



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 #: 0576

Corresponding Measures:

De.2. Measure Title: Follow-Up After Hospitalization for Mental Illness

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

De.3. Brief Description of Measure: The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses and who had a follow-up visit with a mental health provider. Two rates are reported:

1. The percentage of discharges for which the member received follow-up within 30 days after discharge.
2. The percentage of discharges for which the member received follow-up within 7 days after discharge.

1b.1. Developer Rationale: This measure assesses whether health plan members who were hospitalized for a mental illness or intentional self-harm received a timely follow-up visit. Follow-up care following an acute event, such as hospitalization, reduces the risk of negative outcomes (e.g., medication errors, re-admission, emergency department use). Efforts to facilitate treatment following a hospital discharge also lead to less attrition in the initial post-acute period of treatment. Thus, this time period may be an important opportunity for health plans to implement strategies aimed at establishing strong relationships between patients and mental health providers and facilitate ongoing engagement in treatment.

According to an analysis of data from the National Inpatient Sample (NIS), between 2007 and 2014 there were over 1.5 million nonfatal suicide attempts requiring hospitalization, a rate of 67.1 per 100,000 persons (Connor et al., 2019). Another analysis of the NIS found that of 122,574 hospital discharges in 2003 with an injury diagnosis, 7.6% were for intentional self-harm (Patrick et al., 2010).

Fontanella et al. (2020) examined the association between timely outpatient follow-up after a psychiatric hospitalization and risk of death by suicide, and found that youths with a follow-up visit within 7 days of discharge had a significantly lower risk of death by suicide. A study of 90-day readmissions among individuals with schizophrenia and bipolar disorder found that individuals with an outpatient visit within 30-days following discharge experienced a lower risk of readmission within the following 90 days (Marcus et al., 2017). Similarly, Mark and colleagues (2013) found that increased follow-up at community mental health centers was associated with lower risk of re-admission among Medicaid patients hospitalized for mental illness or substance use disorder.

Evidence suggests that brief, low-intensity interventions are effective in bridging the gap between inpatient and outpatient treatment (Dixon 2009) and improving patient experience of continuity of care (Tomita & Herman, 2015). Low-intensity interventions are typically implemented at periods of high risk for treatment dropout, such as following an emergency room or hospital discharge or the time of entry into outpatient treatment. For example, Boyer et al evaluated strategies aimed at increasing attendance at outpatient appointments following hospital discharge. They found that the most common factor in a patient's medical history that was linked to a patient having a follow-up visit was a discussion about the discharge plan between the inpatient staff and outpatient clinicians. Other strategies they found that increased attendance at appointments included having the patient meet with outpatient staff and visit the outpatient program prior to discharge (Boyer 2000).

Barekattain M, Maracy MR, Rajabi F, Baratian H. (2014). Aftercare services for patients with severe mental disorder: A randomized controlled trial. J Res Med Sci. 19(3):240-5.

Boyer, C. A., McAlpine, D. D., Pottick, K. J., & Olsson, M. (2000). Identifying risk factors and key strategies in linkage to outpatient psychiatric care. The American journal of psychiatry, 157(10), 1592–1598. <https://doi.org/10.1176/appi.ajp.157.10.1592>

Conner, A., Azrael, D., & Miller, M. (2019). Suicide Case-Fatality Rates in the United States, 2007 to 2014: A Nationwide Population-Based Study. *Annals of internal medicine*, 171(12), 885–895. <https://doi.org/10.7326/M19-1324>

Dixon L, Goldberg R, Iannone V, et al. Use of a critical time intervention to promote continuity of care after psychiatric inpatient hospitalization for severe mental illness. *Psychiatr Serv*. 2009;60:451–458.

Fontanella, C. A., Warner, L. A., Steelesmith, D. L., Brock, G., Bridge, J. A., & Campo, J. V. (2020). Association of Timely Outpatient Mental Health Services for Youths After Psychiatric Hospitalization With Risk of Death by Suicide. *JAMA network open*, 3(8), e2012887.

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.

