:

- If the discharge is followed by readmission or direct transfer to an emergency department for a principal diagnosis of mental health or alcohol or other drug dependence within the 30-day follow-up period, count only the readmission discharge or the discharge from the emergency department to which the patient was transferred.
- Exclude discharges followed by admission or direct transfer to an acute or nonacute facility within the 30-day follow-up period, regardless of primary diagnosis for the admission.

These discharges are excluded from the measure because hospitalization or transfer may prevent an outpatient follow-up visit from taking place.

De.1. Measure Type: Process

S.17. Data Source: Claims

S.20. Level of Analysis: Health Plan, Population : Regional and State

IF Endorsement Maintenance – Original Endorsement Date: Mar 06, 2015 **Most Recent Endorsement Date:** Mar 06, 2015

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? [Not applicable.](#)

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[EF_-_FUED_73114.docx](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Please update any changes in the evidence attachment in red. Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. If there is no new evidence, no updating of the evidence information is needed.

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

IF a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

IF a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and provide rationale for composite in question 1c.3 on the composite tab.

This measure targets individuals with mental health or alcohol or other drug dependence who are discharged to the community from the emergency department as they may be particularly vulnerable to losing contact with health care system. High use of the emergency department may signal a lack of access to ongoing care or a gap in fulfilling urgent care needs. Therefore, this point of transition presents an opportunity to ensure that the patient is connected to care and receives follow-up. Health plans have access to information and care management processes to ensure that follow-up care occurs. Therefore, health plans have the ability to help connect patients into outpatient care after emergency department use.

Estimates suggest that about half of psychiatric patients discharged from the emergency room transitioned successfully to outpatient care (Bruffaerts, 2005). Low-intensity interventions that can be applied widely are typically implemented at periods of high risk for treatment dropout, such as following an emergency room discharge or the time of entry into outpatient treatment (Kreyenbuhl, 2009).

Individuals discharged from the emergency department face two main risks: (1) disengagement from treatment and (2) readmission to the emergency department. Treatment disengagement is a problem because individuals with the most serious mental health problems or alcohol or drug use disorders may require ongoing support and counseling to live independently in the community. Individuals who lose contact with outpatient care providers begin a vicious cycle of symptom deterioration (Kilaspay, 2007) that necessitates further crisis intervention in emergency settings (Fischer, 2008; Jencks, 2009). Preserving individuals' engagement with post-discharge treatment requires high quality handoffs between emergency settings and ambulatory care providers (Hartley, 2007; Wislar, 1998) as readmission is problematic because it involves further disruptions in life and becomes costly for health care systems, especially the emergency department setting.

Bruffaerts R, Sabbe M, Demyffenaere K. (2005) Predicting Community Tenure in Patients with Recurrent Utilization of a Psychiatric Emergency Service. *Gen Hosp Psychiatry*. 27:269-74.

Fischer, EP, McCarthy JF, Ignacio RV, et al. (2008) Longitudinal Patterns of Health System Retention Among Veterans with Schizophrenia or Bipolar Disorder. *Community Mental Health Journal*. 44:321–330.

Hartley, D, Ziller EC, Loux JA, et al. (2007) Use of Critical Access Hospital Emergency Rooms by Patients with Mental Health Symptoms. *Journal of Rural Health*. 23:108–115.

Jencks, SF, Williams MV, Coleman EA. (2009) Rehospitalizations Among Patients in the Medicare Fee-for-Service Program. *New England Journal of Medicine*. 360:1418–28.

Kreyenbuhl, J, Nossel, I, Dixon, L. (2009) Disengagement from Mental Health Treatment among Individuals with Schizophrenia and Strategies for Facilitating Connections to Care: A Review of the literature. *Schizophrenia Bulletin*. 35:696-703.

Killaspy, H. (2007) Why do psychiatrists have difficulty disengaging with the out-patient clinic? Invited commentary on: Why don't patients attend their appointments? *Advances in Psychiatric Treatment*. 13:435–437.

Wislar, JS, Grossman J, Kruesi MP, et al. (1998) Youth Suicide-Related Visits in an Emergency Department Serving Rural Counties: Implications for Means Restriction. *Annals of Suicide Research*. 4:75–87.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.*

New Measure: Not applicable.

