



## 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 #: 1937**

**Corresponding Measures:**

**De.2. Measure Title:** Follow-Up After Hospitalization for Schizophrenia (7- and 30-day)

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

**De.3. Brief Description of Measure:** The percentage of discharges for individuals 18 – 64 years of age who were hospitalized for treatment of schizophrenia and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner. Two rates are reported.

- The percentage of individuals who received follow-up within 30 days of discharge
- The percentage of individuals who received follow-up within 7 days of discharge

**1b.1. Developer Rationale:** Evidence suggests that only 42 percent of initial appointments following psychiatric hospitalization are kept. As missed appointments increase the likelihood of re-hospitalization and increase costs of outpatient care, this measure will allow state Medicaid programs to capture follow-up rates at 7- and 30-days to ensure continuity of proper care.

**S.4. Numerator Statement:** 30-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization (Table–C) with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

7-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization (Table–C) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

**S.6. Denominator Statement:** Adults 18 – 64 years of age of December 31 of the measurement year

Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal schizophrenia diagnosis.

**S.8. Denominator Exclusions:** Schizophrenia readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a schizophrenia diagnosis within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. 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 for a schizophrenia diagnosis within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place.

Non-mental health readmission or direct transfer: Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis. 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, Population : Regional and State

**IF Endorsement Maintenance – Original Endorsement Date:** Nov 02, 2012 **Most Recent Endorsement Date:** Nov 02, 2012

**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

#### 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.

### 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.

Evidence suggests that only 42 percent of initial appointments following psychiatric hospitalization are kept. As missed appointments increase the likelihood of re-hospitalization and increase costs of outpatient care, this measure will allow state Medicaid programs to capture follow-up rates at 7- and 30-days to ensure continuity of proper care.

**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.

Among 22 states, the 7-day follow-up rate had a minimum value of 8.3%, mean=36.0%, 25th percentile=27.8%, median=34.6%, 75th percentile=42.3% and a maximum value of 66.1%. The 30-day follow-up rate had a minimum value of 25.6%, mean=69.7%, 25th percentile=61.4%, median=72.1%, 75th percentile=78.7% and a maximum value of 88.5%.

**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.**

Using Medicaid Analytic Extract (MAX) claims data from 2007 we included beneficiaries from 22 states who met the following criteria (1) enrolled in fee-for-service plans\* (2) disability as the basis of eligibility; and (3) continuously enrolled in Medicaid for 10 months. From these beneficiaries we drew two analytic samples. Beneficiaries who had a primary diagnosis of schizophrenia on either one inpatient or two outpatient claims on different days were included in our schizophrenia sample. Overall, there were 98,412 beneficiaries in the schizophrenia sample.

Data from the following states were included in both analytic samples: Alabama, Alaska, California, Connecticut, DC, Georgia, Idaho, Illinois, Indiana, Iowa, Louisiana, Maryland, Missouri, Mississippi, Nevada, New Hampshire, North Carolina, North Dakota, Oklahoma, South Dakota, West Virginia and Wyoming.

Beneficiaries ranged in age from 25 – 64 years. Just under half of the schizophrenia population was female (49.2%). About 7% and 34% of the sample was Hispanic and African-American, respectively.

(\*Beneficiaries enrolled in managed care plans (e.g. BHO or HMO plans) that provided usable claims records were included. About 1% of the schizophrenia sample was enrolled in a BHO (1.4%) and 11.5% were enrolled in an HMO).

**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.*

Performance rates varied by gender. For 30-day follow-up after hospitalization, performance generally increased with age. Rates were lowest for Hispanics in both categories of follow-up.

#### 30-day follow-up after hospitalization

##### Gender

Male: 50.2%

Female: 58.2%

##### Age

25 – 30: 51.8%

31 – 40: 51.8%

41 – 50: 54.2%

51 – 60: 58.1%

61 -64: 60.5%

Unknown: 0.0%

##### Race/ethnicity

African American: 52.6%

Caucasian: 60.8%

Hispanic: 41.4%

Other: 41.9%

Unknown: 45.3%

#### 7-day follow-up after hospitalization

##### Gender

Male: 24.9%

Female: 29.0%

##### Age

25 – 30: 26.5%

31 – 40: 25.6%

41 – 50: 26.8%

51 – 60: 28.5%

61 -64: 30.3%

Unknown: 0.0%

##### Race/ethnicity

African American: 26.0%

Caucasian: 31.4%

Hispanic: 16.9%

Other: 18.7%

Unknown: 21.3%

**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**

Using Medicaid Analytic Extract (MAX) claims data from 2007 we included beneficiaries from 22 states who met the following criteria (1) enrolled in fee-for-service plans\* (2) disability as the basis of eligibility; and (3) continuously enrolled in Medicaid for 10