Luxton DD, June JD, Comtois KA. (2013). Can postdischarge follow-up contacts prevent suicide and suicidal behavior? A review of the evidence. *Crisis*. 34(1):32-41. doi: 10.1027/0227-5910/a000158.

Marcus, S. C., Chuang, C. C., Ng-Mak, D. S., & Olsson, M. (2017). Outpatient Follow-Up Care and Risk of Hospital Readmission in Schizophrenia and Bipolar Disorder. *Psychiatric services (Washington, D.C.)*, 68(12), 1239–1246.

Mark, T., Tomic, K. S., Kowlessar, N., Chu, B. C., Vandivort-Warren, R., & Smith, S. (2013). Hospital Readmission Among Medicaid Patients with an Index Hospitalization for Mental and/or Substance Use Disorder. *The Journal of Behavioral Health Services & Research*, 40(2), 207–221.

Patrick, A. R., Miller, M., Barber, C. W., Wang, P. S., Canning, C. F., & Schneeweiss, S. (2010). Identification of hospitalizations for intentional self-harm when E-codes are incompletely recorded. *Pharmacoepidemiology and drug safety*, 19(12), 1263–1275. <https://doi.org/10.1002/pds.2037>

Tomita, A., & Herman, D. B. (2015). The role of a critical time intervention on the experience of continuity of care among persons with severe mental illness after hospital discharge. *The Journal of nervous and mental disease*, 203(1), 65–70.

S.4. Numerator Statement: 30-Day Follow-Up: A follow-up visit with a mental health provider within 30 days after discharge.

7-Day Follow-Up: A follow-up visit with a mental health provider within 7 days after discharge.

S.6. Denominator Statement: Discharges from an acute inpatient setting with a principal diagnosis of mental illness or intentional self-harm on the discharge claim during the first 11 months of the measurement year (i.e. January 1 to December 1) for members 6 years and older.

S.8. Denominator Exclusions: Exclude from the denominator for both rates, members who begin using hospice services anytime during the measurement year (Hospice Value Set)

Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.

Exclude discharges followed by readmission or direct transfer to a nonacute facility within the 30-day follow-up period regardless of principal diagnosis.

Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was not for mental health or intentional self harm.

These discharges are excluded from the measure because rehospitalization 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

IF Endorsement Maintenance – Original Endorsement Date: Dec 04, 2009 **Most Recent Endorsement Date:** Jun 28, 2017

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? N/A

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

[0576_FUH_MEF_nqf_evidence_attachment_7.1.docx](#)

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

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

Yes

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 COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

This measure assesses whether health plan members who were hospitalized for a mental illness or intentional self-harm received a timely follow-up visit. Follow-up care following an acute event, such as hospitalization, reduces the risk of negative outcomes (e.g., medication errors, re-admission, emergency department use). Efforts to facilitate treatment following a hospital discharge also lead to less attrition in the initial post-acute period of treatment. Thus, this time period may be an important opportunity for health plans to implement strategies aimed at establishing strong relationships between patients and mental health providers and facilitate ongoing engagement in treatment.

According to an analysis of data from the National Inpatient Sample (NIS), between 2007 and 2014 there were over 1.5 million nonfatal suicide attempts requiring hospitalization, a rate of 67.1 per 100,000 persons (Connor et al., 2019). Another analysis of the NIS found that of 122,574 hospital discharges in 2003 with an injury diagnosis, 7.6% were for intentional self-harm (Patrick et al., 2010).

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Evidence suggests that brief, low-intensity interventions are effective in bridging the gap between inpatient and outpatient treatment (Dixon 2009) and improving patient experience of continuity of care (Tomita & Herman, 2015). Low-intensity interventions are typically implemented at periods of high risk for treatment dropout, such as following an emergency room or hospital discharge or the time of entry into outpatient treatment. For example, Boyer et al evaluated strategies aimed at increasing attendance at outpatient appointments following hospital discharge. They found that the most common factor in a patient's medical history that was linked to a patient having a follow-up visit was a discussion about the discharge plan between the inpatient staff

and outpatient clinicians. Other strategies they found that increased attendance at appointments included having the patient meet with outpatient staff and visit the outpatient program prior to discharge (Boyer 2000).