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

With the exception of the Olfson (2012) study cited below, few studies have used nationally representative data to examine follow-up care among psychiatric patients discharged from the emergency department to the community. However, several studies have consistently found that roughly half of these patients do not receive follow-up care (Olfson, 2012; Bruffaerts, 2005; Dobsha, 1999, Klinkenberg 1999)

Citations:

Bruffaerts R, Sabbe M, Demyffenaere K. (2005) Predicting Community Tenure in Patients with Recurrent Utilization of a Psychiatric Emergency Service. *Gen Hosp Psychiatry*. 27:269-74.

Dobsha SK, Delucchoi K, Young ML. (1999) Adherence with referrals for outpatient follow-up from a VA psychiatric emergency room. *Community Mental Health Journal*. 35:451-458.

Klinkenberg WD, Calsyn RJ. (1999) Predictors of receiving aftercare 1, 3, and 18 months after a psychiatric emergency room visit. *Psychiatr Q*. 70:39-51.

Olfson M, Marcus SC, Bridge JA. (2012) Emergency treatment of deliberate self-harm. *Arch Gen Psychiatry*. 69:80-8.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., “topped out”, disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b) under Usability and Use.*

Our field test from states in the Medicaid Analytic eXtract (MAX) data showed the following:

Follow-up rates for mental health within 7-days averaged 66.0% across states (range = 35.5 – 89.5%) and follow-up rates within 30 days averaged 76.1% (range = 53.8 – 92.4%). For alcohol or other drug dependence, wide variation was seen between low and high-performing states. Seven day rates averaged 64.3% (range = 15.5 – 90.3%) and 30-day follow-up rates averaged 66.7% (range = 26.8 – 90.3%).

There were no follow-up differences between gender in either mental health or alcohol or other drug dependence populations for 7-day or 30-day rates. Mental health 7-day follow-up rates were lowest in adults 21 to 44 years and highest in adults 75 to 84 years (range = 66.8 - 82.4%). There were no significant follow-up differences by age for the AOD population (7-day range = 64.9 – 71.4%; 30-day range = 67.1 – 71.4%). Variation was seen by mental health diagnosis. Patients with bipolar disorder and major depression had the lowest 7-day (62.5%; range = 62.5 – 79.6%) and 30-day rates (72.0%), respectively. There were no differences in follow-up rates between alcohol and drug dependence populations.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):
Behavioral Health, Behavioral Health : Alcohol, Substance Use/Abuse

De.6. Non-Condition Specific(check all the areas that apply):
Access to Care, Care Coordination, Disparities Sensitive

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):
Populations at Risk

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

Not applicable.

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure **Attachment:**

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment: 2605_Follow_Up_After_ED_Discharge_for_Mental_Health_Conditions_Value_Sets-636220757625866651.xlsx

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

Not applicable.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

The numerator for each denominator population consists of two rates:

Mental Health

- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 7 days after emergency department discharge
- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 30 days after emergency department discharge

Alcohol or Other Drug Dependence

- Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7 days after emergency department discharge
- Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 30 days after emergency department discharge

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Mental Health

Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 7 days after emergency department discharge

- A visit (FUH Stand Alone Visits Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit (FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit (FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set).
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- Transitional care management services (TCM 7 Day Value Set) where the date of service on the claim is 29 days after the date the patient was discharged from the emergency department with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).

Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of mental health within 30 days after emergency department discharge

- A visit (FUH Stand Alone Visits Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit (FUH Visits Group 1 Value Set and FUH POS Group 1 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).

- A visit (FUH Visits Group 2 Value Set and FUH POS Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit to a behavioral healthcare facility (FUH RevCodes Group 1 Value Set).
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- A visit to a non-behavioral healthcare facility (FUH RevCodes Group 2 Value Set) with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- Transitional care management services (TCM 7 Day Value Set) where the date of service on the claim is 29 days after the date the patient was discharged from the emergency department with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- Transitional care management services (TCM 14 Day Value Set) where the date of service on the claim is 29 days after the date the patient was discharged from the emergency department with a primary diagnosis of mental health (Mental Health Diagnosis Value Set).
- Note: Transitional care management is a 30-day period that begins on the date of discharge and continues for the next 29 days. The date of service on the claim is 29 days after discharge and not the date of the face-to-face visit.