months. From these beneficiaries we drew two analytic samples. Beneficiaries who had a primary diagnosis of schizophrenia on either one inpatient or two outpatient claims on different days were included in our schizophrenia sample. Overall, there were 98,412 beneficiaries in the schizophrenia sample.

Data from the following states were included in both analytic samples: Alabama, Alaska, California, Connecticut, DC, Georgia, Idaho, Illinois, Indiana, Iowa, Louisiana, Maryland, Missouri, Mississippi, Nevada, New Hampshire, North Carolina, North Dakota, Oklahoma, South Dakota, West Virginia and Wyoming.

Beneficiaries ranged in age from 25 – 64 years. Just under half of the schizophrenia population was female (49.2%). About 7% and 34% of the sample was Hispanic and African-American, respectively.

(\*Beneficiaries enrolled in managed care plans (e.g. BHO or HMO plans) that provided usable claims records were included. About 1% of the schizophrenia sample was enrolled in a BHO (1.4%) and 11.5% were enrolled in an HMO).

## 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):

Primary Prevention

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

Elderly

**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.)

N/A

**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)

No data dictionary Attachment:

**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.

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.

**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.

No

**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.

**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: An outpatient visit, intensive outpatient encounter or partial hospitalization (Table–C) with a mental health practitioner within 30 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.

7-Day Follow-Up: An outpatient visit, intensive outpatient encounter or partial hospitalization (Table–C) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of 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).

Follow-up visits identified by the following CPT or HCPCS codes must be with a mental health practitioner:

CPT: 90804-90815, 98960-98962, 99078, 99201-99205, 99211-99215, 99217-99220, 99241-99245, 99341-99345, 99347-99350, 99383-99387, 99393-99397, 99401-99404, 99411, 99412, 99510

HCPCS: G0155, G0176, G0177, G0409-G0411, H0002, H0004, H0031, H0034-H0037, H0039, H0040, H2000, H2001, H2010-H2020, M0064, S0201, S9480, S9484, S9485

Follow-up visits identified by the following CPT/POS codes must be with a mental health practitioner:

CPT: 90801, 90802, 90816-90819, 90821-90824, 90826-90829, 90845, 90847, 90849, 90853, 90857, 90862, 90870, 90875, 90876  
WITH

POS: 03, 05, 07, 09, 11, 12, 13, 14, 15, 20, 22, 33, 49, 50, 52, 53, 71, 72

CPT: 99221-99223, 99231-99233, 99238, 99239, 99251-99255

WITH

POS: 52, 53

The organization does not need to determine practitioner type for follow-up visits identified by the following UB revenue codes:

UB Revenue: 0513, 0900-0905, 0907, 0911-0917, 0919

Visits identified by the following revenue codes must be with a mental health practitioner or in conjunction with a diagnosis code: 0510, 0515-0517, 0519-0523, 0526-0529, 0982, 0983.

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

Adults 18 – 64 years of age of December 31 of the measurement year

Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal schizophrenia diagnosis.

**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).

- Medicaid beneficiaries age 18 to 64 years of age as of December 31 of the measurement year
- Two separate claims with schizophrenia as a primary diagnosis or one inpatient claim with schizophrenia as a primary diagnosis and a prescription for any antipsychotic medication in the measurement year
- 10 months continuous enrollment during the measurement year
- Discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal schizophrenia diagnosis on or between January 1 and December 1 of the measurement year.
- The denominator for this measure is based on discharges. Include all discharges for individuals who have more than one discharge on or between January 1 and December 1 of the measurement year.