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Tomita, A., & Herman, D. B. (2015). The role of a critical time intervention on the experience of continuity of care among persons with severe mental illness after hospital discharge. The Journal of nervous and mental disease, 203(1), 65–70.

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 (4b1) under Usability and Use.*

The following data are extracted from HEDIS data collection reflecting the most recent years of measurement for this measure. Performance data are summarized at the health plan level and summarized by mean, standard deviation, minimum health plan performance, maximum health plan performance and performance at the 10th, 25th, 50th, 75th and 90th percentile. Data are stratified by year and product line (i.e. commercial, Medicaid, and Medicare). The following data demonstrate room for improvement among health plans.

HEDIS MY 2018 Variation in Performance across Health Plans- Commercial

Year	Rate	N	Mean	StDev	Min	P10	P25	Median	P75	P90	Max
2018	7-day rate		361	0.44							

.11	0	0.3	0.37	0.44	0.51	0.59	0.79
	30-day rate		358	0.66			

.11	0	0.52	0.6	0.67	0.73	0.78	0.92
2017	7-day rate		356	.46			

.11	.18	.31	.38	.46	.54	.62	.78
	30-day rate		355				

.68

.10	.38	.54	.62	.69	.75	.80	.91
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HEDIS MY 2018 Variation in Performance across Health Plans- Medicare

Year	Rate	N	Mean	St			
Dev	Min	P10	P25	Median	P75	P90	Max
2018	7-day rate		308	0.28			

.13	0	0.13	0.18	0.25	0.34	0.46	0.68
	30-day rate		308	0.48			

.15	0.07	0.3	0.37	0.47	0.6	0.7	0.84
2017	7-day rate		304	.32			

.13	.02	.18	.23	.29	.40	.50	.80
	30-day rate		304	.53			

.15	.05	.35	.42	.52	.65	.74	.93
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HEDIS MY 2018 Variation in Performance across Health Plans- Medicaid

Year	Rate	N	Mean	St Dev	Min	P10	P25	Median	P75	P90	Max
2018	7-day rate		173	0.36							

.12	0.05	0.21	0.29	0.35	0.43	0.52	0.7
	30-day rate		172	0.57			

.13	0.12	0.38	0.5	0.58	0.66	0.72	0.83
2017	7-day rate		183	.37			

.13	.00	.19	.30	.37	.46	.54	.74
	30-day rate		183	.58			

.14	.05	.40	.50	.60	.68	.74	.90
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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.

N/A

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 (4b1) under Usability and Use.

HEDIS data are stratified by type of insurance (e.g., Commercial, Medicaid, Medicare). While not specified in the measure, this measure can also be stratified by demographic variables, such as race/ethnicity or socioeconomic status, in order to assess the presence of health care disparities, if the data are available to a plan. NCQA is actively engaged with partners including the CMS Office of Minority Health in identifying feasible methods to further integrate social risk factors into health plan quality measures,

with a focus on stratification. Our work is aligned with recent recommendations from MedPAC and ASPE on optimal methods for addressing social risk in quality measurement and programs.^{1,2} This is an NCQA wide initiative. Our intent is to implement methods to bridge data concerns in the future.

HEDIS includes two measures that can be used as tools for assessing race/ethnicity and language needs of a plan's population: Race/Ethnicity Diversity of Membership and the Language Diversity of Membership. These measures promote standardized methods for collecting these data and follow Office of Management and Budget and National Academy of Medicine guidance for collecting and categorizing race/ethnicity and language data. In addition, NCQA's Multicultural Health Care Distinction Program outlines standards for collecting, storing, and using race/ethnicity and language data to assess health care disparities.