Alcohol or Other Drug Dependence

Rate 1: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis of alcohol or other drug dependence within 7 days after emergency department discharge. Any of the following code combinations meet criteria:

- IET Stand Alone Visits Value Set with a primary diagnosis of AOD (AOD Dependence Value Set).
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a primary diagnosis of AOD (AOD Dependence Value Set).
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a primary diagnosis of AOD (AOD Dependence Value Set).

Rate 2: An outpatient visit, intensive outpatient encounter or partial hospitalization with any provider with a primary diagnosis alcohol or other drug dependence within 30 days after emergency department discharge. Any of the following code combinations meet criteria:

- IET Stand Alone Visits Value Set with AOD Dependence Value Set
- IET Visits Group 1 Value Set with IET POS Group 1 Value Set and a primary diagnosis of AOD (AOD Dependence Value Set).
- IET Visits Group 2 Value Set with IET POS Group 2 Value Set and a primary diagnosis of AOD (AOD Dependence Value Set).

S.6. Denominator Statement *(Brief, narrative description of the target population being measured)*

Patients who were treated and discharged from an emergency department with a primary diagnosis of mental health or alcohol or other drug dependence on or between January 1 and December 1 of the measurement year.

S.7. Denominator Details *(All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Age: 18 years and older as of the date of discharge

Benefit: Medical and Behavioral Health

Continuous Enrollment: Date of emergency department visit through 30 days after discharge

Diagnosis criteria: Patients who were treated and discharged from an emergency department with a primary diagnosis of mental health (see Mental Health Diagnosis Value Set) or alcohol or other drug dependence (see AOD Dependence Value Set) on or between January 1 and December 1 of the measurement year. The denominator for this measure is based on discharges, not individuals. If a person has more than one discharge, include all discharges on or between January 1 and December 1 of the

measurement year. Use only facility claims to identify denominator events (including admissions or direct transfers). Do not use professional claims.

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)

The following are exclusions from the denominator:

-If the discharge is followed by readmission or direct transfer to an emergency department for a principal diagnosis of mental health or alcohol or other drug dependence within the 30-day follow-up period, count only the readmission discharge or the discharge from the emergency department to which the patient was transferred.

-Exclude discharges followed by admission or direct transfer to an acute or nonacute facility within the 30-day follow-up period, regardless of primary diagnosis for the admission.

These discharges are excluded from the measure because hospitalization or transfer may prevent an outpatient follow-up visit from taking place.

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

See Section S.10 for exclusion details

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)

Not applicable.

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)

Mental Health

Step 1: Determine the eligible population.

Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of mental health.

Step 1B: Exclude patients who meet the exclusion criteria as specified in the “Denominator Exclusion Details” section.

Step 2: Identify the numerator.

Step 2A: Identify those who had a qualifying follow-up visit within 7 days.

Step 2B: Identify those who had a qualifying follow-up visit within 30 days.

Step 3: Calculate the rates.

Step 3A: Calculate the 7-day rate by dividing the number of patients with qualifying follow-up visit within 7 days (Step 2A) by the denominator (after exclusions) (Step 1B).

Step 3B: Calculate the 30-day rate by dividing the number of patients with qualifying follow-up visit within 30 days (Step 2B) by the denominator (after exclusions) (Step 1B).

Alcohol or Other Drug Dependence

Step 1: Determine the eligible population.

Step 1A: Identify patients with who were treated and discharged from an emergency department with a primary diagnosis of alcohol or other drug dependence.

Step 1B: Exclude patients who meet the exclusion criteria as specified in the “Denominator Exclusion Details” section.

Step 2: Identify the numerator.

Step 2A: Identify those who had a qualifying follow-up visit within 7 days.

Step 2B: Identify those who had a qualifying follow-up visit within 30 days.

Step 3: Calculate the rates.

Step 3A: Calculate the 7-day rate by dividing the number of patients with qualifying follow-up visit within 7 days (Step 2A) by the denominator (after exclusions) (Step 1B).