Codes to Identify Schizophrenia Diagnosis:

ICD-9-CM Diagnosis: 295

ICD-10-CM Diagnosis: F20, F25.9

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

Schizophrenia readmission or direct transfer: If the discharge is followed by readmission or direct transfer to an acute facility for a schizophrenia diagnosis within the 30-day follow-up period, count only the readmission discharge or the discharge from the facility to which the member was transferred. 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 for a schizophrenia diagnosis within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place.

Non-mental health readmission or direct transfer: Exclude discharges in which the patient was transferred directly or readmitted within 30 days after discharge to an acute or nonacute facility for a non-mental health principal diagnosis. 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.)*

Exclude discharges followed by readmission or direct transfer to a nonacute facility for a schizophrenia principal diagnosis within the 30-day follow-up period. These discharges are excluded from the measure because readmission or transfer may prevent an outpatient follow-up visit from taking place.

Codes to identify Nonacute Care:

Hospice:

UB Revenue: 0115, 0125, 0135, 0145, 0155, 0650, 0656, 0658, 0659

UB Type of Bill: 81x, 82x

POS: 34

SNF:

UB Revenue: 019x ; UB Type of Bill: 21x, 22x, 28x ; POS: 31, 32

Hospital transitional care, swing bed or rehabilitation:

UB Type of Bill: 18x

Rehabilitation:

UB Revenue: 0118, 0128, 0138, 0148, 0158

Respite:

UB Revenue: 0655

Intermediate care facility:

POS: 54

Residential substance abuse treatment facility:

UB Revenue: 1002

POS: 55

Psychiatric residential treatment center;

HCPCS: T2048, H0017-H0019

UB Revenue: 1001

POS: 56

Comprehensive inpatient rehabilitation facility:

POS: 61

**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.)

1. Determine the eligible population. The eligible population is all individuals who satisfy all specified criteria, including any age, continuous enrollment, benefit, event, or anchor date enrollment requirement.

2. Search administrative systems to identify numerator events for all individuals in the eligible population.

3. Calculate the rate.

**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.

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.)

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

**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.

Not applicable.

**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)

**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)  
Other:Any outpatient setting represented with Medicaid claims data  
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.)

## 2. Validity – See attached Measure Testing Submission Form

### 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.*

### 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.*

### 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.*

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

The proposed measure is claims-based. We identified 22 states in the Medicaid Analytic Extract (MAX) data files with valid and reliable claims data, and we were able to calculate the measure for all states. We observed substantial variability in performance between states, but we believe in nearly all cases that those are related to performance differences rather than data availability differences. Based upon our focus group testing with representatives from the Medicaid Medical Directors Learning Network, state mental health program directors, and MBHOs, we have confidence that states are able to capture these performance data in claims/encounter systems and are capable of programming, reporting, and using the metric.

**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*).

**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

**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?)

**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.)

**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.**

N/A

**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.**

N/A

**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.**

N/A

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

N/A

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

N/A

**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.**

N/A

**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.

**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.**

Validity and reliability testing of the measures has been performed. To our knowledge, there are no known inaccuracies, errors, or unintended consequences of measurement identified during testing, however, there may be potential for underreporting of services that are not billed by Medicaid.

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

**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)

**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.**

The lower age cutoff for this measure was set at 18 years as diagnostic clarity is more favorable in older patients with schizophrenia. The NQF-endorsed measure is specified for health plans, while this new measure is specified for state populations. The NQF-endorsed measure may have a higher data collection burden as the measure is specified to use claims or electronic medical records, while this new measure strictly uses claims data.

**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.

**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), 202-955-1728-

**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.**

[Technical Advisory Group Roster](#)

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The Technical Advisory Group advised Mathematica Policy Research, Inc. and the National Committee for Quality Assurance during measure development. The TAG was responsible for providing feedback on measure concepts, specifications, results from field and data testing. The TAG consisted of a multistakeholder group of experts with knowledge in behavioral health and quality measurement.

### Measure Developer/Steward Updates and Ongoing Maintenance

**Ad.2 Year the measure was first released:**

**Ad.3 Month and Year of most recent revision:**

**Ad.4 What is your frequency for review/update of this measure?**

**Ad.5 When is the next scheduled review/update for this measure?**

**Ad.6 Copyright statement:** © 2012 by the National Committee for Quality Assurance  
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**Ad.7 Disclaimers:**

**Ad.8 Additional Information/Comments:**