1. Medicare Payment Advisory Commission. (2020). The Medicare Advantage program: Status report. In Report to the Congress: Medicare Payment Policy (p. 397). http://medpac.gov/docs/default-source/reports/mar20_medpac_ch13_sec.pdf
2. Office of the Assistant Secretary for Planning and Evaluation, & U.S. Department of Health & Human Services. (2020). Second Report to Congress on Social Risk and Medicare's Value-Based Purchasing Programs. <https://aspe.hhs.gov/social-risk-factors-and-medicare-value-based-purchasing-programs>

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

N/A

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

De.6. Non-Condition Specific(check all the areas that apply):

Care Coordination, Safety

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

Children, Elderly, 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.)

NA

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: 0576_FUH_Fall_2020_Value_Sets.xlsx

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales,

etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure **Attachment:**

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

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.

Yes

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.

Summary of most significant changes since previous submission:

- Since the last submission, several important changes were made to the measure:

- Added telehealth to the measure numerators

- The numerator was revised to no longer include visits that occur on the date of discharge. This change was made because an encounter on the date of discharge after hospitalization should be viewed as an intervention designed to support the patient and improve his or her likelihood of receiving timely follow-up care. Visits on the date of discharge should not be the only follow-up that patients receive and would not be considered good quality of care on their own; therefore, they do not meet the intent of the measure.

- The denominator was revised to include members with a principal diagnosis of intentional self-harm. This change was made to ensure that patients who are hospitalized for intentional self-harm are included in the measure because they warrant follow-up care, even if an accompanying mental health diagnosis is not present on the discharge claim.

- Expanded the definition of mental health provider to include Community Mental Health Centers (CMHC) and Certified Community Behavioral Health Clinics (CCBHC).

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).

30-Day Follow-Up: A follow-up visit with a mental health provider within 30 days after discharge.

7-Day Follow-Up: A follow-up visit with a mental health provider within 7 days after 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).

For both indicators, any of the following meet criteria for a follow-up visit.

- An outpatient visit (Visit Setting Unspecified Value Set) with (Outpatient POS Value Set) with a mental health provider.

- An outpatient visit (BH Outpatient Value Set) with a mental health provider.

- An intensive outpatient encounter or partial hospitalization (Visit Setting Unspecified Value Set) with (Partial Hospitalization POS Value Set).

- An intensive outpatient encounter or partial hospitalization (Partial Hospitalization or Intensive Outpatient Value Set).

- A community mental health center visit (Visit Setting Unspecified Value Set; BH Outpatient Value Set; Observation Value Set; Transitional Care Management Services Value Set) with (Community Mental Health Center POS Value Set).

- Electroconvulsive therapy (Electroconvulsive Therapy Value Set) with (Ambulatory Surgical Center POS Value Set; Community Mental Health Center POS Value Set; Outpatient POS Value Set; Partial Hospitalization POS Value Set).

- A telehealth visit: (Visit Setting Unspecified Value Set) with (Telehealth POS Value Set) with a mental health provider.

- An observation visit (Observation Value Set) with a mental health provider.

- Transitional care management services (Transitional Care Management Services Value Set), with a mental health provider.

- A visit in a behavioral healthcare setting (Behavioral Healthcare Setting Value Set).
 - A telephone visit (Telephone Visits Value Set) with a mental health provider.
- (See corresponding Excel document for the value sets referenced above).

Mental Health Provider Definition:

A provider who delivers mental health services and meets any of the following criteria:

- An MD or doctor of osteopathy (DO) who is certified as a psychiatrist or child psychiatrist by the American Medical Specialties Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry; or, if not certified, who successfully completed an accredited program of graduate medical or osteopathic education in psychiatry or child psychiatry and is licensed to practice patient care psychiatry or child psychiatry, if required by the state of practice.
- An individual who is licensed as a psychologist in his/her state of practice, if required by the state of practice.
- An individual who is certified in clinical social work by the American Board of Examiners; who is listed on the National Association of Social Worker's Clinical Register; or who has a master's degree in social work and is licensed or certified to practice as a social worker, if required by the state of practice.
- A registered nurse (RN) who is certified by the American Nurses Credentialing Center (a subsidiary of the American Nurses Association) as a psychiatric nurse or mental health clinical nurse specialist, or who has a master's degree in nursing with a specialization in psychiatric/mental health and two years of supervised clinical experience and is licensed to practice as a psychiatric or mental health nurse, if required by the state of practice.
- An individual (normally with a master's or a doctoral degree in marital and family therapy and at least two years of supervised clinical experience) who is practicing as a marital and family therapist and is licensed or a certified counselor by the state of practice, or if licensure or certification is not required by the state of practice, who is eligible for clinical membership in the American Association for Marriage and Family Therapy.
- An individual (normally with a master's or doctoral degree in counseling and at least two years of supervised clinical experience) who is practicing as a professional counselor and who is licensed or certified to do so by the state of practice, or if licensure or certification is not required by the state of practice, is a National Certified Counselor with a Specialty Certification in Clinical Mental Health Counseling from the National Board for Certified Counselors (NBCC).
- A physician assistant who is certified by the National Commission on Certification of Physician Assistants to practice psychiatry.
- A certified Community Mental Health Center (CMHC), or the comparable term (e.g. behavioral health organization, mental health agency, behavioral health agency) used within the state in which it is located, or a Certified Community Behavioral Health Clinic (CCBHC).
- Only authorized CMHCs are considered mental health providers. To be authorized as a CMHC, an entity must meet one of the following criteria:
 - The entity has been certified by CMS to meet the conditions of participation (CoPs) that community mental health centers (CMHCs) must meet in order to participate in the Medicare program, as defined in the Code of Federal Regulations Title 42. CMS defines a CMHC as an entity that meets applicable licensing or certification requirements for CMHCs in the State in which it is located and provides the set of services specified in section 1913(c)(1) of the Public Health Service Act (PHS Act).
 - The entity has been licensed, operated, authorized, or otherwise recognized as a CMHC by a state or county in which it is located.
- Only authorized CCBHCs are considered mental health providers. To be authorized as a CCBHC, an entity must meet one of the following criteria:
 - o Has been certified by a State Medicaid agency as meeting criteria established by the Secretary for participation in the Medicaid CCBHC demonstration program pursuant to Protecting Access to Medicare Act § 223(a) (42 U.S.C. § 1396a note); or as meeting criteria within the State's Medicaid Plan to be considered a CCBHC.
 - o Has been recognized by the Substance Abuse and Mental Health Services Administration, through the award of grant funds or otherwise, as a CCBHC that meets the certification criteria of a CCBHC.

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

Discharges from an acute inpatient setting with a principal diagnosis of mental illness or intentional self-harm on the discharge claim during the first 11 months of the measurement year (i.e. January 1 to December 1) for members 6 years and older.

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).

An acute inpatient discharge with a principal diagnosis of mental illness or intentional self-harm (Mental Illness Value Set; Intentional Self-Harm Value Set) on the discharge claim on or between January 1 and December 1 of the measurement year. To identify acute inpatient discharges:

1. Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
2. Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
3. Identify the discharge date for the stay.

The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges on or between January 1 and December 1 of the measurement year.

Acute readmission or direct transfer

Identify readmissions and direct transfers to an acute inpatient care setting during the 30-day follow-up period:

- Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
- Exclude nonacute inpatient stays (Nonacute Inpatient Stay Value Set).
- Identify the admission date for the stay.

Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge.

If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim) exclude both the original and the readmission/direct transfer discharge.

See corresponding Excel document for the Value Sets referenced above in S.2b.

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

Exclude from the denominator for both rates, members who begin using hospice services anytime during the measurement year (Hospice Value Set)

Exclude both the initial discharge and the readmission/direct transfer discharge if the readmission/direct transfer discharge occurs after December 1 of the measurement year.

Exclude discharges followed by readmission or direct transfer to a nonacute facility within the 30-day follow-up period regardless of principal diagnosis.

Exclude discharges followed by readmission or direct transfer to an acute facility within the 30-day follow-up period if the principal diagnosis was not for mental health or intentional self harm.