Step 3B: Calculate the 30-day rate by dividing the number of patients with qualifying follow-up visit within 30 days (Step 2B) by the denominator (after exclusions) (Step 1B).

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

Not applicable.

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

Not applicable.

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Claims

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data is collected.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

Both the numerator and the denominator for this measure are based on administrative claims data.

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Health Plan, Population : Regional and State

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Inpatient/Hospital, Outpatient Services

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

Not applicable.

2. Validity – See attached Measure Testing Submission Form

[TF_FUED_07232014-635427445523371550.docx](#)

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information –

include date of new information in red.)

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. (Do not remove prior testing information – include date of new information in red.)

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes SDS factors is no longer prohibited during the SDS Trial Period (2015-2016). Please update sections 1.8, 2a2, 2b2, 2b4, and 2b6 in the Testing attachment and S.14 and S.15 in the online submission form in accordance with the requirements for the SDS Trial Period. NOTE: These sections must be updated even if SDS factors are not included in the risk-adjustment strategy. If yes, and your testing attachment does not have the additional questions for the SDS Trial please add these questions to your testing attachment:

What were the patient-level sociodemographic (SDS) variables that were available and analyzed in the data or sample used? For example, patient-reported data (e.g., income, education, language), proxy variables when SDS data are not collected from each patient (e.g. census tract), or patient community characteristics (e.g. percent vacant housing, crime rate).

Describe the conceptual/clinical and statistical methods and criteria used to select patient factors (clinical factors or sociodemographic factors) used in the statistical risk model or for stratification by risk (e.g., potential factors identified in the literature and/or expert panel; regression analysis; statistical significance of $p < 0.10$; correlation of x or higher; patient factors should be present at the start of care)

What were the statistical results of the analyses used to select risk factors?

Describe the analyses and interpretation resulting in the decision to select SDS factors (e.g. prevalence of the factor across measured entities, empirical association with the outcome, contribution of unique variation in the outcome, assessment of between-unit effects and within-unit effects)

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for maintenance of endorsement.

[ALL data elements are in defined fields in electronic claims](#)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.
Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF a PRO-PM, consider implications for both individuals providing PRO data (patients, service recipients, respondents) and those whose performance is being measured.

This measure, focused on patients with mental health diagnoses and alcohol or other drug dependence, is adapted from an existing health plan measure (Follow-up After Hospitalization for Mental Illness NQF #0576). We have adapted the existing measure to assess follow-up after emergency department discharges using claims data. The use of administrative claims data for this measure supports the feasibility and usability of the measure concept for the specified populations. The measure imposes minimum burden to calculate as it relies entirely on claims data. The feasibility of NQF #0576 also supports the feasibility of the proposed measure.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

Broad public use and dissemination of these measures is encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
Public Reporting	
Regulatory and Accreditation Programs	

Quality Improvement (Internal to the specific organization)	
---	--

4a.1. For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

Not applicable.

4a.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

New measure.

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

This measure is intended for use by health plans, states and other interested parties to monitor and improve quality of care. Stakeholder input (described in detail in the testing form) supported this measure for public reporting and quality improvement.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

Not applicable.

4c. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4c.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

No unintended negative consequences to patients or populations were identified during development and testing.

4c.2. Please explain any unexpected benefits from implementation of this measure.

4d1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

4d1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

**4d2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.
Describe how feedback was obtained.**

4d2.2. Summarize the feedback obtained from those being measured.

4d2.3. Summarize the feedback obtained from other users

4d.3. Describe how the feedback described in 4d.2 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.
Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

0576 : Follow-Up After Hospitalization for Mental Illness (FUH)

1937 : Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)

3312 : Continuity of Care for Medicaid Beneficiaries after Detoxification (Detox) From Alcohol and/or Drugs

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

Yes

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

Portions of the specifications for this measure have been adapted from the existing health plan measures (Follow-up After Hospitalization for Mental Illness NQF #0576 and Follow-up After Hospitalization for Schizophrenia NQF#1937). The proposed measure is harmonized with the two existing NQF-endorsed measures. The following highlights the differences between the measures: -Population focus (denominator): The proposed measure targets patients discharged from the emergency department (not inpatient) and also focuses on patients with alcohol or other drug dependence disorders.-Numerator: The proposed measure