These discharges are excluded from the measure because rehospitalization 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.)*

Members in hospice are excluded from the eligible population.

Exclude both the initial discharge and the readmission/direct transfer discharge if the last discharge occurs after December 1 of the measurement year.

If the readmission/direct transfer to the acute inpatient care setting was for a principal diagnosis (use only the principal diagnosis on the discharge claim) of mental health disorder or intentional self-harm (Mental Health Diagnosis Value Set; Intentional Self-Harm Value Set), count only the last discharge.

If the readmission/direct transfer to the acute inpatient care setting was for any other principal diagnosis (use only the principal diagnosis on the discharge claim) exclude both the original and the readmission/direct transfer discharge

Exclude discharges followed by readmission or direct transfer to a nonacute inpatient care setting within the 30-day follow-up period, regardless of principal diagnosis for the readmission. To identify readmissions and direct transfers to a nonacute inpatient care setting:

- Identify all acute and nonacute inpatient stays (Inpatient Stay Value Set).
- Confirm the stay was for nonacute care based on the presence of a nonacute code (Nonacute Inpatient Stay Value Set) on the claim.
- Identify the admission date for the stay.

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

See corresponding Excel document for the Value Sets referenced above in S.2b.

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.)

N/A

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.)

Step 1. Determine the denominator. The denominator is all discharges that meet the specified denominator criteria (S7).

Step 2. Remove exclusions. Remove all discharges from the denominator that meet the specified exclusion criteria (S9).

Step 3. Identify numerator events: Search administrative systems to identify numerator events for all discharges in the denominator (S5).

Step 4. Calculate the rate by dividing the events in step 3 by the discharges in step 2.

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

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

N/A

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.)

Specify calculation of response rates to be reported with performance measure results.

N/A

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 are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

This measure is based on administrative claims collected in the course of providing care to health plan members. NCQA collects the Healthcare Effectiveness Data and Information Set (HEDIS) data for this measure directly from Health Management Organizations and Preferred Provider Organizations via NCQA's online data submission system.

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

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.)

N/A

2. Validity – See attached Measure Testing Submission Form
[nqf_testing_attachment_7.1_2020-637395029781340613.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. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

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. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1, 2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

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.

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 a combination of electronic sources

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).

N/A

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 instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

NCQA conducts an independent audit of all HEDIS collection and reporting processes, as well as an audit of the data which are manipulated by those processes, in order to verify that HEDIS specifications are met. NCQA has developed a precise, standardized methodology for verifying the integrity of HEDIS collection and calculation processes through a two-part program consisting of an overall information systems capabilities assessment followed by an evaluation of the organization's ability to comply with HEDIS specifications. NCQA-certified auditors using standard audit methodologies will help enable purchasers to make more reliable "apples-to-apples" comparisons between health plans.

The HEDIS Compliance Audit addresses the following functions:

- 1) information practices and control procedures
- 2) sampling methods and procedures
- 3) data integrity
- 4) compliance with HEDIS specifications
- 5) analytic file production
- 6) reporting and documentation

In addition to the HEDIS Audit, NCQA provides a system to allow "real-time" feedback from measure users. Our Policy Clarification Support System receives thousands of inquiries each year on over 100 measures. Through this system NCQA responds to questions in order to prevent possible errors or inconsistencies in the implementation of the measure. Input from NCQA auditing and the Policy Clarification Support System informs the annual updating of all HEDIS measures including updating value sets and clarifying the specifications. Measures are re-evaluated on a periodic basis and when there is a significant change in evidence. During re-evaluation information from NCQA auditing and Policy Clarification Support System is used to inform evaluation of the usability and feasibility of the 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)

4a1.1 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

HEALTH PLAN RATINGS/REPORT CARDS: This measure is used to calculate health plan ratings which are reported on the NCQA website. These ratings are based on performance on HEDIS measures among other factors. In 2019, a total of 255 Medicare health plans, 515 commercial health plans and 188 Medicaid health plans across 50 states were included in the ratings.

STATE OF HEALTH CARE ANNUAL REPORT: This measure is publicly reported nationally and by geographic regions in the NCQA State of Health Care annual report. This annual report published by NCQA summarizes findings on quality of care. In 2019, the report included results from calendar year 2018 for health plans covering a record 136 million people, or 43 percent of the U.S. population.

MEDICAID CHILD CORE SET: This measure is included in the Medicaid Child Core Set which is a set of children's health care quality measures developed as part of the Children's Health Insurance Program (CHIP) Reauthorization Act for voluntary use by State Medicaid and CHIP programs. The data collected with these measures will help CMS to better understand the quality of health care children receive through Medicaid and CHIP and assist CMS and states in moving toward a national system for quality measurement, reporting, and improvement. As per the CHIPRA legislation, state data derived from the core measures will become part of the Secretary's annual report on the quality of care for children in Medicaid and CHIP. The Secretary's annual report summarizes state-specific and national measurement information on the quality of health care furnished to children enrolled in Medicaid and CHIP.

MEDICAID ADULT CORE SET: There are a core set of health quality measures for Medicaid-enrolled adults. The Medicaid Adult Core Set was identified by the Centers of Medicare & Medicaid (CMS) in partnership with the Agency for Healthcare Research and Quality (AHRQ). The data collected from these measures will help CMS to better understand the quality of health care that adults enrolled in Medicaid receive nationally. Beginning in January 2014 and every three years thereafter, the Secretary is required to report to Congress on the quality of care received by adults enrolled in Medicaid. Additionally, as of 2014, state data on the adult quality measures is part of the Secretary's annual report on the quality of care for adults enrolled in Medicaid.

HEALTH PLAN ACCREDITATION: This measure is used in scoring for accreditation of Medicare Advantage Health Plans. In 2019, 336 commercial health plans covering 87 million lives and 77 Medicaid health plans covering 9.1 million lives were accredited. Health plans are scored based on performance compared to benchmarks

QUALITY COMPASS: This measure is used in Quality Compass which is an indispensable tool used for selecting a health plan,

conducting competitor analysis, examining quality improvement and benchmarking plan performance. Provided in this tool is the ability to generate custom reports by selecting plans, measures, and benchmarks (averages and percentiles) for up to three trended years. Results in table and graph formats offer simple comparison of plans' performance against competitors or benchmarks.

HOSPITAL COMPARE: This measure is used in Hospital Compare which helps improve quality of care by sharing objective, easy to understand data on hospital performance as well as consumer perspectives.

INPATIENT PSYCHIATRIC FACILITY QUALITY REPORTING: This measure is used in the Inpatient Psychiatric Facility Quality Reporting program which provides consumers with quality of care information to make informed decisions about their healthcare options. This program is intended to encourage clinicians and psychiatric facilities to the quality of inpatient care via awareness and reporting of best practices for respective facilities and types of care.

QUALIFIED HEALTH PLAN (QHP) QUALITY RATING SYSTEM (QRS): This measure is used in the Qualified Health Plan (QHP) Quality Rating System (QRS) which provides comparable information to consumers about the quality of health care services and QHP enrollee experience offered in the Marketplaces.

QUALITY PAYMENT PROGRAM:

The Quality Payment Program (QPP) is a quality and cost incentive program that uses payment adjustments to promote high quality and high value care delivery by eligible clinicians (EC). QPP provides performance-based payment adjustments to ECs, both negative and positive, for services furnished to Medicare Part B beneficiaries. EC performance is graded on quality measure performance, cost of care, engagement in clinical practice improvement activities, and use of Certified EHR Technology (CEHRT). Performance can be reported at the individual (clinician) or group (practice) level. In 2017, 1,006,319 ECs participated in MIPS, representing 95% of all eligible clinicians across the 50 states. 54% participated as a part of a group, 12% as individual clinicians, and 34% as a part of an Advanced Payment Model.

4a1.2. 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?)

N/A

4a1.3. 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.)

N/A

4a2.1.1. 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.