[captures follow-up with a primary mental health or alcohol or other drug dependence diagnosis \(regardless of the type of provider\).](#)

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

[Not applicable.](#)

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

[No appendix Attachment:](#)

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [National Committee for Quality Assurance](#)

Co.2 Point of Contact: [Bob, Rehm, \[nqf@ncqa.org\]\(mailto:nqf@ncqa.org\), 202-955-3500-](#)

Co.3 Measure Developer if different from Measure Steward: [National Committee for Quality Assurance](#)

Co.4 Point of Contact: [Jill Marie, Farrell, \[farrell@ncqa.org\]\(mailto:farrell@ncqa.org\), 202-955-1785-](#)

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

[Behavioral Health Quality Measurement Technical Expert Panel](#)

[Francisca Azocar, Ph.D., OptumHealth Behavioral Solutions](#)

[Bruce Bagley, M.D., TransforMED](#)

[Jonathan Delman, J.D., M.P.H., Ph.D., University of Massachusetts Medical School, Department of Psychiatry](#)

[Frank Ghinassi, Ph.D., Western Psychiatric Institute](#)

[Renata Henry, Danya Institute](#)

[Michael Hogan, Ph.D., Independent Advisor](#)

[Kevin Huckshorn, Ph.D., R.N., CADC, Division of Substance Abuse and Mental Health](#)

[Dan Rome, M.D., Rome Healthcare Consulting](#)

[Kathleen McCann, Ph.D., R.N., National Association of Psychiatric Health Systems](#)

[James Schuster M.D., M.B.A., Community Care Behavioral Health](#)

[David Kelley, M.D., M.P.A., Pennsylvania Department of Public Welfare](#)

[Neil Korsen, M.D., M.S., MaineHealth, Behavioral Health Integration Program](#)

[Judy Mohr Peterson, Ph.D, Oregon Health Authority](#)

[Larry Grab, Anthem Blue Cross and Blue Shield, Empire BlueCross BlueShield](#)

[Keris Myrick, Ph.D, M.B.A, M.S., Project Return Peer Support Network](#)

[Alisa Busch, M.D., M.S., McLean Hospital](#)

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: [2014](#)

Ad.3 Month and Year of most recent revision: [07, 2014](#)

Ad.4 What is your frequency for review/update of this measure? [Approximately every 3 years, sooner if the clinical guidelines](#)

change significantly.

Ad.5 When is the next scheduled review/update for this measure? 07, 2015

Ad.6 Copyright statement: © 2014 by the National Committee for Quality Assurance

1100 13th Street, NW, Suite 1000

Washington, DC 20005

Ad.7 Disclaimers: These performance measures are not clinical guidelines and do not establish a standard of medical care, and have not been tested for all potential applications.

THE MEASURES AND SPECIFICATIONS ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND.

Ad.8 Additional Information/Comments: NCQA Notice of Use. Broad public use and dissemination of these measures is encouraged and NCQA has agreed with NQF that noncommercial uses do not require the consent of the measure developer. Use by health care physicians in connection with their own practices is not commercial use. Commercial use of a measure requires the prior written consent of NCQA. As used herein, "commercial use" refers to any sale, license or distribution of a measure for commercial gain, or incorporation of a measure into any product or service that is sold, licensed or distributed for commercial gain, even if there is no actual charge for inclusion of the measure.

These performance measures are owned by NCQA. They are not clinical guidelines and do not establish a standard of medical care. NCQA makes no representations, warranties or endorsement about the quality of any organization or physician that uses or reports performance measures, and NCQA has no liability to anyone who relies on such measures. NCQA holds a copyright in these measures and can rescind or alter these measures at any time. Users of the measures shall not have the right to alter, enhance or otherwise modify the measures, and shall not disassemble, recompile or reverse engineer the source code or object code relating to the measures. Anyone desiring to use or reproduce the measures without modification for a noncommercial purpose may do so without obtaining approval from NCQA. All commercial uses must be approved by NCQA and are subject to a license at the discretion of NCQA. © 2014 by the National Committee for Quality Assurance