Health plans that report HEDIS calculate their rates and know their performance when submitting to NCQA. NCQA publicly reports rates across all plans and also creates benchmarks in order to help plans understand how they perform relative to other plans. Public reporting and benchmarking are effective quality improvement methods.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

NCQA publishes HEDIS results annually in our Quality Compass tool. NCQA also presents data at various conferences and webinars. For example, at the annual HEDIS Update and Best Practices Conference, NCQA presents results from all new measures' first year of implementation or analyses from measures that have changed significantly. NCQA also regularly provides technical assistance on measures through its Policy Clarification Support System, as described in Section 3c1.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

NCQA measures are evaluated regularly. During this “reevaluation” process, we seek broad input on the measure, including input on performance and implementation experience. We use several methods to obtain input, including vetting of the measure with several multi-stakeholder advisory panels, public comment posting, and review of questions submitted to the Policy Clarification Support System. This information enables NCQA to comprehensively assess a measure’s adherence to the HEDIS Desirable Attributes of Relevance, Scientific Soundness and Feasibility.

4a2.2.2. Summarize the feedback obtained from those being measured.

In general, health plans have considered this measure feasible for reporting using the administrative data collection method. Questions received were about clarification of the specifications, such as confirmation that a type of provider met the definition of mental health providers and research supporting the measure. NCQA responded to all questions to ensure consistent implementation of the measure.

4a2.2.3. Summarize the feedback obtained from other users

This measure has been deemed a priority measure by NCQA and other entities, as illustrated by its use in programs such as the Medicaid Child and Adult Core Sets, CMS EHR Incentive Program and CMS Physician Quality Reporting Initiative.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

During the measure’s last major update, feedback obtained through the mechanisms described in 4a2.2.1 informed how we revised the measure specification to include clarifying text and additional examples to further support determining numerator compliance.

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.

4b1. 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.

2017 to 2018 data shows relatively stable performance and room for improvement across Commercial and Medicaid plans. The mean performance for the 7-day rate was .46 in 2017 and .44 in 2018 among Commercial plans. Among Medicaid Plans, the mean performance for the 7-day rate was .37 in 2017 and .36 in 2018. Performance rates for the 30-day rate also remained relatively stable from 2017 to 2018 for commercial and Medicaid plans. Medicare performance rates declined slightly across both rates; in 2017, the mean 7-day performance rate was .32, declining to .28 in 2018. The 30-day mean performance rate declined from .53 in 2017 to .48 in 2018. Across all product lines, there continues to be fairly large variation between the 10th and 90th percentiles, suggesting room for improvement. For example, among Medicare plans, the 2018 7-day rate ranged from 13% for plans in the 10th percentile to 46% among plans in the 90th percentile.

4b2. 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).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

There were no identified unintended consequences for this measure during testing or since implementation.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

There were no identified unexpected benefits for this measure during testing or since implementation.

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. No
5.1a. List of related or competing measures (selected from NQF-endorsed measures) 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? No 5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden. N/A
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.) N/A

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 , 202-955-1728- Co.3 Measure Developer if different from Measure Steward: National Committee for Quality Assurance Co.4 Point of Contact: Brittany, Wade, wade@ncqa.org , 202-530-0463-
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.

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Marissa Finn, MBA, CIGNA
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Lynne Rothney-Kozlak, MPH, Rothney-Kozlak Consulting, LLC
Laurie Spoll, Aetna

Geriatric Measurement Advisory Panel (GMAP):

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Patricia A. Bomba, MD, MACP, FRCP, Excellus BlueCross BlueShield
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Chesley Richards, MD, MPH, FACP Centers for Disease Control and Prevention
Anecia Suneja, CNS-BC Veteran's Health Administration

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 1994

Ad.3 Month and Year of most recent revision: 07, 2020

Ad.4 What is your frequency for review/update of this measure? Approximately every 3-5 years, sooner if the clinical guidelines have changed significantly.

Ad.5 When is the next scheduled review/update for this measure? 12, 2021

Ad.6 Copyright statement: © 2020 by the National Committee for Quality Assurance

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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.

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